

***PHOENIX PAINTING INDUSTRY
TRUST FUND***

Certificate Effective Date: January 1, 2012

PHOENIX PAINTING INDUSTRY TRUST FUND

TO ALL ELIGIBLE MEMBERS:

Welcome! We are pleased to provide you with this booklet which describes the benefits as of January 1, 2012 provided by the Health and Welfare Trust Fund through Trustmark Life Insurance Company, and the procedures that should be followed when making a claim.

We urge you to read this entire booklet, to share it with your family and to keep it handy. We want you to obtain all the benefits to which you are entitled. Also included in the back of the booklet is certain information concerning the administration of the Plan as required by the Employee Retirement Income Security Act of 1974 (ERISA).

If you need assistance in filing a claim or have questions concerning any aspect of this Fund, how you become and remain eligible for the coverage, the benefits provided, or other rights of eligible members, please contact the Administrative Office and they will be happy to assist you in any way they can.

Sincerely,

BOARD OF TRUSTEES

MANDATORY AMENDMENT GRANDFATHERED GROUP

To the extent the benefits described below are more beneficial to the covered person than the terms and conditions of your certificate, the following provisions shall apply for plan years beginning on or after September 23, 2010 to ensure compliance with Federal health care reform known as the Patient Protection and Affordable Care Act, including any amendments, regulations, rules or other guidance issued with respect to the ("Act"):

1. Any lifetime maximum dollar limit referenced pertains only to those health care services and supplies that are not essential benefits as defined in the Act.
2. The annual maximum dollar limit, if any, shall not be applied to essential benefits except as allowed in the Act.
3. Coverage cannot be rescinded except for fraud or intentional misrepresentation of a material fact.
4. If coverage includes dependents, dependent child coverage will continue until the date the dependent child turns age 26 regardless of the marital status of such dependent child. Coverage does not include the spouse or child of such dependent child unless that child meets other coverage criteria established under state law
5. Any preexisting condition exclusions do not apply to enrollees or dependents under age 19.

This amendment takes effect on January 1, 2011. This amendment terminates concurrently with the certificate to which it is attached. It is subject to all the definitions, limitations, exclusions and conditions of the certificate except as stated.

TRUSTMARK LIFE INSURANCE COMPANY



David McDonough
Chief Executive Officer

This group health plan is believed to be a "grandfathered" health plan under the Patient Protection and Affordable Care Act (PPACA). As permitted by PPACA, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted, on March 23, 2010. Being a grandfathered health plan means that your plan may not include certain consumer protections of PPACA that apply to other plans, such as 100% coverage for in-network preventive care services. Grandfathered plans, however, must comply with certain other consumer protections under PPACA, such as the elimination of lifetime limits on benefits.

Questions regarding the protections and what may cause a plan to lose grandfathered health plan status can be directed to your plan administrator or you may contact Account Management at 800.227.9642 You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 866.444.3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans

TRUSTMARK LIFE INSURANCE COMPANY
400 Field Drive
Lake Forest, Illinois 60045
("Company")
(847) 615-1500

POLICYHOLDER: PHOENIX PAINTING INDUSTRY HEALTH AND WELFARE TRUST FUND

CERTIFICATE ISSUE DATE: January 1, 2012, replaces all previous Certificates issued for Contract Number JE882

GROUP ID: JE882

This Booklet becomes your Certificate of Group Insurance when, as described in the Effective Date section of this Booklet, you become covered under the Policy.

The insurance coverages, benefits and principal provisions that apply to insureds are described in this Booklet and are subject to the terms of the Policy which alone constitutes the contract under which payments are made.

The Policy may be inspected at Our office by any Policyholder, Covered Person or beneficiary during regular business hours.

This Certificate was issued on the basis that the information on Your employee enrollment form was correct and complete. **If any of the information on the enrollment form was not correct or complete, write to Us within 10 days of receipt of this Certificate. An error or omission may result in loss of coverage as of its effective date.**

This Certificate automatically supersedes any other Certificate previously issued to You.

Please read this Certificate carefully. This Certificate of Insurance may not provide all benefits and protections provided by law in Arizona.

TRUSTMARK LIFE INSURANCE COMPANY



Joseph L. Pray
Chief Executive Officer



Dennis L. Schoff
General Counsel & Secretary

**TRUSTMARK INSURANCE COMPANY
TRUSTMARK LIFE INSURANCE COMPANY
TRUSTMARK LIFE INSURANCE COMPANY NEW YORK
(We, Us, Our)**

NOTICE OF PRIVACY PRACTICES

Effective date of this notice: February 18, 2011

Our Commitment to Protecting Your Privacy

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

You do not need to respond to this notice in any way.

Our Responsibilities and Privacy Commitment

We understand the importance of protecting your private information. Our highest priority is to maintain your trust and confidence. We will maintain our commitment to safeguarding your information now and in the future.

