COMBINED
SUMMARY PLAN DESCRIPTION
AND
PLAN DOCUMENT
OF
PAINTING INDUSTRY INSURANCE FUND PLAN

January 1, 2019

UNION TRUSTEES

Jim Sherwood, Jr.
Lou Ferrante
Michael Turkal
Anthony Watroba

EMPLOYER TRUSTEES

Brendan McGarry
Don Hansen
Gary Brown
Linda Vasquez

ADMINISTRATIVE MANAGER FOR THE FUND

Shawn D. Kroeger, CPA, CEBS
Painting Industry Funds, Inc.
8257 Dow Circle
Strongsville, Ohio 44136
Ph. (440) 260-0615
Fax. (440) 260-0597

ALLOTTA | FARLEY CO., L.P.A.

Fund Counsel
2222 Centennial Road
Toledo, Ohio 43617
Ph. (419) 535-0075
Fax (419) 535-1935
www.allottafarley.com

PAINTING INDUSTRY INSURANCE PLAN

JANUARY 1, 2019

To All Painting Industry Insurance Fund Plan Participants:

The Trustees of the Painting Industry Insurance Fund Plan are pleased to present you with this new booklet which updates and replaces prior booklets, describes the current provisions of the Painting Industry Insurance Fund Plan (hereinafter "Health and Welfare Plan" or "Plan") and includes the advisory information required by the Employee Retirement Income Security Act of 1974, as amended (ERISA). This booklet includes Health and Welfare Plan provisions which have been adopted through January 1, 2019. As used throughout this booklet, "you" and "your" refer to the Plan Participant on whose behalf contributions are made to the Plan.

We urge you to read this booklet carefully in order to become familiar with the changes, which have been made to the Health and Welfare Plan since the last Summary Plan Description was issued. The Health and Welfare Plan described in this booklet is for employees who are eligible to be covered under the Health and Welfare Plan on or after January 1, 2019. If you have questions pertaining to your coverage under the Health and Welfare Plan, your rights are determined in accordance with the terms of the Health and Welfare Plan then in effect.

Only the full Board of Trustees is authorized to interpret the Health and Welfare Plan. No other individual or organization, such as your union or employer, nor any employee or representative of any individual or organization is authorized to either interpret this Health and Welfare Plan or act as an agent of the Board of Trustees. Should you have any questions regarding the Health and Welfare Plan, please direct them to the Plan's Administrative Manager at the Fund Office.

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

Sincerely,

THE BOARD OF TRUSTEES

TABLE OF CONTENTS

INTRODUCTION

This booklet, distributed in January 2019, is designed to describe the benefits available to you under the Painting Industry Insurance Fund Plan effective as of January 1, 2019. It is intended that this information will satisfy the requirements of the Employee Retirement Income Security Act of 1974, as amended ("ERISA") for a Summary Plan Description (hereinafter "Summary"). This booklet also constitutes the Plan document ("Plan"), setting forth the terms and conditions of the Plan.

This Plan is maintained pursuant to the Collective Bargaining Agreement between International Brotherhood of Painters and Allied Trades, Painters District Council No. 6, Cleveland, Ohio ("Union") and the Northern Ohio Painting and Taping Contractors, Inc., Cleveland, Ohio and/or Employers who negotiate with the Union to participate in the Trust Fund on behalf of themselves, other individual Employers whom they negotiate on behalf of and/or Employers who make contributions into the Trust Fund pursuant to a collective bargaining agreement or written participation agreement with the Board of Trustees (hereinafter "Association"). A copy of this agreement is available for your examination at the Union Hall, and Participants and their Beneficiaries may also obtain a copy of the Collective Bargaining Agreement for a reasonable charge by writing to Painting Industry Funds, Inc. at 8257 Dow Circle, Cleveland, Ohio 44136.

SPECIAL NOTICE!

It is extremely important you keep the Fund Office informed of any change in address or marital status. This is your obligation and failure to fulfill this obligation could jeopardize your eligibility for benefits or subject yourself to legal action.

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

DISCLOSURE OF GRANDFATHERED STATUS

This group health plan believes this plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care 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 preventative health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care 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 8257 Dow Circle Strongsville, Ohio 44136, Phone number (440) 260-0615. 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.

I. PLAN IDENTIFICATION AND GENERAL INFORMATION

A. NAME OF THE PLAN

The formal name of the Plan is the "PAINTING INDUSTRY INSURANCE FUND."

B. THE NAMES AND ADDRESSES OF THE EMPLOYERS

This is a multiemployer plan as that term is defined in the Employee Retirement Income Security Act of 1974, and numerous employers contribute to it. It would not be practical to list them all here. However, upon written request to the Administrative Manager of the Health and Welfare Fund, you will receive information as to whether a particular Employer or Union is contributing to the Health and Welfare Fund, and if so, its address.

C. THE NAME AND ADDRESS OF THE ADMINISTRATOR

Board of Trustees
Painting Industry Insurance Fund
8257 Dow Circle
Strongsville, Ohio 44136
Ph. (440) 260-0615
Fax (440) 260-0597

D. THE NAME AND ADDRESS OF THE ADMINISTRATIVE MANAGER

Shawn D. Kroeger, CPA, CEBS
Painting Industry Funds, Inc.
8257 Dow Circle
Strongsville, Ohio 44136
Ph. (440) 260-0615
Fax (440) 260-0597

Questions pertaining to the Health and Welfare Fund should be directed to the Administrative Manager. The Administrative Manager handles the day-to-day operations of the Health and Welfare Fund.

E. PLAN NUMBERS ASSIGNED TO THE PLAN

The Employer Identification Number (EIN) assigned by the Internal Revenue Service to the Board of Trustees is 34-0695505, and the Plan Number for the purposes of identification is 501.

F. TYPE OF PLAN

The Health and Welfare Plan is maintained for the purpose of providing death, dismemberment, disability, hospitalization, surgical, medical, prescription drug, dental, vision, and other related benefits as described in this Summary.

G. THE PLAN YEAR

The Plan Year is a twelve (12) month period beginning January 1 and ending December 31 for all benefits other than dental benefits. For dental benefits, the coverage year begins July 1 and ends June 30.

H. TYPE OF ADMINISTRATION USED FOR THE PLAN ASSETS

The Trust Fund is administered by a Board of Trustees consisting of not more than ten (10) Trustees, five (5) of whom are designated by the Employers (Employer Trustees), and five (5) of whom are designated by the Union (Union Trustees). At the present time, they are:

UNION TRUSTEES	EMPLOYER TRUSTEES
Jim Sherwood, Jr.	Brendan McGarry
Lou Ferrante	Don Hansen
Michael Turkal	Gary Brown
Anthony Watroba	Linda Vasquez

Correspondence can be made to the Board of Trustees at: Board of Trustees, Painting Industry Insurance Fund, 8257 Dow Circle, Strongsville, Ohio 44136.

I. ATTORNEYS FOR THE FUND AND AGENT FOR SERVICE OF PROCESS

Allotta | Farley Co., LPA
2222 Centennial Road
Toledo, Ohio 43617
Ph. (419) 535-0075
Fax (419) 535-1935

J. FUNDING MEDIUM FOR THE ACCUMULATION OF PLAN ASSETS

Assets are accumulated and benefits are provided directly by the Trust Fund. The principal and income of this Plan are to be used for the exclusive benefit of Participating Employees, their Beneficiaries and for defraying proper expenses of administering the Plan.

K. EFFECTIVE DATE WHEN PLAN BEGAN

October 1, 1949

L. EFFECTIVE DATE OF THE RESTATED PLAN

January 1, 2019

M. SOURCES OF CONTRIBUTIONS TO THE PLAN

Employers make contributions to the Plan together with the self-pay contributions by Participants in accordance with the terms and conditions of the Plan and the requirements of the Fund Office as set by the Board of Trustees and outlined in this Summary Plan Description. Contributions to this Plan made by Employers shall be made to the Trust Fund only under the obligations of the Collective Bargaining Agreement and/or other written agreement between the Employer and the Union. The Union shall be the authority for the specific provisions of the collective bargaining agreement establishing the obligation of the Employer to make contributions.

N. PLAN AMENDMENT AND TERMINATION

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

O. PLAN IS NOT A CONTRACT

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

P. SCOPE OF COVERAGE OF PLAN

The provisions of coverage of this Plan shall be limited to those benefits as provided herein or in the Schedule of Benefits only where accident, injury, illness or related illnesses are incurred when the Participant and/or Dependent is eligible for coverage under the Plan.

II. ELIGIBILITY

A. INITIAL ELIGIBILITY

You will become Initially Eligible for coverage under the Plan effective as of the Corresponding Coverage Period following the Work Period in which you are credited with the required number of hours and provided such hours are reported on the records of the Painting Industry Insurance Fund. On or after January 1, 2018, the required hours for each Work Period are 135. The required work hours for each Work Period are as follows (Please review the previous Summary Plan Description for eligibility requirements prior to January 1, 2018):

Work Period	Required Hours	Corresponding Coverage Month
January	135	April
February	135	May
March	135	June
April	135	July
May	135	August
June	135	September
July	135	October
August	135	November
September	135	December
October	135	January
November	135	February
December	135	March

If you are an Industrial member of the Glaziers, Architectural Metal & Glassworkers Local Union No. 181, or any other Group with an hourly employer contribution rate for contributions to the Fund which is less than the current uniform contribution rate for contributions received by the Fund from Employers (hereinafter "the Fund's current uniform contribution rate"), then you are able to make the self-contributions in the amount of the difference between the Fund's current uniform contribution rate and the amount received from the hourly employer contributions made on your behalf to satisfy the Initial Eligibility requirements provided you have been credited with at least 135 hours in one work month.

You shall be required to complete any application forms and submit to any medical examinations requested by the Trust Fund prior to becoming eligible.

B. CONTINUATION OF ELIGIBILITY

Once you have satisfied the initial eligibility requirements set forth in Section A above, you shall continue to remain eligible for participation in the Plan for each subsequent coverage month, provided you are credited with the required number of hours during the corresponding work month.

If you have satisfied the initial eligibility requirements set forth in Section A above, but you did not have the required number of hours of work with a contributing Employer in a particular work month and/or you have exhausted all of your unused Banked Money, then you may make self-contributions to bring you up to the amount of required contributions in order to continue to remain eligible for participation in the Plan. The amount of required self-pay contributions will simply be the required contributions (Required Hours times Full Contribution Rate) minus the contributions made on your behalf for the work period by a contributing employer.

If you are an industrial member of any other Group with an hourly employer contribution rate for Employer contributions to the Fund which is less than the Fund's current uniform Full Contribution Rate, then the amount of any self-contributions which may be needed to bring you up to the amount required contributions will be calculated at the Fund's current uniform Full Contribution Rate. Please refer to the following example (the contribution rates may vary from time to time, are for illustration purposes only, and are not meant to illustrate the actual contribution rates to the fund):

Uniform Full Contribution Rate = $6.16
Required Hours on or after January 1, 2018 = 135
Participant's Actual Contribution Rate = $5.00
Participant's Actual Hours = 150

Required Contributions	135 x $6.16	$831.60
Actual Contributions	150 x $5.00	$750.00
Required Self-Contributions		$81.60

If you have not satisfied the initial eligibility requirements set forth in Section A above, then you may not make self-pay contributions to the Fund. In addition, if you do not maintain continuous eligibility as provided herein and your eligibility for participation terminates, then you must become initially qualified for coverage under the Plan as provided for in Section A above.

C. BANKED MONEY

The banking rules are based on a monthly bank. The contributions associated with hours in excess of 146 hours per month will be banked and held for future periods. The banked money will be held for 2 years and will have a maximum of $3,200.00 per Participant. For example, the following example illustrates the banking rules:

Month 1 = Participant has 160 hours

160 – 146 = 14 hours banked

14 hours X $6.16 (contribution rate) = $86.24 (amount banked for current month)

$86.24 will be held until used to cover a self-pay shortage, but no longer than 2 years.

The Banked Money is automatically credited to your account and applied to any one or successive Work Periods, if the need arises, until all the Banked Money is expended or expires. Banked Money can be used only during the two calendar years after the calendar year in which it is earned.

Banked Money will be used to provide continuous eligibility only and will not be used to establish or reestablish initial eligibility. The Board of Trustees may, in its discretion, adjust the amount of Banked Money. Your right to use Banked Money is not a vested or an accrued benefit and may be lost under certain conditions determined by the Board of Trustees.

If you lose your Union Membership pursuant to the Union Constitution and/or Collective Bargaining Agreement or Bylaws, then immediately as of the date of the loss of Union Membership and upon notification to the Fund Office you will forfeit any unused Banked Money and will not be eligible to make self-pay contributions. Thereafter, you may elect to continue your health coverage under the Plan as provided for under Continuation Coverage (COBRA) (see Sections K and L below).

D. SELF-PAY CONTRIBUTIONS

Upon expending all unused Banked Money, if any, you may make self-pay contributions at the Fund's current uniform contribution rate as provided for in Sections A and B above for a maximum period of 6 months without hours being contributed on your behalf.

Thereafter, you may elect COBRA coverage to continue you and/or your Eligible Dependent's health coverage as provided for in Sections K and L below. Self-pay contributions must be received in the Fund Office within the specified time as notified by the Administrative Manager in accordance with the Rules and Regulations adopted by the Trustees.

However, if you lose your Union Membership pursuant to the Union Constitution and/or Collective Bargaining Agreement or Bylaws, then immediately as of the date of the loss of Union Membership and upon notification to the Fund Office you will not be eligible to make self-pay contributions pursuant to this Section, and you will forfeit all of your unused Banked Money. Thereafter, you may elect COBRA coverage to continue your health coverage and/or your Eligible Dependent's coverage (see Sections K and L below).

Failure to make a timely self-pay contribution payment or making payment in less than the invoiced amount shall result in a loss of eligibility, the forfeiture of all unused Banked Money earned prior to that point, and loss of the right to make future self-pay contribution payments for that period.

E. TERMINATION OF ELIGIBILITY

Your eligibility to participate in the Plan shall terminate:

1. At the end of the last Coverage Month in which the eligibility requirements were met if you are not credited with the required number of hours; or

2. At the end of the month in which you are employed by an Employer who is not obligated to make contributions to this Plan either directly or through reciprocity, unless the purpose of such employment is to encourage the employer to become signatory in order to begin making contributions; or

3. At the end of the benefit Coverage Month in which you withdraw from the trade jurisdiction of the Union by requesting a withdrawal card; or

4. At the end of the benefit Coverage Month in which you leave the geographical jurisdiction of the Union for employment elsewhere by requesting a clearance card.

In the event an Employer is delinquent in the payment of its Employer Contributions on your behalf, the Trustees may, in their sole discretion, credit your account as though the Employer paid the Employer Contributions.

An Employee having terminated his or her eligibility to participate in the Plan as set forth above shall be required, in order to reestablish eligibility, to comply with the requirements of Initial Eligibility as set forth in Section A above.

F. SUSPENSION OF ELIGIBILITY

You and your Dependents' eligibility to participant in the Plan shall be suspended if you or your Dependents fail to satisfactorily fill out and return to the Fund Office a request for information and subrogation lien agreement as described under Article VII, Section A, below.

G. DISABILITY COVERAGE

If you are found to be totally disabled by the Trustees, then you shall be allowed to make self-pay contributions for the full amount of the insurance premium and continue participation in the Plan (the coverage shall remain either single or family depending on what coverage you have at the time of the disability) until age 65 only if you meet all of the following eligibility requirements:

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

2. You must timely elect disability coverage and make the required Self-pay contributions to the Plan at the contribution rate determined by the Board of Trustees.

Final determination of whether you are eligible for disability coverage will be made by the Trustees in their sole discretion and will be conclusive and binding upon you such that any such determination will not be subject to reversal by a court of competent jurisdiction unless the determination is adjudged to be arbitrary and capricious. The Definition of Total Disability is set forth in Article XIII, Section (JJ) below. Any Participant who qualifies and elects to be covered under the Plan's disability coverage must make self-payments in accordance with the requirements of the Fund Office as set by the Board of Trustees. The monthly self-payment amount shall be determined by the Board of Trustees, but may not exceed 102% of the Plan's full cost. Both the extent of coverage and the amounts of self-payment are subject to revision in accordance with any applicable laws.

If you qualify under these rules of eligibility, then you must elect disability coverage within the first sixty (60) days after the last month in which you were covered for benefits under the Plan and make the required self-pay contributions in accordance with the requirements of the Fund Office as set forth by the Board of Trustees. If you do not elect disability coverage within the sixty (60) days' limitation or make the required self-pay contributions timely to the Fund Office, then you shall not be eligible for disability coverage for that disability at any time in the future. If this occurs and you would subsequently requalify as an Active Participant, your ineligibility for disability coverage for a previous disability would not prohibit you from being eligible for a future disability. However, the Trustees may, in any case where the circumstances appear to warrant such action, in their sole discretion, liberalize the foregoing condition.

If, in the opinion of the Trustees, you should become able to work in the trade as defined by the Constitution of the International Union of Painters and Allied Trades, then your disability coverage shall terminate at the end of the calendar month in which you are no longer disabled. You would then be eligible to continue as a participant without requalifying.

The Trustees reserve the right to change or eliminate Disability Coverage as provided herein at their sole discretion at any time and for any reason. Participants and Disabled Employees and their Dependents do not have any vested rights in the Disability Coverage as provided herein.

H. PARTICIPATION OF NONBARGAINING UNIT EMPLOYEES

Employers are required to contribute on behalf of all nonseasonal, full-time Non-bargaining Unit Employees, defined as officers, owners, partners, shareholders, managers, clerical workers, estimators, supervisors and any other full-time employees (hereinafter collectively referred to as "Non-bargaining Unit Employees"), if they elect such participation in the Plan and enter into a Participation Agreement with the Trust Fund (subject to the review and approval of, and any other conditions regarding contributions and participation, imposed by the Trustees), at the contribution rate determined by the Trustees. Employers that elect participation of Non-bargaining Unit Employees in the Plan shall be required to contribute at the contribution rate determined by the Board of Trustees to become eligible initially and remain eligible.

Contributions shall be due and payable within the specified time as notified by the Administrative Manager. The number of Non-bargaining Unit Employees participating in the Plan shall not exceed ten (10%) percent of the total number of participants. Participants that qualify under this Section shall not be allowed to maintain Banked Money as provided in Section C above. The Trustees shall have the sole discretion to determine whether Employers are permitted to participate in this Plan or eliminate their participation in the Plan at any time, and their decision shall be final.

I. TERMINATION OF COVERAGE AND LOSS OF BANKED MONEY

You shall cease to be eligible to be a Participant in this Plan if you are employed by an Employer which is not obligated to make contributions to this Plan unless the purpose of such employment is to encourage the Employer to become signatory and begin making contributions to this Plan. Your coverage under this Plan shall terminate on the last day of the calendar month during which such employment occurs. In addition, you shall lose any accumulated Banked Money at that time.

J. CANCELLATION OF COVERAGE

Regular coverage will be canceled as of the date:

1. You cease to satisfy the eligibility requirements set forth above, or

2. The Plan or coverage for the class of Employees to which you belong is canceled; or

3. You request that coverage under this Plan be canceled; or

4. You or your Eligible Dependent does not make a required payment for coverage (if you or your Eligible Dependent are required to pay part of the cost).

K. COVERAGE CANCELLED

If your coverage is cancelled, all of your Eligible Dependents' coverage is also cancelled, except as provided by COBRA. In addition, your Eligible Dependent loses regular coverage as of the date:

1. Family coverage is cancelled for the class of Employees to which you belong; or

2. The person ceases to meet this Plan's requirements to qualify as an Eligible Dependent.

L. SELF-PAY CONTRIBUTION CONTINUATION OF GROUP HEALTH INSURANCE COVERAGE

Under the Consolidated Omnibus Budget Reconciliation Act of 1985 and related regulations and amendments ("COBRA"), if you and/or your Eligible Dependent who loses coverage by reason

of any of the "qualifying events" described below then you and/or your Eligible Dependent may elect to continue health coverage under the Plan on a temporary basis from the day the eligibility ends:

1. If you leave the employment of an Employer for any reason, such as voluntary termination, a strike, a lockout, a layoff or an involuntary discharge (except if discharged for gross misconduct), then you and your Eligible Dependents may keep coverage for as long as eighteen (18) months.

2. If you are subject to any decrease in the number of hours worked that does not constitute a termination of employment (such as a switch to part-time status), then you and your Eligible Dependents may keep coverage for eighteen (18) months.

3. If you and/or your Eligible Dependents are disabled as defined by the Social Security Administration on the day you lost eligibility for health coverage under the Plan, or within 60 days after that, then you and/or your Eligible Dependents may elect to keep coverage for 29 months. You and/or your Eligible Dependents must notify the Fund Office in writing of the Social Security Administration disability determination within 60 days of the date it is issued, and before the end of the initial 18-month coverage period. The extended coverage terminates (1) upon your receiving Medicare, or (2) thirty (30) days after the month in which Social Security determines that you are no longer disabled.

4. If you receive Medicare or die, then any of your Eligible Dependents that cease to qualify for regular coverage may keep their coverage up to thirty-six (36) months.

5. If you divorce or legally separate from your spouse, any of your Eligible Dependents that cease to qualify for coverage may keep their coverage for up to thirty-six (36) months effective from the date of the divorce or legal separation. If you get a divorce or legal separation, then you or your spouse must notify the Trust Fund Office that he/she needs an application with sixty (60) days of the date of the divorce or legal separation or he/she forfeits his/her right to COBRA continuation coverage.

6. If your dependent child turns twenty-six (26) or otherwise disqualifies for coverage, then your dependent child may have coverage in his or her own name for up to thirty-six (36) months.

7. If you do not return to work with your employer at the end of your Family Medical Leave Act ("FMLA") leave, then you and your Eligible Dependents may keep your coverage for eighteen (18) months from the last day of the FMLA leave period. You and/or your Eligible Dependent must notify the Trust Fund Office that he/she needs an application within sixty (60) days of the date of the separation of employer or he/she forfeits his/her right to COBRA continuation coverage.

You, your spouse or dependents must notify the Trust Fund Office within sixty (60) days of your divorce, legal separation or when your dependent child loses eligibility. If notification does not occur within this period, then you and your dependents will not be eligible for continuation coverage. If you terminate employment, have a reduction in hours and lose eligibility or become entitled to Medicare, your Employer is required to notify the Trust Fund Office, and you will be informed of your continuation rights. However, if any of these three events occurs, you should notify the Trust Fund Office as well.

If you have a newborn child, adopt a child, or have a child placed with you for adoption (for whom you have financial responsibility) while the continuation coverage is in effect, then you may add this child to your coverage. You must notify the Fund Office in writing within thirty-one (31) days of the birth or placement for adoption in order to add the child to your coverage.

If you and/or your Eligible Dependent qualify for eighteen (18) months of continuation coverage (under COBRA), then you and/or your Eligible Dependent may qualify for an additional continuation period [beyond the eighteen (18) months] if another qualifying event occurs during the original continuation period. The maximum continuation period, regardless of the number of qualifying events, is thirty-six (36) months.

For example, assume that you quit your job, and you and your Eligible Dependents elect COBRA for the allowable eighteen (18) months. Six (6) months later, you die. Your death is a qualifying event for your Eligible Dependents that would normally entitle them to a thirty-six (36) month continuation under COBRA. Because your death in this instance is a second qualifying event, your Eligible Dependents can take an additional thirty (30) months' coverage from the date of your death [or thirty-six (36) months from the date of the original qualifying event (termination)].

If you and/or your Eligible Dependent is disabled, as defined by the Social Security Administration, on the day you lost eligibility for health coverage under the Plan, or within sixty (60) days after that, you may elect an additional eleven (11) months of COBRA continuation coverage for a total of twenty-nine (29) months of COBRA continuation coverage. If you or your Eligible Dependent elects an additional eleven (11) months of COBRA continuation coverage, then all non-disabled members of the family are also entitled to the eleven (11) months of COBRA coverage. A participant and/or Eligible Dependent who qualifies for twenty-nine (29) months of COBRA continuation coverage may qualify for an additional continuation period [beyond the twenty-nine (29) months] if another qualifying event occurs during the COBRA continuation coverage similar to the example above. The maximum continuation period, regardless of the number of qualifying events, is thirty-six (36) months.

M. PAYMENT FOR COBRA COVERAGE

If you or your Eligible Dependent has the right to COBRA coverage, then you and/or your Eligible Dependent must complete the application and make the first payment within the time limits as set forth herein. The Plan is not required to segregate dental, vision, and other miscellaneous benefits provided by the Plan from the COBRA benefit package. The Plan shall offer the same COBRA benefit package to you and your Eligible Dependent as the benefit package to which you were entitled on the day before the qualifying event, including dental,

vision, and any other health care benefits that were part of the benefit package on the day before the qualifying event. In addition, if the Plan permits you and/or Eligible Dependents to elect among different benefit packages, then after the qualifying event the Plan does not have to provide you or your Eligible Dependent with an election among the different packages and shall only offer the same benefit package to which you and/or your Eligible Dependent were entitled on the day before the qualifying event.

You have sixty (60) days from the date you and/or your Eligible Dependent lose regular coverage to elect COBRA continuation coverage. COBRA continuation coverage will be made available for the entire sixty (60) day election period if the election for COBRA continuation coverage was made prior to the end of the sixty (60) day election period. You and/or your Eligible Dependent may reject or waive COBRA continuation coverage but then revoke the waiver at any point during the sixty (60) day period and elect COBRA continuation coverage, however, if this occurs, the COBRA continuation coverage will not apply retroactively to the beginning of the sixty (60) day election period but applies only back to the date on which the rejection or waiver was revoked and COBRA continuation coverage was elected. You and/or your Eligible Dependent are not covered during the election period prior to making the election, but will have retroactive coverage if COBRA continuation coverage is timely elected and timely paid.

You have forty-five (45) days from the date you and/or your Eligible Dependent elect COBRA coverage to make your payment. After the first payment, you and/or your Eligible Dependent are allowed thirty (30) days to make each payment after the date it is due. You and/or your Eligible Dependent are not covered during the forty-five (45) day grace period for the payment of the first COBRA premium or during the thirty (30) day grace period permitted for payment of the monthly COBRA premium prior to the timely payment of the COBRA premium, but you and/or your Eligible Dependent will have retroactive coverage if the COBRA premium is timely paid. The Fund Office will inform you or your Eligible Dependent of the monthly premium to be paid.

The cost of continuation coverage will not exceed one hundred two percent (102%) of the premium applicable to active employees. However, if you and/or your Eligible Dependent have been determined to be disabled as defined by the Social Security Administration and request coverage for twenty-nine (29) months, you may be required to pay one hundred and fifty (150%) of the amount of the regular COBRA premium for all months of coverage after the first eighteen (18) months. However, after the initial eighteen (18) months of COBRA coverage, if the disabled family member decides not to continue his/her COBRA continuation coverage for whatever reason, the remainder of the family, consisting of non-disabled persons, may still continue COBRA for an additional eleven (11) months at the regular COBRA premium. In addition, the cost of the COBRA premium may be increased at any time when the plan is charging less than the allowable COBRA premium (i.e. less than 102% or the 150%) or in a situation where you and/or your Eligible Dependent are permitted by the rules and procedures of the Plan to change to a more expensive form of coverage under the Plan.

Your COBRA coverage and/or that of your Eligible Dependent ends immediately if you and/or your Eligible Dependent:

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

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

3. First becomes covered under another group health care plan except if you or your Eligible Dependent has a pre-existing condition that is not covered under the new group health care plan, then you and/or your Eligible Dependent can continue COBRA coverage under this Plan for the remainder of the continuation coverage period; or

4. COBRA coverage will also be canceled as of the date the Trust Fund terminates all of its group health plans; or

5. At the date of the expiration of the COBRA continuation coverage period applicable to you and/or your Eligible Dependent.

N. CONDITION TO CONTINUE ELIGIBILITY

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

O. RECIPROCAL AGREEMENTS

The Trustees may, at any time and in their discretion, enter into a reciprocity agreement with the Trustees of any other health and welfare plan affiliated with a local union of the International Union of Painters and Allied Trades whereby an individual may qualify for benefits based upon his or her contributions to all of such funds which enter into such a reciprocity agreement(s) under the terms and conditions set forth in such agreement(s). Contributions made on behalf of individuals represented by local unions with which the Plan has reciprocal agreements shall be returned to the appropriate home fund pursuant to the terms of the reciprocal agreement, and no eligibility for benefits shall be established under this Plan.

P. TERMINATION OF COVERAGE AND LOSS OF BANKED MONEY

An employee (or former Employee) shall cease to be eligible to be a Participant in this Plan if such Employee is employed by an employer which is not obligated to make contributions to this Plan under the Collective Bargaining Agreement, unless the purpose of such employment is to encourage the employer to become signatory and begin making contributions to this Plan. An

Employee's coverage under this Plan shall terminate on the last day of the calendar month during which such employment occurs. In addition, an Employee whose coverage is terminated under this provision shall also lose any accumulated Banked Money.

Q. SPECIAL ENROLLMENT RIGHTS

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing towards you or your dependents' other coverage). However, you must request enrollment within 30 days after you or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

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

To request special enrollment or obtain more information, contact the Administrative Manager at 8257 Dow Circle, Strongsville, Ohio 44136, or by phone at (440) 260-0615.

R. NON-COBRA DEPENDENT CONTINUATION COVERAGE

The Eligible Dependent(s) of a deceased Employee will be eligible to continue coverage in the Plan provided the deceased Employee had been participating in the Plan at the time of his or her death. Such Eligible Dependent(s) will be eligible for all benefits provided by the Plan except accident and sickness, life insurance and accidental death and dismemberment benefits. The premium to continue coverage will be equal to the amount in effect for Retired Employees not yet eligible for Medicare.

