OHIO CONFERENCE OF PLASTERERS AND

CEMENT MASONS HEALTH AND

WELFARE PLAN

AND

SUMMARY PLAN DESCRIPTION

IMPORTANT NOTICE: This booklet is the Plan in effect as of December 1, 2000. From time to time, you will receive supplemental bulletins about changes to this Plan. It is your responsibility to review these bulletins.

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INTRODUCTION

YOUR ELIGIBILITY FOR BENEFITS

BASIC BENEFITS

Plan Sponsor and Administrator

The Board of Trustees is both the Plan Sponsor and Plan Administrator.

Plan Administrator

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

Compensation Programs of Ohio, Inc.
P.O. Box 230
Niles, Ohio 44446
(800) 435-2388
(330) 652-9821

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

Identification Numbers

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

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

Agent for Service of Legal Process

The Board of Trustees is the Plan's agent for service of legal process. Accordingly, if legal disputes involving the Plan arise, any legal documents should be served upon the Board of Trustees, upon any individual Trustee at the following address: Ohio Conference of Plasterers and Cement Masons Health and Welfare Plan and Trust, 1123 North Canfield-Niles Road, Austintown, Ohio 44515, or upon fund counsel, Ronald G. Macala, Esq., Macala, Baasten, McKinley, Piattt & Gore, L.L.C., The Belden/Whipple Building, Suite 604, 4150 Belden Village Street, P.O. Box 35186, Canton, Ohio 44735.

Plan Year

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

Source of Contributions

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

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

Trust Fund

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

ADDITIONAL INFORMATION ABOUT THE PLAN

Federal law requires that the following additional information be provided to Eligible Persons.

Board of Trustees

A Board of Trustees is responsible for the operation of this Plan. The Board of Trustees consists of Ohio Conference of Plasterers and Cement Masons Health and Welfare Plan Employer representatives and Ohio Conference of Plasters and Cement Masons Health and Welfare Plan Union representatives. As of December 1, 2000, the Plan Trustees are:

Union Trustees

Mr. Robert Hahn
Cement Masons Local No. 109
2046 South Main Street
Akron, Ohio 44301

Mr. Carl Carcioppolo
Plasterers Local No. 80
1651 East 24th Street
Cleveland, Ohio 44114

Mr. Daniel Owens
Cement Masons Local No. 404
1714 25th Street
Cleveland, Ohio 44114

Mr. John Mylek
Cement Masons Local No. 886
4652 Lewis Avenue
Toledo, Ohio 43612

Mr. Richard Seebacher
Cement Masons Local No. 179
5208 Mahoning Avenue
Suite 225
Youngstown, OH 44515

Mr. Thomas Blevins
Ohio Local No. 1
1407 East Third Street

Employer Trustees

Mr. William Brennan
Toledo Area Carpenters
1845 Collingwood Blvd.
Toledo, Ohio 43624

Mr. James Dougherty
1786 W. Arndale
Akron, Ohio44224

Mr. Randall L. Fox
AGC of America, Inc.
115 Linwood Street
Dayton, Ohio 45405

Mr. John N. Logue
Executive Secretary
The Builders Association of Eastern
Ohio and Western Pennsylvania
Vienna, Ohio 44473

Mr. Alan D. Moore
4343 Weaver Court North
P.O. Box 65
Hillard, Ohio 43206

Dayton, Ohio 45403-1818

SCHEDULE OF BENEFITS (FOR ELIGIBLE CLASS I, CLASS II AND CLASS III ACTIVE PARTICIPANTS AND DEPENDENTS)

Calendar year annual deductible Individual/Family	$250 / $500
Co-Payment	20% of the first $6,250 of incurred expenses, per individual
Calendar year annual out-of-pocket maximum Individual/Family	$1,500 / $3,000
Lifetime maximum per person	$1,000,000
Prescription Drugs	See pages 8-9
Covered Services	Maximum Payable Benefits
Physician office services Office visits, office surgeries, allergy testing/treatment/serum/injections	All benefits are paid at 80% after deductible, up to the out-of-pocket maximum; 100% thereafter, unless otherwise noted
Preventive care (Family)* Medical history, routine physical exams, PSA, mammographies, pelvic exams, Pap testing Immunizations (birth to age 9)	
Outpatient therapy Physical/occupational therapy, spinal Manipulations (10 visits), speech therapy	
Hospital facility services – Inpatient/Outpatient	
Inpatient and outpatient professional and ancillary charges, physician and surgical services	
Home care services/calendar year (Limited to 40 visits)	
Hospice services	
Emergency care/Urgent care Physician services and facility charges	
Ambulance services	
Maternity services	
Skilled nursing care	
Medical supplies, equipment, appliance	
Mental Health (Limits and restrictions apply)	Inpatient care limited to 30 days (lifetime maximum) Outpatient care limited to 20 visits/calendar yr
Substance abuse (Limits and restrictions apply) Inpatient care Outpatient care	 $15,000 per calendar year $2,000 per calendar year Lifetime maximum $20,000
Vision/Dental	80% of $600 per family per year (no deductible)
Other Benefits (eligible Participants only)	
Death benefit	$5,000
Accidental death and dismemberment (AD&D)	See Page 45

Sickness and Accident benefits:	
Non-occupational Class I	$300
Occupational Class I	30
Waiting period for disability:	
Due to accident	None
Due to sickness	7 days
Maximum period of disability	26 weeks
Out-of pocket limits include all co-payments and deductibles incurred by a covered person in the same benefit period.	
All medical benefits are subject to usual, customary and reasonable charges.	
**Up to a maximum of $500/calendar yr.*	

PRESCRIPTION DRUGS
National Prescription Administration

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

Covered Expenses Include:

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

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

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

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

A Prescription Administrator has contracted with the Operative Plasterers and Cement Masons Health and Welfare Fund to provide an efficient and cost effective program that will be easy for you and your dependents to use when you purchase your prescriptions at a Network Pharmacy. Please check with the Fund Office or call the Prescription Drug Administrator at 800-467-2006 directly for a participating pharmacy location near you.

The Prescription Drug Card Program requires you to present your Identification Card at the pharmacy each time you have a prescription filled. If you do not use your identification card, you will have to file a claim for payment directly to the Fund Administrator. Your claim may be subject to deductible and co-insurance amounts. When possible, please check with your pharmacy to determine if a generic equivalent is available which will result in a direct savings to you and the Fund.

The Program works as follows:

If you choose a brand name drug or generic equiavalent prescription, **your co-payment will be 20% of the cost.**

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

1) Oral contraceptives and devices;

2) Therepeutic devices;

3) Artificial appliances;

4) Disposable insulin syringes which are not prescribed;

5) Fees for administering or injecting Prescription Drugs;

6) Charges for more than a 90-day supply of Prescription Drugs (e.g., CFI mail order);

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

8) Drugs you can purchase without a Prescription;

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

10) Fertility drugs;

11) Nicorette gum and/or other tobacco cessation related medications;

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

13) Male sexual dysfunctional drugs (e.g. viagra);

14) Anorexiants (diet pills);

15) Diabetic supplies (e.g., glucometers, lancets, test strips); and

16) Ostomy products.

