PAINTERS DISTRICT COUNCIL NO. 4
HEALTH & WELFARE FUND
SUMMARY PLAN DESCRIPTION

Effective January 1, 2021

PAINTERS DISTRICT COUNCIL NO. 4 HEALTH & WELFARE FUND
SUMMARY PLAN DESCRIPTION

Introduction

The Board of Trustees of the Painters District Council No. 4 Health & Welfare Fund is pleased to present this revised Summary Plan Description, which describes the benefits and eligibility requirements of the Welfare Plan. Also included in this booklet are the procedures that you should follow when filing a claim, and certain information concerning the administration of the Plan as required by the Employee Retirement Income Security Act of 1974 (ERISA).

The benefits described in this booklet are the result of continuous efforts of the Board of Trustees to offer an excellent program of benefits that will help meet the needs of your entire family. We urge you to read this booklet carefully so that you understand the complete package of benefits available to you and your eligible family members. You should share this booklet with your family and keep it in a convenient place for future reference.

The Welfare Plan is designed to help you and your family to meet the continuing rising costs of medical care as well as provide a measure of protection if you are unable to work due to layoff or disability.

This booklet summarizes the key features of your Welfare Fund benefits program. Complete details of the program are also contained in the other official Plan documents, including the Trust Agreement, the Fund's contracts with its benefit insurers and health maintenance organizations, and collective bargaining agreements, which legally govern the operation of the program. All official Plan documents are available for your inspection at the Fund Office during normal business hours. All statements made in this booklet are subject to the provisions and terms of those documents. In case of a conflict or inconsistency between the official Plan documents and this booklet, the official documents will govern in all cases.

The Trustees intend to continue this Plan indefinitely, but reserve the right to amend, modify, suspend, or terminate the Plan at any time. The Plan is maintained for the exclusive benefit of employees and their dependents.

This booklet is not a contract of employment – it neither guarantees employment or continued employment with your employer or any Contributing Employer, nor diminishes in any way the right of Contributing Employers to terminate the employment of any employee.

If you have questions about the Plan or how to apply for benefits, do not hesitate to contact the Fund Office.

Sincerely,

Board of Trustees

I
DEFINITIONS

Certain terms used in this Summary Plan Description have special meanings. These terms will be capitalized and will have the meaning set forth below:

1.1 Certificate of Coverage. The term "Certificate of Coverage" will mean the document provided to you by the insurance company or HMO chosen by the Trustees to provide health and hospitalization coverage. Its purpose is to explain the provisions of the Group Contract.

1.2 Change in Family Status. The term "Change in Family Status" will mean your marriage or divorce, the death of your spouse, the termination of employment of your spouse, or such other change in your spouse's employment status that results in a termination or significant reduction in your health care benefits.

1.3 Code. The term "Code" will mean the Internal Revenue Code of 1986, as amended.

1.4 Collective Bargaining Agreement. The term "Collective Bargaining Agreement" will mean any agreement between the Union and an Employer, which agreement requires the payment of periodic contributions to the Fund or other written participation or other agreement acceptable to the Trustees, which agreement requires the payment of periodic contributions to the Fund.

1.5 Group Contract. The term "Group Contract" will mean the insurance contract used by the Trustees to provide health and hospitalization coverage benefits.

1.6 Contributions. The term "Contributions" will mean those payments made to the Fund as required by the Collective Bargaining Agreement reduced by the hourly administrative fee as established by the Trustees. Presently, the administrative fee is three per cent of the payments required by the Collective Bargaining Agreement.

1.7 Covered Employment. The term "Covered Employment" will mean employment of a type covered by a Collective Bargaining Agreement and requiring contributions to the Fund.

1.8 Dependent. The term "Dependent" means your spouse and each of your children under age 26, including legally adopted children and children placed with you for adoption to the extent required by law. Coverage for adopted children and children placed with you for adoption shall be provided on the same basis as coverage for your natural children. This Plan will also provide benefits pursuant to the terms of any "Qualified Medical Child Support Order," as defined in Section 609 of ERISA (including a National Medical Child Support Notice), as a result of any domestic relations matter.

1.9 Disability. The term "Disability" will mean a physical or mental condition resulting from bodily injury, disease or mental condition which renders a person incapable of continuing any gainful occupation and which entitles him to benefits under the New York State Disability Benefits Law or Worker's Compensation Act. Disability shall be determined by the Trustees in their sole and absolute discretion.

1.10 Employee. The term "Employee" will mean any person employed by an Employer and covered by a Collective Bargaining Agreement.

1.11 Employer. The term "Employer" will mean (i) any one of the employer members of an employer association that enters into a Collective Bargaining Agreement with the Union; (ii) an independent signatory to a Collective Bargaining Agreement that is acceptable to the Board of Trustees; (iii) the Painters District Council No. 4 Security Benefit Fund; and (iv) the Union.

1.12 Fund. The term "Fund" will mean the **Painters District Council No. 4 Health & Welfare Fund**, which includes all contributions to the Trustees pursuant to the terms set forth in the Collective Bargaining Agreement, together with all the income, earnings and profits thereon received by the Trustees, less any expenses paid therefrom. The Fund may be used only for the purposes set forth in the Trust Agreement.

1.13 Hour of Service. The term "Hour of Service" will mean each hour for which you are entitled to payment by the Employer and for which the Employer makes Contributions to the Fund pursuant to its obligation under the Collective Bargaining Agreement.

1.14 Minimum Balance. The term "Minimum Balance" will mean the minimum amount that must be in an individual's Health Care Account in order to be eligible for benefits. The Minimum Balance is $1,500.

1.15 Monthly Premium. The term "Monthly Premium," will mean the amount determined by the Trustees to be the cost of a month of coverage for insured health benefits provided under the Plan.

1.16 Plan. The term "Plan" will mean this written plan of benefits of the Fund adopted by the Trustees setting forth the eligibility rules for the health and welfare benefits to be paid from the Fund.

1.17 Plan Administrator. The term "Plan Administrator" or "Administrator" will mean the Board of Trustees of the Fund. The Plan Administrator will administer the Plan, keep the Plan's records and has discretionary authority to construe the terms of the Plan and make determinations on questions which affect eligibility of benefits.

1.18 Plan Year. The term "Plan Year" will mean the twelve month period beginning on June 1 and continuing to the following May 31.

1.19 Retirees. The term "Retirees" will mean the persons who have retired from the bargaining unit of Employees covered by the Collective Bargaining Agreement and are receiving a pension from the International Brotherhood of Painters and Allied Trades Pension Fund.

1.20 Trust Agreement. The term "Trust Agreement" will mean the Agreement and Declaration of Trust, Painters District Council No. 4 Health & Welfare Fund, dated December 10, 1991, together with any amendments made thereto.

1.21 Trustees. The term "Trustees" will mean the Board of Trustees of the Fund.

1.22 Union. The term "Union" will mean District Council No. 4 of Buffalo and Vicinity, International Union of Painters and Allied Trades of America, AFL-CIO, and its successors and assigns.

II
GENERAL INFORMATION ABOUT THE FUND

This Section contains certain general information which you may need to know about the Fund.

A. General Fund Information

The name of the Fund is the Painters District Council No. 4 Health & Welfare Fund.

The Fund's records are maintained on a twelve-month period of time. This is known as the Plan Year. The Plan Year is the twelve-month period beginning June 1 and ending the following May 31.

B. Plan Administrator

The Plan is sponsored by the Board of Trustees of the Painters District Council No. 4 Health & Welfare Fund. The Board of Trustees is also the Plan Administrator. The Board of Trustees is responsible for the overall operation and administration of the Fund.

The employer identification number of the Plan Sponsor is 16-6070541. The Trustees have assigned plan number 501 to the Fund.

The following individuals currently comprise the Board of Trustees:

Employer Trustees:

Allen Richards
Niagara Coatings Services, Inc.
8025 Quarry Road
Niagara Falls, NY 14304

Tom Marchiole
Mader Construction
970 Bullis Road
Elma, NY 14059

John Lignos
Amstar of WNY
825 Rein Road
Cheektowaga, NY 14225

Aaron Hilger
Construction Industry Association of Rochester, Inc.
180 Linden Oaks
Rochester, NY 14625

Earl Hall
Construction Employers Association of CNY
6563 Ridings Road
Syracuse, NY 13206

Jim Stathopoulous
Ajay Glass & Mirror Co., Inc.
101 North Street
Canandaigua, NY 14424

Martha Gomez
OSO Inc.
3001 Brockport Rd, Suite A
Spencerport, NY 14559

Christine Inluxay (Alternate)
R.W. Painting, Inc.
65 Mid County Drive
Orchard Park, NY 14127

Union Trustees:

Michael Hogan
Painters District Council No. 4
585 Aero Drive
Cheektowaga, NY 14225

Dominic Zirilli
Painters District Council No.4
585 Aero Drive
Cheektowaga, NY 14225

Todd Rotunno
Painters DC#4 Local No. 150
244 Paul Road
Rochester, NY 14624

Daniel LaFrance
Painters DC#4 Local No. 38
12829 Timerson Road
Red Creek, NY 13143

Michael Dems
Painters DC#4 Local No. 31
615 W. Genesee Street
Syracuse, NY 13204

Brian Lipczynski
Glaziers Local 660
585 Aero Drive
Cheektowaga, NY 14225

Robert Casella (Alternate)
IUPAT Local 677
244 Paul Road
Rochester, NY 14624

Daniel Jackson (Alternate)
Painters DC#4 Local No. 178
2025 Warner Road
Moravia, NY 13318

Responsibility for administration of health and hospital insurance claims has been delegated to the claims processor providing those benefits.

Responsibility for administration of life insurance claims has been delegated to the insurance company providing that benefit.

Please remember that no one except the Board of Trustees (and other Plan fiduciaries and individuals to whom the Board of Trustees has delegated responsibility for administration of the Plan) has the authority to interpret the Plan, including this booklet or the other official Plan documents, to make any promises to you about it, or to change the provisions of the Plan. The Board of Trustees (or its duly authorized designee) has the exclusive right and power, in its sole and absolute discretion, to interpret the Plan documents and to decide all matters under the Plan, including, without limitation, the right to make all decisions with respect to eligibility for and the amount of benefits payable under the Plan and the right to resolve any possible ambiguities, inconsistencies or omissions concerning the Fund or the Plan. All determinations by the Board of Trustees (or its duly authorized designee) are final and binding on all persons and will be given full force and effect.