S. DELINQUENT CONTRIBUTIONS

In order to protect the interests of all Participants and Beneficiaries of the Plan, the Trustees reserve the right to promulgate rules and regulations denying further participation in the Plan by Employees, Non-bargaining Unit Employees, Employers or Eligible Dependents where Employer contributions on behalf of one or more Employees have been in arrears for a specified time as determined by the Trustees in their sole discretion, and/or to delay the payment of claims arising on said individual until contributions are received by the Trust Fund office on behalf of all Employees.

III. SCHEDULE OF BENEFITS

The Schedule of Benefits describes the medical benefits payable to Eligible Participants and Eligible Dependents under this Plan. The Schedule of Benefits for those who elect to participate in the Kaiser-Permanente HMO Plan is located within a separate booklet, which was provided to you upon enrollment. If you do not have a copy of the Schedule of Benefits, you may obtain one at the Fund Office by calling (440) 260-0615, and a copy will be provided to you.

A. EFFECTIVE DATE OF SCHEDULE OF BENEFITS

January 1, 2019

B. LIFE INSURANCE BENEFITS

	Participant	Dependent
Life Insurance	$10,000.00	None
Principal Sum for Accidental Death and Dismemberment.....	$10,000.00	None

C. COMPREHENSIVE MAJOR MEDICAL PLAN SCHEDULE OF BENEFITS

The Maximum Allowed Amount is the amount the Claims Administrator will reimburse for services and supplies which meet the definition of Covered Services, as long as such services and supplies are not excluded under the Plan; are Medically Necessary; and are provided in accordance with the Plan. Under certain circumstances, if the Claims Administrator pays the healthcare Provider amounts that are Your responsibility, such as Deductibles, Copayments or Coinsurance, the Claims Administrator may collect such amounts directly from You. You agree that the Claims Administrator has the right to collect such amounts from You.

Schedule of Benefits	Network	Out-of-Network
Calendar Year Deductible		
Individual	$280	$1,000
Family	$560	$2,000
Copayments and charges in excess of the Maximum Allowed Amount do not contribute to the Deductible		
All Covered Services are subject to the Deductible unless otherwise specified in this SPD		
Your Plan has an embedded Deductible which means: • If You, the Participant, are the only person covered by this Plan, only the "Individual" amounts apply to You. • If Your Eligible Dependents are also covered under the Plan, both the "Individual" and the "Family" amounts apply. The "Family" Deductible amounts can be satisfied by any combination of family members, but You could satisfy Your own "Individual" Deductible amount before the "Family" amount is met. You will never have to satisfy more than Your own "Individual" Deductible amount. If You meet Your "Individual" Deductible amount, Your other family member's claims will still accumulate towards their own "Individual" Deductible and the overall "Family" amounts. This continues until Your other family members meet their own "Individual" Deductible or the entire "Family" Deductible is met.		
The Network and Out-of-Network calendar year Deductibles are separate and cannot be combined.		

Schedule of Benefits	Network	Out-of-Network
Coinsurance After the Calendar Year Deductible is Met (Unless Otherwise Specified)		
Plan Pays	80%	60%
Participant Pays	20%	40%
All payments are based on the Maximum Allowed Amount and any negotiated arrangements. For Out-of-Network Providers, You are responsible to pay the difference between the Maximum Allowed Amount and the amount the Provider charges. Depending on the service, this difference can be substantial.		
Out-of-Pocket Maximum Per Calendar Year (Includes Coinsurance. Does NOT include calendar year Deductible, Copayments, Prescription Drug benefits precertification penalties, charges in excess of the Maximum Allowed Amount or Non-Covered Services.)		
Individual	$1,400	$5,000
Family	$2,800	$10,000
Your Plan has an embedded Out-of-Pocket which means: • If You are the only person covered by this Plan, only the "Individual" amounts apply to You. • If Your Eligible Dependents are also covered under this Plan, both the "Individual" and "Family" amounts apply. The "Family" Out-of-Pocket amounts can be satisfied by any combination of family members, but You could satisfy Your own "Individual" Out-of-Pocket amount before the "Family" amount is met. You will never have to satisfy more than Your own "Individual" Out-of-Pocket amount. If You meet Your "Individual" amount, other family member's claims will still accumulate towards their own "Individual" Out-of-Pocket and the overall "Family" amounts. This continues until Your other family members meet their own "Individual" Out-of-Pocket or the entire "Family" Out-of-Pocket is met.		
The Network and Out-of-Network Out-of-Pocket Maximums are separate and cannot be combined		

Benefits	Participant Responsibility	
	Network	Out-of-Network
Note: Copayments only apply to certain services. When a Copayment applies, the Deductible is waived. All Covered Services are subject to the Deductible and applicable Coinsurance unless otherwise specified in this SPD		
Acupuncture	Not Covered	Not Covered
Allergy Care		
Testing	20%	40%
Treatment	20%	40%
Serum and Allergy Shots	20%	40%

Benefits	Participant Responsibility	
	Network	Out-of-Network
Note: Copayments only apply to certain services. When a Copayment applies, the Deductible is waived. All Covered Services are subject to the Deductible and applicable Coinsurance unless otherwise specified in this SPD		
Behavioral Health/Substance Abuse Care		
Hospital Inpatient Services	20%	40%
Outpatient Services	20%	40%
Physician Services (Home, Office Visits and Online Visits) **Note:** Online Visits Out-of-Network and non-Live Online Providers are Not Covered.	$20	40%
Note: Coverage for the treatment of Behavioral Health and Substance Abuse Care conditions is provided in compliance with Federal law.		
Dental, Oral Surgery and TMJ Services		
Accidental Injury to Natural Teeth (Treatment must be completed within 12 months of the Injury)	Benefits are paid based on the setting in which the Covered Services are received	Benefits are paid based on the setting in which the Covered Services are received
Oral Surgery	Not Covered	Not Covered
TMJ – Subject to Medical Necessity – excludes orthodontic treatment	Benefits are paid based on the setting in which the Covered Services are received	Benefits are paid based on the setting in which the Covered Services are received
Diagnostic Physician's Services Diagnostic services (including second opinion) by a Physician or Specialist Physician – office visit or home visit:		
Primary Care Physician Copayment	$20	40%
Specialist Physician Copayment	$20	40%
Diagnostic X-ray and Lab – office or independent lab	20%	20%
Note: The office visit Copayment applies to the office visit procedure code, all other services billed for a Physician visit are subject to the calendar year Deductible and Coinsurance		
Note: Diagnostic services are defined as any claim for services performed to diagnose an illness or Injury.		

Benefits	Participant Responsibility	
	Network	Out-of-Network
Note: Copayments only apply to certain services. When a Copayment applies, the Deductible is waived. All Covered Services are subject to the Deductible and applicable Coinsurance unless otherwise specified in this SPD		
Emergency Care, Urgent Care, and Ambulance Services If an emergency visit is rendered in an office setting, the $20 Primary Care/Specialist Physician Copayment will apply.		
Emergency Room Visit for a Medical Emergency (per visit) Copayment/Coinsurance	$100	Covered at Network Level of Benefits (see note)
All other services	20%	Covered at Network Level of Benefits (see note)
(Copayment waived if admitted).	20%	40%
Emergency room visit for a Non-Emergency All other services	20%	40%
Urgent Care Clinic Visit (per visit) Copayment/Coinsurance	$35	40%
All other services	20%	40%
Ambulance Services (when Medically Necessary) Land/Air	20%	40%
Note: Care received Out-of-Network for a Medical Emergency will be provided at the Network level of benefits if the following conditions apply: A Medical Emergency is a condition of recent onset and sufficient severity, including but not limited to severe pain, that would lead a prudent layperson, possessing an average knowledge of medicine and health, to believe that his or her condition, sickness, or Injury is of such a nature that failure to obtain immediate medical care could place his or her life in danger or serious harm. Care may also be approved as an Authorized Service. **If an Out-of-Network Provider is used, however, You are responsible to pay the difference between the Maximum Allowed Amount and the amount the Out-of-Network Provider charges.**		
Eye Care – Non-Routine		
Office Visit – medical eye care exams (treatment of disease or Injury to the eye)	$20	40%
Treatment other than office visit	20%	40%
Hearing Care – Non-Routine		
Office Visit – hearing evaluation test	$20	40%
Cochlear Implants	20%	40%

Benefits	Participant Responsibility	
	Network	**Out-of-Network**
Note: Copayments only apply to certain services. When a Copayment applies, the Deductible is waived. All Covered Services are subject to the Deductible and applicable Coinsurance unless otherwise specified in this SPD		
Hearing Devices/Hearing Aids • Limited to a $2,000 maximum per year once every three years (a full 36 months must separate each occurrence) • Audiometric exam – limited to a $25 maximum every three years • Hearing Aid Evaluation – limited to a $35 maximum every three years	20%	40%
Home Health Care Services	20%	40%
Maximum Home Care benefit	None	
Private Duty Nursing – only covered if provided in the home	None	
Hospice Care Services **Note:** Respite Care and Bereavement Counseling are covered	20%	40%
Hospital Inpatient Services – Precertification Required		
Room and Board (Semiprivate or ICU/CCU)	20%	40%
Hospital Services and Supplies (x-ray, lab, anesthesia, surgery (Precertification required), Inpatient Physical therapy, etc.)	20%	40%
Pre-Admission Testing	20%	40%
Physician Services		
• Surgeon	20%	40%
• Anesthesiologist	20%	40%
• Radiologist	20%	40%
• Pathologist	20%	40%
Note: Anesthesiologist, radiologist, and pathologist charges are always paid at the Network level of benefits (Coinsurance) when providing Inpatient services. **If an Out-of-Network Provider is used, however, You are responsible to pay the difference between the Maximum Allowed Amount and the amount the Provider charges.**		

Benefits	Participant Responsibility	
	Network	Out-of-Network
Note: Copayments only apply to certain services. When a Copayment applies, the Deductible is waived. All Covered Services are subject to the Deductible and applicable Coinsurance unless otherwise specified in this SPD		
Maternity Care and Other Reproductive Services		
Physician's Office: Global care (includes pre- and post-natal, delivery)		
Primary Care Physician (includes obstetrician and gynecologist)	20%	40%
Specialist Physician	20%	40%
Midwife	20%	40%
Physician Hospital/Birthing Center Services (Precertification Required)		
Physician's Services	20%	40%
Newborn Nursery Services (well-baby care)	20%	40%
Circumcision	20%	40%
Note: Newborn stays in the Hospital after the mother is discharged, as well as any stays exceeding 48 hours for vaginal delivery or 96 hours for a cesarean section, must be pre-certified.		
Infertility Services		
Limited Coverage Diagnostic Services and Limited Treatment (Non-Covered Services include, but are not limited to: in-vitro fertilization, gamete intrafallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT), artificial insemination, reversal of voluntary sterilization.)	20%	40%
Sterilization Services (Precertification required for Inpatient procedures)		
Tubal ligation or Vasectomy	Benefits are paid based on the setting in which Covered Services are received	Benefits are paid based on the setting in which Covered Services are received

Benefits	Participant Responsibility	
	Network	Out-of-Network
Note: Copayments only apply to certain services. When a Copayment applies, the Deductible is waived. All Covered Services are subject to the Deductible and applicable Coinsurance unless otherwise specified in this SPD		
Medical Supplies and Equipment		
Medical Supplies	20%	40%
Durable Medical Equipment	20%	40%
Orthotics Foot and shoe	20%	40%
Prosthetic Appliances (external) • Wigs/Toupees are limited to one per benefit period subject to Medical Necessity for Cancer Patients • Breast Prosthesis are limited to once every two calendar years. Three prosthesis bras are covered each calendar year. • Ocular Prostheses are limited to one every two years. • Below the Knee Prostheses are limited to one every two years. • Above the Knee Prostheses are limited to one every two years. • Below the Elbow Prostheses are limited to one every two years. • Above the Elbow Prostheses are limited to one every two years.	20%	40%
Nutritional Counseling	Not Covered	Not Covered
Outpatient Hospital/Facility Services		
Outpatient Clinic	$35	40%
Outpatient facility	20%	40%
Lab and X-Ray Services	20%	40%
Outpatient Physician Services (surgeon, anesthesiologist, radiologist, pathologist, etc.)	20%	40%

Benefits	Participant Responsibility	
	Network	Out-of-Network
Note: Copayments only apply to certain services. When a Copayment applies, the Deductible is waived. All Covered Services are subject to the Deductible and applicable Coinsurance unless otherwise specified in this SPD		
Physician Services (Home and Office Visits)		
Primary Care Physician Copayment (per visit)	$20	40%
Specialist Physician Copayment (per visit)	$20	40%
Office Surgery	20%	40%
Online Visits from LiveHealth Online Provider (Other than Behavioral Health & Substance Abuse; see Behavioral Health/Substance Abuse Care section for further details)	$20	Out-of-Network and non-LiveHealth Online Providers Not Covered
Prescription Injectables/Prescription Drugs Dispensed in the Physician's Office	20%	20%

Preventive Services

Preventive Services may be performed by a Primary Care or Specialist Physician

Services Include, but are not limited to:

Preventive Services for children age 18 and under

- Age Appropriate Periodic Health Assessments
- Development assessment of the child
- Age Appropriate Immunizations
- Preventive X-Ray and Laboratory Testing (office or independent lab)

Preventive Services for Adults

- Periodic Health Assessments
- Immunizations; Flu Injections
- Preventive X-Ray and Laboratory Testing
- Colorectal Cancer Screening – Fecal Occult Blood Test, Sigmoidoscopy and Colonoscopy

Specific Preventive Services for Women

- Annual Gynecological Exam/Well Woman
- Pap Smear
- Routine Mammography

Specific Preventive Services for Men

- Prostate Screening

Other Preventive Services

- Routine Eye Exams (Covered only for dependents under age 9)
- Routine Hearing Exams (Covered only for dependents under age 9)

Benefits	Participant Responsibility	
	Network	**Out-of-Network**
Note: Copayments only apply to certain services. When a Copayment applies, the Deductible is waived. All Covered Services are subject to the Deductible and applicable Coinsurance unless otherwise specified in this SPD		
Primary Care/Specialist Physician	100% up to a combined maximum of $300 each calendar year, once this maximum is met, services covered at 20% after the Deductible	40%
Skilled Nursing Facility	20%	40%
Maximum Skilled Nursing Benefit	100 days per calendar year, combined Network and Out-of-Network	
Surgical Services	20%	40%
Lasik Surgery – limited to a maximum of $750 per Lifetime	20%	40%
Gastric Bypass/Obesity Surgery	Not Covered	Not Covered
Therapy Services (Outpatient)		
Physical Therapy (See Maximum below)	20%	40%
Occupational Therapy (See Maximum below)	20%	40%
Speech Therapy (See Maximum below)	20%	40%
Cardiac Rehabilitation	20%	40%
Manipulation Therapy (See Maximum below)	20%	40%
Radiation Therapy	20%	40%
Chemotherapy	20%	40%
Respiratory Therapy	20%	40%
Vision Therapy	20%	40%

Benefits	Participant Responsibility	
	Network	**Out-of-Network**
Note: Copayments only apply to certain services. When a Copayment applies, the Deductible is waived. All Covered Services are subject to the Deductible and applicable Coinsurance unless otherwise specified in this SPD		
Maximum Benefits for Therapy: • Physical Therapy and Occupational Therapy are limited to a combined maximum of 24 visits per calendar year, Network and Out-of-Network combined. • Speech Therapy is limited to 24 visits per calendar year Network and Out-of-Network combined. • Manipulation Therapy is limited to 12 visits per calendar year Network and Out-of-Network combined. **Note:** Inpatient therapy services will be paid under the Inpatient Hospital benefit.		
Transplants Any Medically Necessary human organ and stem cell/bone marrow transplant and transfusion as determined by the Claims Administrator including necessary acquisition procedures, collection and storage, including Medically Necessary preparatory myeloablative therapy. **The Center of Excellence requirements do not apply to** Cornea and kidney transplants; and any Covered Services related to a Covered Transplant Procedure, received prior to or after the Transplant Benefit Period. **Note:** Even if a Hospital is a Network Provider for other services, it may not be a Network Transplant Provider for these services. Please be sure to contact the Claims Administrator to determine which Hospitals are Network Transplant Providers (When calling Participant Services, ask to be connected with the Transplant Case Manager for further information).		
	Center of Excellence/ Network Transplant Provider	**Out-of-Network Transplant Provider**
Transplant Benefit Period Starts one day prior to a Covered Transplant Procedure and continues for the applicable case rate/global time period (The number of days will vary depending on the type of transplant received and the Center of Excellence Network Provider Agreement. Contact the Participant Services number on Your Identification Card and ask for the Transplant Case Manager for specific Network Transplant Provider information.)	Covered	Not Applicable

Benefits	Participant Responsibility	
	Center of Excellence/ Network Transplant Provider	**Out-of-Network Transplant Provider**
Note: Copayments only apply to certain services. When a Copayment applies, the Deductible is waived. All Covered Services are subject to the Deductible and applicable Coinsurance unless otherwise specified in this SPD		
Covered Transplant Procedure during the Transplant Benefit Period	Blue Distinction Center for Transplants (BDCT) 0%, Deductible does not apply Network Provider 20%	Not Covered
Bone Marrow & Stem Cell Transplant (Inpatient & Outpatient)	Blue Distinction Center for Transplants (BDCT) 0%, Deductible does not apply Network Provider 20%	Not Covered
Includes unrelated donor search up to $30,000 per transplant.		
Live Donor Health Services (including complications from the donor procedure for up to six weeks from the date of procurement)	Blue Distinction Center for Transplants (BDCT) 0%, Deductible does not apply Network Provider 20%	Not Covered
Eligible Travel and Lodging Limited to a $10,000 maximum per Transplant, subject to Claims Administrator's approval.	Blue Distinction Center for Transplants (BDCT) 0%, Deductible does not apply Network Provider Not Covered	Not Covered
All Other Covered Transplant Services	Blue Distinction Center for Transplants (BDCT) 0%, Deductible does not apply Network Provider 20%	Not Covered

IN ADDITION, MATERNITY BENEFITS ARE NOT COVERED FOR DEPENDENT CHILDREN OF EITHER ACTIVE OR RETIRED PARTICIPANTS.

Participants may be responsible for excess charges not covered by the Plan if using Non-Network providers. Participants risk being balance-billed for charges of the Non-Network Provider in excess of the amount payable pursuant to the terms of the Plan.

Ancillary charges provided by Non-network providers that are performed in In-Network facilities will be covered as In-Network for the following ancillary providers: Emergency Room Doctors, Anesthesiologists, Pathologists, & Radiologists. Therefore, the claim will be subject to In-Network deductibles and co-pays rather than the Out-of-Network deductible and co-pays in such circumstances.

1. Emergency Room Treatment While Working Out Of Town

In response to concerns about emergency room coverage for Eligible Employees and Eligible Dependents when emergency room treatment is medically necessary and the Eligible Employee or Eligible Dependent receives treatment at a hospital located outside the geographical area for network coverage, the Board of Trustees has determined that emergency room claims under such circumstances may be covered at the in-network level, whether or not the treatment is received at an in-network hospital.

Outpatient Emergency claims are limited to emergency care. For this purpose, "emergency care" means the initial care given in a hospital's emergency room immediately after either the sudden and unexpected onset of symptoms or an accident causing injuries that are severe enough to require immediate hospital level of care.

Hospital level of care will be deemed to be required only if:

1. the care could not be safely and adequately provided other than in a hospital; and

2. adequate care was not available elsewhere in the area at the time and place it was necessary.

Generally, the Plan pays Outpatient Emergency claims at 80% in-network and 60% out-of-network. The Plan will pay Outpatient Emergency claims at the out-of-network level for treatment received in a hospital emergency room when an individual is not an inpatient and the treatment is not considered emergency care. However, if the treatment was received in the emergency room of a hospital located in a geographical area in which network coverage is not available and the treatment qualifies as emergency care and/or the individual, immediately following such treatment, is admitted to the hospital as an inpatient, the Board of Trustees may, in its discretion, have the Plan pay the claims for such treatment at the in-network level.

2. Exceptions And Limitations Of Eligible Benefits

The following exceptions and limitations apply:

a. Benefits payable under other group plans or other individual medical expense policies are not covered by the comprehensive benefits.

b. The Allowed Amount for charges for Assistant Surgeons are reduced by the applicable Preferred Provider Organization.

c. Breast Prosthesis will be covered once every two calendar years.

d. Three prosthesis bras will be covered per full calendar year.

e. Private duty professional nursing services by a registered graduate nurse or by a licensed practical nurse, only if prescribed by an attending physician.

f. Annual Maximum on speech therapy is 24 visits per calendar year for both Network and Out-of-Network combined.

g. Consultations will be covered under Comprehensive Major Medical, subject to deductible and co-insurance with the exception of an initial second surgical opinion which will be subject to the physician's office co-pay.

D. EXCLUSIONS

The following items or services are excluded from coverage under the Plan:

1. Weight loss Surgery, including complications related to such Surgery.

2. Services covered under Workers' Compensation, no-fault automobile insurance and/or services covered by a similar statutory program.

3. Charges incurred for any such illness or condition resulting in a Participant's total disablement on the effective date of his/her insurance.

4. For blood which is available without charge and for outpatient blood processing and storage services.

5. Dental care and treatment and oral surgery by Physicians or dentists including dental surgery; dental appliances; dental prostheses such as crowns, bridges or dentures; implants; orthodontic care; operative restoration of the teeth (fillings); dental extractions; endodontic care; apicoectomies; excision of radicular cysts or granuloma; treatment of dental caries, gingivitis, or periodontal disease by gingivectomies or other periodontal surgery. Any treatment of teeth, gums or tooth related service except otherwise specified as a covered service in this SPD.

6. Hospital or Surgical center charges incurred for dental work of any kind. Charges incurred for dental work or treatment except as required by accidental injury of sound teeth.

7. Non-prescription drugs or medicines.

8. Charges or any portion of a charge in excess of the Maximum Allowed Amount as determined by the Claims Administrator.

9. Cosmetic Surgery, reconstructive surgery, pharmacological services, nutritional regimens or other services for beautification, or treatment relating to the consequences of, or as a result of, Cosmetic Surgery except for reconstructive surgery following mastectomy or when Medically Necessary to correct damage caused by an accident, an injury or to correct a congenital defect.

10. Treatments, procedures, equipment, drugs, devices or supplies (hereafter called "services") which are in the Claims Administrator's judgment, Experimental or Investigational for the diagnosis for which the Participant is being treated.

11. Services, treatment or supplies not generally accepted in medical practice for the prevention, diagnosis, or treatment of an illness or injury, as determined by the Claims Administrator.

12. Services or supplies provided by a member of Your family or household.

13. Acupuncture.

14. Elective abortions.

15. Treatment or services resulting from civil insurrection or riot.

16. Care, services or treatment required as a result of complications from a treatment not covered under the Plan.

17. Contraceptive Drugs, except for any contraceptive devices approved elsewhere in the SPD. Moreover, medications for birth control purposes are covered for Participants and eligible spouses of Participants as long as such medications are obtained through a Mail Order Prescription. Medications for birth control purposes that are prescribed to children under the age of 18 are covered only if (1) such medication is determined by a licensed physician to be medically necessary to treat a disease or condition of the child, and (2) the medication is obtained through a Mail Order Prescription.

18. Expenses incurred by a Participant or Eligible Dependent resulting from or occurring.

    i. during the commission of a crime;
    ii. during illegal or willful misconduct;
    iii. while engaged in an illegal occupation;
    iv. while committing or attempting to commit a felonious act or assault; or
    v. while participating in a riot or civil insurrection. The Trustees will make determination in their sole discretion and such determination will be conclusive.

19. Services or supplies for Custodial Care.

20. Services or supplies for confinement for custodial or convalescent care, rest cures or long-term custodial Hospital care.

21. Services for Hospital confinement primarily for diagnostic studies.

22. Eating disorders, other than psychological counseling.

23. Services and supplies primarily for educational, vocational or training purposes, including, but not limited to, structured teaching, applied behavioral analysis, or educational interventions, except as expressly provided in this SPD.

24. Foot care only to improve comfort or appearance, routine care of corns, calluses, toenail (except surgical removal or care rendered as treatment of diabetic foot or ingrown toenails), flat feet, fallen arches, weak feet, chronic foot strain, or asymptomatic complaints related to the feet. Coverage is available, however, for Medically Necessary foot care required as part of the treatment of diabetes and for Participants with impaired circulation to the lower extremities.

25. Shoe inserts, orthotics unless prescribed by a Physician for diseases of the foot or systemic diseases that affect the foot such as diabetes when deemed Medically Necessary.

26. Counseling or testing concerning inherited (genetic) disorders.

27. Care, treatment or supplies where payment is made by any local, state, or Federal government (except Medicaid), or for which payment would be made if the Participant had applied for such benefits. Services that can be provided through a government program for which You as a member of the community are eligible for participation. Such programs include, but are not limited to, school speech and reading programs.

28. Hair transplants, hair pieces or wigs (except for cancer patients), wig maintenance, or prescriptions or medications related to hair growth.

29. Separate charges by interns, residents, house Physicians or other health care professionals who are employed by the covered facility, which makes their services available.

30. Hypnosis.

31. In-vitro Fertilization, Artificial Insemination and other infertility treatments such as gamete intrafallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT), and reversal of voluntary sterilization.

32. Services for which benefits are payable under Medicare Parts A and/or B or would have been payable if you had applied for Parts A and/or B, except as listed in this SPD or as required by federal law. If You do not enroll in Medicare Part B, the Plan will calculate benefits as if You had enrolled. You should sign up for Medicare Part B as soon as possible to avoid large out of pocket costs.

33. Care, services, equipment or supplies not Medically Necessary, as determined by the Claims Administrator, for the treatment of an Injury or illness. This includes, but is not limited to, care which does not meet the Claims Administrator's medical policy, clinical coverage guidelines, or benefit policy guidelines.

34. Services and supplies for weight loss programs. Weight loss programs include, but are not limited to, commercial weight loss programs (Weight Watchers, Jenny Craig, and LA Weight Loss).

35. Personal comfort items such as those that are furnished primarily for Your personal comfort or convenience including those services and supplies not directly related to medical care including, but not limited to, guest meals and accommodations, barber services, telephone charges, radio and television rentals, homemaker services, travel expenses, and take-home supplies.

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

37. Services provided in a halfway house.

38. Charges for or related to sex change surgery or to any treatment of gender identity disorders.

39. Care and treatment for reversal of vasectomy or reversal of tubal ligation.

40. Charges for any of the following:
    a. Failure to keep a scheduled visit;
    b. Completion of claim forms or medical records or reports unless otherwise required by law;
    c. For Physician or Hospital's stand-by services;
    d. For holiday or overtime rates;

e. Membership, administrative or access fees charged by Physicians or other Providers. Examples of administrative fees include, but are not limited to, fees charged for educational brochures or calling a patient to provide their test results;

f. Specific medical reports including those not directly related to the treatment of the Participant, e.g., employment or insurance physicals, and reports prepared in connection with litigation.

41. Any disease or injury resulting from a war, declared or not, or any military duty or any release of nuclear energy. Also excluded are charges for services directly related to military service provided or available from the Veterans' Administration or military facilities except as required by law.

42. Services and supplies for which You have no legal obligation to pay, or for which no charge has been made or would be made if You had no health insurance coverage.

43. Commodes, stools and benches are not covered under Durable Medical Equipment.

44. Maternity benefits, other than for an Active Participant or an Active Participant's Spouse.

45. Hospital or Surgical center charges incurred for dental work of any kind.

46. For Participants covered under the Plan where Medicare is Primary, Incurred charges disallowed by Medicare Parts "A" or "B" will not be covered under this Plan except Lasik Surgery, which is covered with at $750.00 lifetime maximum.

47. Administration charges associated with blood drawing/ Administration charge for injections.

48. Claims incurred while in a Foreign Country will not be covered unless such bill is submitted in English including monetary amounts in United States dollars. Such bill must be submitted from the medical provider.

49. Vitamins, minerals and food supplement, as well as vitamin injections. Nutritional supplements; services, supplies and/or nutritional sustenance products (food) related to enteral feeding.

50. Charges for treatment received before coverage under this Plan began or after coverage is terminated.

51. Court-ordered services, or those required by court order as a condition of parole or probation, unless Medically Necessary and approved by the Plan.

52. Drugs, devices, products or supplies with over the counter equivalents and any Drugs, devices, products or supplies that are therapeutically comparable to an over the counter Drug, device, product or supply.

53. Donor Search/Compatibility, except as otherwise indicated.

54. Religious, marital and sex counseling, including services and treatment related to religious counseling, marital/relationship counseling and sex therapy.

55. Christian Science practitioner services.

56. Except as otherwise specifically provided below and as covered as a prescription drug benefit, services and supplies for smoking cessation programs and treatment of nicotine addiction, including gum, patches, and prescription drugs to eliminate or reduce the dependency on or addiction to tobacco and tobacco products unless otherwise required by law.

57. Treatment or services provided by a non-licensed Provider, or that do not require a license to provide; services that consist of supervision by a Provider of a non-licensed person; services performed by a relative of a Participant for which, in the absence of any health benefits coverage, no charge would be made; services provided to the Participant or a Dependent by a local, state, or Federal government agency, or by a public school system or school district, except when the Plan's benefits must be provided by law; services if the Participant is not required to pay for them or they are provided to the Participant or Dependent for free.

58. Fees or charges made by an individual, agency or facility operating beyond the scope of its license.

59. Routine care is not covered except as otherwise provided for preventive care services.

60. Salabrasion, chemosurgery and other such skin abrasion procedures associated with the removal of scars, tattoos, and actinic changes and/or which are performed as a treatment for acne.