SCHEDULE OF BENEFITS (RETIREE AND DEPENDENTS NON-MEDICARE AGE)

Calendar year annual deductible Individual/Family	$250 / $500
Co-Payment	20% of the first $6,250 of incurred expenses, per individual
Calendar year annual out-of-pocket maximum Individual/Family	$1,500 / $3,000
Lifetime maximum per person	$1,000,000
Prescription Drugs	See pages 8-9
Covered Services	Maximum Payable Benefits
Physician office services Office visits, office surgeries, allergy testing/treatment/serum/injections	All benefits are paid at 80% after deductible, up to the out-of-pocket maximum; 100% thereafter, unless otherwise noted
Preventive care (Family)* Medical history, routine physical exams, PSA, mammographies, pelvic exams, Pap testing	
Outpatient therapy Physical/occupational therapy, spinal Manipulations (10 visits), speech therapy	
Hospital facility services – Inpatient/Outpatient	
Inpatient and outpatient professional and ancillary charges, physician and surgical services**	
Home care services/calendar year (Limited to 40 visits)	
Hospice services	
Emergency care/Urgent care Physician services and facility charges	
Ambulance services	
Maternity services	
Skilled nursing care	
Medical supplies, equipment, appliance	
Mental Health (Limits and restrictions apply)	Inpatient care limited to 30 days (lifetime maximum) Outpatient care limited to 20 visits/calendar year
Substance abuse (Limits and restrictions apply) Inpatient care Outpatient care	 $15,000 per calendar year $2,000 per calendar year Lifetime maximum $20,000
Other Benefits (eligible retiree (non-medicare) age only)	
Death benefit	$2,500
Vision/Dental	80% of $600 per family per year (no deductible)

Out-of pocket limits include all co-payments and deductibles incurred by a covered person in the same benefit period.
All medical benefits are subject to usual, customary and reasonable charges.
**Up to a maximum of $500/calendar yr.*

MEDICARE SUPPLEMENTAL COVERAGE
SCHEDULE OF BENEFITS
(RETIREES AND DEPENDENTS OVER MEDICARE AGE)

SCHEDULE OF BENEFITS – THIS SUPPLEMENTAL PLAN PAYS:

Inpatient Hospital Services	The Plan pays the Medicare Part A deductible, and the Medicare-approved Hospital charges not reimbursed by Medicare for the 61st-150th day of hospitalization, and up to 80% of eligible expenses for additional 365 days per lifetime.
Blood (Inpatient/Outpatient)	$60 of the Medicare Part B deductible, and Medicare co-pay up to 20%.
Skilled Nursing Facility Care	The Plan pays amounts up to the Medicare Approved charges not reimbursed by Medicare per day for 21st-100th days, and up to 80% for the next 100 days.
Inpatient Prescription Drugs For Transplants	$60 of the Medicare Part B deductible and Medicare co-pay up to 20%.
Physician's Care Inpatient/ Outpatient Services and Supplies	$60 of the Medicare Part B deductible and Medicare co-pay up to 20%.
Outpatient Mental/Nervous	Medicare co-pay up to 50%.
Outpatient Physical Therapy	$60 of the Medicare Part B deductible and Medicare co-pay up to 20%.

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

Death Benefit	$2,500

YOUR ELIGIBILITY FOR BENEFITS

Eligibility Class

You are in an Eligible Class under the Plan if you have worked sufficient Covered Employment and are:

- Represented by a Union participating in the Plan and an Employee of an Employer in the Plan (sometimes referred to as a "Class I" employee).

- An Eligible Employee, who is not represented by a Union participating in the Plan, of an Employer who has a current Collective Bargaining Agreement binding the Employer to make contributions to this Plan and has executed an Assent of Participation executed with the Trustees (sometimes referred to as a "Class II" employee). The Board of Trustees reserves the right to decline to accept Class II Employees as Eligible Employees and to terminate the participation of any Class II Employees.

- Employees of any Union or Employer association who has executed an Assent of Participation (sometimes referred to as a “Class III” Employee).

Self-employed persons (for example, partners and sole proprietors) cannot become eligible for benefits.

Covered Employment

If you are a Class I Employee, Covered Employment means any hours you have worked for an Employer for which the Employer is required by the terms of a Collective Bargaining Agreement with the Union to make a contribution into the Fund. The Fund Office will provide you, upon written request, information as to whether a particular employer is contributing to this Plan on behalf of employees, working under the Collective Bargaining Agreements, and, if so, the address of such Employer.

If you are a Class II or Class III Employee, Covered Employment is any period of time you have worked on a full-time basis for a Union or an Employer, for which the Union and the Employer have agreed in writing to provide a contribution into the Fund for benefits under rules and regulations established from time to time by the Board of Trustees.

Enrollment Procedure

A personal information card completed and signed by you must be given to the Fund Office before the Effective Eligibility Date (see below) for benefits for you and your Eligible Dependents.

GENERAL ELIGIBILITY PROVISIONS – CLASSES I – III

Active Employment

Employee must be actively seeking employment unless you are disabled.

CONTINUING COVERAGE - Self-Contributions

At the end of each quarter, if an Employee's coverage should terminate because he cannot meet any of the four tests listed above, or his work hours plus reserve hours do not meet any of the tests listed above, then the individual shall be allowed to make self-contributions. The self-contribution is due in the Fund Office, unless otherwise indicated, on the 10th day of the first month in the eligibility period- i.e., March 10, June 10, September 10, or December 10. Coverage is terminated if self-contributions are not timely received. The self-contributions privilege is limited to two (2) consecutive quarters of full self-contributions. To continue partial self- contributions after one (1) quarter of full self-contributions, an employee must have worked 1,200 reported hours (including disability credits) in the preceding 24 consecutive months.

If you are credited with less than the required hours to continue eligibility, you may make a self-payment for the difference between the hours worked and the required number of hours times the current contribution rate established by the Board of Trustees. COBRA rights will be extended to you if you are not eligible for the above self-contribution requirements.

You may preserve eligibility as set forth above, if you are through the Local Union, subject to the following:

1. If you are laid off or unemployed, your eligibility may be preserved for two (2) quarters.

2. If you are on strike, your eligibility may be preserved for up to two (2) quarters.

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

All self-contributions received become the property of the Fund as of the day received. Hours received relative to the work month for which the self-contribution was made, whether as a result of late payment or a reciprocity agreement, may be refunded or may be credited in their entirety to your credited reserve.

If you continue your eligibility for coverage through a full self-payment contribution rate, as established by the Collective Bargaining Agreement and the guidelines stated above, you will temporarily extend your health care coverage for you and your dependents for a period up to but not to exceed six (6) months.