C. Administrator Information

The Trustees have delegated certain day-to-day administrative duties to Fund office staff. They may be contacted at:

District Council No. 4 Trust Funds
585 Aero Drive
Cheektowaga, NY 14225
(716) 565-0234

As a courtesy, Fund staff may respond informally to your oral questions. However, oral questions and answers are not binding upon the Board of Trustees and cannot be relied upon in a dispute concerning your benefits. If you have an important question, you should contact the Board of Trustees for a written response.

D. Service of Legal Process

The name and address of the Fund's agent for service of legal process is:

Board of Trustees
Painters District Council No. 4
Health & Welfare Fund
585 Aero Drive
Cheektowaga, NY 14225

Legal process may be served on any individual Trustee.

E. Type of Plan

The Plan is a welfare benefit plan providing health, hospitalization, health care reimbursement, supplemental unemployment, life insurance, disability, education, and vacation

benefits. The life insurance benefits are insured while other benefits are provided on a self-insured basis.

The Plan is maintained pursuant to one or more collective bargaining agreements. A copy of any such agreement may be obtained by participants and beneficiaries upon written request to the Plan Administrator, and is available for examination by participants and beneficiaries. In addition, participants and beneficiaries may receive from the Plan Administrator, upon written request, information as to whether a particular Employer or employee organization is a sponsor of the Plan and, if so, the sponsor's address.

III
PERSONAL ACCOUNTS

A. Tax Free vs. Taxable Benefits

For purposes of determining your eligibility for benefits under the Plan, the Plan Administrator will create and maintain individual accounts on your behalf. A Health Care Account will provide you with tax-free medical benefits.

A Wage Replacement Account will provide you with taxable unemployment, disability, and vacation benefits.

The law prohibits the transfer of any balance in your TAX FREE accounts to your TAXABLE accounts and vice versa.

Each account will include a record of contributions received on your behalf, benefits paid, and fees and expenses charged against the account. The maintenance of these accounts is for record keeping purposes only. You do not have a vested right to the balance in the account or any benefit offered by the Plan; accounts are used only to determine your eligibility for benefits and actual segregation of assets does not occur.

If there is no contribution to, or distribution from your Health Care Account or Wage Replacement Account for a period of twenty-four (24) consecutive months, then any balance in those accounts will be forfeited and added to the Fund' reserves. Further, any balance remaining in your Health Care Account upon your death (if you are not survived by a spouse or eligible dependents), or upon the death of the survivor of your spouse or eligible dependents, will be forfeited and added to the Fund's reserves. Any balance remaining in your Wage Replacement Account will be forfeited upon your death and added to the Fund's reserves.

B. Allocation of Contributions

The basis on which Contributions made to the Fund on your behalf will be divided between your accounts will depend on the type of coverage, if any, you are receiving from the Fund. Contributions will be credited to your accounts as of the first of the month following the month they are received by the Trustees.

In order to be eligible for any medical benefits under the Plan, you must first accumulate the Minimum Balance in your Health Care Account. The Minimum Balance is $1,500.

If you fail to enroll in coverage or complete a waiver of insurance form, you will automatically be provided single coverage from the Fund when your Health Care Account balance reaches $3,000.

Contributions will be allocated between Fund accounts according to the percentages set forth in the following table:

		If your Health Care Account balance is:	
		Under $1,500	Over $1,500 *
and your coverage from the Plan is:	Outside Coverage	97% Health	20% Health
	Single	97% Health	50% Health
	Two Person or no coverage	97% Health	80% Health
	Family	97% Health	97% Health**

* The maximum amount that may be accumulated in your Wage Replacement Account is $12,500. Once your Wage Replacement Account equals or exceeds $12,500, all Contributions made to the Fund on your behalf, after reduction for administrative expenses, shall be allocated to your Health Care Account. When the balance in your Wage Replacement Account falls below $12,500, Contributions will again be allocated in accordance with the table above.

**The administrative fee is 3% of employer contributions. This amount is deducted first from contributions to your Wage Replacement Account but, if none, then the administrative fee will be deducted from contributions prior to credit to your Health Care Account.

IV
HEALTH AND RELATED BENEFITS

A. Health and Hospitalization Coverage

Your health and hospitalization coverage is provided on a self-insured basis under a contract with BlueCross BlueShield of Western New York. You should receive a separate Summary Plan Description for the Painters District Council No. 4 Health and Welfare Fund's Health Care Plan (the "Health Care Plan"). In the separate Summary Plan Description you should find information about the specific health and hospitalization benefits to which you and your Dependents are entitled including any deductibles, co-payments, lifetime or annual caps, network providers, and any other conditions or limitations on benefits.

1. **Eligibility**. In order to be entitled to health and hospitalization coverage under the Health Care Plan, you must satisfy the following conditions:

(a) You must be working in Covered Employment or have reported to the Union as eligible to work in Covered Employment;

(b) You must have accumulated the Minimum Balance in your account to pay the Monthly Premium to the Administrator on or before the 1st day of the month; and

(c) You must complete the necessary enrollment forms as provided by the Administrator.

On your enrollment form, you may elect to enroll your spouse and/or eligible dependent children. Upon enrollment and from time to time thereafter, the Administrator (or any insurer or HMO providing coverage) may require that you present satisfactory (as determined by the Administrator, in its sole and absolute discretion) proof of the initial and/or continuing eligibility of your spouse or dependent children.

If you meet all the requirements for health and hospitalization coverage other than completion of the necessary enrollment forms, you will be enrolled in the lowest cost single coverage available.

Special Enrollment Rights. If you decline health and hospitalization coverage from the Fund for yourself or for your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in this Plan, provided that you request enrollment within 30 days after your other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

A child is considered placed for adoption on the date you first become legally obligated to provide support for the child whom you plan to adopt. If the adoption does not become final, coverage for the child will terminate as of the date you no longer have a legal obligation to support the child.

2. Disability. In the event you incur a Disability, you will be entitled to continued health and hospitalization coverage without charge to your Health Care Account for as long as you are disabled, but not in excess of 26 weeks for each disability, provided you meet the Credit Hours requirement set forth below for the insurance quarter in which your Disability began. You will continue to receive the same form of coverage (i.e., single or family), under the same Group Contract or HMO, as you were receiving immediately prior to your disability.

Eligibility Quarter	Insurance Quarter
February, March, April	June, July, August
May, June, July	September, October, November

August, September, October	December, January, February
November, December, January	March, April, May

To meet the Credit Hours requirement you must accumulate:

(a) Two Hundred Seventy-Five (275) Hours of Service in an Eligibility Quarter;

(b) Five Hundred (500) Hours of Service in two (2) consecutive Eligibility Quarters;

(c) Seven Hundred (700) Hours of Service in the three (3) consecutive Eligibility Quarters; and

(d) Eight Hundred (800) Hours of Service in the four (4) consecutive Eligibility Quarters.

3. Termination of Eligibility. If at any time your Health Account is reduced to an amount less than one Monthly Premium, the Administrator will notify you. At that time you may elect self-payment to maintain your health and hospitalization coverage benefit. You must make your payment prior to the beginning of the month for which you elected self-payment. Terms and conditions, as well as the amount required for self-payment, may be obtained from the Fund Office.

If you fail to make the initial payment for health insurance on a self-payment basis, you may still be able to exercise your rights to extend your health insurance coverage under COBRA as set forth in Article IX, below, but the length of your continuation coverage will be limited to the time periods specified. You should review the time limits set forth in Article IX for making a COBRA election.

Unless you are entitled to continue coverage in accordance with Article IX, your health and hospital insurance benefits from the Fund will end on the last day of the month in which occurs the earlier of:

(a) Your Health Care Account balance falls below the Minimum Balance or would fall below the Minimum Balance if you paid the Monthly Premium, or you fail to remit the required Monthly Premium to the Administrator; or

(b) You are no longer working nor are available for work in Covered Employment.

4. **Family and Medical Leave Act and New York Paid Family Leave Law**. If you are eligible for, and are granted leave by your Employer under the Family and Medical Leave Act of 1993, (the "FMLA") and/or the New York Paid Family Leave Law (the "PFLL") you will be entitled to health and hospitalization insurance coverage under the plan throughout the duration of your leave, but your Employer must continue to contribute to the Plan during that period the monthly premium established by the Plan in order for you to continue your coverage. You will

receive the type of coverage (i.e., family or single) you were receiving prior to the leave, subject to any change you may have in family status.

If you fail to return to work after a period of unpaid FMLA leave entitlement has been exhausted or expires, your Health Care Account will be reduced by the costs to maintain health and hospitalization insurance coverage for the term of the unpaid leave, unless the reason you did not return is due to:

- a continuation, recurrence, or onset of a serious health condition, which entitles you to leave under the FMLA; or
- other circumstances beyond your control as defined in the FMLA and the regulations thereunder.

Questions regarding your entitlement to FMLA or PFLL leave should be referred to your Employer.

Questions about the continuation of medical and dental coverage during leave, if available, should be referred to the Fund Office.

If coverage is terminated for failure to make payments while you are on an approved family or medical leave of absence, coverage for you and your eligible dependents will be automatically reinstated on the date you return to employment if you and your dependents are otherwise eligible under the plan. However, all accumulated annual and lifetime maximums will apply.

If you do not return to work at the end of an FMLA of PFLL leave, you may be entitled to elect COBRA Continuation Coverage, even if you were not covered under the Plan during the leave. Coverage continued under this provision is in addition to coverage described below under the section entitled "Continuation Coverage (COBRA).

5. USERRA. If you are covered by the Plan and enter the United States armed forces (including the United States Armed Forces, the Coast Guard, the Army National Guard, the commissioned corps of the Public Health Service, and certain other categories of service), you may be entitled to continue your (and your Dependent's) health coverage under the Plan during your military service.

