OHIO CONFERENCE OF PLASTERERS AND CEMENT MASONS HEALTH AND WELFARE PLAN AND SUMMARY PLAN DESCRIPTION

IMPORTANT NOTICE: This booklet is the Plan in effect as of February 1, 2014. From time to time, you will receive supplemental bulletins and summaries about changes to this Plan.

TABLE OF CONTENTS

OHIO CONFERENCE OF PLASTERERS & CEMENT MASONS HEALTH & WELFARE FUND

INFORMATION ABOUT THE PLAN

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BOARD OF TRUSTEES
OHIO CONFERENCE OF PLASTERERS & CEMENT MASONS
HEALTH & WELFARE FUND

ADMINISTRATIVE MANAGER / THIRD PARTY ADMINISTRATOR

Compensation Programs of Ohio, Inc.
33 Fitch Blvd.
Austintown, Ohio 44515
(800) 435-2388

FUND COUNSEL

Ronald G. Macala, Esq.
Timothy R. Piatt, Esq.
Macala & Piatt, LLC
601 South Main Street
North Canton, Ohio 44720

PLAN YEAR

May 1 – April 30

To all Participants and Beneficiaries:

This Summary Plan Description ("SPD") has been prepared to provide you with details of the coverage through the Ohio Conference of Plasterers & Cement Masons Health & Welfare Fund, how you qualify for benefits, and under what circumstances you may not be eligible. This SPD also tells you how to file a claim for benefits and what action you can take if you are denied benefits.

This SPD is a summary. This booklet summarizes the most important features of the Health & Welfare Fund. No general explanation can adequately give you all of the details of your Plan.

Only the Board of Trustees of the Fund has the authority to answer questions about eligibility and benefits provided through the Fund or to interpret the Rules and Regulations. No Union or management representative, individual Trustee, Union business manager, or other individual has the authority to answer questions or make decisions concerning the provisions of the Plan unless such individual has been given that authority by the Trustees and is acting on their behalf.

The Trustees have delegated the routine day to day administration of the Fund to the Third-Party Administrator and the Administrative Manager. Any questions regarding benefits or any other matters relating to claims processing should be directed to the appropriate Claims Payor. Any questions regarding eligibility or any other matters related to the Fund should be directed to the Administrative Manager, Ohio Conference of Plasterers & Cement Masons Health & Welfare Fund, 33 Fitch Blvd., Austintown, Ohio 44515.

This Plan believes it is a "grandfathered health plan" under the Patient Protection and Affordable Health Care Act (Act) of 2010. As permitted by the Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your Plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the Plan Administrator at 33 Fitch Blvd., Austintown, Ohio 44515, Phone: (800) 435-2388. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

Please read this booklet carefully so that you will know the benefits to which you and the members of your family are entitled. We suggest you put this booklet in a safe place along with other valuable papers. You will receive benefit updates and

other changes to the Plan periodically. You need to insert those notices into this booklet in order to maintain a complete and current list of your benefits and requirements.

When you first become eligible for benefits, you should receive an enrollment package which includes a Summary of Benefit Coverage and forms for you to complete and return to the Administrative Manager. These enrollment forms are vital to the proper administration of your claims for benefits under this Plan. You must provide the Administrative Manager with an updated Enrollment Form whenever you change your address, acquire a new dependent, or lose a dependent through death, divorce, the dependent's reaching age 26, or otherwise.

Sincerely,
BOARD OF TRUSTEES

SCHEDULE OF BENEFITS FOR ELIGIBLE CLASS I ACTIVE PARTICIPANTS AND DEPENDENTS

BENEFITS	HIGH PLAN		MID PLAN		LOW PLAN	
MEDICAL BENEFITS	**IN-NETWORK**	**OUT-OF-NETWORK**	**IN-NETWORK**	**OUT-OF-NETWORK**	**IN-NETWORK**	**OUT-OF-NETWORK**
Annual Deductibles	$350/person	$700/person	$500/person	$1,000/person	$1,000/person	$2,000/person
	$700/family	$1,400/family	$1,000/family	$2,000/family	$2,000/family	$4,000/family
Out-of-Pocket Maximums (Includes deductibles)	$1,750/person $3,500/family	$3,500/person $7,000/family	$3,000/person $6,000/family	$6,000/person $12,000/family	$5,000/person $10,000/family	$10,000/person $20,000/family
BENEFIT %						
Physician's Office						
Visits for Illness/Injury	100% after $20 Copay	60% Allowed Amount**	80%*	60% Allowed Amount**	100% after $30 Copay	50% Allowed Amount**
Allergy Testing/Treatment	80%*	60% Allowed Amount**	80%*	60% Allowed Amount**	70%*	50% Allowed Amount**
Occupational/ Physical/ Speech/ Respiratory	80%*	60% Allowed Amount**	80%*	60% Allowed Amount**	70%*	50% Allowed Amount**
Diagnostic Lab/X-Ray	80%*	60% Allowed Amount**	80%*	60% Allowed Amount**	70%*	50% Allowed Amount**
Surgery (All Related Expenses)	80%*	60% Allowed Amount**	80%*	60% Allowed Amount**	70%*	50% Allowed Amount**
Preventative Care						
Physical/GYN/ 1 Routine PAP	80%*	60% Allowed Amount**	80%*	60% Allowed Amount**	70%*	50% Allowed Amount**
Mammograms/ Prostate/ Colonoscopies	80%*	60% Allowed Amount**	80%*	60% Allowed Amount**	70%*	50% Allowed Amount**
Immunizations/ Pediatric Hearing Exam	80%*	60% Allowed Amount**	80%*	60% Allowed Amount**	70%*	50% Allowed Amount**
EKG/ Chest X-Ray/ Metabolic Panel/ Urinalysis	80%*	60% Allowed Amount**	80%*	60% Allowed Amount**	70%*	50% Allowed Amount**
Well Baby Care	80%*	60% Allowed Amount**	80%*	60% Allowed Amount**	70%*	50% Allowed Amount**
Care in Hospital						
Semi-Private Room	80%*	60% Allowed Amount**	80%*	60% Allowed Amount**	70%*	50% Allowed Amount**
Surgery	80%*	60% Allowed Amount**	80%*	60% Allowed Amount**	70%*	50% Allowed Amount**
Anesthesia	80%*	60% Allowed Amount**	80%*	60% Allowed Amount**	70%*	50% Allowed Amount**
Assistant Surgeon	80%*	60% Allowed Amount**	80%*	60% Allowed Amount**	70%*	50% Allowed Amount**
In-Hospital Physician	80%*	60% Allowed Amount**	80%*	60% Allowed Amount**	70%*	50% Allowed Amount**
Diagnostic Lab/ X-Ray	80%*	60% Allowed Amount**	80%*	60% Allowed Amount**	70%*	50% Allowed Amount**
Respiratory Therapy	80%*	60% Allowed Amount**	80%*	60% Allowed Amount**	70%*	50% Allowed Amount**
Acute Kidney Dialysis	80%*	60% Allowed Amount**	80%*	60% Allowed Amount**	70%*	50% Allowed Amount**

BENEFITS	HIGH PLAN		MID PLAN		LOW PLAN	
MEDICAL BENEFITS	**IN-NETWORK**	**OUT-OF-NETWORK**	**IN-NETWORK**	**OUT-OF-NETWORK**	**IN-NETWORK**	**OUT-OF-NETWORK**
Maternity Care (Employee and/or Spouse only)	80%*	60% Allowed Amount**	80%*	60% Allowed Amount**	70%*	50% Allowed Amount**
Organ Transplant Benefits	80%*	60% Allowed Amount**	80%*	60% Allowed Amount**	70%*	50% Allowed Amount**
Outpatient Care						
Pre-Admission Testing	80%*	60% Allowed Amount**	80%*	60% Allowed Amount**	70%*	50% Allowed Amount**
Surgery (All Related Expenses)	80%*	60% Allowed Amount**	80%*	60% Allowed Amount**	70%*	50% Allowed Amount**
Diagnostic Lab/X-Ray	80%*	60% Allowed Amount**	80%*	60% Allowed Amount**	70%*	50% Allowed Amount**
Emergency Care	80%*	60% Allowed Amount**	80%*	60% Allowed Amount**	70%*	50% Allowed Amount**
Physical/ Occupational Therapy/ Chiropractic/ Speech (Chiropractic limited to 12 visits per calendar year per person/family)	80%*	60% Allowed Amount**	80%*	60% Allowed Amount**	70%*	50% Allowed Amount**
Acute Kidney Dialysis	80%*	60% Allowed Amount**	80%*	60% Allowed Amount**	70%*	50% Allowed Amount**
Second Surgical Opinion	80%*	60% Allowed Amount**	80%*	60% Allowed Amount**	70%*	50% Allowed Amount**
Mental Health						
Inpatient Care/ Outpatient Treatment	80%*	60% Allowed Amount**	80%*	60% Allowed Amount**	70%*	50% Allowed Amount**
Alcohol/Substance Abuse						
Inpatient Care	80%*	60% Allowed Amount**	80%*	60% Allowed Amount**	70%*	50% Allowed Amount**
Outpatient Treatment	80%*	60% Allowed Amount**	80%*	60% Allowed Amount**	70%*	50% Allowed Amount**
Other Services						
Skilled Nursing Facility	80%*	60% Allowed Amount**	80%*	60% Allowed Amount**	70%*	50% Allowed Amount**
Private Duty Nursing	80%*	60% Allowed Amount**	80%*	60% Allowed Amount**	70%*	50% Allowed Amount**
Home Health Care (40 visits per calendar year)	80%*	60% Allowed Amount**	80%*	60% Allowed Amount**	70%*	50% Allowed Amount**
Hospice Care	80%*	60% Allowed Amount**	80%*	60% Allowed Amount**	70%*	50% Allowed Amount**
Durable Medical Equipment	80%*	60% Allowed Amount**	80%*	60% Allowed Amount**	70%*	50% Allowed Amount**
Ambulance	80%*	60% Allowed Amount**	80%*	60% Allowed Amount**	70%*	50% Allowed Amount**

Prescription Benefits			
Retail (34 Day Supply) Mail Order (90 Day Supply)	80%	80%	70%
Death Benefit	$5,000	$5,000	$5,000
AD&D			
Loss of Life	$5,000	$5,000	$5,000
Loss of 2 Limbs, Sight of Both Eyes, 1L/1E	$5,000	$5,000	$5,000
Loss of 1 Limb or Sight of One Eye	$2,500	$2,500	$2,500
Short Term Disability	$30 per week for work-related injury, up to 26 weeks $300 per week, up to 26 weeks, for non-work related injury	$30 per week for work-related injury, up to 26 weeks $300 per week, up to 26 weeks, for non-work related injury	$30 per week for work-related injury, up to 26 weeks $300 per week, up to 26 weeks, for non-work related injury
Dental/Vision Combined	Not Available	Not Available	Not Available

* After satisfaction of In-Network Deductible

** After satisfaction of Out-of-Network Deductible

SCHEDULE OF BENEFITS FOR ELIGIBLE CLASS II, CLASS III AND EARLY RETIREES AND DEPENDENTS

BENEFITS		
MEDICAL BENEFITS	**IN-NETWORK**	**OUT-OF-NETWORK**
Annual Deductibles	$500/person	$1,000/person
	$1,000/family	$2,000/family
Out-of-Pocket Maximums (Includes deductibles)	$3,000/person $6,000/family	$6,000/person $12,000/family
BENEFIT %		
Physician's Office		
Visits for Illness/Injury	80%*	60% Allowed Amount**
Allergy Testing/ Treatment	80%*	60% Allowed Amount**
Occupational/ Physical/ Speech/ Respiratory	80%*	60% Allowed Amount**
Diagnostic Lab/X-Ray	80%*	60% Allowed Amount**
Surgery (All Related Expenses)	80%*	60% Allowed Amount**
Preventative Care		
Physical/GYN/ 1 Routine PAP	80%*	60% Allowed Amount**
Mammograms/ Prostate/ Colonoscopies	80%*	60% Allowed Amount**
Immunizations/ Hearing	80%*	60% Allowed Amount**
EKG/ Chest X-Ray/ Metabolic Panel/ Urinalysis	80%*	60% Allowed Amount**
Well Baby Care	80%*	60% Allowed Amount**
Care in Hospital		
Semi-Private Room	80%*	60% Allowed Amount**
Surgery	80%*	60% Allowed Amount**

BENEFITS		
MEDICAL BENEFITS	**IN-NETWORK**	**OUT-OF-NETWORK**
Anesthesia	80%*	60% Allowed Amount**
Assistant Surgeon	80%*	60% Allowed Amount**
In-Hospital Physician	80%*	60% Allowed Amount**
Diagnostic Lab/ X-Ray	80%*	60% Allowed Amount**
Respiratory Therapy	80%*	60% Allowed Amount**
Acute Kidney Dialysis	80%*	60% Allowed Amount**
Maternity Care (Member and/or Spouse only)	80%*	60% Allowed Amount**
Organ Transplant Benefits	80%*	60% Allowed Amount**
Outpatient Care		
Pre-Admission Testing	80%*	60% Allowed Amount**
Surgery (All Related Expenses)	80%*	60% Allowed Amount**
Diagnostic Lab/X-Ray	80%*	60% Allowed Amount**
Emergency Care	80%*	60% Allowed Amount**
Physical/ Occupational Therapy/ Speech	80%*	60% Allowed Amount**
Chiropractic (Limited to 12 visits)	80%*	60% Allowed Amount **
Acute Kidney Dialysis	80%*	60% Allowed Amount**
Second Surgical Opinion	80%*	60% Allowed Amount**
Mental Health		
Inpatient Care/ Outpatient Treatment	80%*	60% Allowed Amount**
Alcohol/Substance Abuse		
Inpatient Care	80%*	60% Allowed Amount**

BENEFITS		
MEDICAL BENEFITS	**IN-NETWORK**	**OUT-OF-NETWORK**
Outpatient Treatment	80%*	60% Allowed Amount**
Other Services		
Skilled Nursing Facility	80%*	60% Allowed Amount**
Private Duty Nursing	80%*	60% Allowed Amount**
Home Health Care (40 visits per calendar year)	80%*	60% Allowed Amount**
Hospice Care	80%*	60% Allowed Amount**
Durable Medical Equipment	80%*	60% Allowed Amount**
Ambulance	80%*	60% Allowed Amount**

Prescription Benefits	
Retail (34 Day Supply)	80%
Mail Order (90 Day Supply)	
Death Benefit	$5,000
AD&D	
Loss of Life	$5,000
Loss of 2 Limbs, Sigh of Both Eyes, 1L/1E	$5,000
Loss of 1 Limb or Sight of One Eye	$2,500
Dental/Vision Combined	Not Available

* After satisfaction of In-Network Deductible

** After satisfaction of Out-of-Network Deductible

PRESCRIPTION DRUGS

The Prescription Drug Card Benefit covers charges for drugs prescribed by a physician, dispensed by a pharmacist and not available over the counter without a prescription.

Covered Expenses Include:

Federal Legend Drugs - Any medicinal substance which bears the legend: "Caution: Federal law prohibits dispensing without a prescription."

State Restricted Drugs - Any medicinal substance which may be dispensed by prescription only according to state law.

Compounded Medication - Any medicinal substance which has at least one ingredient that is a Federal Legend or State Restricted Drug in a therapeutic amount.

Insulin - Available by prescription only (includes insulin syringes).

A Prescription Administrator, Envision Pharmaceutical Services, Inc., has contracted with the Operative Plasterers and Cement Masons Health and Welfare Fund to provide an efficient and cost effective program that will be easy for you and your dependents to use when you purchase your prescriptions at a Network Pharmacy. Please check with the Fund Office or call the Prescription Drug Administrator at 1-800-361-4542 directly for a participating pharmacy location near you.

The Prescription Drug Card Program requires you to present your Identification Card at the pharmacy each time you have a prescription filled. If you do not use your identification card, you will have to file a claim for payment directly to Envision to be reimbursed.

Your claim may be subject to deductible and co-insurance amounts. For Participants in the High and Mid Plan, the co-pay is 20%. For those in the Low Plan, the co-pay is 30%.

When possible, please check with your pharmacy to determine if a generic equivalent is available which will result in a direct savings to you and the Fund.

If you choose or your physician indicates "Dispense as Written" for a brand name drug which has an FDA approved generic equivalent in existing, you will be responsible to pay the cost difference between the brand and its generic equivalent in addition to the 20% co-payment for the High and Mid Plan and 30% for the Low Plan.

The Program works as follows:

I. Prescription Drug Home Delivery Program

Home Delivery is a convenient way to order maintenance medications and have them delivered to your home. Home Delivery offers you the opportunity to submit your maintenance prescriptions by mail or have your doctor fax in your prescriptions. The prescription is then processed and delivered directly to you.

You can continue to have maintenance medications filled at your local pharmacy for a thirty (30) day supply. You can, but are not required to, also use the Envision Mail Order Program for a ninety (90) day supply.

By using the Envision Pharmacy, you will save money on your copayments for maintenance medications. Plus you will receive:

1. Free Home Delivery of your medication.
2. Up to a 3-month supply of medication with each other.
3. 24-hour access to a pharmacist.

If you or someone under your coverage takes a maintenance medication and wants to use the mail order program, then follow the steps below to order the medication from the Envision Pharmacy:

Online: Visit www.envisionrx.com and follow the instructions to get prescription home delivery. As a courtesy to the members, Envision will contact your doctor to obtain a new prescription for Home Delivery.

By Mail: Ask your doctor to write a prescription for up to a 90-day supply of your medication (plus refills for up to one year). If you are currently using maintenance medications but not Home Delivery, an order form is enclosed for your use. If you begin using maintenance medication or no form is included, you may request a Home Delivery Order Form from the Fund Office or call the Envision Patient Care Advocate at 1-800-361-4542. Complete the order form and mail with your prescription to the address on the form.

Please note that while the mail order program is designed to allow members to receive larger quantities of maintenance medications directly at their home in a safe, convenient way, this service is likely not useful for short term illness or for when your physician does not wish to prescribe a ninety (90) day supply.

II. Prescription Drug Step Therapy Program

Your plan utilizes a program called Step Therapy.

Step Therapy is a program that helps manage trend by encouraging patients and doctors to choose lower-cost, effective drugs first. It helps you get an effective medication to treat your condition while keeping your costs as low as possible.