Once you have reached the end of your six months of continued coverage under the Fund's self-contribution plan and you are not covered under any other group health plan or Medicare benefits at the time, you will be eligible to continue your health care benefits under The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), for an additional 18 months. For more information regarding your continuation of coverage under COBRA, please refer to Pages 23-25 of this booklet. The Trustees shall have the discretion to refuse self-contributions from you if it is determined that you are working in Covered Employment in the craft jurisdiction for an Employer not subject to a collective bargaining agreement.

Amounts of Coverage

The amounts for which you are covered under the Plan shall be those amounts shown in the Schedule of Benefits. Any increase or decrease in the amount of coverage becomes effective on the date of such increase or decrease except:

- If coverage is increased during the period when you are not available for work, such increase shall not take effect until you are available for work.

If coverage is decreased during a period when you are not available for work, such decrease shall take effect on the date of the decrease in coverage.

ELIGIBILITY CONDITIONS - CLASS I

Initial Eligibility Conditions-Active Employees

An active Class I employee working under the bargaining agreement shall become eligible on the first of the calendar month following the month in which the employee works 360 hours within a six-month period, and shall continue to be eligible for the remainder of that eligibility period. However, if only one calendar month or less remains in that eligibility period, the active employee also shall be eligible for the subsequent eligibility period.

Effective Eligibility Date

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

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

Continuation of Eligibility · Active Employees Working Under Bargaining Agreement

After establishing Initial Eligibility, you can continue your eligibility in one of four ways:

You are eligible for the months of March, April and May (an eligibility period") if you work one (1) of the following:

- Three hundred sixty (360) hours for the three-month period October, November, December,
- Seven hundred twenty (720) hours for the six-month period July through December,
- One thousand eighty (1,080) hours for the nine-month period April through December, or
- One thousand four hundred forty (1,440) hours for the 12-month period January through December.
- **You are eligible June, July and August if you work one of the following**
- Three hundred sixty (360) hours for the three-month period January, February, March,
- Seven hundred twenty (720) hours for the six-month period October through March,
- One thousand eighty (1,080) hours for the nine-month period July through March, or
- One thousand four hundred forty (1,440) hours for the 12-month period April through March.

- **You are eligible for September, October and November if you work one of the following:**
  - Three hundred sixty (360) hours for the three-month period April, May, June,

- Seven hundred twenty (720) hours for the six-month period January through June,
- One thousand eighty (1,080) hours for the nine-month period October through June, or
- One thousand four hundred forty (1,440) hours for the 12-month period July through June.

➢ **You are eligible for December, January and February if you work one of the following**

- Three hundred sixty (360) Hours for the three-month period July, August, September,
- Seven hundred twenty (720) hours for the six-month period April through September, or
- One thousand eighty (1,080) hours for the nine-month period January through September, or
- One thousand four hundred forty (1,440) hours for the 12-month period October through September.

Reserve Hours

Reserve hours will be calculated annually at the end of the hours posted for the March work month which qualifies for the June eligibility period. Reserve hours will be calculated on the basis that all hours worked in excess of 1,500 hours for the period of April 1 through March 31 will be credited to a reserve hours bank up to a maximum of seven hundred twenty (720) hours in reserve. This seven hundred twenty (720) hours will allow a person to build up to six months of coverage. When contributions are increased under the Collective Bargaining Agreements, an adjustment will be made in your reserve hours to reflect the increased cost of the Plan.

The use of these hours is expressly conditioned upon the Person's Local Union, where at least a majority of these hours have been accumulated, sponsoring a Collective Bargaining Agreement requiring contributions to this Fund. The Trustees shall also have the discretion to freeze or terminate your reserve hour bank if it is determined that you are performing work in Covered Employment in the craft jurisdiction for an Employer not subject to a collective bargaining agreement. The Reserve hour bank is not a vested benefit and is subject to amendment, reduction or termination.

ELIGIBILITY CONDTIONS - CLASS II & III

Initial Eligibility

A Class II employee who can be eligible to participate will be covered for benefits on the first day of the month immediately following the receipt of the third 3rd consecutive monthly payment. Prepayment shall not expedite coverage.

Initial eligibility will cover the employee for the remaining number of months which fall within an eligibility period as outlined on Pages 15-16 under Continuation of Eligibility. However, if only one calendar month or less remains in that eligibility period, the employee also shall be eligible for the subsequent eligibility period.

Effective Eligibility Date

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

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

Continuing Eligibility

Once having become covered, a Class II employee shall continue to be covered on a quarterly basis in accordance with the eligibility periods listed on Pages 15-16, provided a quarterly contribution for such employee is received by the Welfare Fund by the 15th of the month immediately preceding the appropriate eligibility quarter. Coverage terminates if payments are not timely received. Self-payments are not permitted, other than COBRA continuation coverage.

PARTICIPANTS SERVING IN ARMED FORCES

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

2. In the event a Participant who enters into full-time military duty of the United States has no Reserve Bank, has an insufficient Reserve Bank to maintain coverage while serving in the military service, or does not elect to utilize his Reserve Bank to maintain coverage while serving in active full-time military service, continuation of coverage under the Plan

for the Participant and his Eligible Dependents can be continued for eighteen (18) months upon receipt of a timely application and required contributions established by the Board of Trustees.

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

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

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

Military Reinstatement - Effective Eligibility Date of Coverage

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

Eligible Dependents - Family Coverage

Your Eligible Dependents include the following:

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

- Your children. Children may be covered from the date of birth and may be Eligible Dependents as long as they are unmarried and less than 19 years of age, or less than 23 years of age if they are full-time students, in an accredited University or Technical School, and provided they are not otherwise entitled to benefits under the Plan. A Child, to be your Eligible Dependent, must be under your care, custody and control. The Child must also be dependent on you for such Child's principal support and maintenance, and claimed as an exemption on your Federal Income Tax returns. The Plan will not cover children who are the legal responsibility of an individual other than the Eligible Employee or Eligible Retiree.

  The term **Child or Children** may include:

  - Your natural child,
  - Your adopted child or child placed in your custody, pending adoption,
  - Your stepchild.
  - A foster child for whom you have assumed financial responsibility in writing.
  - A child under the age of 19 for whom a court of competent jurisdiction has established custody.

  The Plan also includes among Eligible Dependents Children for whom you are required to furnish medical coverage under a Qualified Medical Child Support Order. Please contact the Fund Office for Rules and Regulations explaining the provisions which must be included in such court Orders and other requirements which must be met before the Plan will accept any Children as Eligible Dependents under such Orders.

  If an unmarried dependent Child beyond age 19 is incapable of self-sustaining employment because of a physical handicap or mental retardation, and is dependent upon you for support and maintenance, coverage will be continued provided the Child's incapacity began before the age at which the Child's coverage would have terminated. You must submit proof of the Child's incapacity to the Fund Office not later than 31 days after the date such child attains the age at which their coverage would otherwise terminate. Proof of continued incapacity must be furnished to the Fund Office from time to time upon request.