If that happens, you will have two options:

Option 1: You may elect to continue your health coverage without having deductions taken from your Health Care Account. If you elect this option and your military service is 30 days or less, your health insurance coverage continues without any deduction to your Health Care Account (and you will only be required to pay the normal employee contribution). If you elect this option and your military service exceeds 30 days, you will be required to pay the applicable COBRA premium to remain covered, but your Health Care Account will not be reduced. You can receive this self-pay coverage for a period of up to 24 months total (or, if earlier, until the day after the date you fail to apply for or return to covered employment). Payments would generally need to be made under the same procedures required for COBRA premiums.

Option 2: You may elect to continue your health coverage by having deductions taken from your Health Care Account for the normal cost of the coverage (as if you were working). If your Health Care Account falls below the Minimum Balance while you are in military service, you will be able to purchase continued coverage described under Option 1. In addition, if that happens, once you are reemployed (within the time periods prescribed by law), your health coverage may be reinstated but you will be required to pay the cost of the coverage until your Health Care Account has the Minimum Balance.

Separation from uniformed service that is dishonorable or based on bad conduct, on grounds less than honorable, AWOL, or ending in a conviction under court martial would disqualify you from any rights under USERRA. Please contact the Fund Office for more information regarding your options under USERRA.

6. Government Programs and Your Health Benefits

a) Coordination of Benefits.

Under federal law, if you or your spouse become eligible for Medicare while you are in "current employment status" the Plan cannot take into account any Medicare benefits to which you are entitled. This means that the Plan and your health and hospitalization insurance coverage must be your primary insurance and if you or your spouse choose to drop coverage under the Plan, and elect Medicare, the Plan and your health and hospitalization insurance coverage is prohibited from supplementing any Medicare-covered services. The Plan cannot reimburse you for any deductibles, co-insurance, or co-payments for a Medicare covered service. The Plan will continue to cover services that Medicare doesn't cover such as hearing aids, routine dental care, and routine physical exams.

Also, federal law prohibits the Plan from providing any incentive for you or your spouse to drop Plan coverage and elect Medicare while you are in "current employment status." It also prohibits reimbursement of premiums other than group health premiums. Thus, the Plan cannot reimburse Medicare Part B or Part D premiums.

"Current employment status" means (a) you are actively working for an Employer, (b) you are receiving disability benefits from the Fund for up to six months; or (c) you retain employment rights in the industry, are not receiving disability benefits from the Fund for more than six months or from Social Security, and you have group health coverage other than COBRA coverage.

Similar rules also apply to TRICARE (the government health program for military personnel), veterans and their families, and to any health programs operated by the Indian Health Service, Indian tribes, tribal organizations, and Urban Indian organizations (except in limited circumstances as indicated below).

b) Waiver of Coverage.

The Plan permits you to waive health insurance coverage if you have alternative coverage meeting certain requirements. Generally, federal law requires that Medicaid (including organizations that are funded through Medicaid), and certain health programs operated by the Indian Health Service, Indian tribes, tribal organizations, and Urban Indian organizations be the

payer of last resort (unless you provide verification from the Indian Health Service, tribe or tribal organization that you disclosed that you had health coverage available under the Plan). This means that the Plan cannot accept these programs as alternative coverage for purposes of a waiver.

You should also note that if you decide to waive coverage for yourself or any Dependents, you will need to sign a waiver that, among other things, confirms that you are not doing so for purposes of obtaining eligibility for Medicaid or any coverage (such as payer of last resort coverage) for which you or they would not be eligible as a result of your or their eligibility for Fund coverage.

Please note that this SPD describes above significant limitations on your ability to receive Health Care Reimbursements in certain circumstances if you waive coverage. You should review these limitations before deciding whether to waive coverage.

7. Hospital Stays in Connection with Childbirth. Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally 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). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the Fund or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours, as applicable).

8. Reconstructive Breast Surgery. Although cosmetic surgery may be excluded from the health and hospitalization insurance coverage offered by the Fund (see the Certificate of Coverage for further information in that regard), in accordance with the requirements of a Federal law entitled, the Women's Health and Cancer Rights Act of 1998, if the Fund provides medical and surgical benefits in connection with a mastectomy, the Fund will also provide benefits for certain reconstructive surgery. In particular, in such a case, the Fund will provide to a participant or beneficiary who is receiving (or presents a claim to receive) benefits in connection with a mastectomy and who elects breast reconstruction in connection with such mastectomy, coverage for the following:

- reconstruction of the breast on which the mastectomy has been performed;
- surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- prostheses and physical complications associated with all stages of mastectomy, including lymph edemas, in a manner determined in consultation between the attending physician and the patient.

This coverage will be subject to the annual deductible and coinsurance provisions applicable to other surgical procedures. In addition, to the extent permitted by applicable law, this coverage may also be subject to benefit maximums and co-payment provisions that may apply under the Group Insurance Contract. You should review carefully the provisions of the Certificate

of Coverage regarding any such restrictions that may apply. If you have any questions regarding this coverage, please contact the Administrator.

9. Genetic Information Nondiscrimination Act of 2008 (GINA). GINA prohibits health coverage and employment discrimination against employees based on their (or their family members') genetic information. Genetic information includes genetic tests of employees and their family members and the manifestation of a disease or disorder in family members of employees.

Under GINA, group health plans and health insurers providing group health plan coverage cannot use genetic information to set premiums or contribution amounts. They also cannot request, require, or purchase genetic information prior to an individual's enrollment in the Plan or request or require genetic testing of an individual or family member for underwriting purposes.

10. Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA). MHPAEA requires group health plans and health insurance issuers to ensure that financial requirements and treatment limitations for mental health and substance use disorder benefits are no more restrictive than the requirements and limitations applied to medical or surgical benefits. The MHPAEA supplements prior provisions under the Mental Health Parity Act of 1996, which required equal benefits with respect to lifetime and annual dollar limits for mental health benefits.

C. Health Care Reimbursement

1. **Eligibility**. You will be eligible for Health Care Reimbursement coverage under your Health Care Account only after you have accumulated the Minimum Balance and you are enrolled and participating under a group health insurance plan offered through the Fund, through your spouse's employer, or through your parent's employer. If you are enrolled in your spouse's or parent's plan, that plan must provide "Minimum Value." A health plan provides Minimum Value if the health plan's share of the total allowed cost of benefits is at least 60 percent (i.e., has an actuarial value of at least 60 percent). If you do not enroll in coverage through the Fund, you will be eligible to use your Health Care Account only if you present your enrollment card in your spouse's or parent's group health plan and provide a copy of that plan's Summary of Benefits and Coverage (SBC) indicating that it meets the Minimum Value standard.

Effective June 1, 2017, unless your spouse and Dependents are covered by employer group coverage, you may no longer submit their medical expenses for reimbursement.

If you waive health insurance coverage through the Fund for any coverage other than employer-based group coverage, you will not be able to submit any medical expenses for reimbursement regardless of your status with the Union. **Individual coverage purchased through NY State of Health, Medicare, Medicaid, TRICARE or health programs operated by the Indian Health Service, Indian tribes, tribal organizations, and Urban Indian organizations will not qualify.**

Once you become eligible for coverage under this Health Care Reimbursement benefit, you may file a claim for a distribution for the reimbursement of any Qualified Medical Expenses. Distributions reduce your Health Care Account on a dollar for dollar basis.

2. **Qualified Medical Expenses.** Qualified Medical Expenses are those that are not eligible for reimbursement under any other plan or any other source, including another health reimbursement account or flexible spending account, and are medically necessary expenses that are incurred by you, your spouse, and your Dependents during the Plan Year for medical care as defined in Section 213(d) of the Internal Revenue Code. You may include all medical, dental, and vision expenses for the diagnosis, cure, treatment or prevention of disease, and for treatments affecting any part or function of the body that are not covered or not reimbursed by insurance or any other source. Expenses may also be to alleviate or prevent a physical defect or illness. Expenses incurred solely for cosmetic reasons or expenses that are merely beneficial to a person's general health are not eligible for reimbursement. Medical expenses qualify for reimbursement based on when they are incurred and are considered incurred at the time the drugs, medical equipment, or medical care service is provided, not at the time you pay for them.

For purposes of this Health Expense benefit only, Dependents include your spouse and any child of yours who will be under age 27 as of the end of the calendar year, provided your spouse and child are covered under your policy or your spouse's policy. For this purpose, a "child" is an individual who is your son, daughter, stepson, or stepdaughter, and includes a legally adopted individual, an individual lawfully placed with you for legal adoption, and a foster child placed with you by an authorized placement agency or by judgment, decree, or other order of any court of competent jurisdiction.

As provided in Article III, once your Health Care Account falls below the Minimum Balance, you may not use it for any purpose other than the payment of premiums for single coverage for yourself. You may, however, save any Qualified Medical Expenses incurred while you are enrolled in coverage for later reimbursement.

3. Carryover of Health Care Account. If any balance remains in your Health Care Account after all reimbursements have been made for a Plan Year, that balance will be carried over to reimburse you for Qualified Medical Expenses incurred during a subsequent Plan Year. You will remain eligible for the Health Expense benefit if you leave Covered Employment or retire, but only if you are enrolled in qualifying employer group coverage (See Paragraph C. 1., above) and only to the extent of the balance remaining in the Health Care Account.

The balance in your Health Care Account will be forfeited and added to the Fund's reserves at the end of a period of twenty-four (24) consecutive months in which there is no contribution to, or distribution from your Health Care Account. Further, any balance remaining in your Health Care Account upon your death (if you are not survived by a spouse or eligible Dependents), or upon the death of the survivor of your spouse or eligible Dependents, will be forfeited and added to the Fund's reserves.

You will have the option each year at open enrollment, and upon your retirement or termination of employment, to **permanently** opt out of Health Account coverage. If you do so prior to retirement or termination of employment, the balance in your Health Account may only be used for the payment of group health insurance coverage through the Fund. If you opt out of Health Account coverage at retirement, or after a period of 12 months without any Employer Contributions, then your entire Health Account will be forfeited.