In Step Therapy, drugs are grouped in categories based on cost:

- **Front-Line Drugs** – the first step – are generic drugs proven to be safe, effective, and affordable. These drugs should be tried first because they can provide the same health benefit as more expensive drugs at a lower cost to you.

- **Back-Up Drugs** – Step 2 and Step 3 drugs – are brand-name drugs like those that you see advertised on TV. There are lower-cost brand drugs (Step 2) and higher-cost brand drugs (Step 3). Back-up drugs typically cost more than front-line drugs.

The next time your doctor writes you a prescription, ask your doctor if a front-line drug is right for you. It makes good sense to ask for these drugs first because, for most everyone, they work as well as brand-name drugs, they almost always cost less, and they have a more established safety record then new drugs because these drugs have been on the market for a long time.

If you have already tried a front-line drug, or your doctor decides one of these drugs is not appropriate for you, then your doctor can prescribe a back-up drug. Ask your doctor if one of the lower-cost brands (Step 2 drugs) is appropriate. Remember, you can always get a higher-cost brand-name drug at a higher copayment if the front-line or Step 2 back-up drugs are not right for you.

Exclusions From Prescription Benefit Coverage

The following services, supplies, and charges are not covered under the prescription benefit:

1) Emergency and abortafacient contraception;

2) Abortafacient;

3) Therapeutic devices;

4) Artificial appliances;

5) Disposable insulin syringes which are not prescribed;

6) Fees for administering or injecting Prescription Drugs;

7) Charges for more than a 90-day supply of Prescription Drugs per order;

8) Any refill of a Prescription Drug, dispensed after one year from the date of the original Prescription Order;

9) Drugs you can purchase without a Prescription;

10) Prescription Drugs consumed or administered at a location where the Prescription Order is issued;

11) Fertility drugs;

12) Nicorette gum and/or other tobacco cessation related medications, other than Chantix;

13) Genetically engineered drugs (may be paid upon prior authorization);

14) Male sexual dysfunctional drugs (e.g. Viagra);

15) Anorexiants (diet pills);

16) Glucometer diabetic supplies;

17) Ostomy products;

18) Blood and blood plasma;

19) Wasp venom;

20) Cosmetic drugs including Renova and Minoxidil;

21) Blood monitoring units;

22) Fluoride preparation;

23) Impotency drugs;

24) B12, Testosterone;

25) Bandages and splints;

26) Nutrients and dietary supplements;

27) Over-the-counter products;

28) Vaccinations/toxoids; and

29) Fertility drugs.

SCHEDULE OF BENEFITS FOR MEDICARE RETIREE WITH NON-MEDICARE AGE DEPENDENTS (ACTIVE DEPENDENTS)

Calendar year annual deductible Individual/Family	$500/$1,000 In-network $1,000/$2,000 Out-of-network
Co-Insurance (After deductible)	20% per individual in network 40% per individual out-of-network
Calendar year annual out-of-pocket maximum Individual/Family	$3,000/$6,000 In-network $6,000/$12,000 Out-of-network
Prescription Drugs	
Covered Services	Maximum Payable Benefits
Physician office services Office visits, office surgeries, allergy testing/treatment/serum/injections	All benefits are paid at 80% after deductible, up to the out-of-pocket maximum; 100% thereafter, unless otherwise noted
Preventive care (Family) Medical history, routine physical exams, PSA, mammograms, pelvic exams, Pap testing **Outpatient therapy** Physical/occupational therapy, spinal Manipulations (12 visits), speech therapy	
Hospital facility services – Inpatient/Outpatient	
Inpatient and outpatient professional and ancillary charges, physician and surgical services**	
Home care services/calendar year (Limited to 40 visits)	
Hospice services	
Emergency care/Urgent care Physician services and facility charges	
Ambulance services	
Maternity services	
Skilled nursing care	
Medical supplies, equipment, appliances	
Mental Health and Alcohol and Substance Abuse Inpatient Care Outpatient Care	

Other Benefits (eligible retiree (non-Medicare) age only)	
Death benefit	$2,500
Out-of pocket limits include all co-payments and deductibles incurred by a covered person in the same benefit period. *All medical benefits are subject to usual, customary and reasonable charges.*	

MEDICARE SUPPLEMENTAL COVERAGE
SCHEDULE OF BENEFITS FOR MEDICARE RETIREES AND MEDICARE AGE DEPENDENTS

SCHEDULE OF BENEFITS – THIS SUPPLEMENTAL PLAN PAYS:

Inpatient Hospital Services	The Plan pays the Medicare Part A deductible, and the Medicare-approved Hospital charges not reimbursed by Medicare for the 61st-150th day of hospitalization, and up to 80% of eligible expenses for additional 365 days per lifetime.
Blood (Inpatient/Outpatient)	Full Medicare Part B deductible and Medicare co-pay up to 20%.
Skilled Nursing Facility Care	The Plan pays amounts up to the Medicare Approved charges not reimbursed by Medicare per day for 21st-100th days, and up to 80% for the next 100 days.
Inpatient Prescription Drugs For Transplants	Full Medicare Part B deductible and Medicare co-pay up to 20%.
Physician's Care Inpatient/ Outpatient Services and Supplies	Full Medicare Part B deductible and Medicare co-pay up to 20%.
Outpatient Mental/Nervous	Full Medicare Part B deductible and the other 50% that Medicare does not pay.
Outpatient Physical Therapy	Full Medicare Part B deductible and Medicare co-pay up to 20%.

SCHEDULE OF BENEFITS – FOR RETIREES (OVER MEDICARE) AGE ONLY

Death Benefit	$2,500

MEDICAL BENEFITS

Use of in-network providers for your health care services generally results in the greatest savings for you and the Fund. For this reason, we urge you to seek care from providers within the medical network whenever possible. Please note that true emergency services will be treated as in-network regardless of the provider's network status.

As you are aware, the Fund currently uses the Medical Mutual SuperMed Preferred Provider Organization (PPO) for SuperMed service area which includes Ohio, Indiana, South Carolina, and Georgia. Outside of the SuperMed Service area, the Fund uses the PHCS Network. The Plan requires separate deductibles and co-insurance for all medical providers (hospitals and doctors) based upon PPO Network or Non-PPO Network utilization.

Medical Network Change for Northwest Ohio Members Only

FrontPath Health Coalition is the provider network for residents in Northwest Ohio.

FrontPath offers **all** Toledo area hospitals, 37 regional hospitals, 5 specialty care hospitals, and over 5, 000 providers in the network.

We encourage you to access the FrontPath website at www.frontpathcoalition.com to confirm your physician participation in this network. Once you reach the website, click on provider directory to search by: physician's last name, group/hospital name or specialty. If you are not able to locate your physician, please request that FrontPath contact the physician by completing a physician solicitation request or feel free to contact FrontPath at 419-891-5206, ext. 100 or 888-232-5800.

YOUR ELIGIBILITY FOR BENEFITS

RULES FOR ELIGIBILITY – CLASS I

Active Employment
Employee must be actively seeking employment unless the Employee is disabled.

Obtaining Eligibility Credits
You will receive "Dollar Bank Credits" for the contributions your *employer* makes for you. These Credits are used to establish and maintain your eligibility.

Initial Eligibility
When the Fund receives dollar bank credits totaling the appropriate amount (3 months of the Mid Plan cost), as set by the Trustees, each year, in six or fewer consecutive months, you will become eligible for benefits in the Mid Plan only. This initial eligibility will start on the first day of the following month and for the two calendar months following that first month. Credits will be applied towards the work month regardless of when received.

Please note that after you have established initial eligibility, you may select at the next open enrollment period to change to the High Plan or Low Plan.

Effective Eligibility Date
An Employee will be covered on the date you become eligible if you are available for work on that date; otherwise, you shall not become covered until you become available for work.

If a Dependent confined in a Hospital on the date such Dependent would otherwise become covered or on the date the change in coverage would otherwise become effective, the coverage or change in coverage with respect to that particular Dependent shall be deferred until final discharge from the Hospital. However, for a newborn dependent Child, coverage begins from birth.

Dollar Bank Credits
When you have more Dollar Bank Credits than are necessary to establish or maintain eligibility, the excess Dollar Bank Credits are placed in your Dollar Bank on your behalf up to a maximum amount as set by the Trustees each year.

When you do not have enough Credits from *employer* contributions to maintain eligibility, any Credits in your Dollar Bank can be used. However, these credits do not vest. The Trustees may reduce or otherwise adjust the number of Credits in *Covered Person's* Dollar Banks from time to time based on medical inflation and other factors so that the *Plan* can remain financially healthy. You will lose any credit in the Dollar Bank upon the earlier of the following:

- When you cease to be available for covered work; or
- You do not have enough Credits to maintain your eligibility and you fail to make the timely self-payments needed to maintain that eligibility; or
- The Trustees' cancellation of Dollar Bank Credits.

Continuing Your Eligibility
After you have become eligible, Dollar Bank Credits will be used to continue that eligibility. You will remain eligible if you receive the Dollar Bank Credit amounts each month as set by the Trustees.

If you do not have enough Dollar Bank Credits in a Contribution Month, you will lose coverage unless you:

- Have enough Credits available for withdrawal from your Dollar Bank; or
- Make timely self-payments to obtain the needed Credits for the Contribution Month.

You can combine self-payments with your Dollar Bank Credits to maintain eligibility.

The use of these credits is expressly conditioned upon the person's local Union where at least a majority of these credits have been accumulated and which sponsors a Collecting Bargaining Agreement requiring contributions to this Fund. The Trustees shall also have the discretion to freeze or terminate your Dollar Bank if it is determined

that you are performing work in Covered Employment in the craft jurisdiction for an Employer not subject to a collective bargaining agreement. Dollar Bank credits are not a vested benefit and is subject to amendment, reduction or termination.

Self-Payments
Partial self-payments can be made when you do not have enough Credits in your Bank to maintain your eligibility. The amount is determined by subtracting your Credits from the amount of Credits you need in the Eligibility Month to maintain your eligibility.

Full self-payments may be made when you have no Dollar Bank Credits to maintain your eligibility for only six consecutive months and for so long as you continue your self-payments each month and remain available for work.

After six months of consecutive full self-payments:

- Any Dollar Bank Credits you earn will be applied towards reestablishment of Initial Eligibility only; and
- Any further payments must be the applicable premium for COBRA continuation coverage.

If you become disabled so as to prevent you from performing any type of gainful employment, you may preserve your eligibility during the disability for a period not to exceed the earlier of six (6) months following recovery or your eligibility for Medicare. In order to maintain eligibility, you shall remit timely contributions established by the Trustees on forms prescribed by the Trustees and medical certification of your disability. If you become eligible for Medicare, you will be eligible to participate in the Retiree Program. In addition, in order to maintain eligibility, you must semi-annually submit medical certification of your continued disability.

All self-contributions received become the property of the Fund as of the day received. Credits received relative to the work month for which the self-contribution was made, whether as a result of late payment or a reciprocity agreement, will be refunded.

Once you have either reached the end of your six months of continued coverage by making full self-payments or you do not make a partial self-payment, and you are not covered under any other group health plan or Medicare benefits at the time, you will be eligible to continue your health care benefits under The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), for an additional eighteen (18) months. The Trustees shall have the discretion to refuse self-contributions from you if it is determined that you are working in Covered Employment in the craft jurisdiction for an Employer not subject to a collective bargaining agreement.

If you must self-pay, you may at that time select to drop from the High Plan and/or Mid Plan to the Low Plan. However, you cannot return to the High Plan and/or Mid Plan until the next open enrollment period.

ELIGIBILITY CONDITIONS – CLASS II & III

Initial Eligibility

Class II and III employees are eligible to participate in the Mid Plan only. They will then be covered for benefits on the first day of the month immediately following the receipt of the third (3rd) consecutive monthly payment. Prepayment shall not expedite coverage.

Initial eligibility will cover the employee for the remaining number of months which fall within an eligibility period as outlined under Continuation of Eligibility. However, if only one calendar month or less remains in that eligibility period, the employee also shall be eligible for the subsequent eligibility period.

Effective Eligibility Date
An Employee will be covered on the date you become eligible if you are available for work on that date; otherwise, you shall not become covered until you become available for work.

If a Dependent confined in a Hospital on the date such Dependent would otherwise become covered or on the date the change in coverage would otherwise become effective, the coverage or change in coverage with respect to that particular Dependent shall be deferred until final discharge from the Hospital. However, for a newborn dependent Child, coverage begins from birth.

Continuing Eligibility
Once having become covered, Class II and Class III employees shall continue to be covered on a monthly basis provided a monthly contribution for such employee is received by the Welfare Fund by the 15th of the month immediately preceding. Coverage terminates if payments are not timely received. Self-payments are not permitted, other than COBRA continuation coverage.

PARTICIPANTS SERVING IN ARMED FORCES

A Participant who enters the Armed Forces of the United States on a full-time basis shall have the option of freezing his Reserve Bank, if any, until discharged from active full-time military duty, or utilizing his Reserve Bank, if any, to continue coverage under the Plan, as provided hereafter.

In the event a Participant who enters into full-time military duty of the United States has no Reserve Bank, has an insufficient Reserve Bank to maintain coverage while serving in the military service, or does not elect to utilize his Reserve Bank to maintain coverage while serving in active full-time military service, continuation of coverage under the Plan for the Participant and his Eligible Dependents can be continued for eighteen (18) months upon receipt of a timely application and required contributions established by the Board of Trustees.

If a Participant enters the Armed Forces on a short-term basis of thirty-one (31) days or less of continuous military service, coverage under the Plan will be continued for the Participant and Eligible Dependents at Plan expense. For military services that exceeds thirty-one (31) days, the Participant shall be responsible for contributions for those months of service subsequent to the initial service of thirty-one (31) days.

A Participant shall notify the Fund Office as soon as he knows or understands that he will be entering the military service and of his desire to purchase continuation health coverage for that period of time when he is in active military service, not to exceed eighteen (18) months. This notice requirement shall be adhered to by the Participant unless giving such notice is precluded by military necessity or is otherwise impossible or unreasonable.

Upon a Participant's honorable discharge from military service, the Participant's eligibility status under the Plan will be restored to the status that existed when he entered military service, with the exception of any Reserve Bank Dollars that the Participant may have elected to utilize during military service. In order to restore such eligibility in the Plan, the Participant must notify the Fund Office, in writing, within sixty (60) days of his discharge of his intent to return to covered employment. In addition to such written notice, the Participant shall also supply the Fund Office with copies of his discharge papers showing the date of his induction or enlistment in military service and the date of his discharge. Failure on the part of the Participant to file such notice and documentation with the Fund Office may be deemed an indication that the Participant does not wish to restore his eligibility status under the Plan.

Military Reinstatement - Effective Eligibility Date of Coverage

Federal law now provides certain employees who leave employment for active military service and who seek reemployment within the required period after release from military service, with certain rights under the Health and Welfare Plan, such as the right to immediate coverage upon their return from military service. Furthermore, under certain circumstances, military service is treated as a "qualifying event" for COBRA purposes for up to 18 months. HOWEVER, FEDERAL LAW REQUIRES YOU TO NOTIFY THE FUND OFFICE BEFORE ENTERING MILITARY SERVICE TO PROTECT THESE RIGHTS.

Eligible Dependents - Family Coverage

Your Eligible Dependents include the following:

- Your legal Spouse. This means the person who is married to you in a legally recognized civil or religious ceremony. A "spouse" includes a same-sex spouse. If you become divorced or legally separated, your spouse loses eligibility. Common-law relationships are not recognized except to the extent they are recognized in your state of residence and you have furnished a satisfactory affidavit to the Board of Trustees under applicable state law.

- Your children. Your child is covered from the date of birth through the end of the month in which the child reaches age 26. An exception to coverage will exist until January 1, 2014 for the child who is eligible for coverage at the child's place of employment and for so long as such eligibility exists.

The term **Child or Children** include:

- Your natural child,
- Your adopted child or child placed in your custody, pending adoption,
- Your stepchild.
- A foster child for whom you have assumed financial responsibility in writing, the parent of the foster child is not claiming the child as a qualifying child pursuant to IRS Code Section 152(c), and you have a higher adjusted gross income than the foster child's parent. You will be required to provide the documents necessary to verify the existence of these conditions.
- A child under the age of twenty-six (26) for whom a court of competent jurisdiction has established custody.

The Plan also includes among Eligible Dependents children for whom you are required to furnish medical coverage under a Qualified Medical Child Support Order. Please contact the Fund Office for Rules and Regulations explaining the provisions which must be included in such court Orders and other requirements which must be met before the Plan will accept any children as Eligible Dependents under such Orders. Participants and Beneficiaries can obtain, without charge, a copy of this information from the Fund office.

If a child beyond age twenty-six (26) is incapable of self-sustaining employment because of a physical handicap or mental retardation, and is dependent upon you for support and maintenance, coverage will be continued provided the child's incapacity began before the age at which the child's coverage would have terminated. You must submit proof of the child's incapacity to the Fund Office not later than thirty-one (31) days after the date such child attains the age at which their coverage would otherwise terminate. Proof of continued incapacity must be furnished to the Fund Office from time to time upon request.

Documentation of Dependent status may be required from time to time.

Pre-Existing Conditions Limitation

No pre-existing condition limitation is imposed.

Omnibus Budget Reconciliation Act

In compliance with the Omnibus Budget Reconciliation Act of 1993, the following provisions apply to dependent coverage:

A) Adopted children are eligible for coverage immediately upon placement with the family and are not subject to the pre-existing conditions clause of the Plan.

B) If an eligible employee who is covered under this plan is divorced, the children of that employee are eligible dependents for the plan if the eligible employee is court-ordered to provide coverage. The dependent may not be

terminated from coverage as long as the employee is eligible for coverage and the court order is still in effect.

Travel · Class I Employees

When you are asked to perform work outside the Plan area, you should ask whether your Employer will continue to make contributions on your behalf to this Plan based on collective bargaining provisions for travelers.

Reciprocity Agreements with Other Plans - Class I Employees

The Trustees have entered into Reciprocity Agreements with the Trustees of certain other plans in an effort to address the problem of employees working under the jurisdiction of other locals. Under these Agreements, contributions due on your behalf while working under another local's jurisdiction may be transferred from that local's fund to this Plan if you make written request on a proper form. For information regarding other funds which have Agreements with this Plan, contact the Fund Office. However, unless you are a member of Operative Plasterers and Cement Masons Locals 80, 109, 132, 179, 404 and/or 886 at the time in question, you may not establish initial eligibility via such reciprocity payments.