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

PRE-EXISTING CONDITIONS LIMITATION

If an Eligible Member has been treated for an injury or illness within six (6) months prior to becoming eligible for benefits under the Plan, then all expenses incurred as a result of such injury or illness will not be considered as eligible expenses until twelve (12) months after the effective date of coverage.

Effective July 1, 1997, the Pre-Existing Condition Limitations are as follows:

The pre-existing condition coverage exists for 12 months (18 months for late enrollees) after becoming eligible for benefits under the Plan. This period is reduced, however, by counting certain prior coverage toward the exclusion period. Employees with 12 months of coverage with one employer may, therefore, move to a new employer with new coverage without becoming subject to the pre-existing condition exclusion of the new employer.

An employee is credited for prior coverage under a wide variety of health plans, including group health plans, individual policies, HMOs, Medicare, and various governmental programs. Coverage is not counted toward the exclusion period of the new plan, however, if there has been an intervening break in coverage of 63 days or more. Only coverage after the break may be credited.

An individual's prior plan must supply you with a certification of coverage at the time coverage ceases, or, upon your request. You may also request a certificate, free of charge, from the Plan Administrator until twenty-four (24) months after the time your coverage ended. For example, you may request a certificate even before the coverage ends. The certification must specify the period of creditable coverage.

If you do not receive a certificate by the time you should have received it or by the time you need it your first step should be to contact the Plan Administrator of the prior plan responsible for providing the certificate and request one. If any part of your credible coverage was through an insurance company, you can also contact the insurance company for a certificate that reflects that part of your credible coverage as long as you make the request within twenty-four (24) months of your coverage ceasing under the insurance policy.

In any event, if you do not receive a certificate, you may demonstrate to the Plan that you have credible coverage (as well as the time you were in any waiting period) by producing documentation or other evidence of credible coverage (such as pay stubs that reflect the deduction for health insurance, explanation of benefit forms (EOBs) or verification by a doctor or your former health care benefits provider that you had prior health insurance coverage.

Once you obtain a certificate, keep it in case you may later need it. You will need the certificate if you leave your health plan and enroll in a subsequent plan that applies a preexisting condition exclusion, or if you purchase an individual insurance policy from an insurance company.

A special 30-day period also applies for enrollment of new dependents acquired by marriage, birth, adoption, or placement for adoption. No pre-existing condition exclusion may apply to pregnanacy, pregnancy-related conditions, newborns or adoptees enrolled during this period, but the 12-month exclusion could apply to a new spouse or child placed for adoption but not yet adopted.

Omnibus Budget Reconciliation Act

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

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

b) If an eligible employee who is covered under this plan is divorced, the children of that employee are eligible dependents for the plan, regardless of other dependent qualifications, if the eligible employee is court ordered to provide coverage. The dependent may not be terminated from coverage as long as the employee is eligible for coverage and the court order is still in effect.

Travel · Class I Employees

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

Reciprocity Agreements with Other Plans - Class I Employees

The Trustees have entered into Reciprocity Agreements with the Trustees of certain other plans in an effort to address the problem of employees working under the jurisdiction of other locals. Under these Agreements, contributions due on your behalf while working under another local's jurisdiction may be transferred from that local's fund to this Plan if you make written request on a proper form. For information regarding other funds which have Agreements with this Plan, contact the Fund Office. You may not establish initial eligibility via reciprocity payments.

Those employees eligible under this Plan who work in another jurisdiction which has a signed Agreement with this Plan may continue their coverage under this Plan. Those coming from other

jurisdictions to work here and requesting reciprocity will not become eligible under this Plan, but will continue their coverage, if any, under their home Plan.

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

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

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

- are receiving Sickness & Accident benefits from this Fund; **and**
- are seen by a Physician on a regular basis who so states you are Disabled; **and**
- make written application to the Fund Office for such credits within six months after the Disability starts.

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

See also, the Eligibility for Disabled Retirees and Dependents (Pages 26-27).

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

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

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

- The birth of your child and to care for such child.

- Placement of a child with you for adoption or foster care;
- To care for your Spouse, Child or parent with a serious health condition; or
- For your own serious health condition that makes you unable to perform your job.

Please contact the Fund Office for Rules and Regulations governing FMLA Contribution Credits.

TERMINATION OF COVERAGE

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

- The last day of an Eligibility Month if you have insufficient contributions and/or Reserve Hours, and fail to make timely self-payments; or
- When you begin active duty in the armed forces; or
- The last day of an Eligibility period in which you die except that your Eligible Dependents will be allowed to remain eligible until any of your accumulated Reserve Hours are exhausted; or
- The date you cease to be available for work under Covered Employment; or
- The date the Plan terminates.

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

- Ceases to be your legal Dependent as provided by the Plan; or
- Becomes an Eligible Employee under this Plan or another group plan; or
- Begins active duty in the armed forces.

SUSPENSION OF BENEFITS (CLASS I)

Your benefits may be suspended if the Trustees determine that you are:

1) performing work in covered employment within the craft jurisdiction and not pursuant to a collective bargaining agreement; or

2) your membership in the Union has been terminated, other than retirement.

REINSTATEMENT

Class I Employees who lose coverage will be required to again meet the Plan's Initial Eligibility rules. See, Page 14.

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

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

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

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

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

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

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

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

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

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

Under the law, **the employee or a family member has the responsibility to inform the Fund Office in writing within 60 days** of a divorce, legal separation or a child losing dependent status under the Plan. Your Employer has the responsibility to notify the Fund Office of the Employee's death, termination of employment, reduction in hours or Medicare eligibility.

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

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

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

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

- The Plan no longer provides health care coverage; or
- The contribution for your continuation coverage is not paid timely; or
- You become covered under another health care plan (unless there is a preexisting condition limitation that would result in denial of benefits); or
- You become entitled to Medicare; or

- You were divorced from a covered employee and subsequently remarry and are covered under your new spouse's health care plan (unless there is a preexisting condition limitation that would result in a denial of benefits).

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

Eligibility for Early Retirees and Dependents (Under Age 65)

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

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

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

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

- are retired from Covered Employment in the trade.

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

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

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

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

Eligibility for Disabled Retirees and Dependents

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

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

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

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

- you have received your Social Security disability award; and

- you are retired from Covered Employment in the trade.

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

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

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

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

Eligibility for Normal Retirees (Over Age 65)

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

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

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

- you are at least 65 years of age; and

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

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

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

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

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

Eligibility for Surviving Spouses

The Surviving Spouse of an Early Retiree, Disabled Retiree, Normal Retiree or Employee Eligible hereunder at death shall terminate at the end of the Eligibility month in which the Retiree had last obtained eligibility. The Surviving Spouse may continue coverage by making required

self-payments so long as such coverage is elected within 60 days following the Employee's or Retiree's death.

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

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

- The date they no longer meet the definition of a Dependent; or
- The date they become covered by another group plan (excluding Medicare); or
- The date the Spouse remarries; or
- The date the Spouse dies.