61. Services for outpatient therapy or rehabilitation other than those specifically listed as covered in this SPD. Excluded forms of therapy include, but are not limited to, primal therapy, chelation therapy, Rolfing, psychodrama, megavitamin therapy, purging, bioenergetic therapy, in-home wrap around treatment, wilderness therapy and boot camp therapy.

62. Vision care services and supplies are not covered under your medical care benefit but are covered under the Vision benefits set forth below.

63. Vision Surgeries – related to radial keratotomy and keratomileusis or excimer laser photo refractive keratectomy; and surgery, services or supplies for the surgical correction of nearsightedness and/or astigmatism or any other correction of vision due to a refractive program. Provided, however, that Lasik Surgery is covered subject to a $750 lifetime maximum.

64. Massage Therapy.

E. ELIGIBLE BENEFITS

Please refer to the Schedule of Benefits for details. All covered Services must be Medically Necessary, whether provided through Network or Out-of-Network Providers.

1. Ambulance Service

Medically Necessary Ambulance Services are a Covered Service when:

- You are transported by a state licensed vehicle that is designed, equipped, and used only to transport the sick and injured and staffed by Emergency Medical Technicians (EMT), paramedics, or other certified medical professionals. This includes ground, water, fixed wing, and rotary wing air transportation.

And one or more of the following criteria are met:

- For ground ambulance, You are taken:
  - From Your home, the scene of an accident or Medical Emergency to a Hospital;
  - Between Hospitals, including when the Claims Administrator requires You to move from an Out-of-Network Hospital to a Network Hospital
  - Between a Hospital and a Skilled Nursing Facility or other approved Facility.

- For air or water ambulance, You are taken:
  - From the scene of an accident or Medical Emergency to a Hospital;
  - Between Hospitals, including when the Claims Administrator requires You to move from an Out-of-Network Hospital to a Network Hospital
  - Between a Hospital and an approved Facility.

Ambulance Services are subject to Medical Necessity reviews by the Claims Administrator. Emergency ground ambulance services do not require precertification and are allowed regardless of whether the Provider is a Network or Out-of-Network Provider.

Non-Emergency ambulance services are subject to Medical Necessity reviews by the Claims Administrator. When using an air ambulance, for non-Emergency transportation, the Claims Administrator reserves the right to select the air ambulance Provider. If You do not use the air

ambulance Provider the Claims Administrator selects, the Out-of-Network Provider may bill You for any charges that exceed the Plan's Maximum Allowed Amount.

You must be taken to the nearest Facility that can give care for Your condition. In certain cases, the Claims Administrator may approve benefits for transportation to a Facility that is not the nearest Facility.

Benefits also include Medically Necessary treatment of a sickness or Injury by medical professionals from an ambulance service, even if You are not taken to a Facility.

Ambulance Services are not covered when another type of transportation can be used without endangering Your health. Ambulance Services for Your convenience or the convenience of Your family or Physician are not a Covered Service.

Other non-covered Ambulance Services include, but are not limited to, trips to:

- a Physician's office or clinic; or
- a morgue or funeral home.

Important Notes on Air Ambulance Benefits

Benefits are only available for air ambulance when it is not appropriate to use a ground or water ambulance. For example, if using a ground ambulance would endanger Your health and Your medical condition requires a more rapid transport to a Facility than the ground ambulance can provide, the Plan will cover the air ambulance. Air ambulance will also be covered if You are in an area that a ground or water ambulance cannot reach.

Air ambulance will not be covered if You are taken to a Hospital that is not an acute care Hospital (such as a Skilled Nursing Facility), or if You are taken to a Physician's office or Your home.

Hospital to Hospital Transport

If You are moving from one Hospital to another, air ambulance will only be covered if using a ground ambulance would endanger Your health and if the Hospital that first treats cannot give You the medical services You need. Certain specialized services are not available at all Hospitals. For example, burn care, cardiac care, trauma care, and critical care are only available at certain Hospitals. To be covered, You must be taken to the closest Hospital that can treat You. **Coverage is not available for air ambulance transfers simply because You, Your family, or Your Provider prefers a specific Hospital or Physician**.

2. Assistant Surgery

Services rendered by an assistant surgeon are covered based on Medical Necessity.

3. Behavioral health Care and Substance Abuse Treatment

See the Schedule of Benefits for any applicable Deductible, Coinsurance/Copayment information. Coverage for the diagnosis and treatment of Behavioral Health Care and Substance Abuse Treatment on an Inpatient or outpatient basis will not be subject to Deductibles or Copayment/Coinsurance provisions that are less favorable than the Deductibles or Copayment/Coinsurance provisions that apply to a physical illness as covered under this SPD.

Covered Services include the following:

- **Inpatient Services** in a Hospital or any facility that must be covered by law. Inpatient benefits include psychotherapy, psychological testing, electroconvulsive therapy, and Detoxification.

- **Residential Treatment** in a licensed Residential Treatment Center that offers individualized and intensive treatment and includes:
  - observation and assessment by a psychiatrist weekly or more often; and
  - rehabilitation, therapy, and education.

- **Outpatient Services** including office visits, therapy and treatment, Partial Hospitalization/Day Treatment Programs, and Intensive Outpatient Programs.

- **Online Visits** when available in Your area. Covered Services include a medical visit with the Doctor using the internet by a webcam, chat or voice. Online visits do not include reporting normal lab or other test results, requesting office visits, getting answers to billing, insurance coverage or payment questions, asking for referrals to doctors outside the online care panel, benefit precertification, or Doctor to Doctor discussions. Online visits are not covered from Providers other than those contracted with LiveHealth Online.

Examples of Providers from whom You can receive Covered Services include:
- Psychiatrist;
- Psychologist;
- Licensed Clinical Social Worker (L.C.S.W.);
- mental health clinical nurse specialist;
- Licensed Marriage and Family Therapist (L.M.F.T.);
- Licensed Professional Counselor (L.P.C); or
- any agency licensed by the state to give these services, when they have to be covered by law.

4. Breast Cancer Care

Covered Services are provided for Inpatient care following a mastectomy or lymph node dissection until the completion of an appropriate period of stay as determined by the attending Physician in consultation with the Participant. Follow-up visits are also included and may be

conducted at home or at the Physician's office as determined by the attending Physician in consultation with the Participant.

5. Breast Reconstructive Surgery

Covered Services are provided following 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 prostheses and treatment of physical complications, including lymphedemas.

6. Cardiac Rehabilitation

Covered Services are provided as outlined in the Schedule of Benefits.

7. Clinical Trials

Benefits include coverage for services, such as routine patient care costs, given to You as a participant in an approved clinical trial if the services are Covered Services under this Plan. An "approved clinical trial" means a phase I, phase II, phase III, or phase IV clinical trial that studies the prevention, detection, or treatment of cancer or other life-threatening conditions. The term life-threatening condition means any disease or condition from which death is likely unless the disease or condition is treated.

Benefits are limited to the following trials:

1. Federally funded trials approved or funded by one of the following:
    a. The National Institutes of Health.
    b. The Centers for Disease Control and Prevention.
    c. The Agency for Health Care Research and Quality.
    d. The Centers for Medicare & Medicaid Services.
    e. Cooperative group or center of any of the entities described in (a) through (d) or the Department of Defense or the Department of Veterans Affairs.
    f. A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants.
    g. Any of the following in i-iii below if the study or investigation has been reviewed and approved through a system of peer review that the Secretary of Health and Human Services determines 1) to be comparable to the system of peer review of studies and investigations used by the National Institutes of Health, and 2) assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.
        i. The Department of Veterans Affairs.
        ii. The Department of Defense.
        iii. The Department of Energy.

2. Studies or investigations done as part of an investigational new drug application reviewed by the Food and Drug Administration; and

3. Studies or investigations done for drug trials which are exempt from the investigational new drug application.

Your Plan may require You to use a Network Provider to maximize Your benefits.

Routine patient care costs include items, services, and Drugs provided to You in connection with an approved clinical trial that would otherwise be covered by this Plan.

All other requests for clinical trials services, including requests that are not part of approved clinical trials will be reviewed according to the Claims Administrator's Clinical Coverage Guidelines, related policies and procedures.

Your Plan is not required to provide benefits for the following services. The Plan reserves its right to exclude any of the following services:

1. The Experimental/Investigative item, device, or service; or
2. Items and services that are provided only to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; or
3. A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis;
4. Any item or service that is paid for, or should have been paid for, by the sponsor of the trial.

8. Consultation Services

Covered when the special skill and knowledge of a consulting Physician is required for the diagnosis or treatment of an illness or Injury. Second surgical opinion consultations are covered.

Staff consultations required by Hospital rules are excluded. Referrals (the transfer of a patient from one Physician to another for treatment) are not consultations under this Plan.

9. Dental Services Covered As Medical Benefit

A. Related to Accidental Injury

Your Plan includes benefits for dental work required for the initial repair of an Injury to the jaw, sound natural teeth, mouth or face which are required as a result of an accident and are not excessive in scope, duration, or intensity to provide safe, adequate, and appropriate treatment without adversely affecting the Participant's condition. Injury as a result of chewing or biting is not considered an Accidental Injury except where the chewing or biting results from an act of domestic violence or directly from a medical condition.

Treatment must be completed within the timeframe shown in the Schedule of Benefits.

B. Other Dental Services

Your Plan also includes benefits for Hospital charges and anesthetics provided for dental care if the Participant meets any of the following conditions:

- the Participant is under the age of five (5);
- the Participant has a severe disability that requires hospitalization or general anesthesia for dental care; or
- the Participant has a medical condition that requires hospitalization or general anesthesia for dental care.

10. Diabetes

Equipment and outpatient self-management training and education, including nutritional therapy for individuals with insulin-dependent diabetes, insulin-using diabetes, gestational diabetes, and non-insulin using diabetes as prescribed by the Physician. Covered Services for outpatient self-management training and education must be provided by a certified, registered or licensed health care professional with expertise in diabetes.

11. Dialysis Treatment

The Plan covers Covered Services for Dialysis treatment. If applicable, the Plan will pay secondary to Medicare Part B, even if a Participant has not applied for eligible coverage available through Medicare.

12. Durable Medical Equipment

The Plan will pay the rental charge up to the purchase price of the equipment. In addition to meeting criteria for Medical Necessity, and applicable Precertification requirements, the equipment must also be used to improve the functions of a malformed part of the body or to prevent or slow further decline of the Participant's medical condition. The equipment must be ordered and/or prescribed by a Physician and be appropriate for in-home use.

The equipment must meet the following criteria:

- it can stand repeated use;
- it is manufactured solely to serve a medical purpose;
- it is not merely for comfort or convenience;
- it is normally not useful to a person not ill or Injured;
- it is ordered by a Physician;
- the Physician certifies in writing the Medical Necessity for the equipment. The Physician also states the length of time the equipment will be required. The Plan may require proof at any time of the continuing Medical Necessity of any item; and
- it is related to the Participant's physical disorder.

Supplies, equipment and appliances that include comfort, luxury, or convenience items or features that exceed what is Medically Necessary in Your situation will not be covered. Reimbursement will be based on the Maximum Allowed Amount for a standard item that is a Covered Service, serves the same purpose, and is Medically Necessary. Any expense that exceeds the Maximum Allowed Amount for the standard item which is a Covered Service is Your responsibility.

Benefits for Durable Medical Equipment includes coverage for contraceptive devices, implants, and injectables.

13. Emergency Care

Life-threatening Medical Emergency or serious Accidental Injury.

Coverage is provided for Hospital emergency room care for initial services rendered for the onset of symptoms for a life-threatening condition or serious Accidental Injury which requires immediate medical care. A Medical Emergency is a condition of recent onset and sufficient severity, including but not limited to severe pain, that would lead a prudent layperson possessing an average knowledge of medicine and health, to believe that his or her condition, sickness, or Injury is of such a nature that failure to obtain immediate medical care could place his or her life in danger or cause serious harm.

The Copayment and/or Coinsurance percentage payable for both Network and Out-of-Network are shown in the Schedule of Benefits.

14. Employee Assistance Program

Additionally, the Fund has provided an Employee Assistance Program through an independent employee assistance program vendor, which provides the initial assessment and three counseling sessions at no cost to the Participant. If additional counseling is required, it can be provided at the Participant's cost. Please contact the Fund Office to obtain contact information for Recovery Resources.

15. General Anesthesia Services

Covered when ordered by the attending Physician and administered by another Physician who customarily bills for such services, in connection with a covered procedure.

Such anesthesia service includes the following procedures which are given to cause muscle relaxation, loss of feeling, or loss of consciousness:

- spinal or regional anesthesia;
- injection or inhalation of a drug or other agent (local infiltration is excluded).

Anesthesia services administered by a Certified Registered Nurse Anesthetist (CRNA) are only covered when billed by the supervising anesthesiologist.

16. Home Health Care Services

Home Health Care provides a program for the Participant's care and treatment in the home. Your coverage is outlined in the Schedule of Benefits. The program consists of required intermittent skilled care, which may include observation, evaluation, teaching and nursing services consistent with the diagnosis, established and approved in writing by the Participant's attending Physician. Services may be performed by either Network or Out-of-Network Providers. Some special conditions apply:

- The Physician's statement and recommended program must be pre-certified.
- Claims will be reviewed to verify that services consist of skilled care that is medically consistent with the diagnosis. Note: Covered Services available under Home Health Care do NOT reduce outpatient benefits available under the Physical Therapy section shown in this Plan.
- A Participant must be essentially confined at home.

Covered Services:

- Visits by an RN or LPN. Benefits cannot be provided for services if the nurse is related to the Participant.
- Visits by a qualified physiotherapist or speech therapist and by an inhalation therapist certified by the National Board of Respiratory Therapy.
- Visits to render services and/or supplies of a licensed Medical Social Services Worker when Medically Necessary to enable the Participant to understand the emotional, social, and environmental factors resulting from or affecting the Participant's illness.
- Visits by a Home Health Nursing Aide when rendered under the direct supervision of an RN.
- Nutritional guidance when Medically Necessary.
- Administration or infusion of prescribed drugs.
- Oxygen and its administration.

Covered Services for Home Health Care do **not** include:

- food, housing, homemaker services, sitters, home-delivered meals;
- Home Health Care services which are not Medically Necessary or of a non-skilled level of care;
- services and/or supplies which are not included in the Home Health Care plan as described;
- services of a person who ordinarily resides in the Participant's home or is a member of the family of either the Participant or Participant's Spouse;
- any services for any period during which the Participant is not under the continuing care of a Physician;

- convalescent or Custodial Care where the Participant has spent a period of time for recovery of an illness or surgery and where skilled care is not required or the services being rendered are only for aid in daily living, i.e., for the convenience of the Participant;
- any services or supplies not specifically listed as Covered Services;
- routine care and/or examination of a newborn child;
- dietician services;
- maintenance therapy;
- dialysis treatment; or
- purchase or rental of dialysis equipment.

17. Hospice Care Services

The services and supplies listed below are Covered Services when given by a Hospice for the palliative care of pain and other symptoms that are part of a terminal disease. Palliative care means care that controls pain and relieves symptoms but is not meant to cure a terminal illness. Covered Services include:

- care from an interdisciplinary team with the development and maintenance of an appropriate plan of care;
- short-term Inpatient Hospital care when needed in periods of crisis or as respite care;
- skilled nursing services, home health aide services, and homemaker services given by or under the supervision of a registered nurse;
- social services and counseling services from a licensed social worker;
- nutritional support such as intravenous feeding and feeding tubes;
- Physical Therapy, occupational therapy, speech therapy, and respiratory therapy given by a licensed therapist;
- pharmaceuticals, medical equipment, and supplies needed for the palliative care of Your condition, including oxygen and related respiratory therapy supplies; and
- bereavement (grief) services, including a review of the needs of the bereaved family and the development of a care plan to meet those needs, both before and after the Participant's death. Bereavement services are available to surviving Participants and Dependents of the immediate family for one year after the Participant's death. Immediate family means Your Spouse, children, stepchildren, parents, brothers and sisters.

Your Physician and Hospice medical director must certify that You are terminally ill and likely have less than 12 months to live. Your Physician must agree to care by the Hospice and must be consulted in the development of the care plan. The Hospice must keep a written care plan on file and give it to the Claims Administrator upon request.

Benefits for Covered Services beyond those listed above, such as chemotherapy and radiation therapy given as palliative care, are available to a Participant in Hospice. These additional Covered Services will be covered under other parts of this SPD.

18. Hospital Services

You may receive treatment at a Network or an Out-of-Network Hospital. However, payment is significantly reduced if services are received at an Out-of-Network Hospital. Your Plan provides Covered Services when the following services are Medically Necessary.

A. Network

Inpatient Services

- Inpatient room charges. Covered Services include Semiprivate Room and board, general nursing care and intensive or cardiac care. If You stay in a private room, the Maximum Allowed Amount is based on the Hospital's prevalent semiprivate rate. If You are admitted to a Hospital that has only private rooms, the Maximum Allowed Amount is based on the Hospital's prevalent room rate.

Service and Supplies

- Services and supplies provided and billed by the Hospital while You're an Inpatient, including the use of operating, recovery and delivery rooms. Laboratory and diagnostic examinations, intravenous solutions, basal metabolism studies, electrocardiograms, electroencephalograms, x-ray examinations, and radiation and speech therapy are also covered.
- Convenience items (such as radios, TV's, record, tape or CD players, telephones, visitors' meals, etc.) will not be covered.

Length of Stay

- Determined by Medical Necessity.

B. Out-of-Network

Hospital Benefits

- If You are confined in an Out-of-Network Hospital, Your benefits will be significantly reduced, as explained in the Schedule of Benefits section.

19. Hospital Visits

The Physician's visits to his or her patient in the Hospital. Covered Services are limited to one daily visit for each attending Physician specialty during the covered period of confinement.

20. Human Organ and Tissue Transplant Services

To maximize Your benefits, You need to call the Claims Administrator's transplant department to discuss benefit coverage when it is determined a transplant may be needed. You must do this before You have an evaluation and/or work-up for a transplant. Your evaluation and work-up services must be provided by a Network Transplant Provider to receive the maximum benefits.

Contact the Participant Services telephone number on Your Identification Card and ask for the transplant coordinator. The Claims Administrator will then assist the Participant in maximizing their benefits by providing coverage information including details regarding what is covered and whether any medical policies, network requirements or Plan exclusions are applicable. Failure to obtain this information prior to receiving services could result in increased financial responsibility for the Participant.

F. COVERED TRANSPLANT BENEFIT PERIOD

At a Network Transplant Provider Facility, the Transplant Benefit Period starts one day before a Covered Transplant Procedure and lasts for the applicable case rate/global time period. The number of days will vary depending on the type of transplant received and the Network Transplant Provider agreement. Call the Claims Administrator for specific Network Transplant Provider details for services received at or coordinated by a Network Transplant Provider Facility.

At an Out-of-Network Transplant Provider Facility, the Transplant Benefit Period starts one day before a Covered Transplant Procedure and lasts until the date of discharge.

G. PRIOR APPROVAL AND PRECERTIFICATION

In order to maximize Your benefits, the Claims Administrator strongly encourages You to call its' transplant department to discuss benefit coverage when it is determined a transplant may be needed. You must do this before You have an evaluation and/or work-up for a transplant. The Claims Administrator will assist You in maximizing Your benefits by providing coverage information, including details regarding what is covered and whether any clinical coverage guidelines, medical policies, Network Transplant Provider requirements, or exclusions are applicable. Contact the Participant Services telephone number on the back of Your Identification Card and ask for the transplant coordinator. Even if the Claims Administrator issues a prior approval for the Covered Transplant Procedure, You or Your Provider must call the Claims Administrator's Transplant Department for precertification prior to the transplant whether this is performed in an Inpatient or outpatient setting.

Please note that there are instances where Your Provider requests approval for Human Leukocyte Antigen (HLA) testing, donor searches and/or a collection and storage of stem cells prior to the final determination as to what transplant procedure will be requested. Under these circumstances, the HLA testing and donor search charges are covered as routine diagnostic testing. The collection and storage request will be reviewed for Medical Necessity and may be approved. However, such an approval for HLA testing, donor search and/or a collection and storage is NOT an approval for the subsequent requested transplant. A separate Medical Necessity determination will be made for the transplant procedure.

H. TRANSPORTATION AND LODGING

The Plan will provide assistance with reasonable and necessary travel expenses as determined by the Claims Administrator when You obtain prior approval and are required to travel more than 75 miles from Your residence to reach the facility where Your Covered Transplant Procedure

will be performed. The Plan's assistance with travel expenses includes transportation to and from the facility and lodging for the transplant recipient Participant and one companion for an adult Participant, or two companions for a child patient. The Participant must submit itemized receipts for transportation and lodging expenses in a form satisfactory to the Claims Administrator when claims are filed. Contact the Claims Administrator for detailed information. The Claims Administrator will follow Internal Revenue Service (IRS) guidelines in determining what expenses can be paid.

1. Licensed Speech Therapist Services

Services must be ordered and supervised by a Physician as outlined in the Schedule of Benefits. Speech therapy is not covered when rendered for the treatment of Developmental Delay.

2. Maternity Care and Reproductive Health Services

Covered Services are provided for Network Maternity Care as stated in the Schedule of Benefits. If You choose an Out-of-Network Provider, benefits are subject to the Deductible and percentage payable provisions as stated in the Schedule of Benefits.

Maternity benefits are provided for a female Employee or female Spouse of the Employee only. Routine newborn nursery care is part of the mother's maternity benefits. Benefits are provided for well-baby pediatrician visits performed in the Hospital.

Should the newborn require other than routine nursery care, the baby will be admitted to the Hospital in his or her own name. (See the Provision entitled "Special Enrollment Rights" to add a newborn to Your coverage.)

Under Federal law, the Plan may not restrict the length of stay to less than the 48/96 hour periods or require Precertification for either length of stay. The length of hospitalization which is Medically Necessary will be determined by the Participant's attending Physician in consultation with the mother. Should the mother or infant be discharged before 48 hours following a normal delivery or 96 hours following a cesarean section delivery, the Participant will have access to two post-discharge follow-up visits within the 48 or 96 hour period. These visits may be provided either in the Physician's office or in the Participant's home by a Home Health Care Agency. The determination of the medically appropriate place of service and the type of Provider rendering the service will be made by the Participant's attending Physician.

I. ABORTION (THERAPEUTIC)

Your Plan includes benefits for a therapeutic abortion, which is an abortion recommended by a Provider that is performed to save the life or health of the mother, or as a result of incest or rape.

J. INFERTILITY SERVICES

Your Plan also includes benefits for the diagnosis of Infertility. Treatment of infertility is not covered. Covered Services include diagnostic and exploratory procedures to determine whether a Participant suffers from Infertility. This includes surgical procedures to correct any diagnosed

disease or condition affecting the reproductive organs. This includes, but is not limited to, endometriosis, (tissue lining the uterus moves to other parts of the body), collapsed/clogged fallopian tubes or testicular failure. See the Schedule of Benefits for benefit limitations, Coinsurance and Copayment amounts.

K. STERILIZATION SERVICES

Benefits include sterilization services and services to reverse a non-elective sterilization that resulted from an illness or Injury. Reversals of elective sterilizations are not covered.

1. Medical Care

General diagnostic care and treatment of illness or Injury. Some procedures require Precertification.

2. Obesity

Prescription Drugs and any other services or supplies for the treatment of obesity are not covered.

3. Out-of-Network Freestanding Ambulatory Facility

Any services rendered or supplies provided while You are a patient or receiving services at or from an Out-of-Network Freestanding Ambulatory Facility will be payable at the Maximum Allowed Amount.

4. Out-of-Network Hospital Benefits

If You are confined in an Out-of-Network Hospital, Your benefits will be significantly reduced, as explained in the Schedule of Benefits section.

5. Online Visits

When available in Your area, Your coverage will include online visits from a LiveHealth Online Provider. Covered Services include a medical consultation using the internet via a webcam, chat or voice. See Schedule of Benefits for any applicable Deductible, Coinsurance, Copayment and benefit limitation information. For Behavioral Health and Substance Abuse Online Visits, see the "Behavioral Health Care and Substance Abuse Treatment" section. Online visits are not covered from Providers other than those contracted with LiveHealth Online.

Non-Covered Services include, but are not limited to, communications used for:

- reporting normal lab or other test results;
- office appointment requests;
- billing, insurance coverage or payment questions;
- requests for referrals to Physicians outside of the online care panel;
- benefit precertification; and

- Physician to Physician consultation.

6. Other Covered Services

Your Plan provides Covered Services when the following services are Medically Necessary:

- chemotherapy and radioisotope, radiation and nuclear medicine therapy;
- diagnostic x-ray and laboratory procedures;
- dressings, splints and casts when provided by a Physician;
- oxygen, blood and components, and administration;
- pacemakers and electrodes; or
- use of operating and treatment rooms and equipment.

7. Outpatient CT Scans and MRIs

These services are covered at regular Plan benefits.

8. Outpatient Hospital Services

The Plan provides Covered Services when the following outpatient services are Medically Necessary: pre-admission tests, surgery, diagnostic X-rays and laboratory services. Certain procedures require Precertification.

9. Outpatient Surgery

Network Hospital outpatient department or Network Freestanding Ambulatory Facility charges are covered at regular Plan benefits. Benefits for treatment by an Out-of-Network Hospital are explained under "Hospital Services".

10. Physical Therapy, Occupational Therapy, Manipulation Therapy

Services by a Physician, a registered physical therapist (R.P.T.), a licensed occupational therapist (O.T.), or a licensed chiropractor (D.C.) as outlined in the Schedule of Benefits. All services rendered must be within the lawful scope of practice of, and rendered personally by, the individual Provider. No coverage is available when such services are necessitated by Developmental Delay.

11. Physician Services

You may receive treatment from a Network or Out-of-Network Physician. However, payment is significantly reduced if services are received from an Out-of-Network Physician. Such services are subject to Your Deductible and Out-of-Pocket requirements.

12. Prescription Drugs Administered by a Medical Provider

This Plan covers Prescription Drugs including Specialty Drugs, that must be administered to You as part of a Doctor's visit, home care visit, or at an outpatient facility when they are Covered

Services. This may include Drugs for infusion therapy, chemotherapy, blood products, certain injectables, and any Drug that must be administered by a Provider. This section applies when a Provider orders the Drug and a medical Provider administers it to You in a medical setting. Benefits for Drugs You inject or get from a retail pharmacy (i.e. self-administered Drugs) are not covered as a medical benefit, but are covered in the Prescription Drug Benefit provisions of the SPD.

L. IMPORTANT DETAILS ABOUT PRESCRIPTION DRUG COVERAGE

Your Plan includes certain features to determine when Prescription Drugs should be covered, which are described below. As part of these features, Your prescribing Doctor may be asked to give more details before the Plan decides if the Prescription Drug is eligible for coverage. In order to determine if the Prescription Drug is eligible for coverage, the Claims Administrator has established criteria.

The criteria, which are called drug edits, may include requirements regarding one or more of the following:

- Quantity, dose, and frequency of administration,
- Specific clinical criteria including, but not limited to, requirements regarding age, test result requirements, and/or presence of a specific condition or disease,
- Specific Provider qualifications including, but not limited to, REMS certification (Risk, Evaluation and Mitigation Strategies),
- Step therapy requiring one Drug, Drug regimen, or treatment be used prior to use of another Drug, Drug regimen, or treatment for safety and/or cost-effectiveness when clinically similar results may be anticipated,
- Use of an Anthem Prescription Drug List (a formulary developed by the Claims Administrator which is a list of FDA-approved Drugs that have been reviewed and recommended for use based on their quality and cost effectiveness.

M. PRECERTIFICATION

Precertification may be required for certain Prescription Drugs to help make sure proper use and guidelines for Prescription Drug coverage are followed. The Claims Administrator will give the results of the Plan's decision to both You and Your Provider.

For a list of Prescription Drugs that need precertification, please call the phone number on the back of Your Identification Card. The list will be reviewed and updated from time to time. Including a Prescription Drug or related item on the list does not guarantee coverage under Your Plan. Your Provider may check with the Claims Administrator to verify Prescription Drug coverage, to find out which drugs are covered under this section and if any drug edits apply.

If precertification is denied You have the right to file an appeal as outlined in the Your Right To Appeal section of this SPD.

N. DESIGNATED PHARMACY PROVIDER

The Plan in its sole discretion, may establish one or more Designated Pharmacy Provider programs which provide specific pharmacy services (including shipment of Prescription Drugs) to Participants. A Network Provider is not necessarily a Designated Pharmacy Provider. To be a Designated Pharmacy Provider, the Network Provider must have signed a Designated Pharmacy Provider Agreement with the Claims Administrator. You or Your Provider can contact Participant Services to learn which Pharmacy or Pharmacies are part of a Designated Pharmacy Provider program.

For Prescription Drugs that are shipped to You or Your Provider and administered in Your Provider's office, You and Your Provider are required to order from a Designated Pharmacy Provider. A Patient Care coordinator will work with You and Your Provider to obtain Precertification and to assist shipment to Your Provider's office.

You may also be required to use a Designated Pharmacy Provider to obtain Prescription Drugs for treatment of certain clinical conditions such as Hemophilia. The Plan reserves the right to modify the list of Prescription Drugs as well as the setting and/or level of care in which the care is provided to You. The Plan may from time to time, change with or without advance notice, the Designated Pharmacy Provider for a Drug, if in the Plan's discretion, such change can help provide cost effective, value based and/or quality services.

If You are required to use a Designated Pharmacy Provider and You choose not to obtain Your Prescription Drug from a Designated Pharmacy Provider, coverage will be provided at the Out-of-Network level.
You can get the list of the Prescription Drugs covered under this section by calling Participant Services at the phone number on the back of Your Identification Card or check the Claims Administrator's website at *www.anthem.com*.