Those employees eligible under this Plan who work in another jurisdiction which has a signed Agreement with this Plan may continue their coverage under this Plan. Those coming from other jurisdictions to work here and requesting reciprocity will not become eligible under this Plan, but will continue their coverage, if any, under their home Plan.

Reciprocity payments will be credited only after they are received by the Fund Office. Until payments have been confirmed to this Plan, you must make timely self-payments to continue your eligibility. Self-payments made in excess of the minimum amount required to maintain eligibility for a particular quarter are refundable to the Eligible Employee when reciprocity payments are later confirmed.

If You Cannot Work Because You Are Temporarily Disabled - Class I Employees

If you are temporarily disabled and cannot work, you are given Contribution Credits to help maintain your eligibility for benefits for up to thirty (30) hours for each week you are disabled. These Credits will be given up to a maximum of three hundred sixty (360) hours in any twelve (12) consecutive month period. This credit is given if you:

- are receiving Sickness & Accident benefits from this Fund; **and**

- are seen by a Physician on a regular basis who so states you are Disabled; **and**

- make written application to the Fund Office for such credits within six months after the Disability starts.

Credit is given the first day for an injury and beginning the eighth day for an illness. You receive credit until you are no longer receiving Disability or Sickness and Accident Benefits or until you have received three hundred sixty (360) hours in twelve (12) consecutive months, whichever comes first. The Plan may require that you be examined by the Plan's Physicians from time to time.

See also, the Eligibility for Disabled Retirees and Dependents.

Family and Medical Leave Act Credits - Class I, II and III Employees

Contribution Credits of up to twelve (12) weeks in a twelve (12) month period may be available from your Employer for Family and Medical Leave (FMLA). You must have worked one thousand two hundred fifty (1,250) hours in a twelve (12) month period for an Employer covered by FMLA. Certain other requirements must be met.

Forms for seeking these Credits are available from the Fund Office. The Form must be completed by you and your Employer. FMLA Contribution Credits may be available for:

- The birth of your child and to care for such child.
- Placement of a child with you for adoption or foster care;
- To care for your Spouse, Child, or parent with a serious health condition;
- For your own serious health condition that makes you unable to perform your job; or
- As provided below, for Participants with members in the armed services for the reason so provided.

Participants with family members in any regular component of the Armed Forces, including the National Guard and Reserves, are entitled to FMLA leave under the following circumstances:

1) When leave is needed so that the Participant can care for a seriously injured or ill family covered service member in the Armed Forces, including the National Guard, Reserves, and Veterans; and

2) When such leave is required due to “any qualifying exigency” related to a family member’s service or call to covered active duty. This “qualifying exigency leave” extends to family members of individuals in any regular component of the Armed Forces, including National Guard, Reserves, and Veterans.

“Covered Active Duty” means (A) in the case of a member of a regular component of the Armed Forces, duty during the deployment of the member with the Armed Forces to

a foreign country; and (B) in the case of a member of a reserve component of the Armed Forces, duty during the deployment of the member with the Armed Forces to a foreign country under a call or order to active duty under a provision of law referred to in section 101(a)(13)(B) of title 10, United States Code.

A “covered servicemember” means (A) a member of the Armed Forces (including a member of the National Guard or Reserves) who is undergoing medical treatment, recuperation, or therapy, is otherwise in outpatient status, or is otherwise on the temporary disability retired list, for a serious injury or illness; or (B) 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, or therapy.

A “serious injury or illness” means (A) in the case of a member of the Armed Forces (including a member of the National Guard or Reserves), an injury or illness that was incurred by the member in line of duty on active duty in the Armed Forces (or existed before the beginning of the member’s active duty and was aggravated by service in line of duty on active duty in the Armed Forces) and that may render the member medically unfit to perform the duties of the member’s office, grade, rank, or rating; and (B) in the case of a veteran who was a member of the Armed Forces (including a member of the National Guard or Reserves) at any time during a period described in paragraph (15)(B), a qualifying (as defined by the Secretary of Labor) injury or illness that was incurred by the member in line of duty on active duty in the Armed Forces (or existed before the beginning of the member’s active duty and was aggravated by service in line of duty on active duty in the Armed Forces) and that manifested itself before or after the member became a veteran.

The term “veteran” has the meaning given the term in section 101 of title 38, United States Code.’’.

“Qualifying exigencies” include:

- Issues arising from a covered military member's short notice deployment (i.e., deployment on seven or less days of notice) for a period of seven days from the date of notification;

- Military events and related activities, such as official ceremonies, programs or events sponsored by the military or family support or assistance programs and informational briefings sponsored or promoted by the military, military service organizations or the American Red Cross that are related to active duty or call to active duty status of a covered military member;

- Certain childcare and related activities, arising from the active duty or call to active duty status of a covered military member, such as arranging for alternative childcare, providing childcare on anon-routine, urgent, immediate need basis, enrolling or transferring a child in a new school or day care facility, and attending certain meetings at a school or a day care facility if they

are necessary due to circumstances arising from the active duty or call to active duty of the covered military member;

- Making or updating financial and legal arrangements to address a covered military member's absence;

- Attending counseling provided by someone other than a health care provider for oneself, the covered military member, or the child of the covered military member, the need for which arises from the active duty or call to active duty status of the covered military member;

- Taking up to five days of leave to spend time with a covered military member who is on short-term temporary, rest and recuperation leave during deployment;

- Attending to certain post-deployment activities, including attending arrival ceremonies, reintegration briefings and events, and other official ceremonies or programs sponsored by the military for a period of *90* days following the termination of the covered military member's active duty status and addressing issues arising from the death of a covered military member;

- Any other event that the employee and employer agree is a qualifying exigency.

The Participant must be a spouse, parent, child, or nearest blood relative of the member in the Armed Services. A Participant who is eligible for FMLA leave under this provision will be granted up to twenty-six (26) weeks of leave in a single twelve (12) month period.

Further, Participants with members in the Armed Services are entitled to up to twenty-six (26) weeks of FMLA leave under the following circumstances:

3) When leave is needed so that the Participant can care for spouse, child, parent, or next of kin who is recovering from a serious illness or injury sustained in the line of duty in the Armed Services, including the National Guard or Reserve; and

4) When such leave is required due to “any qualifying exigency” related to a family member’s service or call to duty. (However, this “qualifying exigency leave” does not extend to family members of individuals in the regular armed forces).

“Qualifying exigencies” include:

- Issues arising from a covered military member's short notice deployment (i.e., deployment on seven or less days of notice) for a period of **seven** days from the date of notification;

- Military events and related activities, such as official ceremonies, programs or events sponsored by the military or family support or assistance programs and informational briefings sponsored or promoted by the military, military service organizations or the American Red Cross that are related to active duty or call to active duty status of a covered military member;

- Certain childcare and related activities arising from the active duty or call to active duty status of a covered military member, such as arranging for alternative childcare, providing childcare on anon-routine, urgent, immediate need basis, enrolling or transferring a child in a new school or day care facility, and attending certain meetings at a school or a day care facility if they are necessary due to circumstances arising from the active duty or call to active duty of the covered military member;

- Making or updating financial and legal arrangements to address a covered military member's absence;

- Attending counseling provided by someone other than a health care provider for oneself, the covered military member, or the child of the covered military member, the need for which arises from the active duty or call to active duty status of the covered military member;

- Taking up to five days of leave to spend time with a covered military member who is on short-term temporary, rest and recuperation leave during deployment;

- Attending to certain post-deployment activities, including attending arrival ceremonies, reintegration briefings and events, and other official ceremonies or programs sponsored by the military for a period of *90* days following the termination of the covered military member's active duty status and addressing issues arising from the death of a covered military member;

- Any other event that the employee and employer agree is a qualifying exigency.

A Participant who is eligible for FMLA leave under this provision will be granted up to twenty-six (26) weeks of leave in a single twelve (12) month period.

During the FMLA leave, your Employer must make contributions to the Fund on your behalf so that your health coverage will be continued. Federal law requires that you receive continued eligibility. However, arrangements will need to be made for the Eligible Employee to pay his/her applicable share of health insurance premiums while on leave.

Upon return from FMLA leave, the Eligible Employee must be restored to his or her original job or to an equivalent job. In addition, the Eligible Employee’s use of FMLA

leave cannot result in the loss of any employment benefit that the employee earned or was entitled to before using FMLA leave.

Repayment of Contributions to Employer
If you take a leave under the FMLA and you fail to return to your Employer for any reason after such absence, under the Act your Employer has the right to collect all contributions made on your behalf during such leave of absence. Thus, to insure your continuing coverage under this Plan and to prevent possible repayment of all contributions to your Employer, you should return to work at the end of your leave of absence under the FMLA.

Please contact the Fund Office if you have any questions regarding your options under the FMLA.

TERMINATION OF COVERAGE

Coverage for you and your Eligible Dependents will terminate on the earliest of the following dates:

- The last day of an Eligibility Month if you have insufficient contributions and/or Reserve Hours, and fail to make timely self-payments; or

- When you begin active duty in the armed forces; or

- The last day of an Eligibility period in which you die except that your Eligible Dependents will be allowed to remain eligible until any of your accumulated Reserve Hours are exhausted; or

- The date you cease to be available for work under Covered Employment; or

- The date the Plan terminates.

Dependent coverage may also terminate for your Eligible Dependent if that class of coverage is terminated or on the date that your Dependent:

- Ceases to be your legal Dependent as provided by the Plan; or

- Becomes an Eligible Employee under this Plan or another group plan; or

- Begins active duty in the armed forces.

WITHDRAWAL OF A LOCAL UNION OR EMPLOYER FROM THIS WELFARE PLAN

If you are a member of a Local Union which withdraws from this Health & Welfare Plan or an employee of an employer who has discontinued participation in this Plan, the following will occur:

- Any dollar reserve/bank hours which you have shall be forfeited;

- There will be no payment of run-out claims on your behalf;

- Although you shall have access to and use of the amount in your medical reimbursement account as of the date of withdrawal/discontinuance of participation, disbursement to you shall only be done quarterly and a fee of $25.00 per quarter shall be assessed to the account to cover the costs of the administration of the account; and

- If you are receiving coverage under this Plan as a retiree member of the departing Local Union or employer, that coverage under this Plan shall terminate effective on the date of the withdrawal/discontinuance of participation.

SUSPENSION OF BENEFITS (CLASS I)

Your benefits may be suspended if the Trustees determine that:

- you are performing work in covered employment within the craft jurisdiction and not pursuant to a collective bargaining agreement;

- your membership in the Union has been terminated, other than retirement; or

- your membership in the Operative Plasterers and Cement Masons International Association has been terminated, other than due to retirement, and you are now a member in and/or of any other Union or Association (local and/or international) in a craft jurisdiction other than that of the Operative Plasterers and Cement Masons International Association).

SPECIAL ENROLLMENT

If you were eligible under the Plan and declined coverage because of other coverage, and you or your dependent lose the other coverage, you and your Eligible Dependent(s) will be permitted to enroll in the appropriate High, Mid, or Low Plan during a special enrollment period if loss of the other coverage was due to:

- Termination of employment;
- A reduction in hours of employment;
- Termination of the other coverage;
- Termination of employer contributions towards coverage;
- The exhaustion of COBRA continuation coverage;

- The exhaustion of applicable lifetime benefits under the coverage;
- An individual ceases to be a dependent under the Plan;
- The plan terminates a benefit package option;
- If your coverage is provided through a Health Maintenance Organization (HMO) or other arrangement, and you no longer live or work in the HMO's or other arrangement's service area (and there is no other coverage available under the Plan);
- The plan no longer offers coverage to a class of similarly situated individuals that includes you (e.g., the plan terminates coverage for all part-time employees);
- Layoff;
- The death or divorce from your spouse; or
- The employee or dependent is covered under a Medicaid Plan or under a State child health plan and coverage of the employee or dependent under such a plan is terminated as a result of loss of eligibility for such coverage and the employee requests coverage under the group health plan (or health insurance coverage) not later than 60 days after the date of termination of such coverage, or the employee or dependent becomes eligible for assistance, with respect to coverage under the group health plan or health insurance coverage, under a Medicaid plan or State child health plan (including any waiver or demonstration project conducted under or in relation to such a plan), if the employee requests coverage under the group health plan or health insurance coverage not later than 60 days after the date the employee or dependent is determined to be eligible for such assistance.

Enrollment must be supported by written documentation of the termination of the other coverage (including the effective date of the termination). Notice of intent to enroll must be provided to Medical Mutual within 31 days of the event with coverage to be effective on the date the other coverage terminated.

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 Eligible Dependents provided that you request enrollment within 31 days after the marriage, birth, adoption or placement for adoption.

REINSTATEMENT

Class I Employees who lose coverage will be required to again meet the Plan's Initial Eligibility rules.

Where Class II or III coverage has been terminated by an Employer or Eligible Person, it cannot be reinstated without the approval of the Plan's Board of Trustees.

OPTIONAL CONTINUATION COVERAGE UNDER COBRA CLASS I, CLASS II, AND CLASS III EMPLOYEES

Under the Consolidated Omnibus Budget Reconciliation Act (COBRA), all employees and qualified beneficiaries (Eligible Dependents) currently covered under the Plan are eligible for continued coverage if certain conditions are met.

If you are an Employee or Dependent eligible under the Plan you have a right to choose continuation coverage for up to eighteen (18) months if you lose eligibility because of a reduction in the employee's hours of employment or termination of employment (for reasons other than gross misconduct on your part). The potential eighteen (18) months' duration will include any self-payments and will be measured from the day of the triggering event.

The law also requires that the Plan provide you with continued health care coverage for a period of twenty-nine (29) months if you become Disabled while eligible under the Plan (as determined by Social Security). You must inform the Fund Office of your Social Security Disability determination and of your desire to choose continuation coverage within sixty (60) days of the Disability determination. The period of any other self-payments will count toward the twenty-nine (29) months' duration.

If you are the spouse of an Eligible Employee, you have the right to choose continuation coverage for up to thirty-six (36) months for yourself if you lose health care coverage for any of the following reasons:

- The Employee's death; or
- Divorce or legal separation from your spouse; or
- Your spouse's entitlement to Medicare.

For a dependent Child of an Employee covered by the Plan, he or she has the right to continuation coverage for up to thirty-six (36) months if eligibility is lost for any of the following reasons:

- The Employee's death; or
- Parents' divorce or legal separation; or
- A parent's entitlement to Medicare; or
- Loss of eligibility because the dependent ceases to be a "Dependent Child" as defined in this Plan.

The potential thirty-six (36) months' duration for spouses and other dependents will include any self-payments, and will be measured from the day of the triggering event.

Under the law, **the employee or a family member has the responsibility to inform the Fund Office in writing within sixty (60) days** of a divorce, legal separation, or a child losing dependent status under the Plan. Your Employer has the responsibility to

notify the Fund Office of the Employee's death, termination of employment, reduction in hours, or Medicare eligibility.

When the Fund Office is notified that one of these events has happened, it will in turn notify you that you have the right to choose continuation coverage. Under the law, you have sixty (60) days from the date you would lose coverage to inform the Fund Office that you want continuation coverage.

If you do not choose continuation coverage, your health care benefits will end.

If you choose continuation coverage, the Plan is required by law to offer you coverage that, as of the time coverage is being provided, is identical to the coverage provided under the Plan to similarly situated employees or family members (but loss of time, and any death and accidental death and dismemberment benefits are not available).

The law provides that continuation coverage may be cut short for any of the following five reasons:

- The Plan no longer provides health care coverage; or
- The contribution for your continuation coverage is not paid timely; or
- You become covered under another health care plan (unless there is a preexisting condition limitation that would result in denial of benefits); or
- You become entitled to Medicare; or
- You were divorced from a covered employee and subsequently remarry and are covered under your new spouse's health care plan (unless there is a preexisting condition limitation that would result in a denial of benefits).

You do not have to show that you are insurable to choose continuation coverage. However, under the law, you have to pay the cost plus an administrative fee for continuation coverage. Disabled persons may pay a larger fee because of the cost to provide this coverage.

IMPORTANT

- If, after you elect COBRA and while you are paying the reduced premium, you become eligible for other group health plan coverage or Medicare you MUST notify the plan in writing. If you do not, you may be subject to a tax penalty.
- Electing the premium reduction disqualifies you for the Health Coverage Tax Credit. If you are eligible for the Health Coverage Tax Credit, which could be more valuable than the premium reduction, you will have received a notification from the IRS.

- The amount of the premium reduction is recaptured for certain high income individuals. If the amount you earn for the year is more than $125,000 (or $250,000 for married couples filing a joint federal income tax return) all or part of the premium reduction may be recaptured by an increase in your income tax liability for the year. If you think that your income may exceed the amounts above, you may wish to consider waiving your right to the premium reduction. For more information, consult your tax preparer or visit the IRS webpage on ARRA at www.irs.gov.

There may be other coverage options for you and your family. When key parts of the health care law take effect, you'll be able to buy coverage through the Health Insurance Marketplace. In the Marketplace, you could be eligible for a new kind of tax credit that lowers your monthly premiums right away, and you can see what your premium, deductibles, and out-of-pocket costs will be before you make a decision to enroll. Being eligible for COBRA does not limit your eligibility for coverage for a tax credit through the Marketplace. Additionally, you may qualify for a special enrollment opportunity for another group health plan for which you are eligible (such as a spouse's plan), even if the plan generally does not accept late enrollees, if you request enrollment within 30 days.

For general information regarding your plan's COBRA coverage you can contact the Plan's Office of Administrative Manager, Compensation Programs of Ohio, Inc., 33 Fitch Blvd., Austintown, Ohio 44515, (800) 435-2388.

If you are denied treatment as an "Assistance Eligible Individual," you may have the right to have the denial reviewed. For more information regarding reviews or for general information about the ARRA Premium Reduction, go to: www.dol.Qov/COBRA or call 1-866-444-EBSA (3272).

The Trade Act of 2002 created a new tax credit for certain individuals who become eligible for trade adjustment assistance and for certain retired employees who are receiving pension payments from the Pension Benefit Guaranty Corporation (PBGC) (eligible individuals). Under the new tax provisions, eligible individuals can either take a tax credit or get advance payment of 65% of premiums paid for qualified health insurance, including continuation coverage. If you have questions about these new tax provisions, you may call the Health Care Tax Credit Customer Contact Center toll-free at 1-866-628-4282. TTD/TTY callers may call toll-free at 1-866-626-4282. More information about the Trade Act is also available at www.doleta.gov/tradeact/2002act_index.asp.