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

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

Information Regarding Eligibility

Any questions concerning your eligibility should be directed to the Fund Office, P. O. Box 230, Niles, Ohio 44446 or by calling telephone number (800) 435-2388 or (330) 652-9821.

HOW TO FILE A CLAIM

All claims are to be forwarded to the Welfare Fund Office at P. O. Box 230, Niles, Ohio 44446.

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

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

To complete your claim payment, we must have:

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

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

CLAIMS SETTLEMENT/APPEALS PROCEDURE

A. Determination of Benefits and Appeals. If a Participant is not satisfied with the decision in regard to his claim, he may appeal the decision by following these procedures:

1. The Participant may, by written notice received by the Administrator within sixty (60) days of the notice of non-approval, appeal the Administrator's decision to the Board of Trustees. Written notice only needs to state the Participant's name, address and the fact that he is appealing from the decision of the Administrator, giving the date of the decision appealed from.

2. Within sixty (60) days after the receipt of the notice of appeal specified in Section 1, the Board of Trustees shall review the decision of the Administrator. Within thirty (30) days after the Trustees review the decision of the Administrator, the Participant shall be advised in writing, addressed to his residence as shown on the application, by regular mail, of the action taken by the Trustees on his appeal.

3. The Participant may, by written notice received by the Administrator within sixty (60) days of the mailing of the decision of the Trustees specified in Section 2, request a full hearing before the Trustees. The written notice needs to state only the Participant's name, address and the fact that he is requesting a full hearing before the Board of Trustees, giving the date of the decision of the Trustees.

4. Within forty-five (45) days of the receipt of the notice specified in Section 3, the Administrator will notify the Participant of the date, time and place set for a full hearing on his appeal by regular mail, sent to the address on the notice of appeal.

    a. In no case will the date of the hearing be set for a time longer than ninety (90) days after the receipt of the notice of appeal.

    b. The time and place for the appeal will be convenient and accessible to the Participant, and he may, but need not, be represented by an attorney of his choice. At any time prior to the hearing, the Administrator, at the Participant's request, will reveal to the Participant all sources of information outside of the application upon which the decision was based and permit the Participant to examine all documents and records relating to the rejection then in the possession of the Administrator.

5. The Hearing.

a. A full written record will be kept on the proceedings of the hearing.

(i) In conducting the Trustees, the Trustees shall not be bound by the usual common law or statutory rules of evidence.

(ii) The Participant or his attorney will have the right to review the written record of the hearing, make a copy of it and file objections to it.

(iii) There will be copies made of all documents and records introduced at the hearing, attached to the record of the hearing, and made a part of it.

b. All information upon which the Board of Trustees based its original decision will be disclosed to the Participant at the hearing. In the event that additional evidence is introduced by the Trustees which was not made available to the Participant prior to the hearing, he will be granted a continuance of so much time as he may desire, not to exceed thirty (30) days. (For purposes of this section, evidence discovered upon examination of the Participant's own witnesses will not be considered "new evidence.")

c. The Participant will be afforded the opportunity of presenting any evidence on his behalf. If he offers new evidence, the hearing may be adjourned for a period of not more than thirty (30) days so the Trustees may, if they wish, investigate and determine whether additional evidence, or the accuracy of the Participant's new evidence, will be introduced.

PRE-HOSPITAL ADMISSION CERTIFICATION

When it will be necessary for you to be confined in the Hospital as an Inpatient, you must mention to your doctor that he must communicate your treatment to the Plan's utilization review group in advance of your Admission. You are required to obtain precertification from the Plan's utilization review group at least 10 days before the date of a scheduled admission. You and your doctor must complete the Preadmission Review Request Form, and mail it to American Health Care, 921 Eastwind Drive, Suite 104, Westerville, Ohio 43081. If your doctor recommends hospitalization in less than 10 days, you or the doctor must call the utilization review group directly. Likewise, if you are hospitalized on an Emergency basis, your doctor or a family member must call the utilization review group within 24 hours or the first business day after

your admission. Certification is unnecessary if Medicare is primary. If you desire certification for inpatient treatment of alcohol or drug abuse or mental or nervous disorder, you must call American Health Care at 1-800-892-1893.

NOTE: CERTIFICATION OF A HOSPITAL ADMISSION MEANS ONLY THAT THE UTILIZATION REVIEW GROUP ACKNOWLEDGES THAT A HOSPITAL ADMISSION APPEARS NECESSARY. TO DETERMINE WHETHER YOU ARE ELIGIBLE FOR COVERAGE FOR SUCH ADMISSION BASED ON HOURS WORKED AND/OR SELF-PAYMENTS MADE, THE FUND OFFICE MUST BE CONTACTED.

PRE-HOSPITAL ADMISSION OUTPATIENT TESTING

The Plan will provide benefit payment for the Reasonable and Customary charges incurred for preadmission diagnostic tests conducted, at the discretion of the attending Physician, on an Outpatient basis. The tests must be performed at the same Hospital where the individual is scheduled for Admission for treatment of the condition which made the tests necessary.

The test must be performed within seven days prior to actual Admission to the Hospital.

If the scheduled Admission does not take place, the testing will be covered only if the Admission is postponed or cancelled for one or more of the following reasons:

- The tests show a condition requiring medical treatment prior to Admission;
- The individual develops a medical condition that delays the Admission;
- A hospital bed is not available on the scheduled date of Admission; or
- Pre-admission tests indicate, that, contrary to the attending Physician's expectation, the Admission is not necessary.

HOSPITAL BENEFITS

You must obtain Certification for your Hospital Admission from the Plan's utilization review group. See Pre-Hospital Admission Certification at Pages 32-33. Then, if you or a dependent are admitted to a Hospital for a Non-occupational Injury or sickness, you will be reimbursed the charges incurred for room and board and other Hospital expenses in accordance with the Schedule of Benefits.

If you do not obtain Pre-Hospital Admission Certification as required, then a twenty (20%) penalty will be imposed by reducing coverage for Hospital, surgical and all related charges. The cutback does not count toward any out-of pocket or deductible amount.

Hospital Facility Services

You will receive benefits for each day of Hospital room and board expense incurred up to the Daily Room and Board Benefits and Maximum Room and Board Benefit, for any one period of Confinement, specified in the Schedule of Benefits on Pages 6-7 or 10.

Other Hospital Charges

You will also be reimbursed up to the Maximum Miscellaneous Hospital Benefit for the charges made by the Hospital for miscellaneous items, such as the use of an operating room, X-rays, laboratory tests, medicines, charges for the administration of anesthetic and for professional ambulance service to and from the hospital, while Room and Board Benefits are payable under the Plan.

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

Outpatient Hospital Treatment

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

HOME HEALTH CARE BENEFITS

In accordance with the Schedule of Benefits on Pages 6-7 or 10, this benefit is intended to allow you to receive treatment in your home, rather than as a Hospital Inpatient. Payment will be made for necessary medical services and supplies provided in a private residence (not necessarily in your home).