4. **Claims.** You may submit your claim for reimbursement by completing a claim form and providing one of the two types of acceptable documentation. First, you may submit a claim under a medical, dental or vision care plan, which covers the person for whom the medical expense was incurred. The insurer will issue you an Explanation of Benefits (EOB), and the EOB should be provided with your claim as documentation of an unreimbursed medical expense along with evidence that your payment has been made for the total amount you are requesting. Second, for unreimbursed medical expenses not documented by an EOB, you may provide the Administrator with a receipt of the medical expense, which includes: name of the recipient of the service; date of the service (not the paid date); description of the service; cost of the service; and name, address, and Tax I.D. number of the provider, record that shows payments made by insurance or denial by insurance and evidence that payment has been made by the claimant.

Any claims for reimbursement under this benefit must be submitted within eighteen (18) months from the date the expense was incurred, and must be paid by you in order to be reimbursable. All claims must be accompanied by a stamped, self-addressed envelope.

5. Claims Procedure

If a claim for reimbursement under the Health Care Account is wholly or partially denied, claims will be administered in accordance with the claims procedure set forth in Article XI of this Summary Plan Description.

V
INCOME REPLACEMENT AND RELATED BENEFITS

A. Wage Replacement Account

1. Supplemental Unemployment Benefit

You may receive a weekly Supplemental Unemployment Benefit payable from your Wage Replacement Account if you satisfy the following conditions:

(a) You must be involuntarily laid off from a unit covered by the Collective Bargaining Agreement;

(b) You must present proof that you are entitled to New York State Unemployment; and

(c) You must not refuse to accept work as a painter that has been offered by the Union or by an Employer.

The amount of the weekly benefit will be $250 ($400 for the initial waiting week) for any week that you are unemployed.

If you fail to report on the date indicated on the notice to report for referral card, you will forfeit all future benefits until such time as you return to work and are again laid off by an Employer after satisfying the eligibility requirements set forth above. If you refuse employment which is

offered to you, you forfeit the benefit for that week and will continue to forfeit benefits in any following week in which you refuse employment.

You may not receive this benefit if you have voluntarily terminated employment or retired.

Any claim for a Supplemental Unemployment Benefit must be made within one-year of the week for which you are requesting a benefit.

2. Disability Benefits

You will be entitled to a weekly disability benefit payable from your Wage Replacement Account for each week you are unable to work due to a Disability entitling you to a New York disability or workers' compensation benefit. The amount of the benefit is $250 per week ($400 for initial waiting week), but in no event greater than the balance in your Account.

Any claim for a Disability Benefit must be made within one-year of the week for which you are requesting a benefit.

3. Vacation Benefits and Holiday Benefits

You are entitled to up to 6 vacation weeks per Plan Year (June 1 to May 31) and 9 holidays per calendar year. The amount of the journeyman benefit shall be $1,416.80 per five consecutive vacation days and $354.20 per holiday. Vacation and holiday benefits for Apprentices and Industrial Members shall be $752.60 per five consecutive vacation days and $354.20 per holiday. Your account will also be reduced by (as applicable) the employer Social Security, Medicare and unemployment taxes, so that the balance required in your account for five vacation days shall be $1,600 for a journeyman and $850 for an Industrial Members. Holidays require a $400 balance.

Claims for holiday and vacation benefits must be made within 60 days of the end of the Plan Year in which they accrue. The Trustees will presume that you are on vacation for any day you are not working for an Employer and for which you do not receive an Unemployment Benefit or Disability Benefit from the Fund.

These benefits are paid from your Wage Replacement Account and may not exceed the balance in your Account.

VI
SUPPLEMENTAL UNEMPLOYMENT AND DISABILITY BENEFIT

Buffalo-area participants may receive a weekly Supplemental Unemployment or Disability Benefit payable from the reserves of the Fund upon completion of 800 hours of service during a Plan Year. Buffalo-area participants are those working out of a Local Union with a $1.05 hourly contribution required under their Collective Bargaining Agreement for this benefit.

You must satisfy the following conditions in order to be eligible for this supplemental unemployment benefit:

(a) You must be involuntarily laid off from a unit covered by the Collective Bargaining Agreement;

(b) You must present proof that you are entitled to New York State Unemployment; and

(c) You must not refuse to accept work as a painter that has been offered by the Union or by an Employer.

Upon satisfying these requirements, you will be entitled to a weekly benefit of $100.

You will be entitled to a disability benefit for each week you are unable to work due to a Disability entitling you to a New York disability or workers' compensation benefit. This benefit is $100 per week.

For purposes of determining the benefits under this Article, Hours of Service will be measured on a Plan Year basis but shall be effective for the twelve-month period beginning on the next succeeding December 1. A maximum 26 weekly payments will be paid in one Plan Year, in total, for both benefits.

Any claim for a Supplemental Unemployment or Disability Benefit payable under this Article VI must be made within one-year of the week for which you are requesting a benefit.

VII
GROUP LIFE INSURANCE

If you complete 500 Hours of Service during an Eligibility Period, you will be eligible for a group term life insurance benefit paying a death benefit of $50,000 for the next succeeding Coverage Period. In addition, your spouse will be entitled to a group term life insurance benefit of $5,000 and your dependent children, $2,500. Retirees after June 1, 2003 with the Minimum Balance in their Health Care Account will remain eligible for group term life insurance coverage to age 65, provided they were eligible for such coverage at the time of their retirement.

You will remain eligible for coverage in a Coverage Period if you have completed 500 Hours of Service in the prior Eligibility Period.

For purposes of this Article VII, "Eligibility Period" shall mean the twelve month period beginning May 1 and ending on the following April 30, and "Coverage Period" shall mean the twelve month period beginning August 1 and ending on the following July 31.

For purposes of initial eligibility only, you will be entitled to the group life insurance benefit on the first of the month following the completion of 500 hours of service. Thereafter, you must maintain your eligibility as set forth above.

You must be working in Covered Employment, or eligible for work in Covered Employment, to be entitled to the group life benefit provided hereunder.

The group life policy will control in determining the dates of eligibility, the conditions which must be satisfied to become insured (if any), and the benefits and the circumstances under which insurance terminates.

VIII
AMENDMENT AND TERMINATION

The Trustees may amend, modify or terminate the Plan, in whole or in part, at any time and for any reason. Any amendment may reduce or eliminate any benefit provided under the Plan and may result in the forfeiture of the balance of your accounts. Under no circumstances will any Plan benefit become vested or non-forfeitable at any time with respect to any Participant (active, inactive or retired) or beneficiary.

The Trustees have established this Plan with the intent that it will be maintained for an indefinite period of time. However, the funding for the Plan is conditioned on a Collective Bargaining Agreement remaining in effect that provided for continued Employer Contributions to the Fund. Therefore, the Trustees reserve the right to terminate the Plan, in whole or in part, at any time.

IX
CONTINUATION COVERAGE

A. Continuation Coverage Beyond COBRA

1. Health and Hospitalization Coverage.

In lieu of COBRA coverage, an Employee, a former Employee who has terminated employment (both Covered Employment and employment within the industry), Retiree, or surviving spouse (and dependent child) of an Employee or Retiree may continue to receive health and hospitalization insurance coverage under the Plan for as long as he or she has a balance remaining in his or her Health Care Account, provided that he or she resides within the coverage area of the HMO or other insurance contract then being offered by the Plan. This continuation coverage is subject to the terms of the HMO or other insurance contract.

If the individual continuously maintains coverage in accordance with the preceding paragraph, he or she may continue to pay monthly for that coverage through deductions from the Health Care Account or through direct self-payments of the applicable Monthly Premium.

If you discontinue coverage on or after termination of employment, you may re-enroll effective March 1 of each year (during the Fund's annual enrollment), but not at any other time. If that happens, unless you are a Retiree, you will only be entitled to pay the applicable Monthly Premium through deductions from your Health Care Account, and you will not be able to maintain coverage on a self-payment basis beyond your COBRA coverage period.

2. Health Care Reimbursement.

In lieu of COBRA coverage, active Employees, surviving spouses of Employees, Inactive Employees and Retirees may receive reimbursement (in accordance with Section IV.C, including the requirement that they have other group health coverage) for amounts they expend for medical care incurred on behalf of themselves or the Dependents of the Employee to the extent of the balance remaining in the Employee's Health Care Account.

B. Continuation Coverage Under COBRA

1. Introduction.

This Section contains important information about your right to COBRA continuation coverage, which is a temporary extension of group health coverage under the Plan. This Section generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.

In 1986, a Federal Law was enacted (Public Law 99-272, Title X) — the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended ("COBRA") — requiring that most employers sponsoring group health plans offer employees and their families the opportunity for a temporary extension of health coverage (called "continuation coverage") at group rates in certain instances where coverage under the plan would otherwise end (called "qualifying events"). This notice is intended to inform you, in a summary fashion, of your rights and obligations with respect to continuation coverage under the Plan.

Continuation coverage is available only in connection with health and hospitalization benefits. Continuation coverage is not available in connection with any other benefits described in this booklet (e.g., life insurance, educational, wage replacement, vacation benefits, etc.) or any other benefits you may have been receiving prior to the date your coverage terminates.

You should review the following information carefully and share it with your covered dependents. Please remember that COBRA rights are provided only as required by law. Your rights may change in the event that the COBRA law changes.

2. When Are You Eligible for COBRA Coverage?

If you are employed by a Contributing Employer and are covered by the Plan, you have a right to choose continuation coverage if you lose your eligibility for group health coverage by virtue of your failure to maintain the Minimum Balance in your Health Care Account because of a reduction in your hours of employment or the termination of your employment (for reasons other than gross misconduct on your part).

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

(a) the death of your spouse;

(b) a termination of your spouse's employment (for reasons other than gross misconduct) or a reduction in your spouse's hours of employment with a

Contributing Employer) that results in your spouse's failure to maintain the Minimum Balance in your spouse's Health Care Account;

(c) divorce or legal separation from your spouse; or

(d) your spouse becomes entitled to Medicare (Part A or Part B).