And, for more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA web site at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

Eligibility for Early Retirees and Dependents (Under Age 65)

You are able to continue your coverage as an Early Retiree and coverage for your Dependents through timely self-payments if you:

- have had at least twenty (20) quarters of eligible participation in this Welfare Plan out of the forty (40) quarters immediately before retirement date; and

- have had at least twelve (12) consecutive months eligible participation in this Welfare Plan immediate before retirement date; and

- are receiving a pension or early retirement benefits under the Federal Social Security Act; and:

- are retired from Covered Employment in the trade.

You must notify the Fund Office in writing that you want to maintain eligibility through the retiree program within thirty-one (31) days of the last month in which you are covered as an active Employee or Retiree.

You will be notified by the Fund Office of the amount due. Self-payments must be made from the date coverage was lost. These self-payments count toward the duration of COBRA continuation coverage. If you fail to make a self-payment, you lose your coverage and it cannot be reinstated. Benefits will terminate when you become eligible for the Normal Retiree Program.

Coverage for the Early Retiree's Dependents as of the Retiree's effective retirement date may be continued for the same periods, as set forth above, upon timely self-payment. Dependents acquired after the Retiree's effective retirement date will not be eligible for benefits under this Plan.

Retiree benefits have been made available by the Trustees as a privilege, not a right. No person acquires a vested right to such benefits, either before or after their retirement. The Trustees may expand, reduce, or cancel coverage for Retirees, change eligibility requirements or the amount of self-payments and otherwise exercise their prudent discretion at any time without legal right or recourse by a Retiree or any other person.

Eligibility for Disabled Retirees and Dependents

If you are Totally and Permanently Disabled, you are able to continue eligibility under the Disability Retiree program for you and your Dependents through timely self-payments if:

- you were an active, Eligible Employee in the Plan for a total of twenty (20) quarters out of the forty (40) quarters immediately before your Disability; and

- you were an active, Eligible Employee in the Plan for a total of twelve (12) consecutive months immediately before your Disability; and

- you were an Eligible Employee immediately before the date that the Total and Permanent Disability was incurred; and

- you have received your Social Security disability award; and

- you are retired from Covered Employment in the trade.

The Disabled Employee must notify the Fund Office in writing that he wants to maintain his eligibility through self-payments within thirty-one (31) days of the last month in which he was covered as an active employee or retires. He will be notified by the Fund Office of the amount due. If he fails to make a timely self-payment, he loses his eligibility and it cannot be reinstated. Self-payments must be made from the date coverage was lost, and will be counted toward any required COBRA continuation coverage.

Coverage will terminate if your self-payments are late, your Disability ends and you are able to return to active employment, or you become eligible for the Normal Retiree Program.

Coverage for the Disabled Employee's Dependents as of the effective date of disability may be continued for the same periods, as set forth above, upon timely self-payment. Dependents acquired after the Disabled Employee's effective disability date will not be eligible for benefits under this Plan.

Disabled Employee benefits have been made available by the Trustees as a privilege, not a right. No person acquires a vested right to such benefits, either before or after the Employee becomes disabled. The Trustees may expand, reduce or cancel coverage for Disabled Employees, change eligibility requirements or the amount of self-payments and otherwise exercise their prudent discretion at any time without legal right or recourse by a Disabled Employee or any other person.

Eligibility for Normal Retirees (Over Age 65)

If you are a Normal Retiree, you are able to continue your eligibility through timely self-payments if:

- you had at least twenty (20) quarters eligible participation in this Welfare Plan out of the forty (40) quarters immediately before you retire; and

- you had at least twelve (12) consecutive months eligible participation in this Welfare Plan immediately before you retired; and

- you are at least sixty-five (65) years of age; and

- you are retired from Covered Employment in the trade; and

- you are receiving retirement or Total and Permanent Disability benefits from a qualified pension or corporate retirement plan and/or are receiving disability or retirement benefits under the Social Security Act.

You must notify the Fund Office in writing that you want to maintain your eligibility through the Normal Retiree Program within thirty-one (31) days of the last month in which you were covered as an active employee or Early or Disabled Retiree. You will be notified by the Fund Office of the amount due. Self-payments must be made from the date coverage was lost, and will be counted toward any required COBRA continuation coverage. If you fail to make a self-payment, you lose your coverage and it cannot be reinstated.

Coverage for the Normal Retiree's Dependents as of the Retiree's effective retirement date may be continued for the same periods, as set forth above, upon timely self-payment. Dependents acquired after the Retiree's effective retirement date will not be eligible for benefits under this Plan.

Retiree benefits have been made available by the Trustees as a privilege, not a right. No person acquires a vested right to such benefits, either before or after their retirement. The Trustees may expand, reduce or cancel coverage for Retirees, change eligibility requirements or the amount of self-payments and otherwise exercise their prudent discretion at any time without legal right or recourse by a Retiree or any other person.

Eligibility for Surviving Spouses

Coverage under the Plan for the Surviving Spouse at the death of the Spouse’s Early Retiree, Disabled Retiree, Normal Retiree, or Eligible Employee shall terminate at the end of the Eligibility month in which the Retiree/Eligible Employee had last obtained eligibility. The Surviving Spouse may continue coverage by making required self-payments so long as such coverage is elected within sixty (60) days following the Employee's or Retiree's death.

If the surviving spouse fails to join the surviving spouse program within sixty (60) days after the death of the Eligible Retired Employee or Eligible Employee, or if the surviving spouse, upon joining the program, fails to make the contributions required by the Trustees, eligibility for participation shall terminate and the surviving spouse shall not be able to be reinstated to the surviving spouse program in the future.

Coverage for Surviving Spouses would also cease on the earliest of the following:

- The date after the eligible retiree/employee’s death on which the surviving spouse first becomes covered by a plan (excluding Medicare) under which the spouse was not covered prior to the retiree/employee’s death; or

- The date the Spouse remarries; or
- The date the Spouse dies.

Coverage for dependents of the deceased Eligible Employee or Retiree upon death may be continued for the same periods, as set forth above, upon timely self-payment.

Surviving spouse benefits have been made available by the Trustees as a privilege, not a right. No surviving spouse or dependent acquires a vested right to benefits, either before or after the Employee's death. The Board of Trustees may expand, reduce or cancel coverage for surviving spouses and/or dependents, change eligibility requirements and/or the self-pay rate and otherwise exercise its discretion at any time without legal right to recourse by a surviving spouse, dependent or any other person.

Information Regarding Eligibility

Any questions concerning your eligibility should be directed to the Fund Office, 33 Fitch Boulevard, Austintown, Ohio 44515 or by calling telephone number (800) 435-2388.

HOW TO FILE A CLAIM

All claims are to be forwarded to either Medical Mutual of Ohio at P.O. Box 6018, Cleveland, Ohio 44101 or FrontPath Repricing at P.O. Box 5810, Troy, Michigan 48007.

Claim forms and instructions may be obtained from the Fund Office.

Claim forms must be completed by you in all cases. The Hospital may submit their own form and need not complete one of ours. If your doctor is submitting a claim, he must fill out the doctor's portion of the claim form. For every Hospital stay, the doctor must fill out his portion of the claim form before the doctor bill will be processed.

To complete your claim payment, we must have:

- Claim forms completed by yourself and your Physician.
- Itemized bills submitted by the Hospital to which you were admitted.
- Itemized bills for ambulance or anesthesia charges involved in your claim.
- When a Hospital stay is indicated, payment will not be made until both Physician and Hospital forms are submitted to the claim office.

Claims made beyond one year from the date of service will not be paid.

CLAIMS SETTLEMENT/APPEALS PROCEDURE

You or your authorized representative may appeal the decision by the Fund's Administrative Office to deny any claim for medical, dental, vision, sickness, death or accidental death and dismemberment benefits in whole or part. An "authorized representative" must be designated in writing to act on your behalf and the extent of the person's authority must be clearly indicated in the authorization. Additionally, any point of service purchase of prescription benefits which is not covered at the pharmacy can be appealed through this Review Procedure.

First Level Review

You may file a written notice of appeal to the Administrative Manager for the Board of Trustees at any time within 180 days after the mailing of the Notice of Adverse Benefit Determination. The written notice of appeal only needs to state your name, address, social security number, phone number, date, and the fact that you are appealing from the decision of the Fund's Administrative Office, giving the date of the Notice of Adverse Benefit Determination. For appeals from a denial by Medical Mutual, the Notice of Appeal should be sent to Medical Mutual of Ohio, Member Appeals Units, MZ:01-4B-4809, P.O. Box 94580, Cleveland, Ohio 44101. For all other denials at the first level review, the notice of appeal should be sent to:

Administrative Manager
Ohio Conference of Plasterers & Cement Masons Health & Welfare Plan
33 Fitch Blvd.
Austintown, Ohio 44515

During the appeals process, you will also be afforded access to all relevant information related to your claim for benefits and its denial and may submit written issues and comments pertinent to the appeal. Additionally, you or your representative may submit additional information prior to any determination on your appeal.

If an appeal requires medical judgment, the Administrative Manager shall consult an appropriate health professional and will disclose the identity of such individual to you upon request.

The Administrative Manager will consider your appeal of a claim for payment of services which you already obtained, called a "post-service claim", as soon as possible after receipt of your request. You will be notified of the decision of the Administrative Manager within thirty (30) days of the date the request for a First Level review is received.

In the event that the denial is upheld, you will receive a written Notice which includes the following information:

- The specific reason for the denial;

- The sections of the Plan and/or Summary Plan Description upon which the denial was based;

- A statement advising you of any internal guidelines or protocol used in making the decision, if applicable, and your right to receive a copy;

- A notice of your right to a written explanation of any exclusion which affects your claim, if applicable; and

- A notice of your right to file a second level appeal to the Benefits Committee of the Board of Trustees.

The decision of the Administrative Manager is final and binding unless it is appealed to the Benefits Committee under the procedures provided below for Second Level Reviews.

Second Level Review

You may file a written notice of appeal to the Benefits Committee for the Board of Trustees at any time within sixty (60) days after the Administrative Manager's mailing of the Notice of Denial of the First Level Review. The written notice of appeal only needs to state your name, address, phone number, social security number and the fact that you are appealing from the decision of the Fund's Administrative Manager, giving the date of that decision. The Appeal should be addressed as follows:

Benefits Committee
Ohio Conference of Plasterers & Cement Masons Health & Welfare Plan
33 Fitch Blvd.
Austintown, Ohio 44515

During the appeals process, you will also be afforded access to all relevant information related to your claim for benefits and its denial and may submit written issues and comments pertinent to the appeal. Additionally, you or your representative may submit additional information prior to any determination on your appeal.

If an appeal requires medical judgment, the Benefits Committee shall consult an appropriate health professional and will disclose the identity of such individual to you upon request.

The Benefits Committee will consider your appeal of a claim for payment of services which you already obtained, called a "post-service claim", as soon as possible after receipt of your request. You will be notified of the decision of the Benefits Committee within thirty (30) days of the date the request for a Second Level review is received.

In the event that the denial is upheld, you will receive a written Notice which includes the following information:

- The specific reason for the denial;

- The sections of the Plan and/or Summary Plan Description upon which the denial was based;

- A statement advising you of any internal guidelines or protocol used in making the decision, if applicable, and your right to receive a copy;

- A notice of your right to a written explanation of any exclusion which affects your claim, if applicable;

- A notice of your right to file a voluntary appeal to the full Board of Trustees as provided below; and

- A notice of your right to file a lawsuit under ERISA Section 502(a).

The decision of the Benefits Committee for the Board of Trustees is final and binding.

Voluntary Appeal to the Board of Trustees

Once you have filed your appeal through the two levels of review, you have the right to file a lawsuit in federal court. However, prior to filing a lawsuit, you can file a voluntary appeal to the full Board of Trustees. You must file the Notice of Voluntary Appeal to the Board of Trustees within sixty (60) days of the Administrative Manager's mailing Notice of Final Decision by the Benefits Committee.

Your Appeal should be addressed as follows:

Board of Trustees
Ohio Conference of Plasterers & Cement Masons Health & Welfare Plan
33 Fitch Blvd.
Austintown, Ohio 44515

The Board of Trustees will review the appeal at their next regularly scheduled meeting. In the event that the Trustees are unable to address your appeal at their next scheduled meeting, you will be notified that the decision will be delayed and the date of the following meeting at which your appeal will be reviewed. You will receive notice of the decision of the Board of Trustees as soon as possible after the decision is made.

In the event that you file a voluntary appeal with the Board of Trustees:

- The Fund will not assert a failure to exhaust administrative remedies;

- The Fund agrees that any Statute of Limitations applicable to pursuing the claim in court will be tolled during the period of the voluntary appeal process;

- The Fund requires that the voluntary level of appeal is available only after the Claimant has pursued the required appeal(s);

- You, upon request, shall be provided sufficient information relating to the voluntary level of appeal to enable you to make an informed decision about whether to submit a benefit dispute to this procedure including:

    - A statement that using this procedure will have no effect on your right to receive other benefits under this Fund;

    - A statement that you have the right to have a personal representative with regard to your claim;

    - A notice of any circumstances which may impair the impartiality of the Board of Trustees;

- The Fund will not impose any fees or costs on you as part of this voluntary appeal process.

In the event the denial is upheld, you will receive a written notice which includes the following information:

- The specific reason for the denial;

- The sections of the Plan and/or Summary Plan Description upon which the denial was based;

- As statement advising you of any internal guidelines or protocol used in making the decision, if applicable, and your right to receive a copy;

- A notice of your right to a written explanation of any exclusion which affects your claim, if applicable; and

- A notice of your right to file a lawsuit under ERISA Section 502(a).

BASIC BENEFITS

Hospital Facility Services

You will receive benefits for each day of Hospital room and board expense incurred up to the Daily Room and Board Benefits and Maximum Room and Board Benefit, for any one period of Confinement, specified in the Schedule of Benefits.

Other Hospital Charges

You will also be reimbursed up to the Maximum Miscellaneous Hospital Benefit for the charges made by the Hospital for miscellaneous items, such as the use of an operating

room, X-rays, laboratory tests, medicines, charges for the administration of anesthetic and for professional ambulance service to and from the hospital, while Room and Board Benefits are payable under the Plan.

There is no limit to the number of hospital confinements for which benefits will be paid if they are due to unrelated causes or complete recovery from the previous injuries or sickness has occurred or if they are separated by your return to active full-time work for two consecutive weeks.

Outpatient Hospital Treatment

If Hospital charges are incurred where (1) Emergency treatment is provided within twenty-four (24) hours of an Accidental Injury or (2) surgery is performed, payment will be made up to the Maximum Payable Benefit, as outlined in the Schedule of Benefits, although the individual is not an Inpatient.

HOME HEALTH CARE BENEFITS

In accordance with the Schedule of Benefits, this benefit is intended to allow you to receive treatment in your home, rather than as a Hospital Inpatient. Payment will be made for necessary medical services and supplies provided in a private residence (not necessarily in your home).

"Home Health Care Plan" means a program for continued care and treatment of you or your dependent, established and approved in writing by the attending Physician along with the Physician's certification that proper treatment of the injury or illness would require confinement as an Inpatient in the absence of the services and supplies provided as part of the Home Health Care Plan.

The following services are covered under this benefit:

- Part-time or intermittent nursing care by a registered nurse or by a licensed practical nurse under the supervision of a registered nurse if the services of a registered nurse are not available.

- Part-time or intermittent home health aide services, consisting primarily of patient care of a medical or therapeutic nature, by other than a registered or licensed practical nurse;

- Physical therapy, occupational therapy, and speech therapy provided by the home health care agency; and

- Medical supplies, drugs and medication prescribed by a physician and laboratory services by or on behalf of a Hospital, to the extent such items would have been covered under the Plan if the individual was confined in the Hospital.

Limitations

No payment will be made for:

- Services provided by a person who ordinarily resides in the household or is an Immediate Relative;
- Custodial Care;
- Charges made by the owner of the residence;
- Transportation service;
- Charges incurred for housekeeping services, maid services, unless they are necessary in conjunction with services to provide medical treatment to you;
- Charges incurred for services provided in excess of forty (40) days per calendar year (one visit by a member of a home health care team equals one day);
- Services or supplies furnished on account of sickness resulting from Occupational Disease or Occupational Injury.
- Services or supplies not included in the home health care plan; or
- Any period during which the individual is not under the continuing care of a Physician.
- See also, Exclusions and Limitations.

HOSPICE CARE BENEFITS

Eligibility

To be eligible for hospice care benefits you must meet all of the following requirements:

- Be eligible for regular Plan benefits;
- Be certified by a Physician as having a life expectancy of six months or less;
- Have submitted an election statement to the Plan choosing hospice care in lieu of all other Plan benefits.
- An election may be revoked at any time to resume regular Plan benefits.

Covered Services

Covered Services shall include all Reasonable and Necessary services for the care or management of the terminal illness as well as related conditions. Covered services shall include Physician services, nursing services, Inpatient care, home health and homemaker service, physical and occupational therapy, medical supplies, drugs, and counseling services.

Election of hospice benefits results in the waiver of all other Plan benefits except for services of the patient's attending Physician, provided that Physician is not employed or compensated by the hospice. In addition, Plan benefits for items and services for diagnosis and treatment of an illness or injury not related to the terminal illness will be provided.

Benefits

Benefits shall be payable up to the allowance for payments under the federal Medicare law for the geographic area in which the hospice is located, as follows:

- Continuous home care - when patient requires at least eight hours of care daily during crisis periods when a patient elects not to be hospitalized.

- Routine home care.

- General Inpatient care - when continuous care is provided in the hospital or similar facility and when less intensive care is not provided.

- Respite Inpatient care - when short-term Inpatient care is required in the Hospital, nursing home or free standing hospice facility, to relieve the family from home care duties, benefits shall be payable up to a maximum of five consecutive days. Benefits for respite Inpatient care shall be paid only when the patient does not require intensive care and when general inpatient care benefits are not payable.

- Physician's services - benefits for Physician's expenses shall be included in the benefits set forth above except when the Physician renders services to the patient outside the scope of normal supervisory activities or when the expenses are those of the patient's attending Physician. Such expenses shall be covered under the applicable limits of the Plan.