We are required by law to:

- Maintain the privacy of your personal information.
- Provide you with certain rights with respect to your personal information.
- Provide you with a copy of this Notice of our legal duties and privacy practices with respect to your personal information.
- Follow the terms of the Notice that is currently in effect.

We are guided by our respect for the confidentiality of your personal information. We are providing you with this notice in accordance with privacy laws and because we want you to know that we value your privacy.

Information We Collect

Personal Information is any information we obtain about you in the course of issuing insurance and/or providing services. The information we may obtain includes, but is not limited to, your past, present, or future physical or mental health or condition, the provision of health care to you, payment for the provision of health care to you, your Social Security number, employment history, credit history, income information, and bank or credit card information.

We obtain this information from several sources, including but not limited to applications or other forms you complete, your business dealings with us and other companies, and consumer reporting agencies.

Our Privacy and Security Procedures

Our employees who have access to this information are those who must have it to provide products or services to you. Below are some examples of our guidelines for protecting information.

- Paper copies, when used, are viewed, discussed, and retained in private surroundings.
- Individuals viewing information stored in a computer must have passwords to gain access.
- Passwords are provided only to individuals who must have access to provide products or services to our insureds.
- Our business associates use information only for the purpose provided. Business associates sign a contract agreeing to follow our privacy procedures.

Information We Disclose

We will not disclose any Personal Information about you, except as allowed by law, including the Fair Credit Reporting Act. We may share all of the information we collect with insurance companies, agents, companies that help us to conduct our insurance business, companies that are self-insured, or others as permitted by law. Below are examples of the times we may share information for business purposes.

- Underwriting;
- Premium rating;
- Submitting claims;
- Reinsuring risk;
- Assessing quality;

- Business management and planning; and
- Sales, transfer, merger or consolidation of the business.

Your information may also be shared:

- For purposes of treatment, payment, and operations, including assessment of eligibility, case management activities, coordination of care, collection of premium, payment of benefits, and other claims administration.
- With a regulatory, law enforcement, or other government authority as required by law. This may include finding or preventing criminal activity, fraud, material misrepresentation or material nondisclosures in connection with an insurance issue.
- In response to an administrative or judicial order, including a search warrant or subpoena.
- With a medical care institution or professional, to verify coverage, conduct an audit of their activities, discuss a medical problem of which the insured may not be aware, discuss drug and disease management approaches, and other purposes permitted or required by law.
- To conduct actuarial or research studies. In this case, individuals are not identified in the research report. Material identifying an individual is destroyed as soon as it is no longer needed.
- With our business associates for use in auditing services or operations, auditing marketing services, performing various functions on our behalf, or to provide certain services.
- With a group policyholder for reporting claims experience, or for conducting an audit of our operations or services.
- To consult with outside health care providers, consultants and attorneys, and other health related services.
- As otherwise permitted or required by law.

We require those with whom we share information to implement appropriate safeguards regarding your Personal Information. We share only that which is minimally necessary to accomplish a task. Information that we get from a report made by a company that assists us to conduct insurance business may be retained by that company and used for other purposes.

Your written authorization is required for uses and disclosures of Personal Information for purposes other than those described above. If you provide us authorization to use or disclose your Personal Information, you may revoke that authorization, in writing, at any time. If you revoke your authorization, we will no longer use or disclose information for the specific purpose contained in the authorization. We are required to retain any records we may have containing your Personal Information for the periods specified in document retention laws. If you revoke your authorization for payment or health care operations, you may jeopardize the administration of the benefits under your health plan.

Your Rights

Upon written request, you have the right to:

- Inspect and copy certain Personal Information. We may charge a reasonable fee for the costs of copying or mailing.
- Receive confidential communication of Personal Information.
- Request restrictions on certain uses and disclosures of your Personal Information, although we are not required to agree to a requested restriction.
- Request an amendment to your Personal Information, although we are not required to agree to an amendment.
- Receive an accounting of impermissible Personal Information disclosures or disclosures made in compliance with federal law (or state regulations, if applicable) for which an accounting is required.
- Be notified of a breach of unsecured Personal Information.

The written request must reasonably describe the information. The information requested must be reasonably locatable and retrievable.

How to File a Complaint Regarding the Use and Disclosure of Personal Information

If you believe your privacy rights have been violated, you may file a complaint with us, your respective state insurance department, or with the Secretary of Health and Human Services. All complaints must be in writing.

You may not be retaliated against for filing a complaint.

How to Contact Us

You may contact our representative at the following address:

Privacy Officer
Privacy Request
Trustmark Companies
PO Box 7961
Lake Forest, IL 60045-7961

Email – PrivacyComplianceDepartment@Trustmarkinsurance.com

Notification of a revised privacy notice will be provided through one of the following:

- U.S. Postal Service
- Revised Plan Document
- Internet E-mail.