If you are the dependent child of an employee covered under the Plan, you have the right to choose continuation coverage if you lose group health coverage under the Plan for any of the five following reasons:

(a) the death of the employee-parent;

(b) the termination of the employee-parent's employment (for reasons other than gross misconduct) or a reduction in the employee-parent's hours of employment with a Contributing Employer) that results in a failure of the employee-parent to maintain the Minimum Balance in the Health Care Premium Account;

(c) parents' divorce or legal separation;

(d) the employee-parent becomes entitled to Medicare (Part A or Part B); or

(e) the dependent ceases to be an eligible dependent child under the terms of the Plan.

In addition, there may be a right to continuation coverage for certain eligible retirees and their spouses, surviving spouses and dependent children if a Title 11 bankruptcy proceeding is commenced with regard to the retiree's Contributing Employer. If this occurs, you should contact the Fund Office concerning your rights.

3. What You Must Do to Obtain COBRA Coverage

Under the law, the employee or family member has the responsibility to inform the Fund Office of a divorce, legal separation or a child losing dependent status under the Plan within 60 days of the date of the event or the date on which coverage would end under the Plan because of the event, whichever is later. You should contact the Fund Office of these events by use of the form provided for this purpose.

Your employer has the responsibility to notify the Fund Office of your death, termination of employment, reduction in hours of employment or Medicare entitlement. (However, you or your family should also notify the Fund Office if such an event occurs in order to avoid confusion as to your status.)

When the Fund Office is notified that a qualifying event has happened, the Fund Office will notify you and/or your spouse or dependent children of the right to choose continuation coverage and the manner in which to do so.

Under the law, if your (or your family member's) coverage will terminate because of an event described above, you (or your family members) must inform the Fund Office that you want continuation coverage within 60 days from the later of (i) the date you ordinarily would have lost coverage because of one of the events described above, or (ii) the date of the notice of your right to elect continuation coverage. If you (or your family members) do not properly and timely choose continuation coverage, your group health insurance coverage under the Plan will end.

Under the law, you may have to pay all or part of the premium for your continuation coverage. During the initial 18 or 36-month period of continuation coverage, you will have to pay 102% of the applicable premium for your continuation coverage. However, during the additional 11 months of continuation coverage for disability, the Plan may charge up to 150% of the applicable premium for such continuation coverage.

You will be required to make the first premium payment retroactive to the date your benefits ended under the Plan. Your first payment must be made within 45 days after you elected to continue coverage. All subsequent payments will be due on the first of each month for that month's coverage. You will be notified by the Fund Office if the monthly premium amount changes. If payment of amounts due is not timely made, continuation of coverage will cease as of the end of the last month for which you timely paid.

You do not have to show that you are insurable to choose continuation coverage. However, continuation coverage under the law is provided subject to your eligibility for coverage under the Plan. The Plan Administrator reserves the right to terminate your continuation coverage retroactively if you are determined to be ineligible.

Continuation coverage may be elected for some members of the family and not others. In addition, one or more eligible dependents may elect COBRA even if the employee does not elect it. However, in order to elect COBRA Continuation Coverage, the members of the family must have been covered by the Plan on the date of the qualifying event (except in certain cases of added dependents, see the following section). A parent may elect or reject COBRA Continuation Coverage on behalf of dependent children living with him or her. However, dependent children have an independent right to elect COBRA Continuation Coverage if the parent does not elect coverage for the child.

4. Acquiring a New Dependent(s) while Covered by COBRA

Qualified COBRA beneficiaries are entitled to exercise the same rights to enroll dependents under the Plan as are similarly situated active employees who have not had a qualifying event.

In addition, if you acquire a new dependent through marriage while you are enrolled in COBRA continuation coverage, you may add the spouse to your coverage for the balance of the COBRA period. For example, if you have five months of COBRA left and you get married, you can enroll your new spouse for up to five months of COBRA coverage. You must notify the Plan within 30 days of acquiring the new spouse.

In addition, a child who is born to or placed for adoption with a covered employee during the period of the employee's continuation coverage is a "qualified beneficiary" and generally is eligible to be enrolled immediately for COBRA continuation coverage under the Plan. You must

notify the Fund Office within 30 days after you acquire a new dependent. Once the child is enrolled pursuant to the Plan's rules, he or she will be treated like all other COBRA qualified beneficiaries with respect to the same qualifying event. The maximum coverage period for such a child is measured from the same date as for other qualified beneficiaries with respect to the same qualifying event (and not from the date of the birth or adoption).

If COBRA coverage ceases for you before the end of the maximum 18, 29, or 36-month COBRA coverage period, COBRA coverage also will end for any newly added spouse. However, since newborn children or children newly placed for adoption are qualified beneficiaries in their own right, COBRA coverage can continue for such children of an employee until the end of the maximum COBRA coverage period if the required premiums are timely paid. Check with the Fund Office for more details on how long COBRA coverage can last for these children.

To enroll your new dependent for COBRA coverage, you must notify the Fund Office in writing. There may be a change in your COBRA premium amount in order to cover the new dependent.

5. Benefits Under and the Duration of COBRA Coverage

Coverage may continue for:	**If:**	**Maximum length of COBRA coverage:**
You and your eligible dependents	Your employment ends for any reason (except for gross misconduct)	Up to 18 months (29 months if you or your eligible dependent is disabled)*
You and your eligible dependents	You no longer meet the Fund's eligibility requirements due to insufficient covered hours	Up to 18 months (29 months if you or your eligible dependent is disabled)*
Your eligible dependents	You die	Up to 36 months
Your eligible dependents	You are divorced or legally separated	Up to 36 months
Your eligible dependents	You become eligible for Medicare	Up to 36 months
Your covered dependent children	Your covered dependent child no longer qualifies as an eligible dependent under the Plan	Up to 36 months

* Coverage provided under a New York insurance policy may continue for 36 months.

This chart provides basic information regarding COBRA continuation coverage. Important details regarding such coverage are set forth in this section.

If you choose continuation coverage, you are entitled to coverage that is identical to the coverage being provided under the Plan to similarly situated non-COBRA beneficiaries for the types of benefits for which COBRA coverage is available. If group health coverage is lost because of a termination of employment or reduction in hours of employment, the law requires that qualified beneficiaries be afforded the opportunity to maintain continuation coverage for up to 18 months from the date of the initial qualifying event. In the case of other qualifying events, qualified beneficiaries will be afforded the opportunity to maintain continuation coverage for up to 36 months from that time. These maximum COBRA periods may be extended or reduced as described below.

6. Extension of the COBRA Coverage Period

An 18-month period of continuation coverage may be extended for up to 11 months (up to 29 months in total) if the qualified beneficiary has been determined to be disabled (under Title II or XVI of the Social Security Act) as of the date of the employee's termination, reduction in hours or within the first 60 days of continuation coverage (or, in the case of a newborn child or child newly placed for adoption, within 60 days of birth or placement for adoption) and if the Fund Office is timely notified within 60 days of such determination (and within the initial 18 month continuation coverage period).

This 11-month extension applies to all disabled and non-disabled qualified beneficiaries entitled to COBRA continuation coverage as a result of the same qualifying event, subject to the above notice requirements.

Additional qualifying events can occur while continuation coverage is in effect. Such events may extend an 18 or 29 month period of continuation coverage to a period of up to 36 months, but in no event will coverage extend beyond 36 months after the time coverage would otherwise have terminated as a result of the initial qualifying event. This extended coverage is not available to anyone who became your spouse after the termination of employment or reduction in hours. However, it is available to children born to, adopted by or placed for adoption with you (the active employee) during the initial 18-month period of continuation coverage.

Subsequent termination of employment following reduction in hours of employment will not be treated as a second qualifying event. You should notify the Fund Office immediately if a second qualifying event occurs during your continuation coverage period.

7. Why Your COBRA Coverage May End Early

The law also provides that your continuation coverage may be cut short prior to the expiration of the 18, 29 or 36 month period for <u>any</u> of the following five reasons:

(a) The Plan no longer provides group health coverage.

(b) The premium for your continuation coverage is not timely paid. In such case, your coverage will terminate as of the last day of the last period for which a contribution was timely paid.

(c) The individual first becomes covered, after electing COBRA coverage, under another group health plan (as an employee or otherwise) that (i) does not contain any preexisting condition exclusion or limitation applicable to the individual, or (ii) contains a preexisting condition exclusion or limitation, but it does not apply to the individual because he or she has been credited with prior creditable coverage for the duration of the exclusion or limitation period.

(d) The individual becomes entitled to Medicare Part A or Part B (provided that such entitlement occurs after the COBRA election).

(e) Coverage has been extended for up to 29 months due to disability and there has been a final determination that the individual is no longer disabled. You are required to notify the Administrator within 30 days of any such final determination. In such case, coverage will end as of the month that begins at least 30 days following such determination.

Once your continuation coverage terminates for any reason, it cannot be reinstated.

X
HIPAA PRIVACY PROVISIONS

Introduction

Members of the Board have access to the individually identifiable health information of Fund participants for administrative functions of the Fund. When this health information is provided from the Fund to the Trustees, it is Protected Health Information (PHI).

The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and its implementing regulations restrict the Trustees' ability to use and disclose PHI. The following HIPAA definition of PHI applies to this Article X:

> *Protected Health Information.* Protected health information means information that is created or received by the Fund and relates to the past, present, or future physical or mental health or future payment for the provision of health care to a participant; and that identifies the participant or for which there is a reasonable basis to believe the information can be used to identify the participant. Protected health information includes information of persons living or deceased.
>
> *Electronic Protected Health Information.* Electronic Protected Health Information (Electronic PHI) means Protected Health Information that is transmitted by or maintained in electronic media.

The Trustees shall have access to PHI from the Fund only as permitted under this Article or as otherwise required or permitted by HIPAA.

Provision of Protected Health Information to Trustees

1. Permitted Disclosure of Enrollment/Disenrollment Information

The Fund (or a health insurance issuer or HMO with respect to the Fund) may disclose to the Trustees information on whether the individual is participating in the Fund, or is enrolled in or has disenrolled from a health insurance issuer or HMO offered by the Fund.

2. Permitted Uses and Disclosures of Summary Health Information

The Fund (or a health insurance issuer or HMO with respect to the Fund) may disclose Summary Health Information to the Trustees, provided that the Trustees request the Summary Health Information for the purpose of (1) obtaining premium bids from health plans for providing health insurance coverage under the Fund; or (2) modifying, amending, or terminating the Fund.