Maximum Benefits

The maximum benefits payable per Eligible Person for hospice services shall be the maximum allowance under the federal Medicare law for the geographic area in which the hospice is located.

To the extent that services are provided or expenses incurred by the patient which are not part of the hospice program, such services and expenses shall be considered

covered charges under the applicable plan of benefits that the participant was entitled to at the time he elected to waive those benefits to become eligible for hospice benefits.

SKILLED NURSING CARE FACILITY BENEFITS

Benefits are provided for Inpatient care in a Skilled Nursing Facility after you have been in a Hospital when you no longer need all of the services provided by a Hospital but your condition still requires daily nursing or rehabilitation services, which are provided in a Skilled Nursing Care Facility.

The Plan will pay benefits in accordance with the Schedule of Benefits provided all of the following conditions are met:

- Your Confinement is upon the recommendation and under the supervision of a Physician;

- Your Confinement must begin immediately after your discharge from the Hospital where you must have been confined at least three days; and

- Your Confinement must be for the purpose of receiving continued medical care for the illness or injury for which you were Hospital confined.

You must submit a statement from the Physician certifying that you need and actually receive skilled nursing or skilled rehabilitation services on a daily basis.

No benefits will be payable if you are confined in a home for the aged or a nursing home unless you have met the conditions set forth above and the home you are confined in is a qualified Skilled Nursing Care Facility.

NERVOUS OR MENTAL DISORDERS

Such benefits shall be paid in accordance with the Schedule of Benefits.

Covered Hospital charges, charges for convulsive or shock treatment, and charges for surgery performed as a result of a nervous or mental disorder shall be payable in the same manner as for any other illness subject to the following limitations:

- **Inpatient** services will be covered where rendered at a **Treatment Facility** for Mental and Nervous Disorders which is an institution (or distinct part thereof) which fully meets all of the following:

  - It is primarily engaged in providing, for compensation from its patients, a program for diagnosis, evaluation, and effective treatment of mental or nervous disorders and is not primarily a school or a custodial, recreational or training institution;

- It provides all normal infirmary-level medical services required during the treatment period, whether or not related to the mental or nervous disorder and also provides, or has an agreement with a Hospital in the area to provide, any other medical services required;

- It is under the continuous supervision of a psychiatrist who has the overall responsibility for coordinating patient care and who is at the facility on a regularly scheduled basis;

- It is staffed by psychiatric physicians who are directly involved in the treatment program, at least one of whom is present at all times during the treatment day, and continuously provides the services of a psychiatric nurse and a psychiatric social worker.

- It continuously provides skilled nursing services under the direction of a full-time registered graduate nurse, with licensed nursing personnel on duty at all times;

- A written individual treatment plan is prepared and maintained for each patient based on a diagnostic assessment of the patient's medical, psychological and social needs with documentation that the Plan is under the supervision of a psychiatric Physician; and

- It meets any applicable licensing standards established by the jurisdiction in which it is located.

- Services, Supplies and Facility charges must be Medically Necessary.

- If you are initially confined in a Hospital Treatment Facility but are then transferred to another Treatment Facility approved by the Plan Administrator, both periods of confinement shall constitute a single Confinement.

Subject to the limitations in the Schedule of Benefits and Plan, the Plan will cover services legally performed by or under the clinical supervision of a licensed Physician, a licensed psychologist, or a licensed independent social worker, whether performed in an office, Hospital or other Treatment Facility so long as accredited by the Commission on Accreditation of Hospitals or certified by the Department of Mental Health and Mental Retardation.

Limitations

Coverage for mental and nervous disorders does not include:

- Treatment of mental retardation or mental deficiency; or

- Treatment for training or educational purposes, or self-administered services; or

- Services directed towards self-enhancement, development or perceptual therapy, biofeedback or marriage counseling; or

- Orthomolecular testing and therapy, cathectathon therapy, marathon therapy or collaborative therapy; or

- Treatment of a disorder or condition related to, accompanying, or resulting from the individual's alcoholism or drug abuse unless treatment of such disorder or condition is otherwise covered as a medical benefit herein; or

- Treatment excluded under General Exclusions and Limitations.

SUBSTANCE ABUSE

If you are admitted as an Inpatient for a prescribed course of treatment for alcoholism or drug abuse or dependency (including Detoxification) to a Substance Abuse Treatment Facility) approved by the Plan Administrator, upon the recommendation and approval of a Physician, benefits on account of such treatment will be provided in the same manner as for any other sickness, subject to the following limitations:

- Services cannot be limited to detoxification but, rather, must include a program of rehabilitation and therapy.

- Coverage shall be provided only where the Eligible Person completes the prescribed program of rehabilitation and therapy.

A Substance Abuse Treatment Facility is an institution (or distinct part thereof) which meets fully every one of the following tests:

- It is primarily engaged in providing for compensation from its patients a program for diagnosis, evaluation, and effective treatment of alcoholism or drug abuse.

- It provides all medical Detoxification services on the premises, twenty-four (24) hours a day.

- It provides all normal infirmary-level services required during the treatment period, whether or not related to the alcoholism or drug abuse. Also, it provides, or has an agreement with a Hospital in the area to provide, any other medical services that may be required.

- At all times during the treatment period, it is under the supervision of a staff of Physicians and provides skilled nursing services by licensed nursing personnel under the direction of a full-time registered graduate nurse.

- It prepares and maintains a written individual plan of treatment for each patient based on a diagnostic assessment of the patient's medical, psychological and social needs with documentation that the plan is under the supervision of a Physician.

- It meets any applicable licensing standards established by the jurisdiction in which it is located.

Subject to the limitations in the Schedule of Benefits and Plan, the Plan will cover services legally performed by or under the clinical supervision of a licensed-Physician or licensed psychologist where performed in an office or Alcohol or Drug Abuse Treatment Facility approved by the Joint Commission on Accreditation of Hospitals or certificate by the Department of Health.

Limitations

The following are not Covered Expenses:

- Treatment primarily for Detoxification; or

- Treatment primarily of providing an environment without access to alcohol or drugs; or

- Treatment excluded by Exclusions and Limitations; or

- Charges in excess of the Maximum set forth in the Schedule of Benefits.

SURGICAL BENEFIT

Benefits

The fees charged by the surgeon will be paid based on the appropriate amount set by the Schedule of Benefits.

The operation must be recommended and performed by a Physician. Hospital confinement is not required.

If more than one operation is performed during any one continuous period of disability, a benefit is payable for each operation except that:

- If more than one operation is performed through the same abdominal incision, the total payment for all such operations shall not exceed the maximum payment specified in the schedule for that one of such operations for which the largest amount is payable;

- If more than one operation is performed on the anus or rectum or both (except for cancer) at any one time, the total payment for all such operations

shall not exceed 1 times the maximum payment specified in the Schedule for that one operation for which the largest amount is payable;

- The total payment for all operations performed during one continuous period of disability shall not exceed the maximum Surgical Benefits applicable to the covered person.

BENEFITS FOR MOTHERS AND NEWBORNS

This child birth benefit is for any hospital length of stay in connection with childbirth for the mother or newborn child, following a normal vaginal delivery, to a minimum of forty-eight (48) hours. This benefit is for any hospital length stay in connection with childbirth for the mother or newborn child, following a cesarean section, to a minimum of ninety-six (96) hours. This, however, does not prohibit the Mother's or newborn's attending provider after consulting with the mother, from discharging the mother or her newborn earlier than forty-eight (48) hours (or 96 hours as applicable).

WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998

Medical and surgical benefits with respect to a mastectomy will be covered for an eligible Participant and Dependents of the Plan who elects breast reconstruction in connection with such mastectomy as listed below:

- Reconstruction of the breast on which the mastectomy was performed;

- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and/or

- Prostheses and treatment of physical complications at all stages of the mastectomy, including lymphedemas, in a manner determined in consultation with the attending physician and the patient.

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

X-RAY AND LABORATORY BENEFITS

If you or a Dependent undergo an X-ray or laboratory examination made or recommended by a Physician in connection with the diagnosis of Non-occupational Accidental Injury or Sickness, benefits will be paid in accordance with the Schedule of Benefits.

No benefits are payable for therapeutic X-ray, dental X-rays, or eye refractions; for examination made in connection with dental work or treatment or abortion, after termination of coverage, or for any sickness or injury for which benefits are payable

under the Inpatient and Outpatient professional and charges provisions of the Schedule of Benefits. See also, Exclusions and Limitations.

DESCRIPTION OF BENEFITS

After you satisfy your Plan Deductible, the High and Mid Plans pay eighty percent (80%) of in-network covered Expenses and sixty percent (60%) of out-of-network covered expenses as along as those out-of-network expenses are Reasonable and Customary; the Low Plan pays seventy percent (70%) of in-network covered expenses and 50% of out-of-network covered expenses as long as those out-of-network expenses are Reasonable and Customary. The maximum payment is specified in the Schedule of Benefits. Benefits for each Eligible Dependent will be on the same basis as your own.

THE DEDUCTIBLE

The deductible is the amount of expense which you pay before you are entitled to payment of Plan Benefits.

The deductible applies only once in any Calendar Year even though you may have several different disabilities. Your Calendar Year deductibles are:

$350/person and $700/family under the High Plan in-network; and
$700/person and $1,400/family under the High Plan out-of-network

$500/person and $1,000/family under the Mid Plan in-network; and
$1,000/person and $2,000/family under the Mid Plan out-of-network

$1,000/person and $2,000/family under the Low Plan in-network; and
$2,000/person and $4,000/family under the Low Plan out-of-network

COMMON ACCIDENT

Normally, the deductible is applied separately for each injury or sickness to each Eligible Person in the family. However, if two or more Eligible Persons in your family are injured in the same accident, the Medical Expenses which result from the accident will be combined and only one deductible will be charged against all such expenses, regardless of the number of family members injured.

MEDICAL EXPENSES COVERED

Medical Expenses included under the Plan are the Reasonable and Customary charges outlined below for Necessary medical care and services that are ordered by a Physician:

- The fees for diagnosis, treatment, and surgery by a Physician;

- The charges of a registered graduate nurse for private duty nursing services (other than in-patient hospital nursing);

- Charges made by a duly constituted Hospital, except that the daily room and board charges may not exceed the Room Limitations specified in the Schedule of Benefits;

- Charges for the following: local ambulance service to the nearest facility where appropriate medical treatment can be rendered, equipment, medication, appliances, X-ray services, laboratory tests, physical therapy, anesthetic and the administration thereof, the use of radium and radioactive isotopes, oxygen, iron lung, physiotherapy, and similar Covered Medical Expenses.

ROUTINE PREVENTATIVE CARE BENEFIT COVERED

The Plan will pay charges subject to the maximum payable benefit in the Schedule of Benefits for those routine Preventative Care Benefits as follows:

- One routine papanicolaou test (pap test) per Calendar Year and any office visit incidental to such test;

- Routine mammograms and any office visit incidental to such test;

- Pediatric examinations, hearing tests, laboratory tests, and immunizations;

- Charges for routine physical examinations, x-rays, laboratory tests, and preventative care not necessary for the treatment of any Injury or Sickness; and

- PSA test.

NOTE: Routine preventative care for family is subject to your Plan's deductibles, co-payments, and annual out-of-pocket maximums.

OTHER BENEFITS

DEATH BENEFITS
(Active Participants and Retirees Only)

The Fund will pay the amount of death benefit set forth in the Schedule of Benefits at the time of your death. The Fund Office must receive due proof that you died while eligible for benefits under the Plan. This Benefit is payable for Non-Occupational and Occupational Injury and Diseases.

If a beneficiary is designated, the consent of the beneficiary shall not be required to change the beneficiary, or to make any other changes in the certificate, except as may be specifically provided by the Plan. If any beneficiary shall die before the covered employee, the interest of such beneficiary shall thereupon automatically terminate. If there is no beneficiary designated by the Eligible Person, or surviving at the death of

the Eligible Person, payment will be made in a single sum to the first surviving class of the following classes of successive preference beneficiaries: the Eligible Person's (a) widow or widower, (b) the Eligible Person's estate.

If you become Totally and Permanently Disabled before age sixty (60) and while covered under the Fund, the death benefit in effect at the time you become disabled will be extended for twelve (12) months at no cost to you. Satisfactory proof of disability must be provided within twelve (12) months after the disability commences. You can continue this coverage by submitting proof of your continued disability to the Fund Office each year.

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS
(Active Participants Only)

If you sustain any of the following losses solely through external, violent and accidental means, you will receive the following additional benefit:

Loss of Life $5,000

Loss of Two Limbs, Sight of Both Eyes or
Loss of One Limb and Sight of One Eye $5,000
Loss of One Limb or Sight of One Eye $2,500

The Accidental Death and Dismemberment Benefits are payable for Non-Occupational and Occupational Injury.

SICKNESS AND ACCIDENT BENEFITS
(Employee Only)

Non-Occupational

If you are disabled as a result of a NON-OCCUPATIONAL accident or sickness, you will be entitled to the amount of Non-Occupational benefit indicated under the Schedule of Benefits.

These benefits will be payable to you as of the first day of disability if it is due to an accident, or as of the eighth day of disability if it is due to sickness, up to the Maximum Period of Benefits specified in the Schedule of Benefits for any one continuous period of disability due to the same or related cause or causes. Successive periods of disability separated by less than two (2) weeks of continuous active employment shall be considered as one continuous period of disability unless they arise from different and unrelated causes.

It is not necessary to be confined to your home to collect benefits, but you must be under the care of a Physician. No disability will be considered as beginning more than three days before the first visit with a physician.

Occupational

If you are disabled as a result of an OCCUPATIONAL accident or sickness for which you are entitled to receive benefits under a workers' compensation or occupational disease law, you will be entitled to the Occupational Sickness and Accident benefit indicated under the Schedule of Benefits.

Note: You cannot collect State unemployment benefits and Sickness and Accidental benefits for the same period.

SMOKING CESSATION

The Plan provides coverage under the Ohio Tobacco QUIT LINE. The QUIT LINE provides individualized telephone tobacco cessation coaching for Ohio resident members and/or adult dependents.

As part of this program, the QUIT LINE will provide nicotine replacement therapy in the form of nicotine patches to member enrollees. Up to an eight-week supply will be shipped in two four-week supply increments, with the second shipment occurring only upon continued enrollment in the coaching program.

To participate, the Ohio resident member must call the Ohio Tobacco QUIT LINE to enroll and identify his/herself as a member of the Ohio Conference of Plasterers and Cement Masons Health & Welfare Plan. The QUIT LINE specialist will verify such membership, and the member will then receive the patches, as outlined above, free of charge. Members and/or adult dependents are limited to one eight-week supply for each twelve-month period.

Pursuant to the terms and limitations of the Plan’s Prescription Drug Benefit, the Plan also covers the prescribed drug Chantix, a medication for smoking cessation.

EMERGENCY SERVICES

You are covered for Medically Necessary Emergency Services for an Emergency Medical Condition. Emergency Services are available 24 hours a day, 7 days a week. If you are experiencing an Emergency Medical Condition, call 9-1-1 or go to the nearest Hospital to obtain Emergency Services. Care and treatment once you are stabilized are not Emergency Services. Continuation of care beyond that needed to evaluate or stabilize your Emergency Medical Condition will be covered according to your Schedule of Benefits. Please refer to your Schedule of Benefits for a detailed coverage explanation.

EXCLUSIONS AND LIMITATIONS

The Plan will not cover charges related to:

- Confinement in a hospital owned or operated by a government agency or instrumentality.

- Custodial Care, nursing home, rest care, or housekeeping services.

- Charges that a covered individual is not required to pay.

- Services performed on or to the teeth, nerves of the teeth, gingiva or alveolar processes, except to tumors or cysts or except as required because of accidental injuries to sound, natural teeth occurring while insured hereunder.

- Cosmetic surgery, except as required because of Accidental Injuries occurring while insured or, in the case of surgery related to a mastectomy, for reconstruction of the breast on which the mastectomy was performed; surgery and reconstruction of the other breast to produce a symmetrical appearance; and/or prostheses and treatment of physical complications at all stages of the mastectomy, including lymphedemas;

- Eye refractions;

- Transportation, except local ambulance service to the closest facility where appropriate services can be obtained;

- Injuries as a result of war, declared or undeclared, including armed aggression; or service connected disabilities incurred or aggravated in the line of duty;

- Occupational Injury or Occupational Sickness, except for Death Benefits and certain Sickness and Accident Benefits;

- Services, supplies, or facilities which are not Medically Necessary or which are Experimental;

- Charges for telephone, television, patient care kits, personal convenience items or services, barbers and beauty aids;

- Routine physical examination, including, but not limited to, pre-marital or pre-employment examinations; and dental and vision examinations (except as otherwise provided under Preventative Care Benefits and/or the dental/vision plan);

- Cost of social workers, education and job retraining, and learning disabilities;

- Maintenance Therapy;

- Acupuncture and related expenses;

- Sex-change operations, gender dysphoria, penile and breast implant, infertility, artificial insemination, in vitro fertilization, gamete intrafallopian transfer (GIFT), and services of a surrogate mother;

- Services of more than one Physician rendering treatment for the same condition;

- Charges for keratotomies or keratoplasties;

- Charges for telephone consultations, missed appointments, completion of claim forms or preparation of medical reports;

- Family and marital counseling;

- Temporomandibular Joint Syndrome (“TMJ”);

- Maternity and obstetrical benefits for dependent children;

- Hearing aids;

- No benefits are payable for services (treatment) or supplies to treat hair loss or to restore lost hair;

- No benefits are payable for chelation therapy except for arsenic, gold, mercury or lead poisoning;

- Personal hygiene and convenience items (such as, but not limited to, air conditioners, humidifiers, hot tubs, whirlpools, sunbeds, waterbeds, physical fitness equipment or like items), weight control programs, transportation vehicles or home improvements, health club or country club memberships even though a Physician may prescribe them;

- No benefits are payable for services or supplies related to the treatment for abuse of nicotine from tobacco and other sources;

- Any injury sustained while the Participant/Beneficiary performed an act which was in violation of any federal, state or local criminal statute (felony or misdemeanor), and regardless of whether charged, indicted, or convicted;

- Any injury or illness relating, wholly or partly, directly or indirectly, to the ingestion of illegal drugs;

- Services or supplies for sterilization reversal;

- Services, supplies and treatment before you become eligible or after your eligibility terminates;

- Air ambulance costs, where no life-threatening medical emergency is established or to the extent costs exceed Two Thousand Dollars ($2,000);

- Growth hormones, unless the treatment is otherwise Medically necessary;

- Surgery performed for the removal of excess fat of skin after weight loss or pregnancy unless Medically Necessary;

- Over-the-counter drugs or vitamins;

- H1N1 Immunizations;

- Contraceptives;

- Services or treatment provided by an Immediate Relative;

- Charges in excess of those which are Reasonable and Customary;

- An injury for which you are reimbursed or entitled to be reimbursed by any third party for which such third party is liable;

- Food supplements or augmentation;

- Corrective shoes, arch supports and foot care only to improve comfort or appearance such as subluxation (except capsular or bone surgery);

- Court-ordered services; and

- Sales Tax.