O. THERAPEUTIC SUBSTITUTION

Therapeutic substitution is an optional program that tells You and Your Providers about alternatives to certain prescribed Drugs. The Claims Administrator may contact You and Your Provider to make You aware of these choices. Only You and Your Provider can determine if the therapeutic substitute is right for You. For questions or issues about therapeutic Drug substitutes, call Participant Services at the phone number on the back of Your Identification Card.

1. Preventive Services

Covered Services in the Physician's or Specialist Physician's office or independent lab include, but are not limited to:

- treatment or preventive services including periodic health examinations for adults and Dependent children. Employment or insurance-related physicals are not covered;
- well child care;

- preventive lab and x-ray;
- immunizations;
- flu injections;
- gynecological (well woman) exams;
- annual Pap smear;
- annual prostate screening;
- annual routine mammogram (also covered in the Hospital setting);
- colorectal cancer screening including fecal occult blood test, sigmoidoscopy, and colonoscopy;
- audiometric exams (covered for dependents under the age of 9); and
- routine eye exams (covered for dependents under the age of 9).

2. Prosthetic Appliances

Prosthetic devices to improve or correct conditions resulting from Accidental Injury or illness are covered if Medically Necessary and ordered by a Physician.

Prosthetic devices include: artificial limbs and accessories; artificial eyes, one pair of glasses or contact lenses for eyes used after surgical removal of the lens(es) of the eye(s); arm braces, leg braces (and attached shoes); and external breast prostheses used after breast removal.

The following items are excluded: corrective shoes; dentures; replacing teeth or structures directly supporting teeth (except to correct traumatic Injuries); electrical or magnetic continence aids (either anal or urethral); and implants for cosmetic purposes except for reconstruction following a mastectomy.

3. Reconstructive Surgery

Benefits include reconstructive surgery to correct significant deformities caused by congenital or developmental abnormalities, illness, Injury or an earlier treatment in order to create a more normal appearance. Benefits include surgery performed to restore symmetry after a mastectomy. Reconstructive services needed as a result of an earlier treatment are covered only if the first treatment would have been a Covered Service under this Plan.

Note: Coverage for reconstructive services does not apply to orthognathic surgery.

4. Retail Health Clinic

Benefits are provided for Covered Services received at a Retail Health Clinic.

5. Skilled Nursing Facility Care

Benefits are provided as outlined in the Schedule of Benefits. This care must be ordered by the attending Physician. All Skilled Nursing Facility admissions must be pre-certified. Claims will

be reviewed to verify that services consist of Skilled Convalescent Care that is medically consistent with the diagnosis.

Skilled Convalescent Care during a period of recovery is characterized by:

- a favorable prognosis;
- a reasonably predictable recovery time; and
- services and/or facilities less intense than those of the acute general Hospital, but greater than those normally available at the Participant's residence.

Covered Services include:

- semiprivate or ward room charges including general nursing service, meals, and special diets. If a Participant stays in a private room, this Plan pays the Semiprivate Room rate toward the charge for the private room;
- use of special care rooms;
- pathology and radiology;
- Physical or speech therapy;
- oxygen and other gas therapy;
- drugs and solutions used while a patient; or
- gauze, cotton, fabrics, solutions, plaster and other materials used in dressings, bandages, and casts.

This benefit is available only if the patient requires a Physician's continuous care and 24-hour-a-day nursing care.
Benefits will **not** be provided when:

- a Participant reaches the maximum level of recovery possible and no longer requires other than routine care;
- care is primarily Custodial Care, not requiring definitive medical or 24-hour-a-day nursing service;
- no specific medical conditions exist that require care in a Skilled Nursing Facility; or
- the care rendered is for other than Skilled Convalescent Care.

6. Surgical Care

Surgical procedures including the usual pre- and post-operative care. Some procedures require Precertification.

7. Treatment of Accidental Injury in a Physician's Office

All outpatient surgical procedures related to the treatment of an Accidental Injury, when provided in a Physician's office, will be covered under the Participant's Physician's office benefit if services are rendered by a Network Provider. Services rendered by Out-of-Network Providers are subject to Deductible and Coinsurance requirements.

P. LIFE INSURANCE BENEFITS

1. Benefits:

In the event of your death, from any cause, the proceeds set forth in the Schedule of Benefits above will be paid to the named beneficiary. Note: widows carrying the insurance are not eligible for Life Insurance Benefits. **The Life Insurance Benefit is only available if the Participant is eligible for insurance at the time of death.**

2. Beneficiary:

Upon written request, the beneficiary may be changed at any time and as often as desired. A Beneficiary Form must be requested from the Fund Office by calling (440) 260-0615. You must make sure to have an updated Beneficiary Form on file at the Fund Office. The life insurance benefit shall be payable to the beneficiary listed on the Beneficiary Form on file at the Fund Office at the time of your death. If no Beneficiary Form is on file with the Fund Office at the time of your death or if the beneficiary listed on the Beneficiary Form has predeceased you, the life insurance benefit will be paid to the following:

a. Your spouse; or if no spouse
b. Your children in equal shares; or if no spouse or children
c. Your parents in equal shares; or if no spouse, children or parents;
d. Your siblings in equal shares; or if no spouse, children, parents or siblings;
e. Your estate.

3. Continuation of Life Insurance Benefits During Total And Permanent Disability:

If prior to age 60, you become totally and permanently disabled, your life insurance will continue without cost for a period of twelve months. Proof of total and permanent disability must be presented to the Home Office of the Plan's life insurer within the twelve-month period and yearly thereafter to continue the life insurance in force.

4. Conversion Privilege:

When the Life Insurance of a Participant terminates it may be converted to an additional policy of Life Insurance without medical examination within 31 days. The individual policy will be issued on any of the forms customarily written by Medical Life Insurance Company at the time, except term insurance. The amount of such policy shall not exceed the amount provided under the group plan. The premium for the individual policy will be at the then current rates according to occupation and attained age.

Q. ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS

In the event any of the following losses are sustained by you solely through external, violent and accidental means, the following benefits will be paid in addition to any other benefits payable under the Plan:

Condition	Benefit
Loss of Life	Principal Sum
Loss of two limbs, sight of both eyes, or of one limb and sight of one eye	Principal Sum
Loss of one limb or sight of one eye	One-half (1/2) of Principal Sum

The Principal Sum is the amount set forth above in Section B of the Schedule of Benefits. Benefits for loss of life will be payable to your designated Beneficiary under the same terms as set forth above for the Life Insurance Benefits. All other dismemberment benefits will be payable to you.

Loss of limb means dismemberment by severance at or above the wrist or ankle joint. Loss of sight means entire and irrevocable loss of sight.

Loss must occur within ninety days from the day of the accident. If more than one of the losses set forth above is suffered as a result of any one accident, not more than the full amount of insurance for Accidental Death and Dismemberment will be payable.

The insurance is payable whether or not the accident occurs during the course of employment.

No payment will be made for death or any other loss, which is caused by or results from:

(a) Bodily or mental infirmity, hernia, ptomaines, bacterial infections (except infections caused by pyogenic organisms which shall occur with and through an accidental cut or wound), or disease or illness of any kind, or
(b) Intentional self-destruction or intentional self-inflicted injury while sane or insane, or
(c) Participation in the committing of a felony, or
(d) War or an act of war, or service in any military, naval or air force of any country while such country is engaged in war, or police duty as a member of any military, naval or air organization.

R. ACCIDENT AND SICKNESS BENEFITS

Weekly Benefits.....$252.00

Maximum Number of Weeks Payable 18

Weekly Accident and Sickness Benefits are available to members of the International Union of Painters and Allied Trades District Council No. 6, AFL-CIO, who have (1) met the requirements for eligibility, (2) are active participants in the Painting Industry Insurance Plan (hereinafter "Plan"), (3) are not collecting a pension from a defined benefit pension plan affiliated with the International Union of Painters and Allied Trades District Council No. 6, AFL-CIO ; and (4) have become Totally Disabled due to an Accident or Sickness. Weekly Accident and Sickness Benefits are not available to Spouses or Dependents.

The amount of the weekly benefit payable for each full week of disability is $252.00 ($36.00 per day). For any period of disability which is less than a full week, the benefit will be paid at the daily rate of one-seventh (1/7) of the weekly benefit. Benefits begin on the first day of a disability due to an accident and on the 8th day of a disability due to a sickness. It is not necessary to be confined to your home to collect benefits, but you must be under the care of a licensed physician. No disability will be considered to have commenced earlier than 3 days prior to the participant's initial visit to a physician for the condition causing the disability.

Benefits can only be paid up to the date that your physician signs the claim form regardless of the anticipated length of the disability.

Benefits are payable for a maximum of 18 weeks during each continuous period of disability due to one or more causes. Successive periods of disability separated by less than two full weeks of continuous active employment will be considered one period unless the two disabilities arise from totally different and unrelated causes.

1. Definitions

a. "**Totally Disabled"** or **"Total Disability"** means that you are prevented from performing any and every duty pertaining to your occupation and you receive no remuneration for any other work or service.

b. "**Sickness"** means an illness or disease (including mental disorders), which requires treatment by a doctor and is recognized by the terms of this Plan and the Trustees. Sickness shall include pregnancy, childbirth, or miscarriage.

c. **"Accident"** shall mean any accidental bodily injury, which requires treatment by a physician and is recognized by the terms of the Plan and the Trustees.

Determination of whether Sicknesses or Accidents are included or excluded under this Plan will be made by the Trustees in their sole discretion and will be conclusive.

2. Limitations

No Weekly Benefit will be paid for, or on account of, any period of disability:

a. For which you are not under the regular care of a doctor; or

b. For which you have or had a right to payment under any workers compensation law, occupational disease law or similar law; or

c. Which is due to work related Sickness or Accident; or

d. For which you have or had a right to payment under the temporary disability benefit laws of any state or unemployment.

NOTE: Benefits under the Weekly Accident and Sickness provision of the Plan are available for a non-occupational disability only.

3. Illegal and Willful Misconduct

No weekly benefit will be paid for, or on account of, any period of disability resulting from or occurring:

a. During the commission of a crime; or

b. During illegal and willful misconduct; or

c. While engaged in an illegal occupation; or

d. While committing or attempting to commit a felonious act or assault; or

e. From alcoholism or alcohol related injuries or sickness; or

f. From addiction to drugs or narcotics; or

g. From service in the Armed Forces of any country; or

h. While participating in a riot or civil insurrection.

The Trustees will make determination in their sole discretion and such determination will be conclusive.

4. Submission of Claims

To obtain Weekly Accident and Sickness Benefits, you must provide written notice to the Administrative Manager within 180 days after the Accident or Sickness causing your Total Disability occurs. If written notice cannot be given within that time, it must be given as soon as

reasonably possible. The written notice must contain enough information to identify who is making the claim.

The name and address of the Administrative Manager is: Mr. Shawn D. Kroeger, 8257 Dow Circle, Strongsville, Ohio 44136.

When the Administrative Manager receives written notice of a claim, the Administrative Manager will send you a claim form. You must complete and submit the claim form; completed and signed by your Physician stating the nature of the disability, length of disability and date you can return to work. Your last Employer must also sign the claim form.

The Administrative Manager may, in his or her sole discretion, require you to be examined or have your claim reviewed by a physician or clinic chosen by the Administrative Manager on behalf of the Trustees or require you to submit additional evidence to support your claim for Weekly Benefits.

5. In the Event Your Claim is Denied

In the event that your claim for Weekly Accident and Sickness Benefits or Total and Permanent Disability Benefits is denied, you will be notified in writing by the Administrative Manager of the reasons why your claim has been denied. Notification of an adverse decision shall occur within forty-five (45) days of the receipt of your approved claim form by the Administrative Manager. If the Administrative Manager determines that more time is needed to process the claim due to matters beyond his/her control, the Administrative Manager will notify you of a thirty (30) day extension. If a second extension is necessary due to matters beyond his/her control, the Administrative Manager will notify you of a final thirty (30) day extension. No further extensions shall occur. Any notice of an extension shall include the standards on which an entitlement to benefits due to Disability is based, the unresolved issues preventing a decision and any additional information that is needed to resolve the claim.

All claims and appeals for extended coverage and Weekly Sickness and Accident benefits will be adjudicated in a manner designed to ensure the independence and impartiality of the persons involved in making the decision. Accordingly, decisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to any individual (such as a claims adjudicator or medical or vocational expert) will not be made based on the likelihood that the individual will support a denial of benefits.

In the event of non-approval in whole or in part of your claim, notice to you shall provide you all of the following information in the written decision:

(1) the specific reasons for rejecting the application; and

(2) the specific provisions of the Plan or rules and regulations on which the determination is based; and

(3) a description of any additional material or information necessary for you to perfect your claim and an explanation of why such material or information is necessary; and

(4) an explanation of the Appeals Procedure; and

(5) a statement regarding your right to bring a civil action under ERISA §502(a) following an adverse benefit determination on appeal; and

(6) the specific internal rules, guidelines, protocols, standards or other similar criteria of the plan relied upon in making the decision or, alternatively a statement that such rules, guidelines, protocols, standards or similar criteria of the plan do not exist; and

(7) a statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records or other information relevant to your claim for benefits

In addition, in the event the determination disagrees with the views of (1) a health care professional treating you; (2) vocational professionals who have evaluated you; (3) a medical or vocational expert whose advice was obtained on behalf of the Plan in connection with your claim; or (4) a disability determination regarding you made by the Social Security Administration; then the decision to deny shall set forth an explanation of the basis for disagreeing with those views or opinions. If the decision to deny was based on a medical necessity, experimental treatment or similar exclusion or limit, the decision will set forth either (1) an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to your medical circumstances, or (2) a statement that such explanation will be provided free of charge upon request.

The decision shall be final and binding upon you unless that decision is appealed as hereinafter set forth below.

6. Appealing A Decision Denying Weekly Accident and Sickness and Total and Permanent Disability Benefits

You may, by written notice received by the Administrative Manager within one hundred eighty (180) days of the mailing of the notice denying your claim for Weekly Accident Benefits and Sickness Benefits or Total and Permanent Disability benefits, appeal the decision. The written notice should state your name, address and the reasons why you are appealing from the decision of the Administrative Manager, giving the date of the decision from which You are appealing.

The review of your appeal will not afford deference to the initial adverse benefit determination and will be conducted by an appropriate named fiduciary of the Plan who is neither the individual who made the adverse benefit determination that is subject of the appeal nor a subordinate of such individual. If the appeal of a decision based in whole or in part on medical judgment, the appropriate named fiduciary shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment.

Such health care professional shall be an individual who is neither an individual who was consulted in connection with the adverse benefit determination that is the subject of the appeal, nor the subordinate of any such individual. The reviewer will also identify medical or vocational experts whose advice was obtained on behalf of the plan in connection with the initial adverse benefit determination, without regard to whether the advice was relied upon by the initial determination.

Prior to making a decision to deny an appeal, you will be provided, free of charge, with any additional evidence considered, relied upon, or generated by the Plan or other person making the benefit determination in connection with the claim. Such evidence will be provided as soon as possible and sufficiently in advance of the date on which the notice of adverse benefit determination on review is provided so as to give you a reasonable opportunity to respond prior to that date. If the determination is based on new or additional rationale, the plan administrator shall provide you, free of charge, with the rationale as soon as possible and sufficiently in advance of the date on which the notice of adverse benefit determination on review is provided so as to give you a reasonable opportunity to respond prior to that date.

The Trustees shall consider your appeal no later than its next regularly scheduled meeting, which immediately follows the receipt of the notice of appeal unless such notice was filed within thirty (30) days prior to the next regularly scheduled meeting, then the Board of Trustees may consider the appeal at the second meeting following the receipt of the notice of appeal. If special circumstances require an extension of time for processing, then the Board of Trustees may consider the appeal no later than the third meeting following the receipt of the notice of appeal. If such extension is required, you will be provided with written notice of the extension, describing the special circumstances and the date as of which the benefit determination will be made prior to commencement of the extension.

After consideration of the appeal as above, the Board of Trustees shall advise you of its decision in writing within five (5) days after the benefit determination is made. If the determination is averse to you, the written decision shall state all of the following information:

(1) the specific reasons for rejecting the appeal; and

(2) the specific provisions of the Plan or on which the determination is based; and

(3) a statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits; and

(4) a statement of your right to bring an action under Section 502(a) of ERISA; and

(5) the applicable contractual limitations period that applies to your right to bring such an action under Section 502(a) of ERISA, including the calendar date on which the contractual limitations period expires for the claim; and

(6) either the specific internal rules, guidelines, protocols, standards or other similar criteria of the Plan relied upon in making the adverse benefit determination, or, alternatively a statement that such rules, guidelines, protocols, standards or other similar criteria of the plan do not exist; and

(7) a discussion of the decision including an explanation for disagreeing with or not following any of the following:

a. the views of health care professionals treating the claimant; or

b. the views of vocational professionals who evaluated the claimant; or

c. the views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the appeal, without regard to whether the advice was relied upon in making the benefit determination; or

d. a disability determination made by the Social Security Administration.

If the adverse benefit determination is based on medical necessity, experimental treatment or a similar exclusion or limit, you will be provided either with an explanation of the scientific or clinical judgment for the determination applying the terms of the plan to your medical circumstances or a statement that such explanation will be provided free of charge upon request.

All notices to you shall be made in a culturally and linguistically appropriate manner. The Plan will provide oral language services such as a telephone customer assistance hotline that include answering questions in any "applicable non-English language" and providing assistance with filing claims and appeals in "any applicable non-English language." In addition, the Plan will provide, upon request, a notice in any "applicable non-English language" and will include in the English version of all notices a statement prominently displayed in any applicable non-English language clearly indicating how to access the language services provided by the Plan. "Applicable non-English languages" include, with respect to an address in any United States county to which a notice is sent, a non-English language in which ten percent or more of the population residing in the county is literate only in that language.

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

If, after following the applicable review processes outlined above, you are not satisfied with the result, then you may file a legal action against the Plan or the Trustees within two (2) years of receiving the final review notice under these procedures. No legal action may be commenced or maintained more than two (2) years after you receive notice of the Trustees' decision on review

under the Plan's appeal procedure. Any such legal action must be filed in the United States District Court for the Northern District of Ohio, Eastern Division.

7. Payment of Benefits

The Administrative Manager will make benefit payments at regular intervals occurring at least as often as every two weeks. If benefits are due for a period of less than one (1) week, payments will be made at a daily rate of $1/7^{th}$ the weekly benefit. If you are receiving compensation from your Employer, including, but not limited to:

a. Vacation pay; or
b. Salary continuation; or
c. Unemployment benefits

You will not begin receiving payment of the Weekly Accident and Sickness Benefits until such compensation payments cease.

You must notify the Administrative Manager as soon as you return to work and, if you receive benefits for periods of time when you are employed, then you must immediately repay the Plan for any such benefit payments. If you fail to promptly repay the Plan, then you may be subject to criminal prosecution and/or civil litigation. If litigation is commenced against you, then you may be held responsible for the attorney fees and costs of any such litigation. In addition, if you fail to promptly repay the Plan, the Plan may offset the amount owed against any future benefits payable under the other terms of the Plan.

8. When Benefits End

Weekly Accident and Sickness Benefits will cease on the earliest of:

a. The date you are no longer Totally Disabled; or

b. The end of the maximum benefit period (18 weeks); or

c. The date on which you begin to receive benefits under any Painting Industry Retirement Plan; or

d. The date that you die.

NOTE: THESE BENEFITS ARE SUBJECT TO SOCIAL SECURITY AND INCOME TAXES. FEDERAL LAW REQUIRES THE FUND TO DEDUCT SOCIAL SECURITY TAX FROM ACCIDENT AND SICKNESS BENEFITS.

These benefits are self-funded and self-administered through the Painting Industry Insurance Plan. Any questions regarding these benefits should be directed to the Administrative Manager.

S. DENTAL CARE BENEFITS

1. ELIGIBLE PERSONS

Dental Care Benefits are payable for Eligible Persons and dependents, subject to the conditions of this section.

2. ELIGIBILITY

In order to become eligible for Dental Benefits, a person must qualify under the eligibility requirements as set forth in this Health and Welfare Plan.

3. TERMINATION OF COVERAGE

Upon termination of eligibility, benefits will cease on the last day of the month in which eligibility terminated. Eligibility and benefits shall terminate immediately in the event of termination of this Dental Care Benefit Program.

4. DEFINITIONS

a. "Billed Charges" means charges for all services and supplies that the Covered Person has received from the Dental Provider, whether they are a Covered Service or not.

b. "Clinically Necessary" (Clinical Necessity) means a service or supply that is required to diagnose or treat a Condition and which the Plan determines is:

   i. Appropriate with regard to the standards of good dental practice;

   ii. Not primarily for your convenience or the convenience of a Dental Provider; and

   iii. The most appropriate supply or level of service which can be safely provided to you.

c. "Coinsurance" means a percentage of the Fee Schedule amount for Covered Services for which you are responsible.

d. "Dentist" means a person who is currently licensed to practice dentistry by the governmental authority having jurisdiction over the licensure and practice of dentistry and who treats diseases and injuries to the teeth and oral cavity.

e. "Dental Hygienist" means a person who is currently licensed to practice dental hygiene by the governmental authority having jurisdiction over the licensure and practice of dental hygiene, and who works under the supervision and direction of a Dentist.

f. "Eligible Dental Expenses" means those reasonable expenses actually incurred commencing after the effective date of eligibility of the Eligible Person that are covered by the Plan and are incurred for treatment of any dental disease or defect. Such treatment must be rendered by a Dentist and reported by him on a Treatment Plan.

g. "Emergency Palliative Treatment" means treatment given in response to painful or dangerous situation to relive pain and remove a person from immediate danger without rendering definitive treatment (such as a filling).

h. "Essential Services" means x-rays such as panoramic/full mouth, periapical, cephalometric, occlusal and extraoral, fillings, periodontal services, endodontic services, extractions, impactions and root removals, oral or dental Surgery and related anesthesia, alveolectomy, vestibuloplasty and repairing and relining or prosthetics.

i. "Excess Charges" means the amount of Billed Charges less Non-Covered Charges in excess of the Fee Schedule Amount for a Non-PPO Network Provider (also referred to as patient liability).

j. "Fee Schedule Amount" means the maximum dollar allowance for Covered Services that PPO Network Providers have agreed to accept as payment in full. Non-PPO Network Providers will also be reimbursed based on a different Fund Office Schedule.

k. "Incurred" means rendered to you by a Dental Provider.

l. "Lesser Amount" means for PPO Network Providers, the Lesser of the Negotiated Amount or the Covered Charges and for Non-PPO Network Providers, the Fee Schedule Amount.

m. "Maximum Amount Payable" means the aggregate amount payable for Eligible Dental Expenses incurred during any one (1) calendar year for Routine Oral Examination Benefits, Basic Dental Benefits, or any combination thereof, while coverage under the Plan is in effect for the Eligible Person. In no event shall the Maximum Amount Payable for all benefits for any one (1) Benefit Period be in excess of the applicable "Per Person" amount as stated in the Schedule of Benefits.

n. "Negotiated Amount" – means the amount the Provider has agreed with the Plan to accept as payment in full for Covered Services.

o. "Non-PPO Network Provider" means a Dentist which is not designated by the Plan as a PPO Network Provider.

p. "Orthodontics" means the specialty and practice of preventing and correcting irregularities of the teeth, as by braces.

q. "Pediatric Oral Care" means oral care and services provided to Eligible Dependents from birth to age nineteen.

r. "Periodontal Services" means procedures including examination, diagnosis and treatment (including Surgery) of disease affecting the surrounding and supporting tissues of the teeth.

s. "Plan Month" means any calendar month.

t. "PPO Network Provider" means a Dentist designated by the Plan as a PPO Network Provider.

u. "Retention Treatment" means the period of Orthodontic treatment during which the individual is wearing an appliance to maintain the teeth in position.

v. "Routine Preventive Services" means oral evaluations, bitewing x-rays, topical fluoride applications for children age 12 and under with child prophylaxis, prophylaxis, and space maintainers.

w. "Surgery" means:

i. The performance of generally accepted operative and other invasive procedures of the teeth, bone, and soft tissue of the oral structures;

ii. Referring specifically to the operative/cutting procedure of the teeth, bone and soft tissue of the oral structures, which are considered within the scope or practice by the provider's license and specialty and/or as determined by the State Dental Board;

iii. Utilized to correct pathology as a result of decay, fracture, damage, loss, and infection that would necessitate tissue removal, prosthesis placement, placement of dental materials and/or tissue architecture modifications;

iv. Usual and related preoperative and postoperative care; or

v. Other procedure as reasonably approved by the Plan.

x. "Treatment Plan" means a written report showing the recommended treatment of any dental disease or defect prepared by a Dentist for the Eligible Person as a result of any examination made by such Dentist while coverage under the Plan is in effect for such Eligible Person.

5. CARRY-OVER PROVISION

There shall be no carry-over provision under the Dental Care Plan and claims will only be paid based on the date of service as rendered.

6. DESCRIPTION OF DENTAL PLAN BENEFITS

Subject to the Exclusions and Limitations described below, the following is a description of dental services covered by the Plan when rendered by a Dentist and when necessary and customary, as determined by the standards of generally accepted dental practice.

i. **Preventative**. Procedures to prevent the occurrence of oral disease. These services include: oral examinations, prophylaxis (cleaning) two (2) times per calendar year; Topical application of fluoride solutions and/or sealants for children age 12 and under with routine prophylaxis, diagnostic casts, Emergency (Palliative) treatment, and space maintainers.

ii. **Diagnostic**. Procedures to assist the Dentist in evaluating the existing condition to determine the required covered dental treatment. Such procedures under this Plan shall mean x-rays, tests, and laboratory examinations.

iii. **Oral Surgery.** Procedures for extractions, including pre- and post-operative care.

iv. **Restorative Fillings**. Procedures to restore the teeth with amalgam and composite restorations (fillings) for treatment of carious lesions (visible destruction of hard tooth structure resulting from the process of dental decay); including fillings placed after a nerve is removed from a tooth.

v. **Cast Restorations**. Cast restorations which include crowns, jackets, and other cast restorations when fillings cannot be used to restore teeth satisfactorily.

vi. **Endodontics**. Procedures for pulpal therapy and root canal filling (treatment of non-vital teeth).

vii. **Periodontics**. Procedures for treatment of the tissues supporting the teeth.

viii. **Prosthodontics**. Includes bridges, partials and complete dentures. Complete dentures are limited to one denture every five years.

ix. **Orthodontics**. The necessary procedures for the correction of malposed teeth for Dependent children age 19 and under.

7. EXCLUSIONS

No Dental benefits will be paid for:

a. Services for injuries or conditions which are compensable under any Workers' Compensation or Employer's Liability Laws or which are provided the covered person by any Federal or State government agency or are provided without cost to the covered person by any municipality, or county or other political subdivision, or community agency.

b. Services resulting from war, declared or undeclared, or any act of war or aggression.

c. Services paid for, furnished by, or at the direction of, a government agency, but only to the extent so paid or furnished.

d. Services with respect to hereditary, congenital or developmental malformations or cosmetic surgery or dentistry for purely cosmetic reasons including, but not limited to: cleft palate, maxillary and mandibular malformations, enamel hypoplasia, fluorosis, facings posterior to first molar, and bleaching of teeth.

e. General anesthesia, or analgesia other than when administered in conjunction with oral surgery.

f. Treatment which is not Clinically Necessary.

g. Prescribed drugs or premedication.

h. Oral hygiene instruction.

i. Plaque control programs.

j. Myofunctional therapy.

k. Treatment for disturbances of the Temporomandibular Joint (jaw joint).

l. Experimental or Investigational procedures.

m. Procedures, appliances or restorations necessary to increase vertical dimension and/or restore or maintain the occlusion. Such procedures include, but are not limited to, equilibration, periodontal splinting, restoration of tooth structure lost from attrition, occlusal and anesthesia charges.

n. Hospital costs and any additional fees charged by the Dentist for Hospital treatment.

o. Extra oral grafts (grafting of tissues from outside the mouth to the oral tissues).

p. Services, treatment or supplies received from a dental or medical department maintained by the Trustees, a mutual benefit association, labor union, Trustee or other similar group.

q. Services, treatment or supplies which are payable or furnished under any other group or individual insurance coverage with this Fund or any other insurance company, or Hospital, surgical or medical benefit plan or service plan, for which the Trustees shall directly or indirectly, have paid for all or a portion of the cost or made payroll deductions, or any federal or state government plan or law.

r. Services or treatment rendered or supplies furnished primarily for cosmetic purposes, unless resulting from accidental bodily injuries sustained while insured hereunder.

s. No dental, vision, or hearing benefits are provided to Participants who are on reduced benefits.

8. SCHEDULE OF BENEFITS AND LIMITATIONS

a. **Preventative:** Prophylaxis, including periodontal prophylaxis, is a covered benefit no more than two (2) times per person in each calendar year.

b. **Benefit Period:** The Benefit Period for Dental Charges runs from July 1 through June 30.

c. **Orthodontic Benefits**: Orthodontic benefits are limited to Eligible Dependent children from birth to age 19 and are further subject to a maximum of $1,500.00 per participant.

d. **Diagnostic X-Rays and Examinations:** Complete X-rays are covered as Clinically Necessary. Panoramic are covered benefits only once in a three (3) year period, unless special need is shown. Supplementary bitewing x-rays and examinations are covered benefits not more often than two (2) times per person in each Benefit Period, unless special need is shown. Periodic oral examinations are covered benefits no more than two (2) times per person in a Benefit Period.