"Summary Health Information" means information (1) that summarizes the claims history, claims expenses or type of claims experienced by individuals for whom a Trustee had provided health benefits under a Health Fund; and (2) from which the information described at 42 CFR §164.514(b)(2)(i) has been deleted, except that the geographic information described in 42 CFR §164.514(b)(2)(i)(B) need only be aggregated to the level of a five-digit ZIP code.

3. Permitted and Required Uses and Disclosure of Protected Health Information for Fund Administration Purposes

Unless otherwise permitted by law, and subject to the conditions of disclosure described in paragraph 4 and obtaining written certification pursuant to paragraph 6, the Fund (or a health insurance issuer or HMO on behalf of the Fund) may disclose PHI and Electronic PHI to the Trustees, provided that the Trustees use or disclose such PHI only for Fund administration purposes. "Fund administration purposes" means administration functions performed by the Trustees on behalf of the Fund, such as quality assurance, claims processing, auditing, and monitoring. Fund administration functions do not include functions performed by the Trustees in connection with any other benefit or benefit Fund of the Trustees, and they do not include any employment-related functions.

Fund administration shall also include the filing of a claim with the Department of Health and Human Services ("HHS") under the retiree reinsurance program established pursuant to Section 1102 of the Patient Protection and Affordable Care Act. The Fund shall disclose to the Secretary of HHS, on behalf of the Trustees, at such time and in such manner specified by the Secretary in guidance, information, data, documents, and records necessary for the Trustees to comply with the requirements of the program.

Notwithstanding the provisions of this Article X to the contrary, in no event shall the Trustees be permitted to use or disclose PHI or Electronic PHI in a manner that is inconsistent with 45 CFR §164.504(f).

4. Conditions of Disclosure for Fund Administration Purposes

Trustees agree that with respect to any PHI (other than enrollment/disenrollment information and Summary Health Information, and information disclosed pursuant to a signed authorization that complies with the requirements of 45 CFR § 164.508 45 CFR § 164.508, which are not subject to these restrictions) disclosed to it by the Fund (or a health insurance issuer or HMO on behalf of the Fund), Trustees shall:

- not use or further disclose the PHI other than as permitted or required by the Plan or as required by law;

- ensure that any agent, including a subcontractor, to whom it provides PHI received from the Fund agrees to the same restrictions and conditions that apply to the Trustees with respect to PHI;

- not use or disclose the PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit Fund of the Trustees;

- report to the Fund any use or disclosure of the information that is inconsistent with the uses or disclosures provided for of which it becomes aware;

- make available PHI to comply with HIPAA's right to access in accordance with 45 CFR §164.524;

- make available PHI for amendment and incorporate any amendments to PHI in accordance with 45 CFR §164.526;

- make available the information required to provide an accounting of disclosures in accordance with 45 CFR §164.528;

- make its internal practices, books, and records relating to the use and disclosure of PHI received from the Fund available to the Secretary of Health and Human Services for purposes of determining compliance by the Fund with HIPAA's privacy requirements;

- if feasible, return or destroy all PHI received from the Fund that the Trustees still maintain in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible; and

- ensure that the adequate separation between Fund and Trustees (*i.e.*, the "firewall"), required in 45 CFR §405(f)(2)(iii), is satisfied.

The Trustees further agree that if they create, receive, maintain, or transmit any Electronic PHI (other than enrollment/disenrollment information and Summary Health Information, which are not subject to these restrictions) on behalf of the covered entity, it will implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic protected health information, and they

will ensure that any agents (including subcontractors) to whom they provide such Electronic PHI agrees to implement reasonable and appropriate security measures to protect the information. The Trustees will report to the Fund any security incident of which they become aware.

5. Adequate Separation Between Plan and Plan Sponsor.

The Trustees will allow Fund employees access to the PHI. No other persons shall have access to PHI. These employees shall only have access to and use of PHI to the extent necessary to perform the plan administration functions needed for successful operation of the Plan. In the event that any of these specified employees does not comply with the provisions of this Section, that employee shall be subject to disciplinary action by the Trustees for non-compliance pursuant to the Trustees' employee discipline and termination procedures.

The Trustees shall ensure that the provisions of this paragraph 5 are supported by reasonable and appropriate security measures to the extent that the persons designated above create, receive, maintain, or transmit Electronic PHI on behalf of the Plan.

6. Certification of Trustees

As a condition for obtaining PHI (including Electronic PHI) from the Fund and its Business Associates, the Board of Trustees agrees to the conditions of disclosure set forth in this Article X.

XI
CLAIMS PROCESS

This section explains to you the steps you must take to file a claim for benefits, and how to file an appeal if your claim is denied, in whole or in part. As you will see, different claim procedures apply depending on the type of benefits claimed. It is very important that you follow these procedures carefully because your failure to do so may delay or reduce your ability to obtain benefits. In addition, keep in mind that must exhaust your rights under these procedures (including requesting and receiving a determination on review) before you commence any litigation, arbitration or administrative proceeding regarding an alleged failure by the Plan to pay benefits or any matter within the scope of the appeals process.

What is a claim for benefits?

A "claim for benefits" is a request for a Plan benefit made in accordance with the Plan's procedures for filing benefit claims. If you make an inquiry unrelated to a specific benefit claim, such as an inquiry regarding benefits available under the Plan, or the circumstances under which benefits might be paid, or eligibility for benefits, this generally won't be treated as a "claim for benefits" subject to these provisions. In addition, if you request prior approval of a benefit that does not require prior approval under the Plan, this is not considered a "claim for benefits" under these procedures.

A. Claims for Supplemental Unemployment, Disability, or Vacation

If you are filing a claim for Supplemental Unemployment, Disability, or Vacation benefits, you must follow the claim procedures described in this section.

In order to make a claim for benefits for any of these benefits, you are generally required to submit to the Fund Office a completed claim form available from the Fund Office, along with any required documentation.

If your claim for benefits is denied, in whole or in part, or any other adverse benefit determination has been made, the Administrator will notify you (or your duly authorized representative) within 90 days of receiving your claim (or within 45 days if it is a claim for disability benefits).

For all claims other than disability benefit claims, the 90-day period may be extended for an additional 90 days if special circumstances require extra time to process your claim. You will receive written notice of the extension and the reasons for it, as well as the date by which the Administrator expects to make the benefit determination, before the end of the initial 90-day period.

In the case of a claim for disability benefits, there may be two extension periods of up to 30 days each, provided that the Administrator determines that such an extension is necessary due to circumstances beyond the control of the Plan. In the event of such an extension, notice of the extension will be provided to you before expiration of the initial 45-day period (or before expiration of the first 30- day extension, in the case of a second extension). The notice will explain the circumstances requiring the extension and inform you of the date by which the Administrator expects to make a decision. The notice will also specifically explain the standards on which entitlement to the benefit is based, the unresolved issues that prevent a decision on the claim, and the additional information needed to resolve those issues, and you will be afforded at least 45 days in which to provide the specified information.

In the case of a claim for disability benefits, if an extension is required due to your failure to submit information necessary to decide the claim, the period for making the determination will be tolled from the date on which the extension notice is sent to you until the earlier of: (i) the date on which you respond to the Administrator's request for additional information, or (ii) expiration of the 45-day period within which you must provide the requested additional information.

If your claim for a benefit is denied, in whole or in part, or any other adverse benefit determination has been made, you will be sent written notice explaining:

- the specific reason(s) for the denial or other adverse benefit determination;
- the exact plan provision(s) on which the decision was based;
- what additional material or information is needed to process your claim and why such material or information is needed;
- what procedures you should follow to get your claim reviewed again by the Board of Trustees, and the time limits applicable to such procedures; and

- a statement of your right to bring a civil action under ERISA Section 502(a) following an adverse benefit determination on review.

In addition to the above notification requirements, notification with regards to a disability claim shall also include:

- A discussion of the decision, including any reasons for disagreeing with the views of any treating professionals, medical or vocational experts consulted, or a Social Security Administration determination; and

- A description of any internal rule, guideline or similar standard that the Fund relied on in making a decision based on medical necessity, experimental treatment or a similar limitation, or statement that such explanation will be provided (without charge) upon the claimant's request; and

- A description of any scientific or clinical judgment that the Fund relied on in making a decision based on medical necessity, experimental treatment or a similar limitation, or a statement that such explanation will be provided (without charge) upon the claimant's request.

If your claim is denied, or any other adverse benefit determination is made, you have a right to request a review of that determination. In order to do so, you (or your authorized representative) must, **within 60 days** after you receive the notice of denial (or **within 180 days** if your claim is for a disability benefit), submit your written request for review to the Board of Trustees.

In connection with your request for review, you (or your authorized representative) may submit written comments, documents, records or other information relating to your claim. The review will take into account all comments, documents, records and other information you submit relating to your claim, regardless of whether they were submitted in connection with your initial claim for benefits.

In addition, you will be provided, upon written request and free of charge, with reasonable access to (and copies of) all documents, records and other information relevant to your claim. A document, record or other information is considered relevant to your claim if it was relied upon by in making the decision; it was submitted, considered or generated (regardless of whether it was relied upon); it demonstrates compliance with the organization's administrative processes for ensuring consistent decision-making; or, in the case of disability benefits, it constitutes a statement of Plan policy regarding the denied treatment or service.

For disability benefit claims, a different person will review your claim than the one who originally denied the claim and the reviewer will not be a subordinate of the person who originally denied the claim. You will be advised of the identity of any medical or vocational expert who were consulted in connection with the initial denial. The reviewer will not give deference to the initial adverse benefit determination. The decision will be made on the basis of the record, including such additional documents and comments that may be submitted by you. In addition, if your claim

was denied on the basis of a medical judgment, a health care professional who has appropriate training and experience in a relevant field of medicine will be consulted. The health care professional will not be the same person who was consulted with respect to the initial adverse benefit determination (or a subordinate of such person).