- Exogenous Obesity, except for Gastric Restrictive Surgery (surgical treatment of Morbid Obesity), when medically necessary. A Participant's or Dependent's medical necessity for such surgery is defined as follows:

    - Documented five (5) year history of morbid obesity (body mass index (BMI) over 40 kg/m^2) or a BMI greater than thirty-five (35) and a clinically serious condition such as coronary heart disease, type 2 diabetes mellitus, obstructive sleep apnea, or hypertension; and

    - The Participant or Dependent must be treated in a surgical program with experience in obesity surgery and which includes a multidisciplinary preoperative and postoperative approach; and

    - The Participant or Dependent must participate in a six (6) month treatment plan within the year preceding surgery which includes a multidisciplinary non-surgical program including a low or very low calorie

diet, increased physical activity, and behavior reinforcement under the direction of the physician who refers the patient for such surgery; and

- Documented failure of non-surgical methods of weight reduction; and

- Absence of significant pyschopathology that can limit an individual's understanding of the procedure or ability to comply with medical/surgical recommendations; and

- Documentation that the Participant or Dependent has received counseling post-operatively regarding cosmetic difficulties and that the patient has agreed to post-operative treatment plans; and

- Participant or Dependent must be at least eighteen (18) years of age.

Any Gastric Restrictive Surgery must be pre-certified and coordinated with Medical Mutual or, for Frontpath participants, the surgery must be pre-certified by the Plan Administrator. However, Gastric Banding is not covered under this Plan as an Eligible Expense.

If the Participant or Dependent meets the above requirements, the maximum annual benefit shall be as provided in the Schedule of Benefits for each Plan. Payments shall be subject to the respective High, Mid, and Low Plan co-payments and <u>will</u> <u>not</u> be subject to any out-of-pocket maximums.

However, there is a $25,000 lifetime maximum payment for this surgery.

MEDICAL REIMBURSEMENT ACCOUNTS

For Class I, II, and III Participants, contributions may be made to an individual Medical Reimbursement Account ("MRA"). The MRA shall be an individual sub-account of the Plan for each Participant for whom such contributions are made. <u>These contributions shall not create or constitute a vested benefit</u>.

When a Participant or his/her Eligible Dependent has unreimbursed medical expenses and an existing balance in his/her individual MRA, the Participant may submit, on a form provided by the Fund office, proof of such expenses for reimbursement from their individual MRA. Reimbursement checks shall be processed and issued between the 15th and 20th of the month following the month submitted.

Medical expenses will be reimbursed only to the extent that reimbursement for such medical expenses is not available to the Participant under any health insurance policy or plan provided through any employer of the Participant. Reimbursement, to the extent the Participant has funds in his/her individual MRA, shall be made for the following expenses:

- Deductibles, co-payments, and expenses in excess of benefit maximums applied to covered medical expenses under this Plan or other qualified plan for which the Participant or Dependent spouse receive medical benefits;

- Self-payments to maintain eligibility under this Plan or other qualified plan or arrangement or premium or other payments required to maintain coverage under the Plan of Participant's Spouse;

- Unreimbursed prescription medicines (prescribed by a doctor) and insulin, including co-pays;

- Over the counter medicine bought with a prescription;

- Unreimbursed dental, orthodontic, or periodontal expenses except for bleaching or bonding if solely for cosmetic reasons;

- Unreimbursed expenses for special items (i.e. artificial limbs or teeth, eyeglasses, contact lenses, hearing aids, crutches, wheelchair, etc.);

- Unreimbursed expenses for medical service fees;

- Unreimbursed expenses incurred by an organ donor including, but not limited to airplane fare and ambulance costs;

- Unreimbursed expenses for transportation needed for medical care including, but not limited to airplane fare, train fare, rental cars, taxi cabs, ambulance costs, lodging (not to exceed $50.00 per night), mileage and/or parking fees;

- Unreimbursed expenses for hospital services fees (diagnostics lab work, therapy, nursing services, surgery, etc.);

- Unreimbursed expenses for hospital bed if prescribed by a doctor or physician for an individual who has osteoporosis;

- Unreimbursed expenses for physical therapy (pursuant to recommendation of a doctor or physician) chiropractic services or massage therapy;

- Unreimbursed expenses for optometrists' fees, eye exams, eyeglasses, contact lenses, saline solution and lens insurance;

- Unreimbursed expenses for dermatology;

- Unreimbursed expenses for the excess costs of orthopedic shoes (amount in excess of regular cost of shoes) or actual cost of elastic stockings;

- Unreimbursed expenses for Dependent's transportation costs where presence of family member necessary to obtain medical care;

- Unreimbursed expenses for excess cost of protein rich food (to mitigate effects of hypoglycemia) upon written recommendation of doctor or physician;

- Unreimbursed expenses for inpatient care including but not limited to meals and lodging furnished in connection with such health care;

- Unreimbursed expenses for oxygen equipment to alleviate difficulty in breathing;

- Unreimbursed expenses for reclining chair, if prescribed for person with heart condition to give him or her maximum rest;

- Unreimbursed expenses for routine physicals;

- Unreimbursed expenses for swimming pool, therapy spa (in-home) and spa (and upkeep) for treatment of degenerative spinal problems, arthritis, polio, severe emphysema, bronchitis and osteoarthritis;

- Unreimbursed expenses related to TMJ;

- Unreimbursed expenses for trip to a location with therapeutic climate to improve specific medical condition if change in locality is medically recognized treatment;

- Unreimbursed expenses for vaccinations or well-baby care;

- Unreimbursed expenses for weight loss program if prescribed by doctor or physician for treatment of hypertension, obesity, and stress directly related to excessive weight;

- Unreimbursed expenses for gastric restrictive surgery to the extent that a Participant's or Dependent's medical condition or status renders the Participant or Dependent eligible, based upon the Plan's requirements , for such surgery;

- Unreimbursed expenses for installation of an elevator or inclinator (if detachable from the property and bought only for use of sick person) in Participant's home, due to medical necessity;

- Unreimbursed expenses for equipment or improvements to the Employee's home needed for specific medical care needs;

- Unreimbursed expenses associated with building of an attached garage for disabled individual medically limited to walking as little as possible;

- Unreimbursed expenses for room air conditioner (if detachable and bought only for the use of a sick person (for example for allergy relief or difficulty in breathing due to a heart condition));

- Unreimbursed expenses for central air conditioning (where recommended by doctor where a person's medical condition requires relatively constant temperature and high humidity);

- Unreimbursed expenses for an air purifier or humidifier (where prescribed by doctor or physician for individual suffering from allergies);

- Unreimbursed expenses for bathroom facility with shower (if on ground floor and for an individual who cannot climb stairs or get into and out of bathtub as a result of arthritis and severe heart condition;

- Unreimbursed expenses associated with creation of dust-free room built for allergy sufferer upon written recommendation of doctor of physician;

- Unreimbursed expenses for costs and care of guide dogs and other animals aiding the blind, deaf and disabled;

- Unreimbursed expenses for costs of guide to walk blind person(s) from home to school or work;

- Unreimbursed expenses for Braille books and magazines (to the extent the costs of such books exceed the amount paid over regular printed books) for visually impaired Participants or Dependents;

- Unreimbursed expenses for note taker (school) for deaf person;

- Unreimbursed expenses for hearing aids (and batteries) and telephones (for hearing impaired);

- Unreimbursed expenses for visual alert system (for deaf person);

- Unreimbursed expenses for birth control pills (prescribed);

- Unreimbursed expenses for vasectomy or sterilization procedures;

- Unreimbursed expenses for in vitro fertilization due to congenital or other medical problems;

- Unreimbursed abortions, if legal where performed;

- Unreimbursed expenses for a breast pump;

- Unreimbursed expenses for childbirth classes (does not apply to mother's coach);

- Unreimbursed expenses for diapers if medically necessary due to severe neurological condition and upon written recommendation of doctor or physician;

- Unreimbursed expenses for marriage counseling, if performed by a licensed psychologists, psychiatrist, therapist or social worker (not by religious leader, i.e. clergy);

- Unreimbursed expenses for sexual inadequacy and incompatibility treatment;

- Unreimbursed expenses for treatment at a drug or alcohol center (includes meal, lodging provided by the center and mileage for transportation);

- Unreimbursed expenses for special school or home for mentally, physically or learning disabled persons;

- Unreimbursed expenses for confinement in mental institution if mentally ill person is unsafe when left alone;

- Unreimbursed expenses associated with halfway house fee if individual is receiving continuing psychiatric supervision;

- Unreimbursed expenses for language training and remedial reading coursed for children with dyslexia;

- Unreimbursed expenses for parents visits to their child if child's doctor or physician advises it to be a necessary part of the child's therapy;

- Unreimbursed expenses for patterning exercise (i.e. physical manipulation of child's limbs to imitate crawling and other normal movements for mentally retarded or mentally handicapped child;

- Unreimbursed expenses for fees for psychologists' fees, psychoanalysis or social worker (as recommended by a psychiatrist for specific treatment);

- Unreimbursed expenses for invalid care;

- Unreimbursed expenses for a portion of any lump-sum advance payment for lifetime care in retirement home, to the extent allocable to medical care;

- Unreimbursed expenses for nursing care including, but not limited to, nurse's lodging expenses is due to Participant's or Dependent's illness;

- Unreimbursed expenses for the transportation expenses of nursing attendance for disabled Participant or Dependent who travels away from home;

- Unreimbursed expenses for nursing home;

- Unreimbursed expenses for acupuncture;

- Unreimbursed expenses for alternative, non-over-the-counter (i.e. herbalist, holistic and homeopathic practitioner if state licensed);

- Unreimbursed medical expenses for biofeedback if it is not related to a specific medical reason(s);

- Unreimbursed expenses for electrolysis, if medically necessary;

- Unreimbursed expenses for hypnosis;

- Unreimbursed expenses for Indian healing rite, if performed by a medicine man;

- Unreimbursed expenses for pilates classes for chronic arthritis – services performed by physician or licensed provider (RN or therapist);

- Unreimbursed expenses for smoking cessation program or aids (e.g. nicotine gum and patches);

- Unreimbursed expenses for vitamins;

- Unreimbursed expenses for wigs prescribed by doctor or physician for Participant or Dependent who has lost hair as a result of disease; and

- Any other medical expenses identified in Internal Revenue Code Section 213, or regulations promulgated thereunder.

The following items <u>shall</u> <u>not</u> be subject to reimbursement:

- Expenses for which the Participant or Dependent claimed or will claim a medical expense deduction on the Participant's tax returns;

- Expenses incurred before the Participant became initially eligible for medical benefits under the Health and Welfare Plan, unless permitted by Code Section 213;

- Except as otherwise provided herein, expenses incurred after termination of employment and eligibility, unless permitted by Code Section 213;

- Expenses for general health (even if following doctor's advice) such as:
    - Health club dues, unless prescribed by a doctor for a specific health condition;
    - Household help (even if recommended by a doctor);
    - Social activities, such as dancing or swimming lessons; and
    - Trip for general health improvement.
- Surgery or other medical procedures for purely cosmetic reasons;
- Organic food, unless required for specific medical ailment or condition;
- Life insurance or income protection policies or policies providing payment for loss life, limb, sight, etc.
- Nursing services for a healthy baby;
- Medical insurance included in a car insurance policy covering all persons injured in or by the Employee's car;
- Diaper service;
- Bottled or distilled water;
- Toothpaste, toiletries, cosmetics;
- Medical services in a U.S. Government Hospital;
- Medical services provided at no cost through any public program;
- Baby-sitting expenses;
- Expenses for CB radio;
- Expenses for chauffeur;
- Expenses for Church of Scientology "auditing" or processing;
- Expenses for cruises;
- Expenses for dancing lessons;
- Deprogramming fees (for prior member of religious cult);

- Expenses for domestic partner's health expenses unless a dependent for IRS purposes;

- Ear piercing;

- Expenses associated with fallout shelter;

- Funeral expenses;

- Expenses for hair transplants;

- House remodeling, except as otherwise provided for herein;

- Housekeeping and child care expenses;

- Insurance premiums, except as provided for otherwise herein;

- Lawn care expenses;

- Legal expenses, except for expenses associated with having a person legally committed to a hospital;

- Marijuana and other illegal narcotics;

- Maternity clothing;

- Illegal medical operations;

- Dust-elimination system, accept as otherwise provided for herein;

- Except as otherwise provided for herein, remedial reading courses where services are primarily educational rather than medical;

- Resort hotel;

- Any self-treatment;

- Tattoo removal;

- Swimming lessons;

- Television and television equipment, except for closed-caption decoder for deaf person to display audio portion of program (i.e. subtitles);

- Vacation expenses;

- Vacuum cleaning; and

- Medical expenses for which reimbursement is available under another plan or program.

Claims for Medical Expense Reimbursements shall be filed no later than one (1) year following the end of the Calendar Year in which the services were rendered.

In accordance with the Affordable Care Act (ACA), and effective May 1, 2014, the eligible Participant is permitted at least annually to opt out of and waive future reimbursements from the MRA. Further, the Participant is also permitted upon termination of employment, upon retirement, and upon ceasing to be available for covered employment to opt out of and waive future reimbursements from the MRA. However, any such opt out or waiver is permanent, all money in the Participant's MRA account will not go to the Participant but will revert to the general assets of the Plan, and the Participant and his eligible dependent(s) will no longer be entitled to the MRA benefit.

If the Participant does not opt out or waive future reimbursements from his MRA account, then any monies deposited in a Participant's individual MRA shall remain in such account so long as the Participant is actively employed or is available for employment requiring any contributions to the Ohio Conference of Plasterers and Cement Masons Health and Welfare Fund and for a period of time not to exceed eighteen (18) months after the Participant has either terminated employment (other than due to retirement or disability retirement) or is unavailable for employment with an employer who is required to make contributions to the Ohio Conference of Plasterers and Cement Masons Health and Welfare Fund. After the eighteen (18) months have expired since such termination or unavailability, any monies in an individual MRA shall revert to the general assets of the Health and Welfare Fund and shall no longer be a benefit available to the individual Participant or his/her Eligible Dependents. In the event of a Participant's death, his or her individual MRA balance shall be placed in an individual MRA for his or her Spouse, or if unmarried or widowed, for his or her Dependent as allowed by applicable provisions of the Internal Revenue Code or regulations promulgated thereunder. This individual MRA may only be used for reimbursement purposes and shall not be paid directly to the surviving Spouse or the above Dependent other than for reimbursement for eligible expenses.

The Health and Welfare Fund may assess an administrative fee against the Participant's MRA for the administrative costs of processing such reimbursement claims.

COORDINATION OF BENEFITS

Coordination of Benefits (COB) provides a framework for coordinating payment of medical and dental expenses when you and other members of your family have multiple sources for the payment of medical expenses (here called "payment source" or "plan"). For example, if your spouse has coverage under a group benefit plan

sponsored by his or her employer and is also covered under this Plan, then you and your dependents may be eligible for benefits under both your spouse's plan and this Plan. Similarly, you or your spouse may have coverage for medical or dental expenses under general liability, automobile liability, uninsured/underinsured automobile or no-fault automobile insurance policies as well as this Plan.

Coordination of Benefits provides complete payment of your allowable expenses while preventing duplicate payment for the same service. "Allowable expenses" means any Necessary, Reasonable and Customary expense for medical care or treatment provided under at least one of the plans or policies covering the Eligible Person for whom a claim is made. Although Coordination of Benefits does not guarantee one hundred percent (100%) reimbursement for all expenses, it does attempt to provide as close to one hundred percent (100%) reimbursement as the plans involved in coordination allow.

Under COB, benefits are paid using a system where one payment source is determined to be primary, and the other payment source is determined to be secondary. The primary payment source pays first, and the secondary payment source pays second. When both you and your spouse have coverage under a group health plan for the same allowable expenses, the primary payment source is the one that covers you as an employee -- it pays first for you. The secondary payment source is the one that covers you as a dependent -- it pays second. For example, let's assume you work for an Employer in the Plan and your spouse works for another company.

If the claim is for	The Primary Plan will be	The Secondary Plan will be
you	this Plan	the other plan
your spouse	the other plan	this Plan

What about other Eligible Dependents like your Children? Usually, the plan of the parent whose birthday falls earlier in the year (month and day-not year-of birth) will pay first, and the plan of the parent whose birthday falls later in the year will pay second. However, if the claim is for a dependent Child whose parents are **separated or divorced,** coverage will be determined as follows:

Special System for Eligible Dependents of Parents who are SEPARATED or DIVORCED

Order of Plan Payment	Parent with Child Custody and NOT Remarried	Parent with Child Custody and HAS Remarried
First	Plan covering parent with custody of child	Plan covering parent with custody of child
Second	Plan covering parent without custody of child	Plan covering stepparent of child
Third		Plan covering parent

		without custody of child

However, if there is a court decree that establishes an Eligible Employee's financial responsibility as parent - in terms of medical or other health care expenses - the plan covering the child due to the decree will pay first. However, you must be eligible in order for your Child to be eligible.

If a person is covered under more than one plan, the plan such Person was covered under longer pays first. There is an exception for a group plan that covers a person other than as a laid-off or rehired employee, or dependent of such person; that plan will pay first. A group plan that covers a person as a laid-off or rehired employee, or dependent of such person will determine the benefits that are paid second.

Payment sources which are coordinated include group coverages, vehicle insurance (uninsured/underinsured and no-fault), school-sponsored insurance, casualty and liability insurance and governmental coverages. Vehicle, liability, and uninsured/underinsured and no-fault coverages are always primary.

Coordination of Benefits with Health Maintenance Organization (HMO)

If an HMO is primary, the Plan will process claims so that it pays secondary benefits only - even if an HMO member of your family chooses to have health care services provided by a non-HMO provider and the HMO does not have to pay for the services.