Subject to the Exclusions and Limitations set forth, the following sets forth the schedule of benefits provided:

BENEFITS	DELTA DENTAL PPO DENTIST	DELTA DENTAL PREMIER DENTIST	NON-PARTICIPATING DENTIST*
BENEFIT MAXIMUMS			
Maximum Payment **These are not Separate Maximums by Type of Dentist**	$1,000 per person per calendar year for all services Benefit Maximums do not apply for Pediatric Oral Care for Eligible Dependents age 18 and younger		
DIAGNOSTIC AND PREVENTIVE PLAN COINSURANCE			
Emergency Palliative Treatment – to temporarily relieve pain	100%	80%	80%
Diagnostic and Preventive Services – includes exams and cleanings (2 per calendar year), and space maintainers	100%	80%	80%
Sealants and Fluoride – to prevent decay of permanent teeth (to age 12 and under with child prophylaxis)	100%	80%	80%
Radiographs – X-rays	100%	80%	80%
BASIC SERVICES PLAN COINSURANCE			
Oral Surgery Services – extractions and dental surgery	100%	80%	80%
Minor Restorative Services – fillings and crown repair	100%	80%	80%
Endodontic Services – root canals	100%	80%	80%
Other Basic Services – misc. services	100%	80%	80%
Relines and Repairs – to bridges and dentures	100%	80%	80%
Periodontal Services – to treat gum disease	100%	80%	80%
Root Planning and Scaling	100%	80%	80%
Periodontal Surgical Procedures	100%	80%	80%
MAJOR SERVICES PLAN COINSURANCE			
Major Restorative Services – crowns	100%	80%	80%
Prosthodontic Services – includes bridges, implants, and dentures	100%	80%	80%
ORTHODONTIC SERVICES PLAN COINSURANCE			
Orthodontic Services – includes braces $1,500.00 maximum per Eligible Dependent	100%	100%	100%

**** WHEN YOU RECEIVE SERVICES FROM A NONPARTICIPATING DENTIST, THE PERCENTAGES IN THIS COLUMN INDICATE THE PORTION THAT THE PLAN WILL PAY BASED UPON THE COST FOR THE SERVICE AS SET FORTH ON A FUND OFFICE FEE SCHEDULE. THEREFORE, THE PLAN WILL PAY ONLY 80% OF THE FUND OFFICE SCHEDULE, NOT 80% OF WHAT THE DOCTOR CHARGES. YOU WILL BE RESPONSIBLE FOR THE DIFFERENCE.***

9. ALTERNATE COURSES OF TREATMENT

Due to the element of choice involved in the utilization of many dental services, situations frequently arise where there are two (2) or more alternate methods of treatment for a dental condition. In these situations, the amount included as Covered Dental Expenses will be determined in the following manner: If alternate services may be used to treat a dental condition, covered Dental Expenses will be limited to the reasonable and customary charge for that service which is customarily employed nationwide in the treatment of the condition, and is recognized by the profession to be appropriate in accordance with broadly accepted nationwide standards of dental practice taking into account the total current oral condition of the Eligible Person. The purpose of this provision is to define the level of dental care which benefits are based when alternate methods of treatment may be used. The Eligible Person and his dentist may choose a more expensive level of care, but benefits will be payable in accordance with the above provision regardless of the method of treatment used.

10. PRE-TREATMENT REVIEW

If a course of treatment can reasonably be expected to involve Covered Dental Expenses of $100.00 or more, a description of the procedures to be performed, including x-rays, and an estimate of the dentist's charges can be filed with Delta Dental, prior to the commencement of the course of treatment. Delta Dental will notify the dentist of the benefits certified as payable based upon such course of treatment. In determining the amount of benefits payable, consideration will be given to alternate procedures, services or courses of treatment that may be performed for the dental condition concerned in order to accomplish the desires result. The amount included as certified dental expenses will be the appropriate amount as provided herein, determined in accordance with the limitations set forth herein.

11. OPTIONAL TREATMENT

A. If you select a more expensive service than is customarily provided, Delta Dental may make an allowance for certain services based on the fee for the customarily provided service. You are responsible for the difference in cost. In all cases, Delta Dental will make the final determination regarding optional treatment and any available allowance.

Listed below are services for which Delta Dental will provide an allowance for optional treatment. Remember, you are responsible for the difference in cost for any optional treatment.

a. Plastic, resin, porcelain fused to metal, and porcelain crowns on posterior teeth – Delta Dental will pay only the amount that it would pay for a full metal crown.

b. Overdentures – Delta Dental will pay only the amount that it would pay for a conventional denture.

c. Plastic, resin, or porcelain/ceramic onlays on posterior teeth – Delta Dental will pay only the amount that it would pay for a metallic onlay.

d. Inlays, regardless of the material used – Delta Dental will pay only the amount that it would pay for an amalgam or composite resin restoration.
e. All-porcelain/ceramic bridges – Delta Dental will pay only the amount that it would pay for a conventional fixed bridge.
f. Implant/abutment supported complete or partial dentures – Delta Dental will pay only the amount that it would pay for a conventional denture.
g. Gold foil restorations – Delta Dental will pay only the amount that it would pay for an amalgam or composite restoration.
h. Stainless steel crowns with esthetic facings, veneers or coatings – Delta Dental will pay only the amount that it would pay for a conventional stainless-steel crown.

12. COORDINATION AND NON-DUPLICATION OF BENEFITS

All Coordination and Non-Duplication of Benefits provisions of the Plan shall apply to the Dental Care Benefits Program.

T. VISION EXPENSE BENEFITS

If, while insured, you or your Dependent incur any of the following Covered Vision Charges, you will be paid an amount equal to the Covered Vision Charge, but not more than the amount paid.

"Covered Vision Charge" means charges which are for:

i. Examinations performed by a licensed optometrist or ophthalmologist;
ii. Lenses prescribed by such persons;
iii. Frames purchased in conjunction with lenses newly prescribed by such persons.

1. Covered Services:

COMPLETE EXAMINATION	**Maximum Allowance**
Ophthalmologist.....	$75.00
Optometrist	$75.00

The maximum allowance does not apply to Dependent children age 18 and younger.

LENS, CONTACTS AND FRAMES

The following lists the maximum reimbursement per eligible participant or dependent for every two (2) calendar year period beginning January 1, 2016 for the applicable lenses, contacts and frames necessary for the individual:

	Maximum Allowance Every Two Years
Single Vision RX + Frames.....	$275.00
Bi-Focal RX + Frames	$325.00
Tri-Focal RX + Frames	$345.00
Lenticular + Frames	$365.00
Contact Lenses+ Frames	$240.00

For example, if a participant is prescribed bi-focal lenses, the participant will have a total of $325.00 of reimbursement for lenses and frames from January 1, 2018 through December 31, 2018. The participant will not be able to receive any further reimbursement beyond the $325.00 until after January 1, 2020.

One LASIK corrective eye surgery per lifetime is covered for Participants and eligible dependents age 19 and over with a maximum coverage of $750.00. This LASIK eye surgery coverage is not through your vision plan but is instead available under your Comprehensive Major Medical Benefits administered by Medical Mutual.

2. Exclusions:

No vision benefits shall be paid for the following:

a. Examinations not otherwise excluded under these limitations, in excess of one per Participant or Eligible Dependent per calendar year.

b. Routine yearly examinations required by an employer in connection with the occupation of the insured individual.

c. Vision Expense for Covered Services resulting from an accidental bodily injury arising out of or in the course of employment or from a disease compensable under any Workers Compensation, Occupational Disease or similar law.

d. Vision Expense for Covered Services in a hospital owned or operated by the Federal Government or for Covered Service furnished for which the individual is not required to pay.

e. Sunglasses, and the frames therefore, unless they are prescribed to be worn at substantially all times by a licensed ophthalmologist or similar physician, because of an ocular medical condition.

U. HEARING CARE BENEFITS

Maximum Benefit. The following schedule lists the maximum hearing care benefits payable under the Plan:

Benefit	Maximum
Audiometric Evaluation	$25.00
Hearing Aid Evaluation	$35.00
Hearing Aid	$2,000.00 per ear

Hearing care benefits are available **once every three years**. A full 36 months must separate each occurrence.

V. PRESCRIPTION DRUGS

All prescriptions are processed through the Plan's Pharmacy Benefit Manager. A prescription card is provided to all Participants. The co-payment per prescription that is payable by the Participant is as follows:

Generic Drug	$10.00
Preferred Brand (per formulary)	$30.00
Non-Preferred Brand (per formulary)	$60.00

There is no maximum out of pocket per year.

Mail Order Prescriptions are available. Using mail order, the Participant can receive a 90-day supply for the following co-pays:

Generic Drug	$20.00
Preferred Brand (per formulary)	$60.00
Non-Preferred Brand (per formulary)	$120.00

The following provisions also apply to the Plan's prescription drug coverage:

1. Regarding coverage of Over the Counter Drugs, the Plan covers over the counter Prilosec, Claritin & Claritin-D at a $0 co-pay. Each subsequent prescription drug that goes over the counter will be reviewed by the Board for coverage approval.

2. Injectable drugs are covered with a 20% co-pay. You have an annual out-of-pocket maximum of $5,000.00 on injectable prescription drugs only.

3. Injectable drugs are required to be pre-authorized though the Pharmacy Benefit Manager. You are required to utilize a Specialty Pharmacy for injectable drugs. One retail fill is permitted.

4. The Plan utilizes a Mandatory Generic Program. You are responsible for the cost difference of the generic versus the brand name drug in addition to the applicable Co-pay if you choose a brand name drug over the generic equivalent.

5. The Plan utilizes a Formulary Program. The Co-pays will be $20.00 for preferred brand listed on the Pharmacy Benefit Manager's Formulary list and $30.00 for non-preferred brand name drugs not listed on the Pharmacy Benefit Manager's Formulary list.

6. Certain Migraine drugs can only be covered in limited quantities. The chart set forth below references the quantity limits per prescription for the medications listed:

Drug Name	**Quantity Limits**
Amerge tabs	9 tabs per medication
Axert tabs	9 tabs per medication
Frova tabs	9 tabs per medication
Maxalt tabs	9 tabs per medication
Relpax tabs	9 tabs per medication
Sumatriptan tabs	9 tabs per medication
Zomig tabs	9 tabs per medication
Sumatriptan Ini. (cartridges)	2 kits (4 doses)
Sumatriptan NS 20 mg	1 box (6 doses/6 ml)
Sumatriptan NS 5 mg	3 boxes (18 doses/18 ml)
Sumatriptan Inj. Vial	5 vials (5 doses/2.5 ml)
Zomig NS	6 units (1 pack)

You may receive more than the Quantity Limits set forth above if your physician presents a letter of medical necessity for the increased Quantity.

7. You will be required to engage in a step therapy program for the medications listed in the table below. Under a step therapy program, you are required to try the most-cost effective medication for your condition first before progressing to other more costly medications/therapies. In step therapy, medications are grouped into two categories, 1st Step and 2nd Step. 1st Step are first line medications, mostly generic medications proven safe, effective, and affordable. You are required to try these types of medications first. 2nd Step are second line medications, mostly higher cost brand name medications. After you try a 1st Step medication, if it does not provide you with the therapeutic benefit desired, your physician may write a prescription for a 2nd Step medication; however, 2nd Step medications require the usage and failure of a 1st Step medication before qualifying for coverage. The following medications are subject to step therapy:

Step Therapy	Criteria
Statin Step Therapy (Cholesterol control)	Must have tried and failed a generic 1st Step statin prior to obtaining a branded 2nd Step statin
Proton Pump Inhibitors (PPI's)	Must have tried and failed Omeprazole, Prilosec OTC, or Pantoprazole prior to utilizing branded PPI
Sleep Aid Step Therapy (Hypnotics)	Must have tried and failed zolpidem or zaleplon prior to using Ambien CR, Rozerem, or Lunesta
Bisphosphonates (Osteoporosis agents)	Must have tried and failed generic alendronate prior to obtaining Actonel, Boniva or Fosamax
Rheumatoid Arthritis Specialty Medications	Must have tried and failed Humira or Enbrel prior to obtaining Kineret, Cimzia or Simponi
Multiple Sclerosis Specialty Medications	Must have tried and failed Copaxone or Betaseron prior to obtaining Avonex, Rebif or Extavia
Hepatitis C Specialty Medications	Must have tried and failed Pegasys/Peg-Intron prior to obtaining Intron-A or Infergen

8. Allegra and Allegra-D OTC are covered for you at no co-pay both at retail pharmacies and through mail-order (90-day supply).

W. COVERAGE FOR SMOKING CESSATION PRODUCTS

The Plan provides coverage for patches and medication used or taken for the sole purpose of ceasing use of and addiction to the smoking of tobacco products. These smoking cessation benefits are subject to a maximum annual allowance of six hundred dollars ($600.00) per eligible participant or dependent. The smoking cessation products for which this coverage is permitted are limited to the following:

1. Smoking Cessation Patches
2. Generic Zyban subject to a $5.00 Co-Pay.
3. Brand Name Zyban subject to a $30.00 Co-Pay.
4. Brand Name Chantix subject to a $30.00 Co-Pay.

X. VACATION FUND

In order to become a participant in the Vacation Fund, contributions from a Contributing Employer must be made on your behalf to the Vacation Fund. Certain Local Unions' Collective Bargaining Agreements require contributions to the Vacation Fund, while others do not. For a list of Local Unions participating in the Vacation Fund, please contact the Administrative Manager. You will become eligible for benefits under the Vacation Fund on the first day

contributions are made on your behalf. You will remain a participant as long as you have a balance in your account.

When you become a participant in the Vacation Fund, an account is set up in your name. Contributions made on your behalf by your employer are from after-tax dollars and are credited to your account. Contributions accumulated will be automatically distributed once per calendar year by the end of December. You do not have to take vacation in order to receive payment.

Before distribution, your contributions will be invested in accordance with the Investment Policies of the Board of Trustees. Investment earnings and interest accumulations are used to cover the administrative costs, the excess earnings will be distributed amount the participant's accounts as a dividend. In the event that expenses exceed investment earnings, an administrative charge will be applied to the participants' accounts.

An account is considered unclaimed after every reasonable effort has been made to find and distribute the money to the participant. Accounts that remain unclaimed for a period of more than two (2) years will be allocated to a general account used to offset expenses. The participants shall have the sole responsibility to contact the Fund Office to claim any contributions made that have not been distributed for a period of two years beyond the distribution date. If the participant does not contact the Fund Office and claim such contributions, the participant's claim to the money will be lost.

If you should die while you are a participant in this Plan, any remaining distribution will be made to your designated beneficiary on the next distribution date. If no beneficiary has been designated, payment will be made to your estate. The beneficiary of your Vacation Fund benefits is the same as your beneficiary on the Health & Welfare Fund Life Insurance Benefit.

Vacation payments will automatically be mailed to your home address. Alternate arrangements cannot be guaranteed. You can contact the Fund Administrator to attempt to make alternate arrangements, only at the time of the normal distribution. In the event that you are not in good standing with your dues or assessments with your union local, your check will be held at the union hall until your union status is rectified.

IV. RETIREE BENEFIT PROGRAMS

A. RIGHTS OF TRUSTEES WITH RESPECT TO RETIREE BENEFITS

The Trustees reserve the right to change or eliminate the Retiree Benefit Programs and/or the Widow/Widower Benefit Program at their sole discretion at any time and for any reason. Participants, Disabled Employees, Retirees and Widows/Widowers of Retirees or Participants and their Eligible Dependents do not have any vested rights in the Retiree Benefit Programs and/or the Widow/Widower Program.

The privilege of making self-payments for Retiree Benefits is not an "accrued" benefit. The right to change, reduce or eliminate any and all aspects of benefits provided for Retirees and their spouses, including the right to increase the Retiree self-payment rate, is a right specifically reserved by the Trustees. For example, if federal legislation is passed that requires the Plan to

pay its benefits before Medicare pays its benefits for Medicare-eligible Retirees and Dependents, the Trustees reserve the right to terminate Retiree Benefits or to increase the self-payment rate to an amount deemed necessary.

B. ELIGIBILITY REQUIREMENTS FOR RETIRED EMPLOYEE BENEFIT PROGRAM

If you retire and you are not eligible for Medicare, Plan coverage will continue until (1) your Reserve Hours are exhausted or (2) you and your spouse become eligible for Medicare, whichever occurs first. If you exhaust your Reserve Hours before becoming eligible for Medicare and you meet all of the eligibility requirements to be considered an Eligible Retiree under the Retired Employee Benefit Program, then you can continue coverage by making self-contribution payments until you become eligible for Medicare. You will be considered an Eligible Retiree and entitled to coverage under the Retired Employee Benefit Program only if you meet all of the following eligibility requirements:

1. You have retired and you are no longer actively working at the trade as described in Section D below. You will be considered to be retired at the end of the month following retirement from active employment as evidenced by application for benefits under the International Painters and Allied Trades Industry Pension Plan; and

2. You are at least fifty-five (55) years of age or have retired from the International Painters and Allied Trades Industry Pension Plan prior to the age of 55, but you have not reached your sixty-fifth (65^{th}) birthday and you and your spouse are not eligible for Medicare or on Medicare; and

3. You must have been eligible for active Employee coverage under the Plan on the date that you retired and continuously eligible for active Employee coverage for a period of one (1) year prior to the date of your retirement; and

4. You must timely elect coverage under the Retired Employee Benefit Program and make the required self-payments to the Plan at the contribution rate determined by the Board of Trustees.

If you retire before age 65 but you are not eligible to receive a pension under the International Painters and Allied Trades Industry Pension Plan, Plan coverage will continue until your Reserve Hours are exhausted or you reach age 65, whichever occurs first. If you exhaust your Reserve Hours before reaching the age 65, you may be eligible to continue coverage at your own expense as provided for under Continuation Coverage (COBRA), See Article II, Sections K and L above.

If you qualify and timely elect to be covered as a retired Employee, then you must make self-payments in accordance with the requirements of the Fund Office as set by the Board of Trustees. The monthly self-payment amount shall be determined by the Board of Trustees, but may not exceed 102% of the full cost of the Plan. Both the extent of coverage and the amounts of self-payment are subject to revision within the sole discretion of the Trustees. The monthly contributions are payable at the Fund Office. It shall be your responsibility to see that the

required contributions are timely received in the Fund Office, and no notices, billings or reminders of payments are required to be given.

If you qualify under these rules of eligibility, then you must elect coverage in the Retired Employee Benefit Program within the first sixty (60) days after the last month in which you were covered for benefits under the Plan or after exhausting your Reserve Hours, whichever comes last, and make the required self-payments in accordance with requirements of the Fund Office as set by the Board of Trustees. If you do not elect coverage in the Retired Employee Benefit Program within the sixty (60) days limitation or make the required self-payments timely to the Fund Office, you shall not be eligible for coverage in the Retired Employee Benefit Program at any time in the future. If you do not elect coverage in the Retired Employee Benefit Program within the sixty (60) days limitation or you do not make the required self-payments timely to the Fund Office, then you may be eligible to continue coverage at your own expense as provided for under Continuation Coverage (COBRA), See Article II, Sections K and L above.

The Trustees reserve the right to terminate benefits or to change the requirements for participation or eligibility in the Retired Employee Benefit Program at any time within their sole discretion.

C. EARLY RETIREE SUBSIDY

A retired Participant's insurance premium is subsidized by the "Subsidy Amount" if the retired Participant is between ages 55 and 65 and meets the following requirements:

1. The Participant must have worked and received contributions from a Contributing Employer on their behalf to the Escrow Fund. Certain Local Unions' Collective Bargaining Agreements require contributions to the Fund, while others do not. For a list of Local Unions participating in the Escrow Fund, please contact the Administrative Manager;

2. The plan must have received contributions on the Participant's behalf and the Participant must have been eligible for insurance for 16 of last 20 quarters prior to retirement date;

3. The Participant must be retired under either the IUPAT Industry Pension Plan or the Glass & Glazing Industry Pension Plan; and

4. The Participant must be between the ages of 55 and 65 years old.

   If the Participant retires at an age younger than 55, the Participant can contribute at the full premium until such time that he turns 55. At the point that the Participant turns 55, the Participant will be eligible to receive the subsidy.

   The Subsidy Amount is a total of $560.60 for all participants.

These subsidies are only available prior to the Participant turning 65 years old. If the Participant's spouse is younger than 65 at the time that the Participant reaches that age, they can continue the insurance at the full premium rate.

D. RETIREE MUST NOT BE WORKING AT THE TRADE

It is a condition to your coverage under the Retiree Programs that you shall not engage in or perform employment in the trade jurisdiction (including, but not limited to, related supervisory activities) as defined in the current Constitution of the International Union of Painters and Allied Trades for remuneration or profit, except that you may work as an instructor in a recognized apprenticeship program of the International Union of Painters and Allied Trades, AFL-CIO. The Board of Trustees in their sole discretion shall determine if you are engaging in or performing employment. Retirees working under a waiver of suspension of benefits from the IUPAT Industry Pension Plan are not entitled to the Early Retiree Subsidy while working under such a waiver. If the employee provides the Fund Office advanced notice of the plan to work under a waiver, then the subsidy will be suspended until the Fund Office is notified that the employee has stopped working under the wavier. If the employee fails to notify the Fund Office of the plan to work under the waiver and the Fund Office receives contributions on the Early Retiree for work, the Fund Office shall suspend the Early Retiree Subsidy for each month following a month in which such employer contributions are received on the employee's behalf.

If, after your retirement, you return to active employment and work sufficient hours again to become eligible for benefits under the active employee benefit program, your coverage under the applicable Retiree Program shall terminate on the date your eligibility under the Active Program becomes effective and you may again become entitled to coverage under the applicable Retiree Program, if you fulfill the eligibility requirements under the applicable Retiree Program, upon re-retirement.

E. CANCELLATION OF COVERAGE

Your coverage under the Retiree Programs will be canceled as of the date:

1. You cease to satisfy the eligibility requirements set forth above; or

2. The Plan or coverage for Retirees is canceled; or

3. You request that your coverage under the applicable Retiree Program of this Plan be canceled; or

4. You or your spouse do not make a required payment for coverage; or

5. Both you and your spouse become eligible for Medicare.

F. COVERAGE CANCELED

If your coverage under the Retiree Program is canceled, your spouse's coverage is also canceled, except as provided by COBRA. In addition, your spouse will also lose coverage under the Retiree Programs as of the date:

1. Coverage of spouses is canceled for Retirees; or

2. Your spouse ceases to meet this Plan's requirements to qualify as an Eligible Dependent.

G. WIDOW/WIDOWER BENEFIT PROGRAM

If you should die as an Active or Disabled Employee eligible for coverage under this Plan at the time of your death, then your surviving spouse and dependent children (or if you should die as a Retiree eligible for coverage under a Retiree Benefit Program at the time of your death, then your surviving spouse only) may elect to maintain eligibility for benefits from the Plan in the Widow/Widower Benefit Program by making self-payments in a timely manner as set forth by the Trustees provided your spouse meets the following rules of eligibility:

i. He/she makes application to the Trustees no later than 90 days following your death; or

ii. He/she makes application to the Trustees no later than 90 days after the expiration or cancellation of any other health care plan, program or policy in effect on the date of your death, which provided coverage to such widow or widower, including COBRA coverage.

A widow or widower who qualifies under these rules of eligibility must elect coverage in the Widow/Widower Benefit Program within the time limits set forth above and make the required self-payments in accordance with the requirements of the Fund Office as set by the Board of Trustees. The initial eligibility date of coverage shall be the first (1st) day of the month following the date the application is approved and proper payment is received. If such widow or widower does not elect coverage in the Widow/Widower Benefit Program within the time limits set forth above or make the required self-payments timely to the Fund Office, he or she shall not be eligible to coverage in the Widow/Widower Benefit Program at any time in the future. The Trustees may in their sole discretion and on a case-by-case basis extend the time period of a widow or widower to elect coverage in the Widow/Widower Benefit Program.

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

H. SELF CONTRIBUTION PAYMENTS

Self-contribution payments must be made on a monthly basis and are due on the 10th day of the month prior to the coverage month and are considered late if received in the Fund Office after the 15th day of the month prior to the coverage month. The widow/widower shall be able to apply towards the self-contribution payment any available Reserve Hours in your account until all the Reserve Hours are expended. Failure to make timely and continuous payments shall terminate the individual's right to make further payments and be covered under this Plan. No late payments shall be accepted.

I. BENEFITS

The benefits payable to your surviving spouse and/or dependent children under the Widow/Widower Benefit Program shall be under the same benefit coverage they were eligible for on the date of your death. Provided, however, that if a surviving spouse or dependent child covered under the Plan becomes eligible for Medicare during the covered period, then the surviving spouse or dependent child shall no longer be eligible for coverage under the Plan and may apply for participation in any Medicare Supplement Program which from time to time may be sponsored by the Plan. The surviving spouse and dependent children are not entitled to any Death, Accidental Death and Dismemberment or Weekly Disability Benefits. In addition, all benefits shall be coordinated with any other group health insurance plan, health and welfare program, and Medicare or Medicaid program.

J. TERMINATION OF COVERAGE

Coverage under the Widow/Widower Benefit Program shall terminate on the earliest of the following that occurs:

a. The first (1st) day of any month for which no correct and timely self-payment was made; or

b. The first (1st) day of the month following the month in which the widow or widower remarries; or

c. The first (1st) day of the month in which the widow or widower is covered for benefits under Medicare or another group health care or group insurance plan; or

d. With respect to a Dependent child, the first (1st) day of the month following the month in which the child is no longer an Eligible Dependent under the Plan.

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

K. INCORPORATION OF OTHER PLAN DOCUMENTS

All plan documents and all definitions, terms, conditions and provisions therein are adopted and made a part of the Retiree and Widow/Widower coverages. Any questions, interpretations and disputes concerning eligibility for and amount of benefits shall be resolved by the Trustees, but any Retiree and/or Widow/Widower who is unsatisfied with any determination by the Trustees may request to appear before the Trustees to state his or her case.

V. MEDICAL CLAIM PROCEDURE

Providers who participate in the PPO Network have agreed to submit claims directly to the local Claims Administrator in their area. Therefore, if PPO Network Hospitals, Physicians and ancillary Providers are used, claims for their services will generally not have to be filed by the Participant. In addition, many Out-of-Network Hospitals and Physicians will also file claims if the information on Your Identification Card is provided to them. If the Provider requests a claim form to file a claim, a claim form can be obtained by contacting the Fund Office or by visiting www.anthem.com.
Please note You may be required to complete an authorization form in order to have Your claims and other personal information sent to the Claims Administrator when You receive care in foreign countries. Failure to submit such authorizations may prevent foreign Providers from sending Your claims and other personal information to the Claims Administrator.

A. HOW TO FILE CLAIMS

Under normal conditions, the Claims Administrator should receive the proper claim form within 12 months after the service was provided. This section of the SPD describes when to file a benefit claim and when a Hospital or Physician will file the claim for You.

Each person enrolled through the Plan receives an Identification Card. Remember, in order to receive full benefits, You must receive treatment from a Network Provider. When admitted to a Network Hospital, present Your Identification Card. Upon discharge, You will be billed only for those charges not covered by the Plan.

When You receive Covered Services from a Network Physician or other Network licensed health care Provider, ask him or her to complete a claim form. Payment for Covered Services will be made directly to the Provider.
For health care expenses other than those billed by a Network Provider, use a claim form to report Your expenses. You may obtain these from the Fund Office or the Claims Administrator. Claims should include Your name, Plan and Group numbers exactly as they appear on Your Identification Card. Attach all bills to the claim form and file directly with the Claims Administrator. Be sure to keep a photocopy of all forms and bills for Your records. The address is on the claim form.

Save all bills and statements related to Your illness or Injury. Make certain they are itemized to include dates, places and nature of services or supplies.

B. MAXIMUM ALLOWED AMOUNT

This section describes how the Claims Administrator determines the amount of reimbursement for Covered Services. Reimbursement for services rendered by Network and Out-of-Network Providers is based on this Plan's Maximum Allowed Amount for the Covered Service that You receive.

The Maximum Allowed Amount for this Plan is the maximum amount of reimbursement the Claims Administrator will allow for services and supplies:

- that meet the Plan's definition of Covered Services, to the extent such services and supplies are covered under Your Plan and are not excluded;
- that are Medically Necessary; and
- that are provided in accordance with all applicable preauthorization, utilization management or other requirements set forth in Your Plan.

You will be required to pay a portion of the Maximum Allowed Amount to the extent You have not met Your Deductible or have a Copayment or Coinsurance. In addition, when You receive Covered Services from an Out-of-Network Provider, You may be responsible for paying any difference between the Maximum Allowed Amount and the Provider's actual charges. This amount can be significant.

When You receive Covered Services from a Provider, the Claims Administrator will, to the extent applicable, apply claim processing rules to the claim submitted for those Covered Services. These rules evaluate the claim information and, among other things, determine the accuracy and appropriateness of the procedure and diagnosis codes included in the claim. Applying these rules may affect the Claims Administrator's determination of the Maximum Allowed Amount. The Claims Administrator's application of these rules does not mean that the Covered Services You received were not Medically Necessary. It means the Claims Administrator has determined that the claim was submitted inconsistent with procedure coding rules and/or reimbursement policies. For example, Your Provider may have submitted the claim using several procedure codes when there is a single procedure code that includes all of the procedures that were performed. When this occurs, the Maximum Allowed Amount will be based on the single procedure code rather than a separate Maximum Allowed Amount for each billed code.

Likewise, when multiple procedures are performed on the same day by the same Physician or other healthcare professional, the Plan may reduce the Maximum Allowed Amounts for those secondary and subsequent procedures because reimbursement at 100% of the Maximum Allowed Amount for those procedures would represent duplicative payment for components of the primary procedure that may be considered incidental or inclusive.

C. PROVIDER NETWORK STATUS

The Maximum Allowed Amount may vary depending upon whether the Provider is a Network Provider or an Out-of-Network Provider.