A decision on review will be made by no later than the date of the meeting of the Board of Trustees immediately following the plan's receipt of your request for review, unless the request is received within 30 days of the meeting, in which case the determination will be made by no later than the date of the second meeting following the plan's receipt of the request. If the Board of Trustees determines that special circumstances require an extension of time for processing, then the decision on review will be made by no later than the third meeting following the Plan's receipt of the request for review. You will be notified of the extension in writing before the extension begins, and the extension notice will indicate the special circumstances requiring the extension as well as the date by which the Board of Trustees expects to make the determination on review. You will be notified of the determination on review within 5 days after the determination is made.

With regard to disability benefit claims, if an extension is required due to your failure to submit information necessary to decide the claim, the period for making the determination on review will be tolled from the date on which the extension notice is sent to you until the earlier of: (i) the date on which you respond to the Board of Trustees' request for additional information, or (ii) expiration of the 45-day period within which you must provide the requested additional information.

You will be notified in writing of the determination on review. If an adverse benefit determination is made on review, the notice will include all the information set forth above with respect to an initial determination. All decisions on review are final and binding on all parties.

B. Claims for Health Care Account Reimbursement Benefits

You must follow the procedures in this Section if you are filing a claim for (i) reimbursement under your Health Care Account (under Section IV.C. of this SPD).

Generally, group health claims are grouped into one of four categories. Your claim can be: (i) a pre service claim, (ii) a post service claim, (iii) an urgent care claim, or (iv) a concurrent care claim.

Generally, a "pre service claim" is any claim for a benefit under the Plan that must be approved (in whole or in part) *before* you can receive the medical care. An "urgent care claim" is a claim for medical care or treatment with respect to which application of the time periods for making non urgent care claim decisions (as described above): (i) could seriously jeopardize your life, health, or ability to regain maximum function, or (ii) in the opinion of a physician with knowledge of your medical condition, would subject you to severe pain that cannot be adequately managed without the treatment that you are requesting in your claim. A "concurrent care claim" is a claim relating to an ongoing course of treatment approved by the plan, which is provided to you over a period of time or for a specified number of treatments.

A "post service claim" is any claim that is not deemed a "pre service claim" (as defined above). These are claims for which you do not need *advance* approval before receiving medical care. Essentially, all claims for Health Care Account reimbursement benefits will be post-service claims because you must have already incurred an expense and received the services before you are entitled to benefits.

In order to make a claim for a Health Care Account reimbursement benefit, you are generally required to submit to the Fund Office the required documentation of your expense. **You must submit the claim within 90 days after the end of the calendar year in which the related expense was incurred.**

The Administrator will notify you of an adverse benefit determination no later than 30 days after receipt of your claim. If the Administrator determines that an extension of time is necessary due to matters beyond the control of the plan, this period may be extended for up to an additional 15 days. You will be notified of the extension before the initial 30-day period expires, and the notice will describe the circumstances requiring the extension and inform you of the date by which the Administrator expects to make a decision on your claim. If the extension is necessary because you failed to submit information necessary to decide the claim, the notice of extension will specifically describe the required information, and you will have 45 days from your receipt of the notice to provide the requested information.

If an extension is required due to your failure to submit information necessary to decide the claim, the period for making the determination will be tolled from the date on which the extension notice is sent to you until the earlier of: (i) the date on which you respond to the Administrator's request for additional information, or (ii) expiration of the 45-day period within which you must provide the requested additional information.

If your claim is denied, in whole or in part, or any other adverse benefit determination has been made, the Administrator will notify you (or your authorized representative) of the benefit determination in writing within the time periods described above. This notification will include:

- the specific reason(s) for the denial or other adverse benefit determination;
- references to the specific Plan provisions on which the determination was based;
- a description of any additional material or information necessary for you to perfect your claim, and an explanation of why that material or information is necessary;
- a description of the Plan's review procedures and the applicable time limits;
- a statement of your right to bring a civil action under ERISA Section 502(a) following an adverse benefit determination on review;
- if an internal rule, guideline or protocol was relied upon in deciding your claim, either a copy of the rule or a statement that it is available upon request at no charge; and
- if the determination was based on the absence of medical necessity, or because the treatment was experimental or investigational, or other similar

exclusion, an explanation of the scientific or clinical judgment for the determination applying the terms of the Plan to your claim, or a statement that it is available upon request at no charge.

If your claim is denied, in whole or in part, or any other adverse benefit determination has been made, you have the right to request a review of that determination. In order to do so, you (or your authorized representative) must, **within 180 days** after you receive the notice of denial, submit your written request for review to the Board of Trustees. In connection with your request for review, you (or your authorized representative) may submit written comments, documents, records or other information relating to your claim. The review will take into account all comments, documents, records and other information you submit relating to your claim, regardless of whether they were submitted in connection with your initial claim for benefits.

In addition, you will be provided, upon written request and free of charge, with reasonable access to (and copies of) all documents, records and other information relevant to your claim. A document, record or other information is considered relevant to your claim if it was relied upon by in making the decision; it was submitted, considered or generated (regardless of whether it was relied upon); it demonstrates compliance with the organization's administrative processes for ensuring consistent decision-making; or it constitutes a statement of Plan policy regarding the denied treatment or service.

A different person will review your claim than the one who originally denied the claim and the reviewer will not be a subordinate of the person who originally denied the claim. The reviewer will not give deference to the initial adverse benefit determination. The decision will be made on the basis of the record, including such additional documents and comments that may be submitted by you. If your claim was denied on the basis of a medical judgment (such as a determination that the treatment or service was not medically necessary, or was investigational or experimental), a health care professional who has appropriate training and experience in a relevant field of medicine will be consulted. The health care professional will not be the same person who was consulted with respect to the initial adverse benefit determination (or a subordinate of such person).

The decision on review will be made by no later than the date of the meeting of the Board of Trustees immediately following the plan's receipt of your request for review, unless the request is received within 30 days of the meeting, in which case the determination will be made by no later than the date of the second meeting following the plan's receipt of the request. If the Board of Trustees determines that special circumstances require an extension of time for processing, then the decision on review will be made by no later than the third meeting following the plan's receipt of the request for review. You will be notified of the extension in writing before the extension begins, and the extension notice will indicate the special circumstances requiring the extension as well as the date by which the Board of Trustees expects to make the determination on review. You will be notified of the determination on review within 5 days after the determination is made.

If an extension is required due to your failure to submit information necessary to decide the claim, the period for making the determination on review will be tolled from the date on which the extension notice is sent to you until the earlier of: (i) the date on which

you respond to the Board of Trustees' request for additional information, or (ii) expiration of the 45-day period within which you must provide the requested additional information.

If your claim for benefits is denied on appeal, you will receive a written notice of the claim denial including the same information set forth in the initial notice of denial, as well as a statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to your claim. All decisions on review are final and binding on all parties. You and the Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency.

Voluntary External Review

If you are enrolled in a non-grandfathered group health plan that is not subject to a State external review process, and your internal appeal of a claim for benefits (not related to employee classifications) under such plan is denied for: (a) an adverse benefit determination (including a final internal adverse benefit determination) by a plan or issuer that involves medical judgment (including, but not limited to, those based on the plan's or issuer's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit; or its determination that a treatment is experimental or investigational), as determined by the external reviewer; and (b) a rescission of coverage (whether or not the rescission has any effect on any particular benefit at that time), you will have the right to request an external (i.e., independent) review if you do so within four months after receiving notice of an adverse benefit determination or final internal adverse benefit determination. Within five business days after receiving your request, a preliminary review will be completed to determine whether: (i) you are/were covered under the Plan; (ii) the denial was based on your ineligibility under the terms of the Plan; (iii) you exhausted the Plan's internal process, if required; and (iv) you provided all information necessary to process the external review. Within one business day after completing the preliminary review, you will be notified in writing if your appeal is not eligible for an external review or if it is incomplete. If your appeal is complete but not eligible, the notice will include the reason(s) for ineligibility. If your appeal is not complete, the notice will describe any information needed to complete the appeal. You will have the remainder of the four month filing period or 48 hours after receiving the notice, whichever is greater, to cure any defect. If eligible for an external review, your appeal will be assigned to an independent review organization (IRO). If the IRO reverses the Plan's denial, the IRO will provide you written notice of its determination.

In addition, you will have the right to an expedited external review in the following situations:

- Following an adverse benefit determination involving a medical condition for which the timeframe for completion of an expedited internal appeal would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function and you have filed a request for an expedited internal appeal; and
- Following a final internal adverse benefit determination involving (i) a medical condition for which the timeframe for completion of a standard external review would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function or (ii) an admission, availability of care, continued

stay, or health care item or service for which you received emergency services but have not been discharged from a facility.

The IRO will provide notice of its final external review decision as expeditiously as your medical condition or circumstances require, but not more than 72 hours after the IRO receives the request.

E. Judicial Review

You (or an appointed representative) must timely pursue all the claim and appeal rights described above before you may file a lawsuit under Section 502(a) of ERISA. This rule means that you may not bring any action to recover benefits under the terms of the Plan, to enforce your rights under the terms of the Plan, or to clarify your right to future benefits under the terms of the Plan unless and until the applicable claim and appeal rights described above have been exercised and the benefits (current or future) or rights requested in such appeal have been denied in whole or in part (or there is any other adverse benefit determination). If you wish to seek judicial review of the denial of any appeal under the Plan, unless the documents governing a fully-insured plan provide for a different length of time, you must file a lawsuit under Section 502(a) of ERISA (to the extent applicable) within one year after the date on which all administrative remedies under the Plans are exhausted, that is by the earlier of the date on which an adverse benefit determination on review is issued by the appeals reviewer (or, if you are enrolled in a group health plan subject to the voluntary external review process noted above, the IRO) or the last day on which a final decision should have been issued, or you will be forever prohibited from commencing such action.

F. Health and Hospitalization Benefits

Claims for health benefits under the self-insured Health Care Plan as well as requests for review of adverse benefit determination with respect to those claims, are made and reviewed in accordance with the procedures contained in the separate summary plan description for the Painters District Council No. 4 Health and Welfare Fund Health Care Plan.

If you need an additional copy of the booklet, you may obtain one free of charge from the Fund Office.