Coordination with Medicare

The Participant must be retired and currently receiving Medicare Parts A & B benefits.

The Plan will pay its benefits **before** Medicare **only**

- For an active employee who is age sixty-five (65) or;
- For an active employee's dependent spouse who is age sixty-five (65) or older (unless the employee works for an employer with less than twenty (20) employees);
- The first thirty (30) months of treatment for end-stage renal disease received by an Eligible Person who is in the Active Employee Program;
- For Disabled, Eligible Dependents of Active Employees; and
- Where otherwise explicitly required by federal law.

When the rules above do not apply, the Plan will pay its benefits only **after** Medicare has paid its benefits.

NOTE: IF YOU ARE ELIGIBLE FOR MEDICARE, THE PLAN WILL PAY BENEFITS ONLY UP TO THE AMOUNT THAT WOULD BE PAID UNDER THE ABOVE RULES WHETHER OR NOT YOU HAVE APPLIED FOR MEDICARE BENEFITS. BECAUSE YOUR BENEFITS MAY BE AFFECTED BY MEDICARE, YOU MAY WANT TO CONTACT YOUR LOCAL SOCIAL SECURITY OFFICE FOR INFORMATION ABOUT MEDICARE. THIS SHOULD BE DONE BEFORE YOUR 65TH BIRTHDAY OR THAT OF YOUR SPOUSE, OR IF YOU OR ONE OF YOUR DEPENDENTS BECOME DISABLED. MEDICARE COVERAGE, EVEN ON A SECONDARY BASIS, CAN PROVIDE VALUABLE BENEFITS.

Right to Receive and Release Needed Information

Certain facts are needed to apply Coordination of Benefits rules. The Plan has the right to decide which facts it needs. It may get needed facts from, or give them to any other organization or person.

The Plan need not tell, or get the consent of, any person to do this. Each person claiming benefits under this Plan must give the Plan any facts it needs to pay the claim.

SUBROGATION

The Plan shall be entitled to subrogation and reimbursement if you or your Dependent (claimant) are paid benefits under the Plan for claims due to injuries or illness for which a third-party may be obligated to pay you for any person.

Right to Subrogate

The Plan is subrogated to any and all rights of recovery and causes of action that the claimant may have against any third party, whether by suit, settlement, or otherwise, that may be liable for a claimant's injury or illness for which the Plan has paid or is obligated to pay benefits on the claimant's behalf.

Rights to Reimbursement With Source of Funds Specifically Identified

The Plan shall also be entitled, to the extent of payments made or to be made on account of the claim, to the proceeds of any settlement, judgment, or payment from any source liable for making a payment relating to the claimant's injury, illness, or condition. A source includes, but is not limited to, a responsible party and/or responsible party's insurer (or self-funded protection), no-fault protection, personal injury protection, medical payments coverage, financial responsibility, uninsured or underinsured insurance coverage, an employer under the provisions of a workers' compensation law, an individual policy of insurance maintained by a claimant, and organization, corporation, or government agency.

Rejection of Make-Whole Doctrine

Such subrogation and reimbursement rights shall apply on a priority, first dollar basis to any recovery, whether by suit, settlement, or otherwise, whether there is a partial or full recovery and regardless of whether the amounts are characterized or described as

medical expenses or as amounts other than for medical expenses. **This provision is intended to and does reject and superseded any "make-whole" rule/doctrine, which rule/doctrine might otherwise require that you be "made whole" before the Plan may be entitled to assert its subrogation right.**

Equitable Lien by Agreement
Once the Plan makes or is obligated to make payments on behalf of a claimant, the Plan is granted, and the claimant consents to, an equitable lien by agreement or a constructive trust on the proceeds of any payment, settlement, or judgment received by the claimant or dependent from any source to the extent of payments made or to be made by the Plan on the claimant's behalf.

Claimant Must Set Aside Funds
The claimant shall hold in trust for the Plan's benefit that portion of the total recovery from any source that is due for payments made or to be made. The claimant shall reimburse the Plan immediately upon recovery. The claimant shall immediately notify the Plan if he or she is involved in or suffers an accident or injury for which a third party may be liable. The claimant shall again notify the Plan if he or she pursues a claim to recover damages or other relief relating to an injury or illness for which the Plan may make payments on the claimant's behalf. The claimant shall do nothing to impair, release, discharge or prejudice the Plan's rights to subrogation and/or reimbursement. The claimant shall assist and cooperate with representatives the Plan designates. The claimant shall do everything necessary to enable the Plan to enforce its subrogation and reimbursement. The claimant shall immediately notify the Plan upon receiving a judgment, settlement offer or compromise offer and shall not settle or compromise any claims without the Plan's consent.

First-Dollar Recovery
The Plan's subrogation and reimbursement rights shall apply on a priority first-dollar basis to any recovery whether by suit, settlement, or otherwise regardless of whether a claimant is made whole.

Disavowal of "Common-Fund" Doctrine
The Plan's subrogation and reimbursement rights apply to any recovery by the claimant without regard to legal fees and expenses of the claimant. The claimant shall be solely responsible for paying all legal fees and expenses in connection with any recovery for the underlying injury, sickness, accident or condition, and the Plan's recovery shall not be reduced by such legal fees or expenses.

The Plan specifically disavows any claims that a claimant or dependent may make under any federal or state common law defense including, but not limited to, the make-whole doctrine and/or the common-fund doctrine.

Cooperation
The Plan Administrator may require the claimant to complete and/or execute certain documentation to assist the Plan in the enforcement of its subrogation rights including, but not limited to, a subrogation and reimbursement questionnaire and a repayment

agreement. **The completion and/or execution of any documents requested by the Plan Administrator shall be a condition to receiving payment for a claim. Further, the Plan shall have the right to suspend all benefit payments due to a claimant, the employee of whom a claimant is a dependent, and/or any other dependent of such an employee if the claimant fails to complete and/or execute such documentation.**

ADMINISTRATION OF THE FUND

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

Amendment or Termination of Plan or Benefits
The Trustees may change or terminate this Plan, or any part thereof, in their sole and exclusive discretion. Benefits will terminate when the Plan, or any applicable portion thereof, is terminated.

Payment of Claims and Assignment of Benefits
Any benefits payable under this Plan are payable to the Eligible Employee. However, unless the Eligible Person requests otherwise, in writing, not later than the time proof of loss is filed, the Plan may pay any part or all of any benefits provided on account of hospital, nursing, medical, or surgical service directly to the person or entity which provided the service or treatment. The coverage and benefits under the Plan are not assignable without the consent of the Fund. Assigned benefits shall be paid to the assignee, regardless of the intervening death of the Eligible Person. Otherwise, except as otherwise provided by law, benefits due under this Plan shall not be assignable nor subject to attachment, garnishment or other legal process for debts of Eligible Persons.

Payment of Unassigned Benefits in Event of Death
If an Eligible Person expires before the payment to him of any and all unassigned benefits, the Plan Administrator may pay the amount of the unassigned but unpaid benefits as follows:

- If a probate administration is commenced in the Probate Court of the country in which the Eligible Person was domiciled at the time of his death, the Plan Administrator shall make prompt payment of the amount of the unassigned but unpaid benefit to the legal representative of the deceased, Eligible Person appointed by the Probate Court, upon receipt of a Certificate of Official Character from said legal representative.

- If a probate administration is not commenced on behalf of the deceased Eligible Person, the Plan Administrator, in the absence of a designated beneficiary shall make prompt payment of the amount of the unassigned but unpaid benefit to the survivors in the following order of priority and upon evidence acceptable to the Plan Administrator of their status and priority, to wit: (a) spouse, (b) children, pro rata; (c) parents; (d) brothers and sisters, pro rata; and (e) next of kin.

Misstatements
If any facts relevant to the existence or amount of coverage shall be misstated, the true facts will determine whether or not, and how much, coverage is in force.

Presentment of Claims on Behalf of Person Who is Incapacitated
If an Eligible Person shall become incapacitated and be unable to prepare, complete, and/or execute the forms and documents prescribed by the Trustees and/or their Plan Administrator for the filing of claims and/or receipt of benefits, the forms and documents may be signed for and on behalf of the Eligible Person by other persons, as follows:

- If a guardian has been appointed by a court of competent jurisdiction for the Eligible Person, by the guardian;

- If no guardian has been appointed, then by the persons in the following order of priority and upon evidence acceptable to the Plan Administrator of status and priority: (1) spouse; (2) a child; (3) a parent; or (4) a brother or sister.

Claims for Medical Service Rendered Outside of the United States
Due to the increasing mobility of Eligible Persons in the Plan, claims may be paid which arise from medical treatment received outside the United States, provided certain conditions are first met:

- If there has been Emergency medical care, the Eligible Person, upon returning to the United States, should submit the bills which have been paid for the Emergency treatment in order to be reimbursed according to the provisions and limitations within the Plan.

- If there will be elective medical care, the Eligible Person must first submit to the Fund Office or utilization review group a request stating the intended medical procedures to be undergone. The Eligible Person will receive a determination on whether or not it is in accordance with accepted medical procedures within the United States and whether it is encompassed within the framework of the Plan's benefits. Until such a determination is received, the Eligible Person cannot be assured that elective medical treatment will be covered under the Plan.

- Payment will be made in accordance with the foreign exchange rate as of the date of the medical care. Foreign currency will be converted to United States values as of that date.

Recovery of Overpayment
If the Plan Administrator ascertains that an Eligible Person has received an erroneous overpayment of a benefit, the Plan Administrator shall immediately notify such Eligible Person in writing, explaining the nature of the erroneous overpayment, and requesting return of the amount of such overpayment. If the initial request for restitution is not successful, the Plan Administrator shall renew the demand in writing upon the Eligible Person and may take other reasonable actions to obtain reimbursement of the erroneous overpayment

If reasonable steps taken to obtain repayment of the overpayment have been unsuccessful, the Plan Administrator may treat the overpayment of benefits as an advance payment of benefits due to the Eligible Person and offset the amount of such overpayment against any Plan benefits due or which may become due to the Eligible Person until the full amount of the overpayment has been repaid to the Plan.

Validity of Plan and Plan Provisions
This Welfare Plan is established in the State of Ohio and all questions pertaining to the validity and construction of this Plan and of the acts and transactions of the parties hereto shall be determined in accordance with the laws of the State of Ohio, except as preempted by Federal law. Where all or part of a Plan provision is declared invalid, any remaining balance of such provision will remain valid.

Construction by Trustees
Under the Plan of Benefits and the Trust Agreement creating the Plan, the Trustees or persons acting for them, such as a Trustee Review Committee, have the sole and exclusive authority to make final determinations regarding any application for benefits and the interpretation of the Plan of Benefits, the Trust Agreement, the Plan document or any other rules, regulations, procedures or administrative rules adopted by the Trustees. Any questions or interpretations about the Plan or Trust Agreement, or disputes about eligibility for and amount of benefits, shall be resolved by the Board of Trustees. Decisions of the Trustees or, where appropriate, decisions of those acting for the Trustees in such matters, are final, binding and conclusive on all persons dealing with the Plan or claiming a benefit from the Plan. If a decision of the Trustees or those acting for the Trustees is challenged in court, it is the further intention of the parties to the Trust that such a decision is to be upheld unless it is determined to be arbitrary and capricious.

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.

Legal Actions
No action at law or in equity shall be brought to recover any benefits provided under this Plan before the expiration of one hundred twenty (120) days after written proof of loss

has been furnished nor shall any such action be brought after the expiration of three years after the time written proof of loss is required to be furnished.

DEFINITIONS

This section defines certain terms used in the booklet to help you understand how these terms apply in the administration of the Plan:

Accidental Injury -- a trauma to the body resulting from an accident, such as a strain, sprain, abrasion or contusion.

Allowed Amount – For In-Network Providers, the Allowed Amount is the less of the negotiated amount or the Covered Medical Expense. For Out-of-Network Providers, the Allowed Amount is the Non-Contracting Amount, which will likely be less than the provider's billed charges. The Non-Contracting Amount is the maximum amount allowed for Covered Medical Expenses to Eligible Persons based on various factors, including, but not limited to, market rates for that service, negotiated amounts for that service, and Medicare reimbursement for that service. The Non-Contracting Amount will likely be less than the provider's billed charges. If you receive services from an out-of-network Provider, and you are balanced billed for the differed between the Non-Contracting Amount and the bill charges, you may be responsible for the full amount up to the provider's billed charges, even if you have met your out-of-pocket maximum.

Assignment of Benefits -- a written request by an Eligible Person that the Plan pay any part or all of any benefits provided on account of hospital, nursing, medical or surgical service directly to the person or entity which provided the service or treatment. A written request will include a proper notation on a provider billing form.

Association – Any Employer Association who is a party to a Collective Bargaining Agreement with one or more of the Local Unions participating in the Ohio Conference of Plasterers and Cement Masons Health and Welfare Fund.

Calendar Year -- that period commencing at 12:01 a.m. Standard Time and continuing until 12:01a.m. Standard Time on the immediately following January 1.

Chiropractor -- an individual licensed to practice chiropractic by the applicable agency of the state in which the individual renders care or treatment, and acting within the scope of such individual's 1icense.

Collective Bargaining Agreement -- the agreement between your Union and Employer which governs the wages and conditions of your work.

Confinement or Continuous Periods of Confinement -- the number of days during which an Eligible Person is a registered Inpatient in a Hospital, Skilled Nursing or other Facility. Successive periods of Hospital Confinement shall be considered a "Continuous Period of Confinement" unless evidence acceptable to the Welfare Fund is furnished that:

- The latest Confinement is due to causes entirely unrelated to causes of all previous confinements;

- Complete recovery has taken place since the last Confinement for a related cause; or

- The Eligible Employee has returned to work for at least one (1) full day. For all other Eligible Persons, when the last date of discharge and date of readmission are separated by ninety (90) days or more.

Continuation Coverage -- the opportunity offered to employees and their dependents for a temporary extension of health coverage in certain instances where coverage under the Plan would otherwise end.

Covered Medical Expense or Covered Expense -- a type of expense for services or supplies for which the Plan will provide benefits.

Custodial Care -- services, supplies and facilities furnished to an individual, whether Disabled or not, primarily to assist the individual in the activities of daily living. The provider by whom prescribed, recommended or performed, does not affect a determination that care is custodial.

Dentist -- an individual licensed to practice dentistry by the applicable agency of the state in which the individual renders care or treatment, and acting within the usual scope of the individual's license.

Dependent -- see Pages 23-24.

Detoxification or Detoxification Treatment -- any recognized treatment to alleviate adverse physiological or psychological effects of withdrawal from the sustained use of alcohol or a narcotic drug, such as dispensing a narcotic drug in decreasing doses to an individual, to bring the individual to a drug- and/or alcohol-free state.

Disabled -- unless the context indicates otherwise, a participant is "Disabled" when such participant's physician certifies that the participant is unable to perform the participant's job because of injury, illness or pregnancy. Totally and Permanently Disabled or Totally Disabled means the participant is unable to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or has lasted or can be expected to last for a continuous period of not less than twelve (12) months.

Durable Medical Equipment -- equipment recognized as such by Medicare Part B, which meets all of the following requirements:

- It can withstand repeated use;

- It is primarily and customarily used to serve a medical purpose rather than being primarily for comfort or convenience; and

- It is usually not useful to a person in the absence of illness or injury; and

- It is appropriate for home use; and

- It is certified in writing by a Physician as being Medically Necessary; and

- It is related to the patient's physical disorder; and

- It is for temporary use only. The anticipated length of time the equipment will be required for therapeutic use must be certified in writing; and

- It is for the exclusive use of the Eligible Person for whom the Physician has certified that is Medically Necessary.

Effective Eligibility Date -- the date you become eligible for reimbursement of your Covered Medical Expenses based on the Schedule of Benefits and this Plan.

Eligible Employee -- unless the context indicates otherwise, "Eligible Employee" shall mean **any** full-time employee or former employee of an Employer who is eligible for benefits consistent with the terms and provisions of collective bargaining agreements ("Class I" Employees) or other labor-management agreements, or a representative of any association representing employers who are signatories to a current collective bargaining agreement and have executed an Asset of Participation (sometimes referred to as a "Class II" Employee) or an Employee of a Union or Employer Association who has executed Assent of Participation ("Class III" Employee) and meeting the eligibility rules adopted by the Trustees from time to time.

Eligible Person -- unless the context indicates otherwise, "eligible person" shall mean an Eligible Employee, an Eligible Dependent or a qualified beneficiary who meets all requirements for continuation coverage based on the Plan's eligibility rules.

Emergency Medical Condition - a medical Condition manifesting itself by acute symptoms of sufficient severity, including severe pain, so that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

- Placing an individual's health in serious jeopardy, or with respect to a pregnant woman, the health of the woman or her unborn child;
- Result in serious impairment to the individual's bodily functions; or
- Result in serious dysfunction of a bodily organ or part of the individual.

Emergency Services - a medical screening examination as required by federal law that is within the capability of the emergency department of a Hospital, including ancillary services routinely available to the emergency department to evaluate such

Emergency Medical Condition; and such further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the Hospital, as are required under section 1867 of the Social Security Act (42 U.S.C. 1395dd) to Stabilize the patient.

Employer -- in the context of this Plan, the term "Employer" or "Employers" include those who:

- Have assigned their bargaining rights to an Employer Association which is a party to a collective bargaining agreement with a local union participating in the Plan which requires contributions to the Plan; or

- Have directly executed a collective bargaining agreement with a local union participating in the Plan which requires contributions to the Plan and which is acceptable to the Trustees; or

- Have executed an Employer Participation Agreement with the Plan which requires contributions to the Plan and which is acceptable to the Trustees.

Experimental or Investigational Drug, Device, Medical Treatment or Procedure - a drug, device, medical treatment or procedure is Experimental or Investigational:

- if the drug or device 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 drug or device is provided; or
- if reliable evidence shows that the drug, device, medical treatment or procedure is not considered to be the standard of care, is the subject of ongoing phase I, II or III clinical trials, or is under study to determine maximum tolerated dose, toxicity, safety, efficacy, or efficacy as compared with the standard means of treatment or diagnosis; or
- if reliable evidence shows that the consensus of opinion among experts is that the drug, device, medical treatment or procedure is not the standard of care and 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 may consist of any one or more of the following:

- published reports and articles in the authoritative medical and scientific literature;
- opinions expressed by expert consultants retained by Medical Mutual to evaluate requests for coverage;
- the written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same drug, device, medical treatment or procedure;
- the written informed consent used by the treating facility or by another facility studying substantially the same drug, device, medical treatment or procedure;
- corporate medical policies developed by Medical Mutual; or

- any other findings, studies, research and other relevant information published by government agencies and nationally recognized organizations.