A Network Provider is a Provider who is in the managed network for this specific product or in a special Center of Excellence or other closely managed specialty network, or who has a participation contract with the Claims Administrator. For Covered Services performed by a Network Provider, the Maximum Allowed Amount for this Plan is the rate the Provider has agreed with the Claims Administrator to accept as reimbursement for the Covered Services. Because Network Providers have agreed to accept the Maximum Allowed Amount as payment in full for those Covered Services, they should not send You a bill or collect for amounts above the Maximum Allowed Amount. However, You may receive a bill or be asked to pay all or a portion of the Maximum Allowed Amount to the extent You have not met Your Deductible or have a Copayment or Coinsurance. Please call Member Services on Your Identification Card for help in finding a Network Provider or visit *www.anthem.com*.

Providers who have not signed any contract with the Claims Administrator and are not in any of the Claims Administrator's networks are Out-of-Network Providers.

For Covered Services You receive from an Out-of-Network Provider, the Maximum Allowed Amount for this Plan will be one of the following as determined by the Claims Administrator:

1. An amount based on the Claims Administrator's Out-of-Network Provider fee schedule/rate, which the Claims Administrator has established at its discretion, and which the Claims Administrator reserves the right to modify from time to time, after considering one or more of the following: reimbursement amounts accepted by like/similar Providers contracted with the Claims Administrator, reimbursement amounts paid by the Centers for Medicare and Medicaid Services for the same services or supplies, and other industry cost, reimbursement and utilization data; or
2. An amount based on reimbursement or cost information from the Centers for Medicare and Medicaid Services ("CMS"). When basing the Maximum Allowed Amount upon the level or method of reimbursement used by CMS, the Administrator will update such information, which is unadjusted for geographic locality, no less than annually; or
3. An amount based on information provided by a third-party vendor, which may reflect one or more of the following factors: (1) the complexity or severity of treatment; (2) level of skill and experience required for the treatment; or (3) comparable Providers' fees and costs to deliver care; or
4. An amount negotiated by the Claims Administrator or a third-party vendor which has been agreed to by the Provider. This may include rates for services coordinated through case management; or
5. An amount based on or derived from the total charges billed by the Out-of-Network Provider.

Providers who are not contracted for this Plan but contracted for other products with the Claims Administrator are also considered Out-of-Network. For this Plan, the Maximum Allowed Amount for services from these Providers will be one of the five methods shown above unless the contract between the Claims Administrator and that Provider specifies a different amount.

For Covered Services rendered outside the Claims Administrator's Service Area by Out-of-Network Providers, claims may be priced using the local Blue Cross Blue Shield plan's non-participating Provider fee schedule/rate or the pricing arrangements required by applicable state or Federal law. In certain situations, the Maximum Allowed Amount for out of area claims may be based on billed charges, the pricing the Plan would use if the healthcare services had been obtained within the Claims Administrator's Service Area, or a special negotiated price.

Unlike Network Providers, Out-of-Network Providers may send You a bill and collect for the amount of the Provider's charge that exceeds the Plan's Maximum Allowed Amount. You are responsible for paying the difference between the Maximum Allowed Amount and the amount the Provider charges. This amount can be significant. Choosing a Network Provider will likely result in lower Out-of-Pocket costs to You. Please call Member Services for help in finding a Network Provider or visit the Claims Administrator's website at www.anthem.com.

Member Services is also available to assist You in determining this Plan's Maximum Allowed Amount for a particular service from an Out-of-Network Provider. In order for the Claims Administrator to assist You, You will need to obtain from Your Provider the specific procedure code(s) and diagnosis code(s) for the services the Provider will render. You will also need to know the Provider's charges to calculate Your Out-of-Pocket responsibility. Although Member Services can assist You with this pre-service information, the final Maximum Allowed Amount for Your claim will be based on the actual claim submitted by the Provider.

D. MEMBER COST SHARE

For certain Covered Services, You may be required to pay a part of the Maximum Allowed Amount as Your cost share amount (for example, Deductible, Copayment, and/or Coinsurance).

Your cost share amount and Out-of-Pocket Limits may vary depending on whether You received services from a Network or Out-of-Network Provider. Specifically, You may be required to pay higher cost sharing amounts or may have limits on Your benefits when using Out-of-Network Providers. Please see the Schedule of Benefits in this SPD for Your cost share responsibilities and limitations, or call Member Services to learn how this Plan's benefits or cost share amounts may vary by the type of Provider You use.

The Plan will not provide any reimbursement for Non-Covered Services. You may be responsible for the total amount billed by Your Provider for Non-Covered Services, regardless of whether such services are performed by a Network or Out-of-Network Provider. Non-Covered Services include services specifically excluded from coverage by the terms of this SPD and services received after benefits have been exhausted. Benefits may be exhausted by exceeding, for example, benefit caps or day/visit limits.

In some instances, You may only be asked to pay the lower Network cost sharing amount when You use an Out-of-Network Provider. For example, if You go to a Network Hospital or Provider facility and receive Covered Services from an Out-of-Network Provider such as a radiologist, anesthesiologist or pathologist who is employed by or contracted with a Network Hospital or facility, You will pay the Network cost share amounts for those Covered Services. However,

You also may be liable for the difference between the Maximum Allowed Amount and the Out-of-Network Provider's charge.

The Claims Administrator and/or its designated pharmacy benefits manager may receive discounts, rebates, or other funds from drug manufacturers, wholesalers, distributors, and/or similar vendors, which may be related to certain Prescription Drug purchases under this Plan and which positively impact the cost effectiveness of Covered Services. These amounts are retained by the Claims Administrator. These amounts will not be applied to Your Deductible, if any, or taken into account in determining Your Copayment or Coinsurance.

E. AUTHORIZED SERVICES

In some circumstances, such as where there is no Network Provider available for the Covered Service, the Plan may authorize the Network cost share amounts (Deductible, Copayment, and/or Coinsurance) to apply to a claim for a Covered Service You receive from an Out-of-Network Provider. In such circumstance, You must contact the Claims Administrator in advance of obtaining the Covered Service. The Plan also may authorize the Network cost share amounts to apply to a claim for Covered Services if You receive Emergency services from an Out-of-Network Provider and are not able to contact the Claims Administrator until after the Covered Service is rendered. If the Plan authorizes a Network cost share amount to apply to a Covered Service received from an Out-of-Network Provider, You also may still be liable for the difference between the Maximum Allowed Amount and the Out-of-Network Provider's charge. Please contact Member Services for Authorized Services information or to request authorization.

F. SERVICES PERFORMED DURNG SAME SESSION

The Plan may combine the reimbursement of Covered Services when more than one service is performed during the same session. Reimbursement is limited to the Plan's Maximum Allowed Amount. If services are performed by Out-of-Network Providers, then You are responsible for any amounts charged in excess of the Plan's Maximum Allowed Amount with or without a referral or regardless if allowed as an Authorized Service. Contact the Claims Administrator for more information.

G. PROCESSING YOUR CLAIM

You are responsible for submitting Your claims for expenses not normally billed by and payable to a Hospital or Physician. Always make certain You have Your Identification Card with You. Be sure Hospital or Physician's office personnel copy Your name, and identification numbers (including the 3-letter prefix) accurately when completing forms relating to Your coverage.

H. TIMELINES OF FILING FOR PARTICIPANT SUBMITTED CLAIMS

To receive benefits, a properly completed claim form with any necessary reports and records must be filed by You within 12 months of the date of service. Payment of claims will be made as soon as possible following receipt of the claim, unless more time is required because of incomplete or missing information. In this case, You will be notified of the reason for the delay and will receive a list of all information needed to continue processing Your claim. After this

data is received, the Claims Administrator will complete claims processing. No request for an adjustment of a claim can be submitted later than 24 months after the claim has been paid.

I. NECESSARY INFORMATION

In order to process Your claim, the Claims Administrator may need information from the Provider of the service. As a Participant, You agree to authorize the Physician, Hospital, or other Provider to release necessary information.

The Claims Administrator will consider such information confidential. However, the Plan and the Claims Administrator have the right to use this information to defend or explain a denied claim.

J. CLAIMS REVIEW

The Claims Administrator has processes to review claims before and after payment to detect fraud, waste, abuse and other inappropriate activity. Participants seeking services from Out-of-Network Providers could be balance billed by the Out-of-Network Provider for those services that are determined to be not payable as a result of these review processes. A claim may also be determined to be not payable due to a Provider's failure to submit medical records with the claims that are under review in these processes.

K. EXPLANATION OF BENEFITS

After You receive medical care, You will generally receive an Explanation of Benefits (EOB). The EOB is a summary of the coverage You receive. The EOB is not a bill, but a statement sent by the Claims Administrator, to help You understand the coverage You are receiving. The EOB shows:

- total amounts charged for services/supplies received;
- the amount of the charges satisfied by Your coverage;
- the amount for which You are responsible (if any); and
- general information about Your appeals rights and for ERISA plans, information regarding the right to bring an action after the appeals process.

L. INTER-PLAN ARRANGEMENTS

1. Out-of-Area Services

The Claims Administrator has a variety of relationships with other Licensees. Generally, these relationships are called “Inter-Plan Arrangements.” Whenever You access healthcare services outside the geographic area the Claims Administrator serves (the “Service Area”), the claim for those services may be processed through one of these Inter-Plan Arrangements. The Inter-Plan Arrangements are described below.

When You receive care outside of the Claims Administrator’s Service Area, You will receive it from one of two kinds of Providers. Most Providers (“participating Providers”) contract with the

local Plan in that geographic area ("Host"). Some Providers ("nonparticipating Providers") don't contract with the Claims Administrator. Explained below is how both kinds of Providers are paid.

2. Inter-Plan Arrangements Eligibility – Claim Types

Most claim types are eligible to be processed through Inter-Plan Arrangements, as described above. Examples of claims that are not included are Prescription Drugs that You obtain from a Pharmacy and most dental or vision benefits.

3. Host Program

Under the Host Program, when You receive Covered Services within the geographic area served by a Host Provider, the Claims Administrator will still fulfill its contractual obligations. When You receive Covered Services outside the Service Area and the claim is processed through the Host Provider Program, the amount You pay is calculated based on the lower of:

- The billed charges for Covered Services; or
- The negotiated price that the Host Provider makes available to the Claims Administrator.

Often, this "negotiated price" will be a simple discount that reflects an actual price that the Host Provider pays to the medical Provider. Sometimes, it is an estimated price that takes into account special arrangements with that Provider. Sometimes, such an arrangement may be an average price, based on a discount that results in expected average savings for services provided by similar types of Providers. Estimated and average pricing arrangements may also involve types of settlements, incentive payments and/or other credits or charges.

Estimated pricing and average pricing also take into account adjustments to correct for over- or underestimation of past pricing of claims, as noted above. However, such adjustments will not affect the price the Plan used for Your claim because they will not be applied after a claim has already been paid.

4. Negotiated (non–Host Program) Arrangements

With respect to one or more Host Provider, instead of using the Host Program, the Claims Administrator may process Your claims for Covered Services through Negotiated Arrangements for National Accounts.

The amount You pay for Covered Services under this arrangement will be calculated based on the lower of either billed charges for Covered Services or the negotiated price made available to the Claims Administrator by the Host Provider.

5. Special Cases: Value-Based Programs

Host Program

If You receive Covered Services under a Value-Based Program inside a Host Provider's Service Area, You will not be responsible for paying any of the Provider Incentives, risk-sharing, and/or

Care Coordinator Fees that are a part of such an arrangement, except when a Host Provider passes these fees to the Claims Administrator through average pricing or fee schedule adjustments. Additional information is available upon request.

Value-Based Programs: Negotiated (non–Host Program) Arrangements

If the Claims Administrator has entered into a Negotiated Arrangement with a Host Provider to provide Value-Based Programs to the Plan on Your behalf, the Claims Administrator will follow the same procedures for Value-Based Programs administration and Care Coordinator Fees as noted above for the Host Program.

6. **Inter-Plan Programs: Federal/State Taxes/Surcharges/Fees**

Federal or state laws or regulations may require a surcharge, tax or other fee. If applicable, the Plan will include any such surcharge, tax or other fee as part of the claim charge passed on to You.

7. **Nonparticipating Providers Outside the Claims Administrator's Service Area**

a. Allowed Amounts and Participant Liability Calculation

When Covered Services are provided outside of Anthem's Service Area by non-participating Providers, the Plan may determine benefits and make payment based on pricing from either the Host Blue or the pricing arrangements required by applicable state or Federal law. In these situations, the amount You pay for such services as Deductible, Copayment or Coinsurance will be based on that allowed amount. Also, You may be responsible for the difference between the amount that the non-participating Provider bills and the payment the Plan will make for the Covered Services as set forth in this paragraph. Federal or state law, as applicable, will govern payments for Out-of-Network Emergency services.

b. Exceptions

In certain situations, the Plan may use other pricing methods, such as billed charges or the pricing the Plan would use if the healthcare services had been obtained within the Anthem Service Area, or a special negotiated price to determine the amount the Plan will pay for services provided by nonparticipating Providers. In these situations, You may be liable for the difference between the amount that the nonparticipating Provider bills and the payment the Plan make for the Covered Services as set forth in this paragraph.

8. **Foreign Services Program**

If You plan to travel outside the United States, call Member Services to find out Your Global Core benefits. Benefits for services received outside of the United States may be different from services received in the United States. Remember to take an up to date health Identification Card with You.

When You are traveling abroad and need medical care, You can call the Global Core Service Center any time. They are available 24 hours a day, seven days a week. The toll-free number is 800-810-2583. Or You can call them collect at 804-673-1177.

If You need inpatient hospital care, You or someone on Your behalf, should contact the Claims Administrator for preauthorization. Keep in mind, if You need Emergency medical care, go to the nearest hospital. There is no need to call before You receive care.

In most cases, when You arrange inpatient hospital care with Global Core, claims will be filed for You. The only amounts that You may need to pay up front are any Copayment, Coinsurance or Deductible amounts that may apply.

You will typically need to pay for the following services up front:

- Doctors services;
- Inpatient hospital care not arranged through Blue Cross Blue Shield Global Core; and
- Outpatient services.

You will need to file a claim form for any payments made up front. When You need Global Core claim forms You can get international claims forms in the following ways:

- Call the Global Core Service Center at the numbers above; or
- Online at www.bcbsglobalcore.com.

You will find the address for mailing the claim on the form.

9. Unauthorized Use Of Identification Card

If You permit Your Identification Card to be used by someone else or if You use the card before coverage is in effect or after coverage has ended, You will be liable for payment of any expenses incurred resulting from the unauthorized use. Fraudulent misuse could also result in termination of the coverage. Fraudulent statements on enrollment forms and/or claims for services or payment involving all media (paper or electronic) may invalidate any payment or claims for services and be grounds for voiding the Participant's coverage. This includes fraudulent acts to obtain medical services and/or Prescription Drugs.

10. Assignment

You authorize the Claims Administrator, on behalf of the Employer, to make payments directly to Providers for Covered Services. The Claims Administrator also reserves the right to make payments directly to You. Payments and notice regarding the receipt and/or adjudication of claims, may be made to an alternate recipient, or that person's custodial parent or designated representative. Any payments made by the Claims Administrator will discharge the Plan's obligation to pay for Covered Services. You cannot assign Your right to receive payment to

anyone, except as required by a "Qualified Medical Child Support Order" as defined by, and if subject to, ERISA or any applicable Federal law.

Once a Provider performs a Covered Service, the Claims Administrator will not honor a request to withhold payment of the claims submitted.

The coverage and any benefits under the Plan are not assignable by any Participant without the written consent of the Plan, except as provided above.

11. Questions About Coverage Or Claims

If You have questions about Your coverage, contact Your Plan Administrator or the Claims Administrator's Member Services Department. Be sure to always give Your Member identification number.

When asking about a claim, give the following information:

- identification number;
- patient's name and address;
- date of service and type of service received; and
- Provider name and address (Hospital or Physician).

To find out if a Hospital or Physician is a Network Provider, call them directly or call the Claims Administrator.

The Plan does not supply You with a Hospital or Physician. In addition, neither the Plan nor the Claims Administrator is responsible for any Injuries or damages You may suffer due to actions of any Hospital, Physician or other person. In order to process Your claims, the Claims Administrator or the Plan Administrator may request additional information about the medical treatment You received and/or other group health insurance You may have. This information will be treated confidentially.

An oral explanation of Your benefits by an employee of the Claims Administrator, Plan Administrator or Plan Sponsor is not legally binding.

Any correspondence mailed to You will be sent to Your most current address. You are responsible for notifying the Plan Administrator or the Claims Administrator of Your new address.

12. Appealing A Medical Claim Denial

The Plan wants Your experience to be as positive as possible. There may be times, however, when You have a complaint, problem, or question about Your Plan or a service You have received. In those cases, please contact Member Services by calling the number on the back of Your Identification Card. The Claims Administrator will try to resolve Your complaint informally by talking to Your Provider or reviewing Your claim. If You are not satisfied with

the resolution of Your complaint, You have the right to file an appeal, which is defined as follows:

For purposes of these appeal provisions, "claim for benefits" means a request for benefits under the plan. The term includes both pre-service and post-service claims.

- A pre-service claim is a claim for benefits under the plan for which You have not received the benefit or for which You may need to obtain approval in advance.
- A post-service claim is any other claim for benefits under the plan for which You have received the service.

If Your claim is denied or if Your coverage is rescinded:

- You will be provided with a written notice of the denial or rescission; and
- You are entitled to a full and fair review of the denial or rescission.

The procedure the Claims Administrator will follow will satisfy the requirements for a full and fair review under applicable Federal regulations.

A. Notice of Adverse Benefit Determination

If Your claim is denied, the Claims Administrator's notice of the adverse benefit determination (denial) will include:

- information sufficient to identify the claim involved;
- the specific reason(s) for the denial;
- a reference to the specific plan provision(s) on which the Claims Administrator's determination is based;
- a description of any additional material or information needed to perfect Your claim;
- an explanation of why the additional material or information is needed;
- a description of the Plan's review procedures and the time limits that apply to them, including a statement of Your right to bring a civil action under ERISA, if this Plan is subject to ERISA, within one year of the grievance or appeal decision if You submit a grievance or appeal and the claim denial is upheld;
- information about any internal rule, guideline, protocol, or other similar criterion relied upon in making the claim determination and about Your right to request a copy of it free of charge, along with a discussion of the claims denial decision;
- information about the scientific or clinical judgment for any determination based on Medical Necessity or experimental treatment, or about Your right to request this explanation free of charge, along with a discussion of the claims denial decision; and,

For claims involving urgent/concurrent care:

- the Claims Administrator's notice will also include a description of the applicable urgent/concurrent review process; and

- the Claims Administrator may notify You or Your authorized representative within 72 hours orally and then furnish a written notification.

B. Appeals

You have the right to appeal an adverse benefit determination (claim denial or rescission of coverage). You or Your authorized representative must file Your appeal within 180 calendar days after You are notified of the denial or rescission. You will have the opportunity to submit written comments, documents, records, and other information supporting Your claim. The Claims Administrator's review of Your claim will take into account all information You submit, regardless of whether it was submitted or considered in the initial benefit determination.

The Claims Administrator shall offer a single mandatory level of appeal and an additional voluntary second level of appeal which may be a panel review, independent review, or other process consistent with the entity reviewing the appeal. The time frame allowed for the Claims Administrator to complete its review is dependent upon the type of review involved (e.g., pre-service, concurrent, post-service, urgent, etc.).

For pre-service claims involving urgent/concurrent care, You may obtain an expedited appeal. You or Your authorized representative may request it orally or in writing. All necessary information, including the Claims Administrator's decision, can be sent between the Claims Administrator and You by telephone, facsimile or other similar method. To file an appeal for a claim involving urgent/concurrent care, You or Your authorized representative must contact the Claims Administrator at the number shown on Your Identification Card and provide at least the following information:

- the identity of the claimant;
- the date(s) of the medical service;
- the specific medical condition or symptom;
- the Provider's name;
- the service or supply for which approval of benefits was sought; and
- any reasons why the appeal should be processed on a more expedited basis.

All other requests for appeals should be submitted in writing by the Participant or the Participant's authorized representative, except where the acceptance of oral appeals is otherwise required by the nature of the appeal (e.g., Urgent Care). You or Your authorized representative must submit a request for review to:

Anthem Blue Cross and Blue Shield,
ATTN: Appeals
P.O. Box 105568
Atlanta, Georgia 30348

You must include Your Member Identification Number when submitting an appeal.

Upon request, the Claims Administrator will provide, without charge, reasonable access to, and copies of, all documents, records, and other information relevant to Your claim. "Relevant" means that the document, record, or other information:

- was relied on in making the benefit determination; or
- was submitted, considered, or produced in the course of making the benefit determination; or
- demonstrates compliance with processes and safeguards to ensure that claim determinations are made in accordance with the terms of the plan, applied consistently for similarly-situated claimants; or
- is a statement of the plan's policy or guidance about the treatment or benefit relative to Your diagnosis.

The Claims Administrator will also provide You, free of charge, with any new or additional evidence considered, relied upon, or generated in connection with Your claim. In addition, before You receive an adverse benefit determination or review based on a new or additional rationale, the Claims Administrator will provide You, free of charge, with the rationale.

For Out of State Appeals You have to file Provider appeals with the Host Plan. This means Providers must file appeals with the same plan to which the claim was filed.

C. How Your Appeal will be Decided

When the Claims Administrator considers Your appeal, the Claims Administrator will not rely upon the initial benefit determination or, for voluntary second-level appeals, to the earlier appeal determination. The review will be conducted by an appropriate reviewer who did not make the initial determination and who does not work for the person who made the initial determination. A voluntary second-level review will be conducted by an appropriate reviewer who did not make the initial determination or the first-level appeal determination and who does not work for the person who made the initial determination or first-level appeal determination.

If the denial was based in whole or in part on a medical judgment, including whether the treatment is experimental, investigational, or not Medically Necessary, the reviewer will consult with a health care professional who has the appropriate training and experience in the medical field involved in making the judgment. This health care professional will not be one who was consulted in making an earlier determination or who works for one who was consulted in making an earlier determination.

D. Notification of the Outcome of the Appeal

If You appeal a claim involving urgent/concurrent care, the Claims Administrator will notify You of the outcome of the appeal as soon as possible, but not later than 72 hours after receipt of Your request for appeal.
If You appeal any other pre-service claim, the Claims Administrator will notify You of the outcome of the appeal within 30 days after receipt of Your request for appeal.

If You appeal a post-service claim, the Claims Administrator will notify You of the outcome of the appeal within 60 days after receipt of Your request for appeal.

E. Appeal Denial

If Your appeal is denied, that denial will be considered an adverse benefit determination. The notification from the Claims Administrator will include all of the information set forth in the above section entitled "Notice of Adverse Benefit Determination."

If, after the Plan's denial, the Claims Administrator considers, relies on or generates any new or additional evidence in connection with Your claim, the Claims Administrator will provide You with that new or additional evidence, free of charge. The Claims Administrator will not base its appeal decision on a new or additional rationale without first providing You (free of charge) with, and a reasonable opportunity to respond to, any such new or additional rationale. If the Claims Administrator fails to follow the Appeal procedures outlined under this section, the Appeals process may be deemed exhausted. However, the Appeals process will not be deemed exhausted due to minor violations that do not cause, and are not likely to cause, prejudice or harm so long as the error was for good cause or due to matters beyond the Claims Administrator's control.
Voluntary Second Level Appeals

If You are dissatisfied with the Plan's mandatory first level appeal decision, a voluntary second level appeal may be available. If You would like to initiate a second level appeal, please write to the address listed above. Voluntary appeals must be submitted within 60 calendar days of the denial of the first level appeal.

F. Requirement To File An Appeal Before Filing A Lawsuit

No lawsuit or legal action of any kind related to a benefit decision may be filed by You in a court of law or in any other forum, unless it is commenced within one year of the Plan's final decision on the claim or other request for benefits. If the Plan decides an appeal is untimely, the Plan's latest decision on the merits of the underlying claim or benefit request is the final decision date. You must exhaust the Plan's internal appeals procedure but not including any voluntary level of appeal, before filing a lawsuit or taking other legal action of any kind against the Plan. If Your health benefit plan is sponsored by Your Employer and subject to the Employee Retirement Income Security Act of 1974 (ERISA) and Your appeal as described above results in an adverse benefit determination, You have a right to bring a civil action under Section 502(a) of ERISA within one year of appeal decision.

The Claims Administrator reserves the right to modify the policies, procedures and timeframes in this section upon further clarification from Department of Health and Human Services and Department of Labor.

VI. ASSIGNMENT OF BENEFITS

You or your dependent may only assign benefits under this Plan to a provider of services only. Assigned benefits shall be paid to the Assignee regardless of your intervening death. No claim

payment may be made to your creditors or any other person or entity except as provided specifically in this Plan. If you have a right or interest to Death, Accidental Death and Dismemberment or Weekly Disability payments provided under this Plan, then such right or interest shall not be assignable, pledged, alienated, transferred or otherwise encumbered.

A. COORDINATION OF BENEFITS (COB).

The Coordination of Benefits ("COB") provision applies when a person has health care coverage under more than one Plan. "Plan" is defined below.

The order of benefit determination rules govern the order in which each Plan will pay a claim for benefits. The Plan that pays first is called the Primary plan. The Primary plan must pay benefits in accordance with its policy terms without regard to the possibility that another Plan may cover some expenses. The Plan that pays after the Primary plan is the Secondary plan. The Secondary plan may reduce the benefits it pays so that payments from all Plans do not exceed 100% of the total Allowable expense.

1. Definitions:

   a. A "Plan" is any of the following that provides benefits or services for medical or dental care or treatment. If separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same plan and there is no COB among those separate contracts.

      i. **Plan** includes: group and nongroup insurance contracts, health insuring corporation ("HIC") contracts, closed panel plans or other forms of group or group-type coverage (whether insured or uninsured); medical care components of long-term care contracts, such as skilled nursing care; medical benefits under group or individual automobile contracts; and Medicare or any other federal governmental plan, as permitted by law.

      ii. **Plan** does not include: hospital indemnity coverage or other fixed indemnity coverage; accident only coverage; specified disease or specified accident coverage; supplemental coverage as described in Revised Code sections 3923.37 and 1751.56; school accident type coverage; benefits for non-medical components of long-term care policies; Medicare supplement policies; Medicaid policies; or coverage under other federal governmental plans, unless permitted by law.

Each contract for coverage under "i" or "ii" above is a separate Plan. If a Plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate Plan.

   b. "This plan" means, in a COB provision, the part of the contract providing the health care benefits to which the COB provision applies and which may be reduced because of the benefits of other plans. Any other part of

the contract providing health care benefits is separate from this plan. A contract may apply one COB provision to certain benefits, such as dental benefits, coordinating only with similar benefits, and may apply another COB provision to coordinate other benefits.

c. The order of benefit determination rules determines whether This Plan is a Primary plan or Secondary plan when the person has health care coverage under more than one plan. When This Plan is primary, it determines payment for its benefits first before those of any other Plan without considering any other Plan's benefits. When this Plan is secondary, it determines its benefits after those of another plan and may reduce the benefits it pays so that all Plan benefits do not exceed 100% of the total Allowable expense.

d. "Allowable expense" is a health care expense, including Deductibles, Coinsurance and Copayments, that is covered at least in part by any Plan covering the person. When a Plan provides benefits in the form of services, the reasonable cash value of each service will be considered an Allowable expense and a benefit paid. An expense that is not covered by any plan covering the person is not an Allowable expense. In addition, any expense that a Provider by law or in accordance with a contractual agreement is prohibited from charging a Covered Person is not an Allowable expense. The following are examples of expenses that are not Allowable expenses:

i. The difference between the cost of a semi-private Hospital room and a private Hospital room is not an Allowable expense, unless one of the Plans provides coverage for private Hospital room expenses.

ii. If a person is covered by 2 or more Plans that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for a specific benefit is not an Allowable expense.

iii. If a person is covered by 2 or more Plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an Allowable expense.

iv. If a person is covered by one Plan that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology and another Plan that provides its benefits or services on the basis of negotiated fees, the Primary plan's payment arrangement shall be the Allowable expense for all

Plans. However, if the Provider has contracted with the Secondary plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the Primary plan's payment arrangement and if the Provider's contract permits, the negotiated fee or payment shall be the Allowable expense used by the Secondary plan to determine its benefits.

v. The amount of any benefit reduction by the Primary plan because a Covered Person has failed to comply with the Plan provisions is not an Allowable expense. Examples of these types of plan provisions include second surgical opinions, precertification of admissions, and preferred provider arrangements.

e. "Closed panel plan" is a plan that provides health care benefits to covered persons primarily in the form of services through a panel of providers that have contracted with or are employed by the Plan, and that excludes coverage for services provided by other Providers, except in cases of Emergency or referral by a panel member.

f. "Custodial parent" is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than one half of the calendar year excluding any temporary visitation.

2. Order of Benefit Determination Rules: When a person is covered by two or more Plans, the rules for determining the order of benefit payments are as follows:

a. The Primary plan pays or provides its benefits according to its terms of coverage and without regard to the benefits under any other Plan.

b. Except as provided in subparagraph "i" below, a plan that does not contain a coordination of benefits provision that is consistent with this Plan is always primary unless the provisions of both Plans state that the complying plan is primary.

i. Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage shall be excess to any other parts of the Plan provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base plan Hospital and surgical benefits, and insurance type coverages that are written in connection with a Closed panel plan to provide out-of-network benefits.

c. A plan may consider the benefits paid or provided by another plan in calculating the payment of its benefits only when it is secondary to that other plan.

d. Each Plan determines its order of benefits using the first of the following rules that apply:

i. **Non-Dependent or Dependent**. The plan that covers the person other than as a dependent, for example as an employee, member, policyholder, subscriber or retiree, is the Primary plan and the plan that covers the person as a dependent is the secondary plan. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the Plan covering the person as a dependent, and primary to the plan covering the person as other than a dependent (e.g. a retired employee), then the order of benefits between the two Plans is reversed so that the Plan covering the person as an employee, member, policyholder, subscriber or retiree is the Secondary plan and the other Plan is the Primary plan.

ii. **Dependent child covered under more than one plan**. Unless there is a court decree stating otherwise, when a dependent child is covered by more than one plan, the order of benefits is determined as follows:

A. For a dependent child whose parents are married or living together, whether or not they have ever been married, the plan of the parent whose birthday falls earlier in the calendar year is the Primary plan; or, if both parents have the same birthday, the plan that has covered the parent the longest is the Primary plan. However, if one spouse's plan has some other coordination rule (for example, a "gender rule" which says the father's plan is always primary), we will follow the rules of that plan.