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

The following services are covered under this benefit:

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

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

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

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

Limitations

No payment will be made for:

- Services provided by a person who ordinarily resides in the household or is an Immediate Relative;

- Custodial Care;

- Charges made by the owner of the residence;

- Transportation service;

- Charges incurred for housekeeping services, maid services, unless they are necessary in conjunction with services to provide medical treatment to you;

- Charges incurred for services provided in excess of 40 days per calendar year (one visit by a member of a home health care team equals one day);

- Services or supplies furnished on account of sickness resulting from Occupational Disease or Occupational Injury.

- Services or supplies not included in the home health care plan; or

- Any period during which the individual is not under the continuing care of a Physician.

- See also, Exclusions and Limitations at Pages 46-49.

HOSPICE CARE BENEF1TS

Eligibility

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

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

Covered Services

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

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

Benefits

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

- Continuous home care--when patient requires at least eight hours of care daily during crisis periods when a patient elects not to be hospitalized.
- Routine home care.
- General Inpatient care--when continuous care is provided in the hospital or similar facility and when less intensive care is not provided.
- Respite Inpatient care--when short-term Inpatient care is required in the Hospital, nursing home or free standing hospice facility, to relieve the family from home care duties, benefits

shall be payable up to a maximum of five consecutive days. Benefits for respite Inpatient care shall bepaid only when the patient does not require intensive care and when general inpatient care benefits are not payable.

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

Maximum Benefits

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

To the extent that services are provided or expenses incurred by the patient which are not part of the hospice program, such services and expenses shall be considered covered charges under the applicable plan of benefits that the participant was entitled to at the time he elected to waive those benefits to become eligible for hospice benefits.

SKILLED NURSING CARE FACILITY BENEFITS

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

The Plan will pay benefits in accordance with the Schedule of Benefits on Pages 6-7 or 10, provided all of the following conditions are met:

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

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

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

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

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

Nervous or Mental Disorders

Such benefits shall be paid in accordance with the Schedule of Benefits on Pages 6-7 or 10. However, such benefits shall have a lifetime maximum of thirty (30) days of inpatient care and an annual maximum of twenty (20) outpatient visits.

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

- Before being treated on an Inpatient basis for mental/nervous disorders, you must obtain advance approval from the Plan's utilization review group. For Inpatient treatment you must contact the utilization review group within two weeks before a scheduled admission or within 24 hours of an Emergency Admission or the first business day after your admission. If you fail to obtain pre-approval, to the extent that the Plan's utilization review group does not approve the treatment afterwards, **no coverage will be provided.** Even if the Plan's utilization review group does approve the treatment, the amount of the Plan will pay will be reduced by a percent of coverage otherwise available based on the Schedule of Benefits because you failed to obtain pre-approval. This cutback will not count toward any deductibles or out-of-pocket amounts, and is not covered under Major Medical Benefits.

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

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

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

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

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

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

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

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

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

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

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

Limitations

Coverage for mental and nervous disorders does not include:

- Treatment of mental retardation or mental deficiency; or

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

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

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

- Treatment of a disorder or condition related to, accompanying or resulting from the individual's alcoholism or drug abuse; or

- Treatment excluded under General Exclusions and Limitations; or

- Charges in excess of the Maximum set forth in the Schedule of Benefits; or

- Services, supplies and charges related to diagnosis and treatment of Nervous or Mental Disorders are covered under Basic Benefits only, and are not covered under the Plan's Major Medical provisions.

Substance Abuse

If you are admitted as an Inpatient for a prescribed course of treatment for alcoholism or drug abuse or dependency (including Detoxification) to a Substance Abuse Treatment Facility) approved by the Plan Administrator, upon the recommendation and approval of a Physician, benefits on account of such treatment will be provided in the same manner as for any other sickness, subject to the following limitations. Such benefits are limited to $15,000 per calendar year for inpatient care and $2,000 per calendar year for outpatient care up to a total lifetime maximum benefit of $20,000.

- For Inpatient treatment you must contact American Health Care at 1-800-892-1893 for pre-certification and utilization review within two weeks before a scheduled admission or within 24 hours of an Emergency Admission or the first business day after your admission. If you fail to obtain preapproval, to the extent that the Plan's gatekeeper does not approve the treatment afterwards, **no coverage will be provided.** Even if the Plan's gatekeeper does approve the treatment, the amount of the Plan will pay will be reduced by a percent of coverage otherwise available based on the Schedule of Benefits because you failed to obtain pre-approval. This cutback will not count toward any deductibles or out-of-pocket amounts, and is not covered under Major Medical Benefits.

- Benefits shall not be paid for Confinement exceeding $15,000 per calendar year per Eligible Person per calendar year ($20,000 per lifetime).

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

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

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

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

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

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

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

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

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

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

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

Limitations

The following are not Covered Expenses:

- Treatment primarily for Detoxification; or

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

- Treatment excluded by Exclusions and Limitations at Page 46-49; or

- Charges in excess of the Maximum set forth in the Schedule of Benefits; or

- Services, Supplies and Facility Charges related to diagnosis and treatment of Alcohol or Drug abuse are covered under Basic Benefits only, and are not covered under the Plan's Major Medical provisions.

SURGICAL BENEFIT

Benefits

You will be reimbursed the fee charged by the surgeon, in accordance with the Schedule of Benefits on Pages 6-7 or 10.

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

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

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

- If more than one operation is performed on the anus or rectum or both (except for cancer) at any one time, the total payment for all such operations shall not exceed 1 times the maximum payment specified in the Schedule for that one operation for which the largest amount is payable;

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

BENEFITS FOR MOTHERS AND NEWBORNS

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

WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998

The Women's Health and Cancer Rights Act of 1998 provides you with certain medical benefits in connection with a mastectomy. If you elect breast reconstruction, coverage will be provided, in a manner, determined in consultation with the attending physician and the patient, 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 at all stages of the mastectomy, including lymphedemas.

X-RAY AND LABORATORY BENEFITS

If you or a Dependent undergo an X-ray or laboratory examination made or recommended by a Physician in connection with the diagnosis of Non-occupational Accidental Injury or Sickness, you will be paid the Schedule of Benefits on Pages 6-7 or 10.

No benefits are payable for therapeutic X-ray, dental X-rays or eye refractions; for examination made in connection with dental work or treatment or abortion, after termination of coverage, or for any sickness or injury for which benefits are payable under the Inpatient and Outpatient professional and charges provisions of the Schedule of Benefits. See also, Exclusions and Limitations at Pages 46-49.

DESCRIPTION OF BENEFITS

After you satisfy your Plan Deductible, the Plan pays 80 percent of covered Medical Expenses so long as charges and Reasonable and Customary. The maximum payment is specified in the Schedule of Benefits. Benefits for each Eligible Dependent will be on the same basis as your own. For different coverage levels, applicable to Nervous or Mental Disorders and Alcohol or Drug Abuse, See, Pages 38-41.