Even if a drug, device, or portion of a medical treatment or procedure is determined to be Experimental or Investigational, the Plan will cover those Medically Necessary services associated with the Experimental or Investigational drug, device, or portion of a medical treatment or procedure that the Plan would otherwise cover had those Medically Necessary services been provided on a non-Experimental or non-Investigational basis.

The determination of whether a drug, device, medical treatment or procedure is Experimental or Investigational shall be made by the Plan and/or Medical Mutual in their sole discretion, and that determination shall be final and conclusive, subject to any available appeal process.

Hospital -- any institution which is an approved and accredited hospital recognized as such **by the** American Hospital Association and which is primarily engaged in providing diagnostic and therapeutic facilities for the medical care of injured and sick persons on a basis other than as a rest home, a nursing home, a convalescent home, a place for the aged, a place for drug addicts, or a place for alcoholics; or any institution which maintains permanent and full-time facilities for bed care of five or more resident patients; has a doctor in regular attendance; continuously provides 24 hour a day nursing service by registered nurses; provided such institution is operating lawfully in the jurisdiction where it is located.

Immediate Relative -- the Eligible Person's Spouse, parent, Child, brother or sister by blood, marriage or adoption.

Incurred -- unless the context indicates otherwise, the time when a particular service or supply is rendered or obtained.

Inpatient -- "Inpatient" shall mean a patient who receives room and board in a Hospital, Convalescent or other Facility while undergoing treatment.

Maintenance Therapy -- The repetitive services required to maintain function. Therapy is Maintenance Therapy where there is no medically appropriate expectation that the Eligible Person's condition will improve significantly from a continued therapy in a reasonable and generally predictable period of time based on Physician assessment of the Person's restoration potential.

Medical Emergency or Emergency -- a medical or surgical condition demanding immediate action.

Medically Necessary or Medical Necessity -- means that the services, supplies, treatment and confinement must be generally recognized within the Physician's profession as effective and essential for treatment of the injury or illness for which it is

ordered; and that they must be rendered at the appropriate level of care in the most appropriate setting based on diagnosis. To be considered "Medically Necessary", the care must be based on generally recognized and accepted standards of medical practice in the United States and it must be the type of care that could not have been omitted without an adverse effect on the patient's condition or the quality of medical care. In addition, services, treatment, supplies or confinement shall not be considered "Medically Necessary" if they are an Experimental Procedure, or if investigational or primarily limited to research in their application to the injury or illness; or if primarily for scholastic, educational, vocational or developmental training; or if primarily for the comfort, convenience or administrative ease of the provider or the patient or his or her family or caretaker; if services rendered by a provider do not require the technical skills of such a provider.

Occupational Disease or Sickness -- a disease or sickness arising out of, or in any way resulting from, any work for pay or profit.

Occupational Injury -- an accidental injury arising out of or in the course of any work for pay or profit, or in any way resulting from an injury which does.

Outpatient -- A patient who goes to the Hospital, clinic or dispensary for diagnosis and/or treatment, but does not occupy a bed or stay overnight.

Physician -- any of the following professionals who are licensed by the applicable agency of the state in which they render care or treatment, and acting within the usual scope of their license:

- Doctor of Osteopathy (D.O.)
- Doctor of Dental Surgery (D.D.S. or D.M.D.)
- Medical Doctor (M.D.)
- Optometrist
- Podiatrist
- Psychologist

Plan or Fund -- the Ohio Conference of Plasterers Health and Welfare Fund.

Preferred Provider -- a provider or facility that participates in a network of providers with which the Plan has contracted directly or indirectly for services, supplies and/or facilities at a pre-negotiated rate. Such providers are also referred to as "network" providers or "participating" providers. These providers are independent contractors.

Qualified Medical Child Support Order -- a court order requiring medical support which meets the Plan's Rules and Regulations and federal law requirements to be a

Qualified Medical Child Support Order. Please contact the Fund Office for a copy of applicable Rules and Regulations.

Skilled Nursing Facility -- "Skilled Nursing Care Facility" means an institution or part of an institution which is primarily engaged in providing to inpatients skilled nursing care and related services for patients who require medical or nursing care, or rehabilitation services for injured, disabled or sick persons. The facility must have a Physician, a registered professional nurse or a medical staff responsible for the supervision of the nursing care and related medical services it provides for every patient. The facility must be licensed by the state in which it operates.

Trust Agreement -- the agreement and declaration of trust establishing and providing for the maintenance of the Ohio Conference of Plasterers Health and Welfare Fund, as now stated or amended hereafter.

Union -- a Union participating in this Plan, as defined in the Plan's Trust Agreement.

STATEMENT OF RIGHTS UNDER THE EMPLOYEE RETIREMENT SECURITY ACT OF 1974 (ERISA)

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

(A) Examine, without charge, at the Board of Trustees'/Funds' office and at other specified locations, such a work sites and union halls, all plan documents, including insurance contracts, collective bargaining agreements and copies of all documents filed by the plan with the U.S. Department of Labor, such as detailed annual reports and plan descriptions.

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

(C) A complete list of the employers and employee organizations sponsoring the plan may be obtained by participants and beneficiaries upon written request to the Plan Administrator, and is available for examination by participants and beneficiaries at the Plan Administrator's office or your union hall. Information as to whether a particular employer or employee organization upon written request of the Plan Administrator is a sponsor of the plan and, if the employer or employee organization is a plan sponsor and the sponsor's address.

(D) The Plan is maintained pursuant to one or more collective bargaining agreements and a copy of any such agreement may be obtained by you upon written request of the Plan Administrator and is available for examination by participants or beneficiaries at the Union hall.

(E) Receive a summary of the Plan's annual financial report. The Board of Trustees is required by law to furnish each Participant with a copy of this summary annual report.

(F) Obtain a statement telling you whether you have a right to receive a pension at normal retirement age and if so, what your benefits would be at normal retirement age if you stop working under the Plan now. If you do not have a right to a pension, the statement will tell you how many more years you have to work to obtain a right to a pension. This statement must be requested in writing and is not required to be given more than once a year. The Plan must provide the statement free of charge.

(G) In addition to creating rights for Plan participants, ERISA imposes duties upon the individuals who are responsible for the operation of the employee benefit plan. The individuals 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 benefit or exercising your rights under ERISA. If your claim for a 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 you claim.

(H) 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 the within thirty (30) days, you may file suit in a federal court. In such a case, the court may require the Board of Trustees to provide the materials and pay you up to One Hundred Ten Dollars ($110) a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Board of Trustees. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the individuals you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous. If you have any questions about your Plan, you should contact the Board of Trustees.

(I) If you have any questions about this statement or about your rights under ERISA, you should contact the nearest Area Office of the U.S. Labor-Management Services Administration, Department of Labor or at the Pension and Welfare Benefit Administration Office located as follows:

U.S. Department of Labor
Pension & Welfare Benefits Administration
1730 K Street
Suite 556
Washington, DC 20006
(202) 254-7013

or

U.S. Department of Labor
Pension & Welfare Benefits Administration
1885 Dixie Highway
Suite 210
Ft. Wright, KY 41011-2664
(859) 578-4680 or toll-free at
(866) 444-3272

or

Division of Technical Assistance and Inquiries
Employee Benefits Security Administration
U.S. Department of Labor
200 Constitution Avenue, N.W.
Washington, DC 20210

USES AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Use and disclosure of Protected Health Information (PHI): The privacy regulations govern the use and/or disclosure of protected health information ("PHI"). "Protected health information" means individually identifiable health information that is transmitted or maintained by electronic media or is transmitted or maintained in any other form or medium. "Individually identifiable health" information is health information that either actually identifies an individual or creates a reasonable basis to believe that the information would identify an individual. The Plan will use protected health information to the extent and in accordance with the uses and disclosures permitted by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Specifically, the Plan will use and disclose protected health information for purposes related to health care treatment, payment for health care, and health care operations.

"Payment" includes activities undertaken by the Plan to obtain premiums or determine or fulfill its responsibility for coverage and provision of plan benefits that relate to an individual to whom health care is provided. These activities include, but are not limited to, the following:

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

2.Coordination of benefits

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

4.Subrogation of health benefit claims

5.Establishing employee contributions

6.Risk adjusting amounts due based on enrollee health status and demographic characteristics

7.Billing, collection activities and related health care data processing

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

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

10.Medical necessity reviews, or reviews of appropriateness of care or justification of charges

11.Utilization review, including precertification, preauthorization, concurrent review and retrospective review

12.Reimbursement to the plan

“Health Care Operations” include, but are not limited to, the following activities:

1.Quality Assessment

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

3.Rating provider and Plan performance, including accreditation, certification, licensing, or credentialing activities.

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

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

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

7.Business management and general administrative activities of the entity, including, but not limited to:

a) Management activities relating to implementation of and compliance with the requirements of HIPAA Administrative Simplification;

b) Customer service, including the provision of data analyses for policyholders, plan sponsors, or other customers.

c) Resolution of internal grievances. Filing of governmental forms, including Form 5500 and other activities necessary to ensure compliance with applicable federal laws, including ERISA and the Internal Revenue Code. “Treatment” includes, but is not limited to, the provision, coordination or management of health care and related services. It also includes but is not limited to consultations and referrals between one or more of your providers.

The Plan will use and disclose PHI as required by law and as permitted by authorization of the Participant or Beneficiary.

For purposes of this section the Board of Trustees for the Tri-County Building Trades Health Fund is the Plan Sponsor. The Plan will disclose PHI to the Plan Sponsor only upon receipt of a certification from the Plan Sponsor that the plan documents have been amended to incorporate the following provisions:

With respect to PHI, the Plan Sponsor agrees to:

1.Not use or further disclose the information other than as permitted or required by the plan document or as required by law;

2.Ensure that any agents, including a subcontractor, to whom the Plan Sponsor provides PHI agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such information;

3.Not use or disclose the information for employment-related actions and decisions unless authorized by the individual;

4.Not use or disclose the information in connection with any other benefit or employee benefit plan of the Plan Sponsor unless authorized by the individual;

5.Report to the Plan any use or disclosure of the information that is inconsistent with the uses or disclosures provided for of which it becomes aware;

6.Make PHI available to the individual in accordance with the access requirements of HIPAA;

7.Make PHI available for amendment and incorporate any amendments to PHI in accordance with HIPAA;

8.Make available the information required to provide an accounting of disclosures;

9.Make internal practices, books, and records relating to the use and disclosure of PHI received from the group health plan available to the Secretary of HHS for the purposes of determining compliance by the group health plan with HIPAA;

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

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

1.The Fund's Administrative Manager;

2.Staff designated by the Fund's Administrative Manager; and

3.Board of Trustees of the Tri-County Building Trades Health Fund.

The persons described in this section B may only have access to and use and disclose PHI for plan administration functions that are performed on behalf of the Fund. If the persons described in section B do not comply with this Plan document, the Plan Sponsor shall provide a mechanism for resolving issues of noncompliance, including disciplinary sanctions.

ADDITIONAL RIGHTS

Certain uses and disclosures of PHI require an individual authorization, including uses and disclosures for marketing purposes, disclosures that constitute a “sale” of PHI, and most uses and disclosures of psychotherapy notes.

You have the right to opt out of receiving any fundraising communications.

You have the right to direct any of your providers to restrict certain protected health information from disclosure to the Plan where you pay out of pocket in full for the care and you request such a restriction.

The Plan is prohibited from using or disclosing genetic information for underwriting purposes.

Your Rights Regarding Medical Information About You

You also have the following rights regarding medical information we maintain about you:

Right to Inspect and Copy. You have the right to inspect and copy medical information that may be used to make decisions about your Plan benefits. To inspect and copy such medical information, you must submit your request in writing to the Plan Office. 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 deadline. If you request a copy of this information, we may charge a fee for the costs of copying, mailing or other supplies associated with your request. We may deny your request to inspect and copy your medical information in certain very limited circumstances. If you are denied access to medical information, you may request that the denial be reviewed.

Right to Amend. If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for the Plan. To request an amendment, your request must be made in writing and submitted to the Plan Office. In addition, you must provide a reason that supports your request. 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 in 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 health information.

We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that (1) is not part of the medical information kept by or for the Plan, (2) was not created by us, unless the person or entity -that created the information is no longer available to make the amendment, (3) is not part of the information which you would be permitted to inspect and copy, or (4) or is accurate and complete.

Right to an Accounting of Disclosures. You have a right to obtain an accounting of certain disclosures of your medical information. This right to an accounting extends to disclosures, other than disclosures made (1) to carry out treatment, payment or health care operations, (2) to individuals about their own medical information, (3) incident to an otherwise permitted use or disclosure, (4) pursuant to an authorization, (5) for purposes of creation of a facility directory or to persons involved in the patient's care or other notification purposes, (6) as part of a limited data set, (7) for other national security or to correctional institutions or law enforcement officials, or (8) before April 14, 2003.

To request an accounting of disclosures, you must submit your request in writing to the Plan Office. 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 deadline. Your request must specify a time period, which may not be longer than six years. Your request should indicate in what form you want the accounting (for example,

paper or electronic). The first accounting you request within a 12-month period will be free. For additional accountings, we may charge you for the costs of providing the accounting. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

Right to Receive a Notice from the Plan whenever a breach of your unsecured private health information (PHI) occurs**.**

Right to Request Restrictions. You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or health care operations. We are not, however, required to agree to your request. To request restrictions, you must make your request in writing to the Plan Office. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure or both; and (3) to whom you want the limits to apply.

Right to Request Confidential Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail. Such requests shall be honored if, in the sole discretion of the Plan, the requests are reasonable and can be accommodated with minimal disruption to Plan administration. However, the Plan shall accommodate such a request if the participant clearly provides information that the disclosure of all or part of that information could endanger the participant. To request confidential communications, you must make your request in writing to the Plan Office. Your request must specify how or where you wish to be contacted.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice.

Prohibition Against Discrimination Based on the Use of "Genetic Information"

This section of the Plan is intended to implement the requirements of the Genetic Information Nondiscrimination Act of 2008 (GINA).

"Genetic information" means, with respect to any individual, information about:

1. such individual's genetic tests;

2. the genetic tests of family members of such individual; and

3. the manifestation of a disease or disorder in family members of such individual.

Pursuant to GINA, the Plan:

1. may not adjust premium or contribution amounts on the basis of genetic information; need space here, will not allow me to change

2. shall not request or require an individual or a family member of such individual to undergo a genetic test;

3. shall not request, require, or purchase genetic information for "underwriting purposes", as that term is defined at ERISA 733; and

4. shall not request, require, or purchase genetic information with respect to any individual prior to such individual's enrollment under the Plan or coverage in connection with such enrollment.

5. No use or disclosure of genetic information may be made for insurance underwriting purposes.

Notwithstanding the foregoing, the Plan may use genetic information as otherwise allowed by GINA.

IMPORTANT INFORMATION ABOUT THE FUND

This booklet describes the health and welfare benefits available to you and your beneficiaries under the Plan, known as the Ohio Conference of Plasterers and Cement Masons Health and Welfare Fund.

The Board of Trustees is responsible for the operation of the Plan, is the Plan Sponsor, and acts as Plan Administrator. It is responsible for reporting Plan information to government agencies and disclosing the same information to Plan Participants and beneficiaries. The Board consists of equal representation by the Employers and the Unions who have entered into collective bargaining agreements which are related to the Plan.

You can contact the Board of Trustees at the address:

Board of Trustees
Ohio Conference of Plasterers & Cement Masons Health and Welfare Fund
33 Fitch Blvd.
Austintown, Ohio 44515

Plan Administrator

Compensation Programs of Ohio, Inc., handles the day-to-day administration of the Fund.

Compensation Programs of Ohio, Inc.
33 Fitch Blvd.
Austintown, Ohio 44515
(800) 435-2388

Benefits are paid through the Board of Trustees' Plan Administrator.

Identification Numbers

The number assigned to this Plan by the Board of Trustees based on the Internal Revenue Service requirements is 501.

The number assigned to the Board of Trustees by the Internal Revenue Service is 31-6051539.

Agent for Service of Legal Process

The Board of Trustees is the Plan's agent for service of legal process. Accordingly, if legal disputes involving the Plan arise, any legal documents should be served upon the Board of Trustees, upon any individual Trustee at the following address: Ohio Conference of Plasterers and Cement Masons Health and Welfare Plan and Trust, 33 Fitch Blvd., Austintown, Ohio 44515, or upon Fund Counsel Macala & Piatt, LLC, 601 South Main Street, North Canton, Ohio 44720.

Plan Year

The fiscal records of the Plan are kept separately for each Plan Year. The Plan Year is a twelve-month period which begins on May 1 and ends on the following April 30.

Source of Contributions

The benefits described in the Plan generally are provided through employer contributions. Employer contributions are based on an hourly rate and are determined by the provisions of the collective bargaining agreements in effect between the participating local unions and the participating signatory employers. You may obtain a copy of the collective bargaining agreements by writing to the Plan Administrator, or you may examine them at the Fund Office.

Additionally, certain Plan income consists of self-payments and investment income.

All assets are held in trust by the Board of Trustees for the purpose of providing benefits to covered participants and defraying reasonable administrative expenses.

A complete list of the employers and employee organizations contributing to and/or sponsoring the Plan may be obtained by Participants and Beneficiaries upon written request to the Fund office and is otherwise available for examination by Participants and Beneficiaries at the Fund office.

Union Trustees

Greg Daniels
Operative Plasterers & Cement
Masons Local Union No. 109
2046 South Main Street
Akron, Ohio 44309

Employer Trustees

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The Great Lakes Way
Hinckley, Ohio 44233

Kevin Smith
45 Collingwood Blvd
Toledo, Ohio 43624

IN WITNESS WHEREOF, the Trustees of the Ohio Conference of Plasterers and Cement Masons Health and Welfare Fund have adopted the Summary Plan Description in its restated form on this _____ day of _____ _____, but effective as of February 1, 2014 (except as otherwise noted herein).

EMPLOYER TRUSTEES	UNION TRUSTEES
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____