B. For a dependent child whose parents are divorced or separated or not living together, whether or not they have ever been married:

I. If a court decree states that one of the parents is responsible for the dependent child's health care expenses or health care coverage and the plan of that parent has actual knowledge of those terms, that plan is primary. This rule applies to plan years commencing after the Plan is given notice of the court decree;

II. If a court decree states that both parents are responsible for the dependent child's health care expenses or heath care coverage, the provisions of

Subparagraph (A) above shall determine the order of benefits;

III. If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of Subparagraph (A) above shall determine the order of benefits; or

IV. If there is no court decree allocating responsibility for the dependent child's health care expenses or health care coverage, the order of benefits for the child are as follows: (1) the plan covering the Custodial parent; (2) the plan covering the spouse of the Custodial parent; (3) The plan covering the non-custodial parent; and then (4) the plan covering the spouse of the non-custodial parent.

C. For a dependent child covered under more than one plan of individuals who are not the parents of the child, the provisions of Subparagraph (A) or (B) above shall determine the order of benefits as if those individuals were the parents of the child.

iii. **Active employee or retired or laid-off employee**. The plan that covers a person as an active employee, that is, an employee who is nether laid off nor retired, is the Primary plan. The plan covering that same person as a retired or laid-off employee is the Secondary plan. The same would hold true if a person is a dependent of an active employee and that same person is a dependent of a retired or laid-off employee. If the other plan does not have this rule, and as a result, the plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule set forth above in Subsection (i) "Non-Dependent or Dependent" can determine the order of benefits.

iv. **COBRA or state continuation coverage**. If a person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another plan, the plan covering the person as an employee, member, subscriber or retiree or covering the person as a dependent of an employee, member, subscriber or retiree is the Primary plan and the COBRA or state or other federal continuation coverage is the Secondary plan. If the other plan does not have this rule, and as a result, the plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule

set forth above in Subsection (i) "Non-Dependent or Dependent" can determine the order of benefits.

v. **Longer or shorter length of coverage**. The plan that covered the person as an employee, member, policyholder, subscriber or retiree longer is the Primary plan and the plan that covered the person for the shorter period of time is the Secondary plan.

vi. **Medicare**. When Medicare is involved, Medicare is considered to be the primary payer when allowed by law.

vii. **Automobile Insurance**. When automobile insurance is involved, it is the primary payer when allowed by law. If this Plan pays, a Subrogation Agreement must be signed by the Participant or their eligibility for benefits under the Plan will be suspended.

viii. If the preceding rules do not determine the order of benefits, the Allowable expenses shall be shared equally between the plans meeting the definition of Plan. In addition, This Plan will not pay more than it would have paid had it been the Primary plan.

3. Effect On The Benefits Of This Plan: When This Plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all plans during a Plan Year are not more than the total Allowable expenses. In determining the amount to be paid for any claim, the Secondary plan will calculate the benefits it would have paid in the absence of other health care coverage and apply that calculated amount to any Allowable expense under its plan that is unpaid by the Primary plan. The Secondary plan may then reduce its payment by the amount so that, when combined with the amount paid by the Primary plan, the total benefits paid or provided by all Plans for the claim do not exceed the total Allowable expense for that claim. In addition, the Secondary plan shall credit to its plan Deductible any amounts it would have credited to its Deductible in the absence of other health care coverage.

   If a Covered Person is enrolled in two or more Closed panel plans and if, for any reason, including the provision of service by a non-panel Provider, benefits are not payable by one Closed panel plan, COB shall not apply between that plan and other Closed panel plans.

4. Right To Receive And Release Needed Information. Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under This Plan and other plans. The PPO Provider or this Plan may get the facts it needs from or give them to other organizations or persons for the purpose of applying these rules and determining benefits payable under This plan and other Plans covering the person claiming benefits. The PPO Provider or 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 or the PPO Provider any facts it needs to apply those rules and determine benefits payable.

5. Facility of Payment: A payment made under another Plan may include an amount that should have been paid under This plan. If it does, the PPO Provider or this Plan may pay that amount to the organization that made the payment. That amount will then be treated as though it were a benefit paid under this plan. The Plan will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means the reasonable cash value of the benefits provided in the form of services.

6. Right of Recovery: If the amount of the payments made by this plan is more than it should have paid under this COB provision, this plan may recover the excess from one or more of the persons it has paid or for whom it has paid, or any other person or organization that may be responsible for the benefits or services provided for the Covered Person. The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

7. Coordination Disputes: If you believe that we have not paid a claim properly, you should attempt to resolve the problem by contacting the Plan's Administrative Manager or Claims Manager listed on the front of your Explanation of Benefits (EOB) form and/or identification card.

VII. SUBROGATION.

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

1. Definitions

a. "Constructive Trust" shall mean a trust in which any amount, compensation and/or money You recover shall be deemed to be held for Your exclusive benefit and not comingled with other funds. Any such Constructive Trust shall be subject to an equitable lien by the Plan and any other equitable remedies available to the Plan under ERISA §502(a)(3) for the purpose of preserving the Plan's right to restitution for benefits paid by the Plan on Your behalf.

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

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

d. "Subrogation" shall mean the Plan's right to recover any benefit payment:

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

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

e. "Third party" shall mean another person, entity or organization.

f. "You" or "Your" shall mean the following: You, Your Dependents and/or You or Your Dependent's heirs, estate, parents, representative, guardian, trustee, or assigns. Therefore, all references herein to "You" or "Your" shall also include Your Dependents and/or You or Your Dependents heirs, estate, parents, representative, guardian, trustee, and assigns.

2. Subrogation, Restitution and Reimbursement Rights

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

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

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

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

iv. Any worker's compensation award or settlement;

v. Any recovery made pursuant to no-fault insurance;

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

b. The Plan has a first priority lien on any recovery. You and Your attorney are deemed to hold any recovery in Constructive Trust on behalf of the Plan. The Plan is entitled to repayment in full, without reduction for attorney's fees and costs, and regardless of whether You are made whole

or fully compensated. The make-whole doctrine and/or the common fund doctrine shall not apply to any recovery that You receive. The Plan will not pay future claims to the extent of any recovery You received in the past in connection with an accident, unless the Plan's claim for subrogation, restitution or reimbursement has been satisfied.

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

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

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

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

g. You and/or Your attorney will be required to sign the Plan's subrogation, restitution and reimbursement agreement. If You or Your attorney fail to sign the Plan's subrogation, restitution and reimbursement agreement within thirty days following a request by the Plan to do so, the Plan will suspend You and Your Dependents' coverage until the Plan receives a signed subrogation, restitution and reimbursement agreement. This Plan's

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

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

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

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

k. You may not assign any right, claim or cause of action against a Responsible Third Party to recover for any illness, disease, injury or condition on account of which benefits were paid by the Plan.

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

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

VIII. QUALIFIED MEDICAL CHILD SUPPORT ORDERS

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

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

A. Provides for child support with respect to your child under a group health plan or provides for health benefit coverage to your child; and

B. Is made pursuant to a State domestic relations law.

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

IX. FAMILY AND MEDICAL LEAVE

This Plan will provide benefits in accordance with the applicable requirements of the Family and Medical Leave Act of 1993 ("FMLA"). To be eligible for leave under FMLA, you must work for the same contributing Employer for at least twelve (12) months and for at least 1,250 hours during the twelve (12) month period before the leave begins. Generally, your Employer is obligated to provide family and medical leave only if it employs fifty (50) or more employees each working day during each of twenty (20) or more work weeks during the current or preceding calendar year. In order to prevent a loss of eligibility to you, you and/or the Employer granting your FMLA leave must comply with the following requirements:

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

2. Obtain and submit to the Fund Office a certificate of your eligibility for FMLA leave; and

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

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

1. for the birth or placement of a child for adoption or foster care;

2. to care for an immediate family member (spouse, child or parent) with a serious health condition;

3. to take medical leave when the Employee is unable to work because of a serious health condition; or

4. for any qualifying exigency as determined by the Secretary of Labor arising out of the fact that your spouse, son, daughter or parent is on active duty

Moreover, an Employer must grant an eligible Employee up to a total of twenty-six (26) work weeks of unpaid leave during any 12-month period if you are caring for your spouse, son, daughter, parent, or next of kin who is a member of the Armed Forces that is undergoing medical treatment, recuperation, or therapy, or is otherwise on the temporary disability retired list, for a serious injury or illness. A serious injury or illness is one that may render a member of the Armed Forces medically unfit to perform the duties of the member's office, grade, rank or rating.

The Employer granting your FMLA leave is required to pay the cost of your coverage during your FMLA leave in an amount equal to contributions for 32.5 hours of work per week for each week you are on FMLA leave. The Employer must remit payment monthly, in arrears, upon billing by the Fund Office.

Your eligibility will not be extended during your FMLA leave if the Employer granting your FMLA leave does not make the required contributions to the Fund. The usual procedures of the Fund will be followed if the Employer does not make timely contributions, including but not limited to, initiating collection procedures and a loss of your eligibility will result.

In addition, if you advised the Employer granting your FMLA leave that you do not intend to return to work, then the Employer must notify the Fund Office of the date you advised the Employer that you do not intend to return to work.

X. MISCELLANEOUS PROVISIONS

A. CHANGE OF PLAN PROVISIONS

The Board of Trustees, in their sole discretion, are empowered to change or amend any Plan provision, including but not limited to, the Eligibility Rules or Schedule of Benefits at any time by amendment or resolution duly executed. You have no vested right to any of the benefits set forth herein.

B. CHANGE IN TERMS

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

C. AMENDMENTS

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

D. CONSTRUCTION BY TRUSTEES

The Board of Trustees has complete authority and sole discretion to determine eligibility for benefits and to construe and interpret the provisions of the Plan and Trust Agreement such that any determination of benefits eligibility or construction of plan terms shall not be reversed by a court of competent jurisdiction unless such determination or construction is determined to be both arbitrary and capricious. This means that if you challenge a decision of the Board of Trustees in court, the judge will be required to defer to the Trustees' determinations. No Employer, Union or representative of any Employer or Union is authorized to interpret the provisions of either the Plan or Trust Agreement. Any interpretation of the Plan or Trust Agreement made by the Trustees shall, subject to the Claimant's right to legal action, be final and binding on all parties. No provision of this Plan shall be construed to conflict with any Treasury Department, Department of Labor or Internal Revenue Service regulation, ruling, release or proposed regulation or other which affects or could affect the terms of this Plan, and this Plan shall be deemed to be amended to such extent necessary to resolve any such conflict.

E. LEGAL ACTIONS

No action, at law or in equity, shall be brought against Medical Mutual or the Plan to recover benefits within 60 days after Medical Mutual receives written proof in accordance with this Benefit Book that Covered Services have been given to you. No such action may be brought later than three years after expiration of the required claim filing limit as specified in the Proof of Loss Section.

F. RIGHT TO RECEIVE AND RELEASE NECESSARY INFORMATION

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

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

G. RIGHT OF RECOVERY

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

H. NONDISCRIMINATION RIGHTS

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

I. PAYMENT OF BENEFITS

All benefits under the Plan shall be payable through Employees or agents of the Trustees acting under their authority. Benefits as authorized under the Plan will be paid as long as the Fund can

operate on a sound financial basis. Anything in the Plan to the contrary notwithstanding, no benefits shall be payable except those which can be provided under the Plan, and no person shall have any claim for benefits against the Union, the Association, any Employer, or the Trustees. The Trustees, the Employers and the Union shall not be held liable for any benefits or contracts, except as provided in the Agreement between the Employers and the Union.

J. SEVERABILITY

In the event that any provision of this Plan Document/Summary Plan Description is determined to be illegal or invalid, such illegality or invalidity shall not affect the remaining provisions of this Plan Document/Summary Plan Description as presently written or subsequently amended.

K. GOVERNING LAW

This Plan shall be construed, enforced and administered and the validity determined in accordance with the Employee Retirement Income Security Act of 1974 (ERISA), as amended, the Internal Revenue Code of 1986, and (to the extent not preempted by federal law) the law of the State of Ohio.

XI. USERRA

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

A. CONTINUATION OF COVERAGE DUE TO MILITARY LEAVE

If your coverage would otherwise terminate due to a call to active duty from reserve status, you are entitled to continue coverage for yourself and your Eligible Dependents. Your group shall notify you of your right to continue coverage at the time you notify the group of your call to active duty. You must file a written election of continuation with the group and pay the first contribution for continued coverage no later than 31 days after the date on which your coverage would otherwise terminate. Continuation coverage will end on the earliest of the following dates:

- the date you return to reserve status from active military duty;
- 24 months from the date continuation began (or 36 months if any of the following occurs during this 24-month period: death of the reservist; divorce or separation of a reservist from the reservist's spouse or a child ceasing to be an Eligible Dependent);
- the date coverage terminates under the Benefit Book for failure to make timely payment of a required contribution;
- the date the entire Benefit Book ends; or
- the date the coverage would otherwise terminate under the Benefit Book.

B. REINSTATEMENT OF COVERAGE FOLLOWING MILITARY LEAVE

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

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

1. You have given advance written or verbal notice of the military leave to the Company (advance notice to the Company is not required in situations of military necessity or if giving notice is otherwise impossible or unreasonable under the circumstances);

2. The cumulative length of the leave and all previous absences from employment do not exceed five (5) years;

3. Reemployment follows a release from military service under honorable conditions; and

4. You report to, or submit an application to the Company as follows:

    a. On the first business day following completion of military service for a leave of thirty (30) days or less; or

    b. Within fourteen (14) days of completion of military service for a leave of thirty-one (31) days to one hundred-eighty (180) days; or

    c. Within ninety (90) days of completion of military service for a leave of more than one hundred-eighty days.

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

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

If the requirements for reemployment are satisfied, coverage will continue as though employment had not been interrupted by a military leave, even if you decline continued coverage during the leave. No new waiting periods or preexisting conditions limitation would apply to You or Your Dependents.

XII. HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT

The Plan is required to protect the confidentiality of your private health information under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and the rules issued by the U.S. Department of Health and Human Services.

A. DEFINITION OF PROTECTED HEALTH INFORMATION.

The Board of Trustees of the Plan sponsors the Plan and is the Plan's designated Plan Sponsor. The Plan's administrative staff may have access to the individually identifiable health

information of Plan participants required for the Plan's administrative functions. When this health information is provided by the Plan to the Plan Sponsor, Business Associates, subcontractors, and other service providers to the Plan, such information is Protected Health Information ("PHI").

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

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

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

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

    a. physical or mental health condition of a Covered Person;

    b. provision of health care to a Covered Person;

    c. payment for the provision of health care to a Covered Person;

    d. identification of the Covered Person; or

    e. belief that the information can be used to identify the Covered Person.

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

    a. by electronic media;

    b. in electronic media; or

    c. in any other written or oral form or medium.

3. PHI excludes individually identifiable health information contained in:

    a. education records covered by the Family Educational Rights and Privacy Act, as amended;

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

c. employment records held by a covered entity in its role as Employer; and

d. records of a Covered Person who has been deceased for more than 50 years.

B. PERMITTED USES OF PROTECTED HEALTH INFORMATION.

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

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

2. coordination of benefits;

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

4. subrogation of health benefit claims;

5. establishing employee contributions;

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

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

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

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

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

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

12. reimbursements to the Plan.

For purposes of determining uses or disclosures of PHI relating to health care operations, the term "health care operations" includes, but is not limited to, the following activities:

1. quality assessment;

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

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

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

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

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

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

    a. management activities relating to implementation of and compliance with the requirements of HIPAA administrative simplification;

    b. participant and provider service, including the provision of data analysis;

    c. resolution of internal grievances; and

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

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

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

C. PERMITTED USES AND DISCLOSURE OF SUMMARY HEALTH INFORMATION.

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

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

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

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

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

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

D. ACTIVITIES THAT REQUIRE PERMISSION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION.

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

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

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

3. the sale of PHI for any reason; or

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

Covered Persons who wish to provide written permission/authorization to the Plan to use or disclose PHI for such activities may obtain permission/authorization forms from the Fund Office.

In addition, Covered Persons may revoke such express written permission/authorization at any time by contacting the Fund Office and executing an updated form.

E. USE OF GENETIC PROTECTED HEALTH INFORMATION PROHIBITED.

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

F. DISCLOSURE RESTRICTIONS ON PROTECTED HEALTH INFORMATION FOR HEALTH CARE EXPENSES PAID IN FULL BY COVERED PERSONS.

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

G. OPTING OUT OF FUNDRAISING ACTIVITIES INVOLVING PROTECTED HEALTH INFORMATION.

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

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

H. PROTECTED HEALTH INFORMATION BREACHES REQUIRED TO BE DISCLOSED UNDER HIPAA REGULATIONS.

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

I. COVERED PERSON'S RIGHT TO RECEIVE PROTECTED HEALTH INFORMATION FROM THE PLAN SPONSOR.

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

J. CONDITIONS OF DISCLOSURE FOR PLAN ADMINISTRATION PURPOSES.

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

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

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

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

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

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

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

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

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

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

10. if feasible, return or destroy all PHI received from the Plan that the Board of Trustees still maintains in any form and retain no copies of such information when no longer needed for the purpose for which permissible disclosure was

made. If return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction infeasible; and

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

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

K. BUSINESS ASSOCIATE AGREEMENTS.

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

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

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

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

1. legal services;
2. actuarial services;
3. accounting services;
4. consulting services;

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

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

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

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

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

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

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

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

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

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

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

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

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

L. PERSONS ENTITLED TO ACCESS TO PROTECTED HEALTH INFORMATION.

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

1. the Plan's Administrative Manager;

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

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

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

M. ADEQUATE SEPARATION BETWEEN PLAN AND PLAN SPONSOR.

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

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

N. CERTIFICATION OF PLAN SPONSOR.

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

The Plan and the Plan Sponsor will comply with the security regulations issued pursuant to HIPAA, 45 C.F.R. Parts 160, 162 and 164 (the "Security Regulations"). The following provisions apply to electronic Protected Health Information ("ePHI") that is created, received, maintained or transmitted by the Plan Sponsor on behalf of the Plan, except for ePHI (a) that it receives pursuant to an appropriate authorization (as described in 45 C.F.R. section 164.504(f)(1)(ii) or (iii)), or (b) that qualifies as Summary Health Information and that it receives for the purpose of either (i) obtaining premium bids for providing health insurance coverage under the Plan, or (ii) modifying, amending or terminating the Plan (as authorized under 45 C.F.R. section 164.508). If other terms of the Plan conflict with the following provisions, the following provisions shall control. The Security Regulations are incorporated in this Summary by reference. Unless defined otherwise in the Plan, all capitalized terms herein have the definition given to them by the Security Regulations.

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

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

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

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

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

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

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

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

indecipherable to unauthorized individuals through the use of technology or methodology specified in guidance issued by HHS.

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

XIII. DEFINITIONS

A. ACCIDENTAL INJURY

"Accidental Injury" means bodily Injury sustained by a Participant as the result of an unforeseen event and which is the direct cause (independent of disease, bodily infirmity or any other cause) for care which the Participant receives. Such care must occur while this Plan is in force. It does not include injuries for which benefits are provided under any Workers' Compensation, Employer's liability or similar law.

B. AGREEMENT AND DECLARATION OF TRUST OR TRUST AGREEMENT

"Agreement and Declaration of Trust" or "Trust Agreement" means the Agreement and Declaration of Trust which has been entered into by and between the Union and the Association and those Employers who, by virtue of Collective Bargaining Agreements with the Union, have agreed to participate in and contribute to this Trust Fund and who became parties thereto and that document, as may from time to time be amended.

C. ALLOWED AMOUNT

"Allowed Amount" means the following: For PPO Network and Contracting Providers, the Allowed Amount is the lesser of the Negotiated Amount or Covered Charge. For Non-Contracting Providers, the Allowed Amount is the Non-Contracting Amount, which will likely be less than the Provider's Billed Charges.

D. AMBULANCE SERVICES

A state-licensed emergency vehicle which carries injured or sick persons to a Hospital. Services which offer non-emergency, convalescent or invalid care do not meet this definition.

E. ASSOCIATION

"Association" means the Northern Ohio Painting and Taping Contractors Association, Inc. and/or Employers who negotiate with the Union to participate in the Trust Fund on behalf of themselves, other individual Employers whom they negotiate on behalf of and/or Employers who make contributions into the Trust Fund pursuant to a collective bargaining agreement or written participation agreement with the Board of Trustees and any successors thereof.

F. AUTHORIZED SERVICE(S)

"Authorized Service(s)" means a Covered Service rendered by any Provider other than a Network Provider, which has been authorized in advance (except for Emergency Care which may be authorized after the service is rendered) by the Claims Administrator to be paid at the Network level. The Participant may be responsible for the difference between the Out-of-Network Provider's charge and the Maximum Allowed Amount, in addition to any applicable Network Coinsurance, Copayment or Deductible.

G. BEHAVIORAL HEALTH CARE

"Behavioral Health Care" includes services for Mental Health and Substance Abuse. Mental Health and Substance Abuse is a condition that is listed in the current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) as a mental health or substance abuse condition.

H. BENEFIT PERIOD

"Benefit Period" means one year, January 1 – December 31 (also called year or the calendar year). It does not begin before a Participant's Effective Date. It does not continue after a Participant's coverage ends.

I. CENTERS OF EXCELLENCE (COE) NETWORK

"Centers of Excellence (COE) Network" means a network of health care facilities selected for specific services based on criteria such as experience, outcomes, efficiency, and effectiveness. For example, an organ transplant managed care program wherein Participants access select types of benefits through a specific network of medical centers. A network of health care professionals contracted with the Claims Administrator or one or more of its affiliates, to provide transplant or other designated specialty services.

J. CLAIMANT

"Claimant" means the person making the claim.

K. CLAIMS ADMINISTRATOR

"Claims Administrator" means the company the Plan Sponsor chose to administer its health benefits. The Claims Administrator provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims.

L. COINSURANCE

"Coinsurance" means, if a Participant's coverage is limited to a certain percentage, for example 80%, then the remaining 20% for which the Participant is responsible is the Coinsurance amount. The Coinsurance may be capped by the Out-of-Pocket Maximum.

M. COLLECTIVE BARGAINING AGREEMENT

"Collective Bargaining Agreement" means any Collective Bargaining Agreement existing between an Employer and the Union which provides for contributions into the Trust Fund as well as any extension or extensions, renewal or renewals of any such Collective Bargaining Agreement or any Collective Bargaining Agreement which provides for contributions into this Trust Fund.

N. COMBINED LIMIT

"Combined Limit" means the maximum total of Network and Out-of-Network benefits available for designated health services in the Schedule of Benefits.

O. COMPLICATIONS OF PREGNANCY

"Complications of Pregnancy" means complications that result from conditions requiring Hospital confinement when the pregnancy is not terminated. The diagnoses of the complications are distinct from pregnancy but adversely affected or caused by pregnancy.

Such conditions include acute nephritis, nephrosis, cardiac decompensation, missed or threatened abortion, preeclampsia, intrauterine fetal growth retardation and similar medical and surgical conditions of comparable severity. An ectopic pregnancy which is terminated is also considered a Complication of Pregnancy.

Complications of Pregnancy shall not include false labor, caesarean section, occasional spotting, Physician-prescribed rest during the period of pregnancy, morning sickness, hyperemesis gravidarum and similar conditions associated with the management of a difficult pregnancy which are not diagnosed distinctly as Complications of Pregnancy.

P. CONGENITAL ANOMALY

"Congenital Anomaly" means a condition or conditions that are present at birth regardless of causation. Such conditions may be hereditary or due to some influence during gestation.

Q. COORDINATION OF BENEFITS

"Coordination of Benefits" means a provision that is intended to avoid claims payment delays and duplication of benefits when a person is covered by two or more plans providing benefits or services for medical, dental or other care or treatment. It avoids claims payment delays by establishing an order in which plans pay their claims and providing an authority for the orderly transfer of information needed to pay claims promptly. It may avoid duplication of benefits by permitting a reduction of the benefits of a plan when, by the rules established by this provision, it does not have to pay its benefits first.

R. COPAYMENT

"Copayment" means a cost-sharing arrangement in which a Participant pays a specified charge for a Covered Service, such as the Copayment indicated in the Schedule of Benefits for an office visit. The Participant is usually responsible for payment of the Copayment at the time the health care is rendered. Copayments are distinguished from Coinsurance as flat dollar amounts rather than percentages of the charges for services rendered and are typically collected by the Provider when services are rendered. Your Copayment will be the lesser of the amount shown in the Schedule of Benefits or the Maximum Allowed Amount.

S. COSMETIC SURGERY

"Cosmetic Surgery" means any non-Medically Necessary surgery or procedure, the primary purpose of which is to improve or change the appearance of any portion of the body, but which does not restore bodily function, correct a disease state, physical appearance or disfigurement caused by an accident, birth defect, or correct or naturally improve a physiological function. Cosmetic Surgery includes but is not limited to: rhinoplasty, lipectomy, surgery for sagging or extra skin, any augmentation or reduction procedures (e.g., mammoplasty, liposuction, keloids, rhinoplasty and associated surgery) or treatment relating to the consequences or as a result of Cosmetic Surgery.

T. COVERAGE

"Coverage" means the benefits payable under this Plan as a consequence of Injury or Illness, which are allowed under this Plan.

U. COVERED DEPENDENT

"Covered Dependent" means any Dependent in a Participant's family who meets all the requirements of the Eligibility section of this SPD and has enrolled in the Plan.

V. COVERED SERVICES

"Covered Services" means Medically Necessary health care services and supplies that are: (a) defined as Covered Services in the Plan, (b) not excluded under such Plan, (c) not Experimental/Investigative and (d) provided in accordance with such Plan.

W. COVERED TRANSPLANT PROCEDURE

"Covered Transplant Procedure" means any Medically Necessary human organ and stem cell/bone marrow transplants and transfusions as determined by the Claims Administrator including necessary acquisition procedures, collection and storage, and including Medically Necessary prepa**r**atory myeloablative therapy.

X. CUSTODIAL CARE

"Custodial Care" means any type of care, including room and board, that (a) does not require the skills of professional or technical personnel; (b) is not furnished by or under the supervision of such personnel or does not otherwise meet the requirements of post-Hospital Skilled Nursing Facility care; (c) is a level such that the Participant has reached the maximum level of physical or mental function and is not likely to make further significant improvement. Custodial Care includes, but is not limited to, any type of care the primary purpose of which is to attend to the Participant's activities of daily living which do not entail or require the continuing attention of trained medical or paramedical personnel. Examples of Custodial Care include, but are not limited to, assistance in walking, getting in and out of bed, bathing, dressing, feeding, using the toilet, changes of dressings of non-infected, post-operative or chronic conditions, preparation of special diets, supervision of medication that can be self-administered by the Participant, general maintenance care of colostomy or ileostomy, routine services to maintain other services which, in the sole determination of the Plan, can be safely and adequately self-administered or performed by the average non-medical person without the direct supervision of trained medical and paramedical personnel, regardless of who actually provides the service, residential care and adult day care, protective and supportive care including educational services, rest care and convalescent care.

Y. DEDUCTIBLE

"Deductible" means the portion of the bill You must pay before Your medical expenses become Covered Services. It is applied on a calendar year basis.

Z. DENTIST

"Dentist" means a Doctor of Dental Surgery (D.D.S.), Doctor of Dental Medicine (D.M.D.), or other letters or titles in connection with dentistry practicing within the scope of his or her license.

AA. DEPENDENT

"Dependent" means the Spouse and all children until attaining age limit stated in the Eligibility section. Children include natural children, legally adopted children, foster children that live with the Employee and for whom the Employee is the primary source of financial support, and stepchildren. Also included are Your children (or children of Your Spouse) for whom You have legal responsibility resulting from a valid court decree. Mentally, intellectually or physically disabled children remain covered no matter what age. You must give the Claims Administrator evidence of Your child's incapacity within 31 days of attainment of age 26. The certification form may be obtained from the Claims Administrator or Your Employer. This proof of incapacity may be required annually by the Plan. Such children are not eligible under this Plan if they are already 26 or older at the time coverage is effective.

BB. DESIGNATED PHARMACY PROVIDER

"Designated Pharmacy Provider" means a Network Pharmacy that has executed a Designated Pharmacy Provider Agreement with the Claims Administrator or a Network Provider that is designated to provide Prescription Drugs, including Specialty Drugs, to treat certain conditions.

CC. DETOXIFICATION

"Detoxification" means the process whereby an alcohol or drug intoxicated or alcohol or drug dependent person is assisted, in a facility licensed by the appropriate regulatory authority, through the period of time necessary to eliminate, by metabolic or other means, the intoxicating alcohol or drug, alcohol or drug dependent factors or alcohol in combination with drugs as determined by a licensed Physician, while keeping the physiological risk to the patient to a minimum.

DD. DEVELOPMENTAL DELAY

"Developmental Delay" means the statistical variation, as defined by standardized, validated developmental screening tests, such as the Denver Developmental Screening Test, in reaching age appropriate verbal/growth/motor skill developmental milestones when there is no apparent medical or psychological problem. It alone does not constitute an illness or an Injury.