G. Group Life Insurance Benefits

Claims for insured Life Insurance Benefits, as well as requests for review of adverse benefit determination with respect to those claims, are made and reviewed in accordance with the procedures contained in the insurance contracts with those insurers. These procedures are set forth in the Insurance Benefits Booklet provided by the life insurance company. If you need an additional copy, you may obtain one free of charge from the Fund Office.

The following is a description of the current general procedure for claims and requests for review with respect to Life Insurance Benefits. To the extent anything herein conflicts with the Insurance Benefit Booklet provided by the life insurance company, that Insurance Benefit Booklet will control.

In order to make a claim for Life Insurance Benefits, you should submit to the Fund Office an original death certificate (and any other required documentation). The Fund Office will forward a claim form to the life insurance company for a determination.

If your claim for benefits is denied by the life insurance company, in whole or in part, or any other adverse benefit determination has been made, the life insurance company will notify you (or your duly authorized representative) within 90 days of receiving your claim. The 90-day period may be extended for an additional 90 days if special circumstances require extra time to process your claim. You will receive written notice of the extension and the reasons for it, as well as the date by which the life insurance company expects to make the benefit determination, before the end of the initial 90-day period.

If your claim for a benefit is denied, in whole or in part, or any other adverse benefit determination has been made, you will be sent written notice explaining:

- the specific reason(s) for the denial or other adverse benefit determination;
- the exact plan provision(s) on which the decision was based;
- that additional material or information is needed to process your claim and why such material or information is needed;
- what procedures you should follow to get your claim reviewed again by the life insurance company, and the time limits applicable to such procedures; and
- a statement of your right to bring a civil action under ERISA Section 502(a) following an adverse benefit determination on review.

If your claim is denied, or any other adverse benefit determination is made, you have a right to request a review of that determination. In order to do so, you (or your authorized representative) must, **within 60 days** after you receive the notice of denial, submit your written request for review directly to the life insurance company.

In connection with your request for review, you (or your authorized representative) may submit written comments, documents, records or other information relating to your claim. The review will take into account all comments, documents, records and other information you submit relating to your claim, regardless of whether they were submitted in connection with your initial claim for benefits.

In addition, you will be provided, upon written request and free of charge, with reasonable access to (and copies of) all documents, records and other information relevant to your claim. A document, record or other information is considered relevant to your claim if it was relied upon by in making the decision; it was submitted, considered or generated (regardless of whether it was relied upon); or it demonstrates compliance with the organization's administrative processes for ensuring consistent decision-making.

A decision on review will be made by the life insurance company no later than 60 days after receipt of a request for a review. If the life insurance company determines that special circumstances require an extension of time for processing, then an additional processing period of up to 60 days may be required. You will be notified of any extension in writing before the extension begins, and the extension notice will indicate the special circumstances requiring

the extension as well as the date by which the life insurance company expects to make the determination on review.

You will be notified in writing of the determination on review. If an adverse benefit determination is made on review, the notice will include the specific reason(s) for the determination, with references to the specific plan provisions on which it is based. All decisions on review are final and binding on all parties.

H. A Special Note

You should keep in mind that you are allowed to designate an authorized representative to act on your behalf in pursuing a benefit claim or appeal of an adverse benefit determination. You can obtain a form for doing so from the Fund Office or, for insured benefits, the insurance company. Of course, the Plan may request additional information to verify that this person is authorized to act on your behalf. For insured benefits, you should review the booklets you received from your insurance company for more information on their procedures for designating a representative. Note that, for urgent care claims, a health care professional with knowledge of your medical condition may act as your authorized representative without you having to complete an authorization form.

XIV
ADDITIONAL PLAN INFORMATION

A. Your Rights Under ERISA

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

- Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Pension and Welfare Benefit Administration.

- To obtain copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and an updated summary plan description, you may submit a written request to the Plan Administrator,. The administrator may make a reasonable charge for the copies.

- Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

- Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have

to pay for such coverage. Review this summary plan description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

- The reduction or elimination of exclusionary periods of coverage for preexisting conditions under the Plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from the Plan or health insurance issuer when you lose coverage under the Plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a pre-existing condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan participants ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide 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 administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in Federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance form the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits

Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

B. Right to Reclaim Overpayment or to Offset

If this Fund has paid benefits in excess of the amount required under the terms of the Plan, then it may recover the overpayment from you and/or your Dependent(s), or any relevant person, company, or organization. In such a case, you and your Dependent(s) must sign any document which the Trustees determine is needed to help the Fund recover its over-payment and otherwise make good faith attempts to assist the Fund in such recovery. Additionally, if the payment is made to you or your Dependent (or on your behalf) in error, you or your Dependent must repay the amount of the erroneous payment to the Fund. If the Fund owes you or your Dependent a payment for other claims incurred, then it has the right to subtract the amount you or your Dependent owe it from any payment it owes you or your Dependent.

C. Plan Interpretations, Determinations, and Amendments

No individual other than the Plan Administrator or its duly authorized designee(s) has any authority to interpret the Plan documents, including this Summary Plan Description or the official Plan documents, or to make any promises to you about the Plan, or your benefits under the Plan, or to change the provisions of the Plan.

The Plan Administrator and its duly authorized designee(s) has the exclusive right, power, and authority, in its sole and absolute discretion, to administer, apply and interpret the Plan, including this booklet, the Trust Agreement, any collective bargaining agreement or participation agreement, and any other Plan documents, and to decide all matters arising in connection with the operation or administration of the Plan or Fund. Without limiting the generality of the foregoing, the Plan Administrator and/or its duly authorized designee(s) shall have the sole and absolute discretionary authority to:

- Take all actions and make all decisions with respect to the eligibility for, and the amount of, benefits payable under the Plan;
- Formulate, interpret and apply rules, regulations and policies necessary to administer the Fund in accordance with the terms of the Plan;
- Decide questions, including legal or factual questions, relating to the calculation and payment of benefits under the Plan;
- Resolve and/or clarify any ambiguities, inconsistencies and omissions arising under the Plan, including this booklet, the Trust Agreement or other Plan documents;
- Process and approve or deny benefit claims; and
- Determine the standard of proof required in any case.

All determinations and interpretations made by the Plan Administrator and/or its duly authorized designee(s) shall be final and binding upon all participants, beneficiaries and any other

individuals claiming benefits under the Plan, and shall be given deference in all courts of law, to the greatest extent permissible by law.

D. Third Party Liability Cases

This Plan will be reimbursed 100% of any amounts paid whenever another party or parties is legally responsible or agrees to pay money due to an *illness* or *injury* suffered by you or your dependent(s).

Any settlement or recovery received shall first be deemed for reimbursement of medical expenses paid by the Plan, without reduction for attorney's fees, costs, comparative negligence, limits of collectability or responsibility, provisions of state law or otherwise.

Acceptance of benefits under this Program is constructive notice of this provision in its entirety and that you, your covered dependent, your representative, your covered dependent's representative or anyone else who might derive financial gain from a settlement agrees:

1. That you will notify the Plan Administrator of any settlement with any party and notify the Plan Administrator of any lawsuit or claim filed by you or on your behalf, or on behalf of any heirs or otherwise interested parties against any party.

2. To fully cooperate with the terms and conditions of this Program. If you or your covered dependent, heir or otherwise interested party choose not to act to recover money from any source, the Plan Administrato*r* reserves the right to initiate its own direct action to obtain reimbursement.

3. That the benefits paid or to be paid by this Plan will be secondary, not primary.

4. That reimbursement to this Plan will be 100% of amounts paid without reduction for attorney's fees, costs, comparative negligence, limits of collectability or responsibility, provisions of state law or otherwise.

5. That reimbursement to this Plan will be made immediately upon collection of any sum(s) recovered regardless of its legal, financial or other sufficiency.

6. That you or any attorney that is retained by you will not assert the Common Fund or Made-Whole Doctrine;

7. That any amount recovered by a dependent minor or on behalf of a dependent minor by a trustee, guardian, parent or other representative of the minor shall be reimbursed to the Plan regardless of whether the minor's representative has access or control of any recovery funds.

8. To sign any documents requested by the Plan Administrato*r*, or any representative of the Plan Administrator including but not limited to reimbursement and/or subrogation agreements. In addition, you agree to furnish any other information that might be requested by the Plan Administrator or representative of the Plan Administrato*r*. Failure or refusal to execute such agreements or furnish information does not preclude the Plan Administrato*r*

or any representative of the Plan Administrator from exercising its right to subrogation or obtaining full reimbursement.

9. To take no action which will, in any way, prejudice the rights of the Plan. (If it becomes necessary for the Plan Administrator or any representative of the Plan Administrator to enforce this provision by initiating any action against you, your covered dependent, your representative, your covered dependent's representative or anyone else, you will be responsible to pay the fees of the Plan Administrator's attorney and all costs associated with the action regardless of the outcome of the action.)

10. That any portion of the lien not satisfied will be deducted from any covered family member's future claims regardless of whether they are accident related. The plan may withhold future benefits from any family member until the lien is repaid.

11. The term settlement or recovery shall include funds recovered through a wrongful death action regardless of whether state law precludes the inclusion of medical expenses as part of the claim.

Any claims related to the accident or *illness* made after satisfaction of this obligation shall be the responsibility of the covered person, not the Plan.

E. No Liability for the Practice of Medicine

None of the Fund, the Plan, the Plan Administrator, the Administrator nor any of their designees are engaged in the practice of medicine; nor does any of them have any control over any diagnosis, treatment, care or lack thereof, or any health care services provided or delivered to you or your Dependents by any health care provider; nor will any of them have any liability whatsoever for any loss or injury caused to you or your Dependents by any health care provider by reason of negligence, failure to provide care or treatment, or otherwise.

F. Facility of Payment

Every person receiving or claiming benefits through the Plan will be presumed to be mentally and physically competent and of age. However, in the event the Plan Administrator (or its designee) determines that the covered person is incompetent or incapable of executing a valid receipt and no guardian has been appointed, or in the event the covered person has not provided the Fund Office with an address at which he or she can be located for payment, the Fund may pay any amount otherwise payable to such person to his spouse, relative or any other person or entity determined by the Plan Administrator (or its designee), in its sole and absolute discretion, to be equitably entitled thereto. Any such payment will discharge entirely the obligation of the Fund.