THE DEDUCTIBLE

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

The deductible applies only once in any Calendar Year even though you may have several different disabilities. So that you will not have to meet a deductible late in one Calendar Year and soon again in the following year, any expenses applied against the deductible in the last three months of a Calendar Year may also be applied against the deductible for the next Calendar Year. Your Calendar Year deductibles are $250.00 (Individual) and $500.00 (Family).

COMMON ACCIDENT

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

deductible will be charged against all such expenses, regardless of the number of family members injured.

MEDICAL EXPENSES COVERED

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

- The fees for diagnosis, treatment and surgery by a Physician;
- The charges of a registered graduate nurse for private duty nursing services (other than in-patient hospital nursing);
- Charges made by a duly constituted Hospital, except that the daily room and board charges may not exceed the Room Limitations specified in the Schedule of Benefits;
- Charges for the following: local ambulance service to the nearest facility where appropriate medical treatment can be rendered, equipment, medication, appliances, X-ray services, laboratory tests, physical therapy, anesthetic and the administration thereof, the use of radium and radioactive isotopes, oxygen, iron lung, physiotherapy, and similar Covered Medical Expenses.

MAXIMUM PAYMENT

The maximum payment under the Plan with respect to all sickness or injuries of any one Eligible Person during such Person's entire lifetime is $1,000,000 as specified in the Schedule of Benefits on Pages 6-7 or 10.

ROUTINE PREVENTATIVE CARE BENEFIT COVERED

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

- One routine papanicolaou test (pap test) per Calendar Year and any office visit incidental to such test;
- Routine mammograms and any office visit incidental to such test;
- Pediatric examinations, hearing tests, laboratory tests and immunizations from birth to age nine; and

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

- PSA test

- NOTE: Routine preventative care for family is limited to an annual $500 cumulative maximum payable benefit for the entire family, subject to your Plan's deductibles, co-payments and annual out-of-pocket maximums.

OTHER BENEFITS

DEATH BENEFITS
(Active Participants and Retirees Only)

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

If a beneficiary is designated, the consent of the beneficiary shall not be required to change the beneficiary, or to make any other changes in the certificate, except as may be specifically provided by the Plan. If any beneficiary shall die before the covered employee, the interest of such beneficiary shall thereupon automatically terminate. If there is no beneficiary designated by the Eligible Person, or surviving at the death of the Eligible Person, payment will be made in a single sum to the first surviving class of the following classes of successive preference beneficiaries: the Eligible Person's (a) widow or widower, (b) the Eligible Person's estate.

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

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS
(Active Participants Only)

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

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

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

SICKNESS AND ACCIDENT BENEFITS
(Employee Only)

Non-Occupational

If you are disabled as a result of a NON-OCCUPATIONAL accident or sickness, you will be entitled to the amount of Non-Occupational benefit indicated under the Schedule of Benefits on Pages 6-7.

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

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

Occupational

If you are disabled as a result of an OCCUPATIONAL accident or sickness for which you are entitled to receive benefits under a workers' compensation or occupational disease law, you will be entitled to the Occupational Sickness and Accident benefit indicated under the Schedule of Benefits on Pages 6-7.

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

EXCLUSIONS AND LIMITATIONS

The Plan will not cover charges related to:

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

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

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

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

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

- Eye refractions;

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

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

- Occupational Injury or Occupational Sickness, except for Death Benefits and certain Sickness and Accident Benefits (See Page 46);

- Nervous or Mental Disorders except as provided under the Nervous or Mental Disorders section;

- Treatment of alcohol or drug abuse except as provided under Alcoholism or Drug Abuse or Dependency section;

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

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

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

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

- Maintenance Therapy;
- Acupuncture and related expenses;
- Sex-change operations, gender dysphoria, penile and breast implant, infertility, artificial insemination, in vitro fertilization, gamete intrafallopian transfer (GIFT), and services of a surrogate mother;
- Services of more than one Physician rendering treatment for the same condition;
- Charges for keratotomies or keratoplasties;
- Charges for telephone consultations, missed appointments, completion of claim forms or preparation of medical reports;
- Family and marital counseling;
- Temporomandibular Joint Syndrome ("TMJ");
- Maternity and obstetrical benefits for dependent children;
- Hearing aids;
- No benefits are payable for services (treatment) or supplies to treat hair loss or to restore lost hair;
- No benefits are payable for chelation therapy except for arsenic, gold, mercury or lead poisoning;
- Personal hygiene and convenience items (such as, but not limited to, air conditioners, humidifiers, hot tubs, whirlpools, sunbeds, waterbeds, physical fitness equipment or like items), weight control programs, transportation vehicles or home improvements, health club or country club memberships even though a Physician may prescribe them;
- No benefits are payable for services or supplies related to the treatment for abuse of nicotine from tobacco and other sources;
- Suicide or for the natural, proximate or foreseeable consequences of an attempt to commit suicide;

- Any voluntary, advertent or intentional conduct, the natural, proximate and foreseeable result of which will be some form of self-injury;

- Any injury sustained while engaged in any conduct which was in violation of any federal, state or local criminal statute (felony or misdemeanor), and regardless of whether charged, indicted or convicted;

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

- Services or supplies for sterilization reversal;

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

- Exogenous obesity, a condition usually caused by overeating, unless the Eligible Person is 60 percent over normal body weight and treatment is otherwise Medically Necessary;

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

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

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

- Over-the-counter drugs or vitamins;

- Immunizations (other than pediatric);

- Contraceptives;

- Services or treatment provided by an Immediate Relative;

- Charges in excess of those which are Reasonable and Customary (See, definition at Page 62);

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

- Food supplements or augmentation;

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

- Court-ordered services; and

- Sales Tax.

COORDINATION OF BENEFITS

Coordination of Benefits (COB) provides a framework for coordinating payment of medical and dental expenses when you and other members of your family have multiple sources for the payment of medical expenses (here called "payment source" or "plan"). For example, if your spouse has coverage under a group benefit plan sponsored by his or her employer and is also covered under this Plan, then you and your dependents may be eligible for benefits under both your spouse's plan and this Plan. Similarly, you or your spouse may have coverage for medical or dental expenses under general liability, automobile liability, uninsured/underinsured automobile or no-fault automobile insurance policies as well as this Plan.

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

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

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

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

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

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

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

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

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

Coordination of Benefits with Health Maintenance Organization (HMO)

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

Coordination with Medicare

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

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

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

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

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

Right to Receive and Release Needed Information

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

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

SUBROGATION AND RECOUPMENT

This Plan will use its right of Subrogation and Recoupment if you or your Dependent are paid benefits under this Plan for expenses due to injuries or illnesses for which someone else may be obligated to pay you for any reason.