EE. DURABLE MEDICAL EQUIPMENT

"Durable Medical Equipment" means equipment which is (a) made to withstand prolonged use; (b) made for and mainly used in the treatment of a disease or Injury; (c) suited for use while not confined as an Inpatient at a Hospital; (d) not normally of use to persons who do not have a disease or Injury; (e) not for exercise or training.

FF. EFFECTIVE DATE

"Effective Date" means the date for which the Plan approves an individual for coverage.

GG. ELECTIVE SURGICAL PROCEDURE

"Elective Surgical Procedure" means a surgical procedure that is not considered to be an emergency and may be delayed by the Participant to a later point in time.

HH. EMPLOYEE

"Employee" means and includes

1. A member of a Collective Bargaining Unit represented by the Union who is eligible to participate in and receive the benefits of the Health Welfare Plan and Trust in accordance with the Agreement and Declaration of Trust; and

2. A Full-time, regular Employee of the Union, the Trustees, the Fund Office, and/or the Joint Apprenticeship Training Committee, subject to the review and approval of, and any conditions regarding contributions and participation imposed on the Trustees; and

3. A Full-time, nonseasonal, Employee of an Employer who is not a member of a Union Collective Bargaining Unit represented by the Union including, but not limited to, an officer, owner, partner, shareholder, manager, clerical worker, estimator, supervisor and any other full-time employee (hereinafter collectively referred to as "Non-bargaining Unit Employees"), but only if: (i) equal contributions are made for all Employees, (ii) all Employees receive benefits, (iii) all full-time Employees are covered under the Plan established hereunder, and (iv) subject to the review and approval of, and any other conditions regarding contributions and participation imposed by the Trustees. The Employer shall contribute to the Fund for all of its full-time, nonseasonal, Employees subject to the non-discrimination requirements of applicable provisions of the Internal Revenue Code and the Regulations thereunder. At no time may such Non-bargaining Unit Employees exceed ten percent (10%) of the Participants covered by and receiving benefits under the Plan.

4. An individual formerly employed by an Employer as a member of the Collective Bargaining Unit represented by the Union for purposes of allowing Self-Contribution direct payments to the Fund in accordance with the Rules and Regulations adopted by the Trustees and as set forth herein.

II. EMPLOYER

"Employer" means:

1. Any individual, firm, association, partnership or corporation who is a member of the Association and/or is represented in collective bargaining by the Association and who is bound by the Collective Bargaining Agreement with said Union, and in accordance therewith, participates in and contributes to the Trust Fund herein created and provided for.

2. Any individual, firm, association, partnership or corporation who is not a member of nor represented in collective bargaining by the Association, but who has duly executed and/or is bound by the Collective Bargaining Agreement with said Union or signs a participation agreement with the Trust Fund and in accordance therewith agrees to participate in and contribute to the Trust Fund herein created and provided for.

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

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

JJ. EMPLOYER CONTRIBUTIONS

"Employer Contributions" means payments made to the Trust Fund by an Employer.

KK. EXPERIMENTAL/INVESTIGATIONAL

"Experimental/Investigational" means any Drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply used in or directly related to the diagnosis, evaluation, or treatment of a disease, Injury, illness, or other health condition which the Claims Administrator determines to be unproven.

The Claims Administrator will deem any Drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply to be Experimental/Investigative if the Claims Administrator, determines that one or more of the following criteria apply when the service is rendered with respect to the use for which benefits are sought. The Drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply:

- cannot be legally marketed in the United States without the final approval of the Food and Drug Administration (FDA), or other licensing or regulatory agency, and such final approval has not been granted;
- has been determined by the FDA to be contraindicated for the specific use; or
- is subject to review and approval of an Institutional Review Board (IRB) or other body serving a similar function; or
- is provided pursuant to informed consent documents that describe the Drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply as Experimental/Investigative, or otherwise indicate that the safety, toxicity, or efficacy of the Drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply is under evaluation.

Any service not deemed Experimental/Investigative based on the criteria above may still be deemed Experimental/Investigative by the Claims Administrator. In determining whether a service is Experimental/Investigative, the Claims Administrator will consider the information described below and assess whether:

- the scientific evidence is conclusory concerning the effect of the service on health outcomes;
- the evidence demonstrates the service improves net health outcomes of the total population for whom the service might be proposed by producing beneficial effects that outweigh any harmful effects;

- the evidence demonstrates the service has been shown to be as beneficial for the total population for whom the service might be proposed as any established alternatives; and
- the evidence demonstrates the service has been shown to improve the net health outcomes of the total population for whom the service might be proposed under the usual conditions of medical practice outside clinical investigatory settings.

The information considered or evaluated by the Claims Administrator to determine whether a Drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply is Experimental/Investigative under the above criteria may include one or more items from the following list which is not all inclusive:

- published authoritative, peer-reviewed medical or scientific literature, or the absence thereof; or
- evaluations of national medical associations, consensus panels, and other technology evaluation bodies; or
- documents issued by and/or filed with the FDA or other Federal, state or local agency with the authority to approve, regulate, or investigate the use of the Drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply; or
- documents of an IRB or other similar body performing substantially the same function; or
- consent document(s) and/or the written protocol(s) used by the treating Physicians, other medical professionals, or facilities or by other treating Physicians, other medical professionals or facilities studying substantially the same Drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply; or
- medical records; or
- the opinions of consulting Providers and other experts in the field.

The Claims Administrator has the sole authority and discretion to identify and weigh all information and determine all questions pertaining to whether a Drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply is Experimental/Investigative.

LL. FAMILY/FAMILY MEMBER

"Family" or "Family Member" means the Eligible Employee and all of his or her Eligible Dependents, provided however; that if both the husband and the wife are Eligible Employees under the Plan, their eligible children shall be considered Eligible Dependents of either parent, but not both. However, benefits shall be coordinated so that 100% of the Expenses Incurred or Charges shall be compensated. A dependent legal spouse who is also an Eligible Employee shall only receive benefits as an Eligible Employee and benefits will be coordinated so that 100% of the Expenses Incurred or Charges shall be compensated.

MM. FORMULARY

A document setting forth certain rules relating to the coverage of pharmaceuticals, that may include but not be limited to (1) a listing of preferred Prescription medications that are covered and/or prioritized in order of preference by the Claims Administrator and are dispensed to Participants through pharmacies that are Network Providers, and (2) Precertification rules. This

list is subject to periodic review and modification. Charges for medications may be Ineligible Charges, in whole or in part, if a Participant selects a medication not included in the Formulary.

NN. FREESTANDING AMBULATORY FACILITY

A facility, with a staff of Physicians, at which surgical procedures are performed on an outpatient basis (no patients stay overnight). The facility offers continuous service by both Physicians and registered nurses (R.N.s). It must be licensed and accredited by the appropriate agency. A Physician's office does not qualify as a Freestanding Ambulatory Facility.

OO. GROUP HEALTH PLAN OR PLAN

"Group Health Plan" or "Plan" means the plan, program, methods and procedures for the payment of benefits from the Trust Fund (directly or indirectly) by the Trustees in accordance with such eligibility requirements as the Trustees may, from time to time, adopt and promulgate, and as set forth herein.

PP. HOME HEALTH CARE

"Home Health Care" means care, by a licensed program or Provider, for the treatment of a patient in the patient's home, consisting of required intermittent skilled care, which may include observation, evaluation, teaching and nursing services consistent with the diagnosis, established and approved in writing by the patient's attending Physician.

QQ. HOME HEALTH CARE AGENCY

"Home Health Care Agency" means a Provider who renders care through a program for the treatment of a patient in the patient's home, consisting of required intermittent skilled care, which may include observation, evaluation, teaching and nursing services consistent with the diagnosis, established and approved in writing by the patient's attending Physician. It must be licensed and accredited by the appropriate agency.

RR. HOSPICE

"Hospice" means a Provider which provides care for terminally ill patients and their families, either directly or on a consulting basis with the patient's Physician. It must be licensed and accredited by the appropriate agency.

SS. HOSPICE CARE PROGRAM

"Hospice Care Program means a coordinated, interdisciplinary program designed to meet the special physical, psychological, spiritual and social needs of the terminally ill Participant and his or her covered family members, by providing palliative and supportive medical, nursing and other services through at-home or Inpatient care. The Hospice must be licensed and accredited by the appropriate agency and must be funded as a Hospice as defined by those laws. It must provide a program of treatment for at least two unrelated individuals who have been medically diagnosed as having no reasonable prospect of cure for their illnesses.

TT. HOSPITAL

"Hospital" means an institution licensed and accredited by the appropriate agency, which is primarily engaged in providing diagnostic and therapeutic facilities on an Inpatient basis for the surgical and medical diagnosis, treatment and care of injured and sick persons by or under the supervision of a staff of Physicians duly licensed to practice medicine, and which continuously provides 24-hour-a-day nursing services by registered graduate nurses physically present and on duty. "Hospital" does not mean other than incidentally:

- an extended care facility; nursing home; place for rest; facility for care of the aged;
- a custodial or domiciliary institution which has as its primary purpose the furnishing of food, shelter, training or non-medical personal services; or
- an institution for exceptional or disabled children.

UU. IDENTIFICATION CARD

"Identification Card" means the latest card given to You showing Your identification and group numbers, the type of coverage You have and the date coverage became effective.

VV. ILLEGAL AND WILLFUL MISCONDUCT

"Illegal and Willful Misconduct" means expenses incurred by a Participant or Eligible Dependent resulting from or occurring (1) during the commission of a crime; or (2) during illegal and willful misconduct; or (3) while engaged in an illegal occupation; or (4) while committing or attempting to commit a felonious act or aggravated assault, or (5) while participating in a riot or civil insurrection. No payment shall be made under any health benefit of this Plan for expenses incurred by a Participant or Dependent resulting from Illegal and Willful Misconduct (except Death Benefit). The Trustees will make determination in their sole discretion and such determination will be conclusive.

WW. INELIGIBLE CHARGES

"Ineligible Charges" means charges for health care services that are not Covered Services because the services are not Medically Necessary, or Precertification was not obtained. Such charges are not eligible for payment.

XX. INELIGIBLE PROVIDER

"Ineligible Provider" means a Provider which does not meet the minimum requirements to become a contracted Provider with the Claims Administrator. Services rendered to a Participant by such a Provider are not eligible for payment.

YY. INFERTILE OR INFERTILITY

"Infertile" or "Infertility" means the condition of a presumably healthy Participant or Dependent who is unable to conceive or produce conception after a period of one year of frequent, unprotected heterosexual vaginal intercourse. This does not include conditions for men when the cause is a vasectomy or orchiectomy or for women when the cause is tubal ligation or hysterectomy.

ZZ. INJURY

"Injury" means Bodily harm from a non-occupational accident.

AAA. INPATIENT

"Inpatient" means a Participant or Dependent who is treated as a registered bed patient in a Hospital and for whom a room and board charge is made.

BBB. INTENSIVE CARE UNIT

"Intensive Care Unit" means a special unit of a Hospital that: (1) treats patients with serious illnesses or Injuries; (2) can provide special life-saving methods and equipment; (3) admits patients without regard to prognosis; and (4) provides constant observation of patients by a specially trained nursing staff.

CCC. INTENSIVE OUTPATIENT PROGRAMS

"Intensive Outpatient Programs" means short-term behavioral health treatment that provides a combination of individual, group and family therapy.

DDD. MATERNITY CARE

"Maternity Care" means obstetrical care received both before and after the delivery of a child or children. It also includes care for miscarriage or abortion. It includes regular nursery care for a newborn infant as long as the mother's Hospital stay is a covered benefit and the newborn infant is an eligible Participant under the Plan.

EEE. MAXIMUM ALLOWED AMOUNT

"Maximum Allowed Amount" means the maximum amount that the Plan will allow for Covered Services You receive.

FFF. MEDICAL EMERGENCY

"Emergency services", "emergency care" or "Medical Emergency" means those health care services that are provided for a condition of recent onset and sufficient severity, including but not limited to, severe pain, that would lead a prudent layperson, possessing an average knowledge of medicine and health, to believe that his or her condition, sickness, or Injury is of such a nature

that failure to obtain immediate medical care could result in: (a) placing the patient's health in serious jeopardy; (b) serious impairment to bodily functions; or (c) serious dysfunction of any bodily organ or part. Such conditions include but are NOT limited to, chest pain, stroke, poisoning, serious breathing difficulty, unconsciousness, severe burns or cuts, uncontrolled bleeding, or convulsions and such other acute conditions as may be determined to be Medical Emergencies by the Plan.

GGG. MEDICAL FACILITY

"Medical Facility" means a facility, including but not limited to, a Hospital, Freestanding Ambulatory Facility, Chemical Dependency Treatment Facility, Skilled Nursing Facility, Home Health Care Agency or mental health facility, as defined in this SPD. The facility must be licensed, accredited, registered or approved by The Joint Commission or the Commission on Accreditation of Rehabilitation Facilities (CARF), as applicable, or meet specific rules set by the Claims Administrator.

HHH. MEDICAL NECESSITY OR MEDICALLY NECESSARY

"Medical Necessity" or "Medically Necessary" means an intervention that is or will be provided for the diagnosis, evaluation and treatment of a condition, illness, disease or Injury and that is determined by the Claims Administrator to be:

- medically appropriate for and consistent with the symptoms and proper diagnosis or treatment of the Participant's condition, illness, disease or Injury;
- obtained from a Provider;
- provided in accordance with applicable medical and/or professional standards;
- known to be effective, as proven by scientific evidence, in materially improving health outcomes;
- the most appropriate supply, setting or level of service that can safely be provided to the Participant and which cannot be omitted consistent with recognized professional standards of care (which, in the case of hospitalization, also means that safe and adequate care could not be obtained in a less comprehensive setting);
- cost-effective compared to alternative interventions, including no intervention. Cost effective does not always mean lowest cost. It does mean that as to the diagnosis or treatment of the Participant's illness, Injury or disease, the service is: (1) not more costly than an alternative service or sequence of services that is medically appropriate, or (2) the service is performed in the least costly setting that is medically appropriate;
- not Experimental/Investigative;
- not primarily for the convenience of the Participant, the Participant's family or the Provider; or,
- not otherwise subject to an exclusion under this SPD.

The fact that a Provider may prescribe, order, recommend, or approve care, treatment, services or supplies does not, of itself, make such care, treatment, services or supplies Medically Necessary or a Covered Service and does not guarantee payment.

III. NETWORK PROVIDER

"Network Provider" means a Physician, health professional, Hospital, Pharmacy, or other individual, organization and/or facility that has entered into a contract, either directly or indirectly, with the Claims Administrator to provide Covered Services to Participants through negotiated reimbursement arrangements. A Network Provider for one plan may not be a Network Provider for another. Please see "How to Find a Provider in the Network" in the section How Your Plan Works for more information on how to find a Network Provider for this Plan.

JJJ. NON-COVERED SERVICES

"Non-Covered Services" means services that are not benefits specifically provided under the Plan, are excluded by the Plan, are provided by an Ineligible Provider, or are otherwise not eligible to be Covered Services, whether or not they are Medically Necessary.

KKK. OUT-OF-NETWORK PROVIDER

"Out-of-Network Provider" means a Provider, including but not limited to, a Hospital, Freestanding Ambulatory Facility (Surgical Center), Physician, Skilled Nursing Facility, Hospice, Home Health Care Agency, other medical practitioner or Provider of medical services or supplies, that does not have an agreement or contract with the Claims Administrator to provide services to Plan Participants at the time services are rendered.

LLL. OUT-OF-POCKET MAXIMUM

"Out-of-Pocket Maximum" means the maximum amount of a Participant's Coinsurance payments during a given calendar Plan year. When the Out-of-Pocket Maximum is reached, the level of benefits is increased to 100% of the Maximum Allowed Amount for Covered Services, exclusive of Copayments and other scheduled charges.

MMM. PARTIAL HOSPITALIZATION PROGRAM

"Partial Hospitalization Program" means structured, short-term behavioral health treatment that offers nursing care and active treatment in a program that operates no less than 6 hours per day, 5 days per week.

NNN. PARTICIPANT

"Participant" means individuals, including the eligible Employee and his/her Dependents, who have satisfied the Plan eligibility requirements of the Plan.

OOO. PHARMACY

"Pharmacy" means an establishment licensed to dispense Prescription Drugs and other medications through a duly licensed pharmacist upon a Physician's order. A Pharmacy may be a Network Provider or an Out-of-Network Provider.

PPP. PHYSICAL THERAPY

"Physical Therapy" means the care of disease or Injury by such methods as massage, hydrotherapy, heat, or similar care.

QQQ. PHYSICIAN

"Physician" means any licensed Doctor of Medicine (M.D.) legally entitled to practice medicine and perform surgery, any licensed Doctor of Osteopathy (D.O.) legally licensed to perform the duties of a D.O., any licensed Doctor of Podiatric Medicine (D.P.M.) legally entitled to practice podiatry, and any licensed Doctor of Dental Surgery (D.D.S.) legally entitled to perform oral surgery; Optometrists and Clinical Psychologists (PhD) are also Providers when acting within the scope of their licenses, and when rendering services covered under this Plan.

RRR. PLAN

"Plan" means the Painting Industry Insurance Fund Plan Document, as the same may, from time to time, be amended as hereinafter provided.

SSS. PLAN ADMINISTRATOR

"Plan Administrator" means the Board of Trustees of the Painting Industry Insurance Fund. **The Plan Administrator is not the Claims Administrator.**

TTT. PLAN SPONSOR

"Plan Sponsor" means the Board of Trustees of the Painting Industry Insurance Fund. **The Plan Sponsor is not the Claims Administrator.**

UUU. PRESCRIPTION DRUG (DRUG) (ALSO REFERRED TO AS LEGEND DRUG)

"Prescription Drug" or "Drug" or "Legend Drug" means a medicine that is approved by the Food & Drug Administration (FDA) to treat illness or injury. Under the Federal Food, Drug & Cosmetic Act, such substances must bear a message on its original packing label that says, "Caution: Federal law prohibits dispensing without a prescription."

VVV. PRIMARY CARE PHYSICIAN

"Primary Care Physician" means a Provider who specializes in family practice, general practice, internal medicine, pediatrics, obstetrics/gynecology, geriatrics or any other Provider as allowed

by the Plan. A PCP supervises, coordinates and provides initial care and basic medical services to a Participant and is responsible for ongoing patient care.

WWW. PRIOR AUTHORIZATION

"Prior Authorization" means the process applied to certain drugs and/or therapeutic categories to define and/or limit the conditions under which these drugs will be covered. The drugs and criteria for coverage are defined by the Pharmacy and Therapeutics Committee.

XXX. PROVIDER

"Provider" means a duly licensed person or facility that provides services within the scope of an applicable license and is a person or facility that the Plan approves. This includes any Provider rendering services which are required by applicable state law to be covered when rendered by such Provider. Providers that deliver Covered Services are described throughout this SPD. If You have a question if a Provider is covered, please call the number on the back of Your Identification Card.

YYY. QMCSO OR MCSO – QUALIFIED MEDICAL CHILD SUPPORT ORDER OR MEDICAL CHILD SUPPORT ORDER

"QMCSO" or "Qualified Medical Child Support Order" means a court order that creates or recognizes the right of a child who is recognized under the order as having a right to be enrolled under the health benefit plan to receive benefits for which the Participant Employee is entitled under the plan; and includes the name and last known address of the Participant Employee and each such child, a reasonable description of the type of coverage to be provided by the plan, the period for which coverage must be provided and each plan to which the order applies.

An "MCSO" or "Medical Child Support Order" is any court judgment, decree or order (including a court's approval of a domestic relations settlement agreement) that:

- provides for child support payment related to health benefits with respect to the child of a group health plan Participant or requires health benefit coverage of such child in such plan, and is ordered under state domestic relations law; or
- enforces a state law relating to medical child support payment with respect to a group health plan.

ZZZ. RESIDENTIAL TREATMENT CENTER/FACILITY

"Residential Treatment Center/Facility" means a Provider licensed and operated as required by law, which includes:

- Room, board and skilled nursing care (either an RN or LVN/LPN) available on-site at least eight hours daily with 24-hour availability;
- A staff with one or more Doctors available at all times;
- Residential treatment takes place in a structured Facility-based setting;

- The resources and programming to adequately diagnose, care and treat a psychiatric and/or substance use disorder;
- Facilities are designated residential, subacute, or intermediate care and may occur in care systems that provide multiple levels of care; and
- Is fully accredited by The Joint Commission (TJC), the Commission on Accreditation of Rehabilitation Facilities (CARF), the National Integrated Accreditation for Healthcare Organizations (NIAHO), or the Council on Accreditation (COA).

The term Residential Treatment Center/Facility does not include a Provider, or that part of a Provider, used mainly for:

- Nursing care
- Rest care
- Convalescent care
- Care of the aged
- Custodial Care
- Educational care

AAAA. RETAIL HEALTH CLINIC

"Retail Health Clinic" means a facility that provides limited basic medical care services to Participants on a "walk-in" basis. These clinics normally operate in major pharmacies or retail stores. Medical services are typically provided by Physicians Assistants and Nurse Practitioners. Services are limited to routine care and treatment of common illnesses for adults and children.

BBBB. SEMIPRIVATE ROOM

"Semiprivate Room" means a Hospital room which contains two or more beds.

CCCC. SKILLED CONVALESCENT CARE

"Skilled Convalescent Care" means care required, while recovering from an illness or Injury, which is received in a Skilled Nursing Facility. This care requires a level of care or services less than that in a Hospital, but more than could be given at the patient's home or in a nursing home not certified as a Skilled Nursing Facility.

DDDD. SKILLED NURSING FACILITY

"Skilled Nursing Facility" means an institution operated alone or with a Hospital which gives care after a Participant leaves the Hospital for a condition requiring more care than can be rendered at home. It must be licensed by the appropriate agency and accredited by The Joint Commission or the Commission on Accreditation of Rehabilitation Facilities (CARF), as applicable, or meet specific rules set by the Claims Administrator.

EEEE. SPECIALIST (SPECIALTY CARE PHYSICIAN/PROVIDER OR SCP)

"Specialist" or "Specialty Care Physician/Provider" or "SCP" means a doctor who focuses on a specific area of medicine or group of patients to diagnose, manage, prevent, or treat certain types of symptoms and conditions. A non-Physician Specialist is a Provider who has added training in a specific area of health care.

FFFF. SPECIALTY DRUGS

"Specialty Drugs" mean typically high cost drugs that are injected or infused in the treatment of acute or chronic diseases. Specialty Drugs often require special handling such as temperature-controlled packaging and expedited delivery. Most Specialty Drugs require preauthorization to be considered Medically Necessary.

GGGG. SPOUSE

"Spouse" or "spouse" means that person, if any, who:

1. Is recognized as legally married to the Participant by a domestic or foreign jurisdiction whose laws authorized the marriage at the time the Participant and such person entered into the marital relationship; and
2. Has not been declared legally separated or divorced from the Participant by judicial order.

HHHH. THERAPEUTIC EQUIVALENT DRUGS

"Therapeutic/Clinically Equivalent Drugs" mean drugs that can be expected to produce similar therapeutic outcomes for a disease or condition.

IIII. TOTAL DISABILITY OR TOTALLY DISABLED

"Total Disability" or "Totally Disabled," unless otherwise specifically defined, means as a direct result of an Injury or Illness, the Participant is unable to:

1. In the case of an Eligible Employee during the first twelve (12) months of such disability, perform the material and substantial duties of the occupation of the Eligible Employee at the onset of the disability; or

2. In the case of an Eligible Employee during the period after the first twelve (12) months of such disability, perform, in the opinion of the Board of Trustees, the material and substantial duties of any occupation for which the Eligible Employee is qualified by education, training or experience which provides other health insurance coverage; or

3. In the case of an Eligible Dependent, perform the normal substantial activities of a person of like age and sex in good health. Determination of whether an Eligible

Employee or an Eligible Dependent is Totally Disabled or Total Disability will be made by the Trustees in their sole discretion and will be conclusive.

JJJJ. TRANSPLANT PROVIDERS

"Network Transplant Provider" means a Provider that has been designated as a "Center of Excellence" for Transplants by the Claims Administrator and/or a Provider selected to participate as a Network Transplant Provider by the Blue Cross and Blue Shield Association. Such Provider has entered into a transplant Provider agreement to render Covered Transplant Procedures and certain administrative functions to You for the transplant network. A Provider may be a Network Transplant Provider with respect to:

- certain Covered Transplant Procedures; or
- all Covered Transplant Procedures.

"Out-of-Network Transplant Provider" means any Provider that has NOT been designated as a "Center of Excellence" for Transplants by the Claims Administrator nor has not been selected to participate as a Network Transplant Provider by the Blue Cross and Blue Shield Association.

KKKK. TRUST FUND, TRUST OR FUND

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

LLLL. TRUSTEE

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

MMMM. UNION

"Union" means the International Union of Painters & Allied Trades, Painters District Council No. 6, Strongsville, Ohio, the affiliated local unions and their successors, and any other local union that by contract with an Employer approved by the Board of Trustees agrees to become a part of the Painting Industry Insurance Fund and to be bound by the Trust Agreement, Plan document and the rules and procedures prescribed by the Trustees.

NNNN. URGENT CARE

"Urgent Care" means services received for a sudden, serious, or unexpected illness, Injury or condition. Urgent Care is not considered an emergency. Care is needed right away to relieve pain, find out what is wrong, or treat a health problem that is not life-threatening.

OOOO. UTILIZATION REVIEW

"Utilization Review" means evaluation of the necessity, quality, effectiveness, or efficiency of medical or behavioral health services, Prescription Drugs (as set forth in the section "Prescription Drugs Administered by a Medical Provider"), procedures, and/or facilities.

PPPP. YOU AND YOUR

"You" and "Your" mean the Participant and each Covered Dependent.

XIV. STATEMENT OF ERISA RIGHTS

As a Participant in the Painting Industry Insurance Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974. ERISA provides that all plans participants are entitled to:

A. RECEIVE INFORMATION ABOUT YOUR PLAN AND BENEFITS.

You have the right to:

a. Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts, your collective bargaining agreement and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration (EBSA);

b. Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts, your collective bargaining agreement and copies of the latest annual report (Form 5500 Series) and updated Summary Plan Description (the Plan Administrator may make a reasonable charge for the copies and currently charges $0.25 per page); and

c. Receive a summary of the Plan's annual financial report, which the Plan Administrator is required by law to furnish to each Participant.

B. CONTINUE GROUP HEALTH PLAN COVERAGE.

You also have the right to:

a. Continue health care coverage for yourself, Spouse or dependents if there is a loss of coverage under the Plan as a result of a qualifying event (You or your dependents may have to pay for such coverage; review this Summary Plan Description and the documents governing the Plan on the rules governing your COBRA Continuation Coverage Rights); and

b. Reduce or eliminate exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan. You should be provided with a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when:

i. You lose coverage under the Plan;
ii. You become entitled to elect COBRA Continuation Coverage; or
iii. Your COBRA Continuation coverage ceases.

You must request the certificate of creditable coverage before losing coverage or within 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

C. PRUDENT ACTIONS BY PLAN FIDUCIARIES.

In addition to creating rights for Plan Participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called fiduciaries of the Plan, have a duty to do so prudently and in the interest of you and other Plan Participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

D. ENFORCE YOUR RIGHTS.

If your claim for a health benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of the Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator.

If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

E. ASSISTANCE WITH YOUR QUESTIONS.

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the EBSA, U.S. Department of Labor, listed in your telephone directory or at:

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

You may also find answers to your Plan questions, your rights and responsibilities under ERISA and a list of EBSA field offices by contacting the EBSA by calling (866) 444-3272 or by visiting the website of the EBSA at www.dol.gov/ebsa.

F. INFORMATION FOR INDIVIDUALS WITH LIMITED ENGLISH PROFICIENCY

ATTENTION: If English is not your primary language and you have difficulty communicating effectively in English, language assistance services, free of charge, are normally available to you. Call the Plan's Civil Rights Coordinator at **440-260-0615** for more information.

Spanish:
ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llam al. **1-440-260-0615**

Chinese:
注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電, **1-440-260-0615**。

German
ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: **1-440-260-0615**

Arabic
0615-260-440-1 ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم

Russian
ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните **1-440-260-0615**.

Pennsylvania Dutch
Wann du [Deitsch (Pennsylvania German / Dutch)] schwetzscht, kannscht du mitaus Koschte ebber gricke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff: Call **1-440-260-0615**.

Vietnamese
CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số **1-440-260-0615**.

Korean
주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-440-260-0615번으로 전화해 주십시오.

Italian
ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero **1-440-260-0615**.

Japanese:
注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。**1-440-260-0615** まで、お電話にてご連絡ください。

Dutch
AANDACHT: Als u nederlands spreekt, kunt u gratis gebruikmaken van de taalkundige diensten. Bel
1-440-260-0615.

Ukrainian
УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером **1-440-260-0615**.

French
ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le **1-440-260-0615**.

Romanian
ATENȚIE: Dacă vorbiți limba română, vă stau la dispoziție servicii de asistență lingvistică, gratuit. Sunați la **1-440-260-0615**.

Greek
Εάν εσείς ή κάποιος που βοηθάτε έχετε ερωτήσεις γύρω απο το Painting Industry Insurance Fund, έχετε το δικαίωμα να λάβετε βοήθεια και πληροφορίες στη γλώσσα σας χωρίς χρέωση.Για να μιλήσετε σε έναν διερμηνέα, καλέστε **1-440-260-0615**.

THE BOARD OF TRUSTEES
PAINTING INDUSTRY INSURANCE FUND

ON BEHALF OF
UNION TRUSTEES:

James Sherwood, Secretary

ON BEHALF OF
EMPLOYER TRUSTEES:

Brendan J. McGarry, Chair