Subrogation means that this Plan can recoup from the person who caused the injury, or that person's insurance company, the benefits paid on your behalf for that injury, including, but not limited to, claims compensable under state workers' compensation laws, medical malpractice or tortious conduct by a third party. Recoupment means that this Plan can recoup from you or any insurance policy, including but not limited to, a fault or no-fault automobile insurance policy, underinsured/uninsured automobile insurance policy, or other casualty or liability insurance policy, the amount of benefits paid by this Plan that should have been paid by another plan or insurance policy in accordance with the coordination of benefits rules in this Plan.

Your claims and benefit payments will normally continue to be paid in the same way as they always have been. However, you or your dependent will have certain responsibilities to this Plan. When you or your dependent submit a claim for injuries, the Fund Office will have you complete forms requesting information as to how the injuries occurred and the identity of any potentially responsible third parties; the disclosure of any applicable insurance coverage; and requesting acknowledgement of this Plan's subrogation and recoupment provision by you and your attorney. At the request of the Fund Office, you must also sign any other documents and do whatever else is reasonably necessary to secure the Plan's right of subrogation and recoupment, including written acknowledgement of a lien in favor of this Plan that may be delivered in any way to the person whose act caused the injuries, his agent or his insurance company or any other insurance company, or that may be filed with a court having jurisdiction in the matter.

In consideration of this Plan's advancing your expenses, which may be the responsibility of the tortfeasor, or other insurer, including but not limited to, a fault or no-fault automobile insurer, underinsured/uninsured insurer, or other casualty or liability insurer, you, the tortfeasor and your respective agents and representatives agree to acknowledge and abide by the subrogation lien and reimburse this Plan directly to the extent of any benefits paid. You must not do anything to impair or negate this right of subrogation and recoupment, and if any of your acts or omissions compromise this right of subrogation and recoupment, this Plan will seek reimbursement of all appropriate benefits paid directly to you and/or your eligible dependents and/or will offset benefits otherwise payable to you under this Plan. Claim processing **may be suspended** until the Fund Office receives adequate information and completed forms.

The eligible Participant, Eligible Retired Participant and the Eligible Dependent ("Eligible Person") shall reimburse the Fund for any benefits paid out of any monies recovered from the third party as the result of judgment, settlement or otherwise.

To the extent of the aforesaid payments made or to be made by the Fund to the Eligible Person, any money that may be recovered by the Eligible Person as a result of such payments by the Fund, or otherwise, from any third-party with respect to the matter giving rise to the above-referenced loss, whether by judgment, settlement or otherwise, together with such costs as are

allowed by law, shall be repaid to the Fund by the Eligible Person. The Fund, however, shall not be obligated to share, set-off or reimburse any portion of the Eligible Person's attorney fees and/or costs and expenses associated with any lawsuit, judgment or settlement which preceded such recovery by the Eligible Person. Moreover, the Fund may seek reimbursement from the Eligible Person for any amounts paid by the Fund to the Eligible Person and/or on behalf of the Eligible Person, regardless of whether the Eligible Person has received full reimbursement or been made whole for any or all losses claimed by the Eligible Person.

ADMINISTRATION OF THE FUND

Payments of Benefits Limited to Plan

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

Amendment or Termination of Plan or Benefits

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

Payment of Claims and Assignment of Benefits

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

Payment of Unassigned Benefits in Event of Death

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

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

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

Misstatements

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

Presentment of Claims on Behalf of Person Who is Incapacitated

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

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

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

Claims for Medical Service Rendered Outside of the United States

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

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

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

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

Recovery of Overpayment

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

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

Validity of Plan and Plan Provisions

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

Construction by Trustees

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

Any interpretation of the Plan or Trust Agreement made by the Trustees shall, subject to the claimant's right to legal action, be final and binding on all parties.

Legal Actions

No action at law or in equity shall be brought to recover any benefits provided under this Plan before the expiration of 120 days after written proof of loss has been furnished nor shall any such action be brought after the expiration of three years after the time written proof of loss is required to be furnished.

DEFINITIONS

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Dependent -- see Pages 18-19.

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

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

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

- It can withstand repeated use;

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

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

- It is appropriate for home use; and

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

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

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

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

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

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

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

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

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

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

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

Experimental -- any medical procedure, equipment, treatment or course of treatment, or drugs or medicines that are meant to investigate or are limited to research. This term also means techniques that are restricted to use at those centers that are capable of carrying out disciplined clinical efforts and scientific studies. "Experimental Procedure" also includes procedures which are not proven in an objective manner to have therapeutic value or benefit. Any procedure or treatment whose effectiveness is medically questionable is also deemed experimental.

Experimental may be determined through studies, opinions and reference to or by the American Medical Association, The Federal Drug Administration, The Department of Health and Human Services, the National Institutes of Health, the Council of Medical Specialty Societies or any other medical association or Federal program or agency that has the authority to approve medical testing and treatment.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Qualified Medical Child Support Order -- a court order requiring medical support which meets the Plan's Rules and Regulations and federal law requirements to be a Qualified Medical Child Support Order. Please contact the Fund Office for a copy of applicable Rules and Regulations.

Reasonable and Customary Charges (also referred to as UCR) -- the highest allowable expenses that the Plan will accept for a given treatment or procedure. The terms means charges for services and supplies essential to the care of the individual which do not exceed the usual charges for those services and supplies by health providers in that area. The amount the Plan will pay will be based on the amount for a service or supply customarily charged by the majority of health providers in that geographic area. If the charge is more than the customary charge determined by the Plan, the Eligible Person will have to pay the difference.

For purposes of determining the Reasonable and Customary charge of a majority of health care providers in the geographical area for a specific procedure, the Trustees shall use such published data as they determine appropriate and reasonable for that purpose. The Trustees shall not be limited to any specific source of data, but may decide that determination will be made based on specific data sources they deem appropriate from time to time.

UCR may also have reference to rates negotiated with Preferred Providers.

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

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

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

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

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

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

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

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

(D) The Plan is maintained pursuant to one or more collective bargaining agreements and a copy of any such agreement may be obtained by you upon written request of

the Plan Administrator , and is available for examination by participants or beneficiaries at the Union hall.

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

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

(G) In addition to creating rights for Plan participants, ERISA imposes duties upon the individuals who are responsible for the operation of the employee benefit plan. The individuals who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan Participants and Beneficiaries. No one, including your employer, your union or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA. If your claim for a benefit is denied in whole or in part you must receive a written explanation of the reason for the denial. You have the right to have the Plan review and reconsider you claim.

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

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

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

or

U.S. Department of Labor
Pension & Welfare Benefits Administration
1885 Dixie Highway
Suite 210
Ft. Wright, KY 41011-2664

IN WITNESS WHEREOF, the Trustees of the Ohio Conference of Plasterers and Cement Masons Health and Welfare Fund have adopted the Plan in its restated form on this _____ day of _____ 2000, but effective as of December, 2000 (except as otherwise noted herein).

EMPLOYER TRUSTEES	UNION TRUSTEES
_____	_____
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