Any right a consumer, claimant, or beneficiary may have under this notice is not limited by any other privacy notice used by Trustmark Mutual Holding Company or its subsidiaries and affiliates.

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Effective date of Notice
April 14, 2004

The PHOENIX PAINTING INDUSTRY TRUST FUND is required by law to take reasonable steps to ensure the privacy of your personally identifiable health information and to inform you about:

1. the Plan's uses and disclosures of Protected Health Information (PHI);
2. your privacy rights with respect to your PHI;
3. the Plan's duties with respect to your PHI;
4. your right to file a complaint with the Plan and to the Secretary of the U.S. Department of Health and Human Services; and
5. the person or office to contact for further information about the Plan's privacy practices.

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

Section 1 **Notice of PHI Uses and Disclosures**

Required PHI Uses and Disclosures

Upon your request, the Plan is required to give you access to your PHI in order to inspect and copy it.

Use and disclosure of your PHI may be required by the Secretary of the Department of Health and Human Services to investigate or determine the Plan's compliance with the privacy regulations.

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

The Plan and its business associates will use PHI without your authorization or opportunity to agree or object to carry out treatment, payment and health care operations. The Plan and its business associates (and any health insurers providing benefits to the Plan participants) may also disclose the following to the Plan's Board of Trustees: (1) PHI for purposes related to Plan administration (payment and health care operations); (2) summary health information for purposes of health or stop loss insurance underwriting or for purposes of modifying the Plan; and (3) enrollment information (whether an individual is eligible for benefits under the Plan). The Trustees have amended the Plan to protect your PHI as required by federal law.

Treatment is the provision, coordination or management of health care and related services. It also includes but is not limited to consultations and referrals between one or more of your providers.

For example, the Plan may disclose to a treating physician the name of your treating radiologist so that the physician may ask for your X-rays from the treating radiologist.

Payment includes but is not limited to actions to make coverage determinations and payment (including billing, claims processing, subrogation, reviews for medical necessity and appropriateness of care, utilization review and preauthorizations).

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

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

For example, the Plan may use information to project future benefit costs or audit the accuracy of its claims processing functions.

Uses and disclosures that require your written authorization.

The Plan will obtain your authorization before releasing your PHI in those circumstances where the law or the Plan's privacy practices do not otherwise permit disclosure. For example, your written authorization generally will be obtained before the Plan will use or disclose psychotherapy notes about you prepared by your psychotherapist. Psychotherapy notes are separately filed notes about your conversations with your mental health professional during a counseling session. They do not include summary information about your mental health treatment.

Uses and disclosures that require that you be given an opportunity to agree or disagree prior to the use or release.

Disclosure of your PHI to family members, other relatives and your close personal friends is allowed if:

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

The Plan will disclose your PHI to your spouse unless you object.

Additional rules and exceptions apply with family members. You may request additional information from the plan.

Uses and disclosures for which your consent, authorization or opportunity to object is not required.

The Plan is allowed to use and disclose your PHI without your authorization under the following circumstances:

- (1) For treatment, payment and health care operations.
- (2) Enrollment information can be provided to the Trustees.
- (3) Summary health information can be provided to the Trustees for the purposes designated above.
- (4) When required by law.
- (5) When permitted for purposes of public health activities, including when necessary to report product defects and to permit product recalls. PHI may also be disclosed if you have been exposed to a communicable disease or are at risk of spreading a disease or condition, if required by law.
- (6) When required by law to report information about abuse, neglect or domestic violence to public authorities if there exists a reasonable belief that you may be a victim of abuse, neglect or domestic violence. In such case, the Plan will promptly inform you that such a disclosure has been or will be made unless that notice would cause a risk of serious harm. For the purpose of reporting child abuse or neglect, it is not necessary to inform the minor that such a disclosure has been or will be made. Disclosure may generally be made to the minor's parents or other representatives although there may be circumstances under federal or state law when the parents or other representatives may not be given access to the minor's PHI.
- (7) The Plan may disclose your PHI to a public health oversight agency for oversight activities required by law. This includes uses or disclosures in civil, administrative or criminal investigations; inspections; licensure or disciplinary actions (for example, to investigate complaints against providers); and other activities necessary for appropriate oversight of government benefit programs (for example, to investigate Medicare or Medicaid fraud).
- (8) The Plan may disclose your PHI when required for judicial or administrative proceedings. For example, your PHI may be disclosed in response to a subpoena or discovery request provided certain conditions are met. One of those conditions is that satisfactory assurances must be given to the Plan that the requesting party has made a good faith attempt to provide written notice to you, and the notice provided sufficient information about the proceeding to permit you to raise an objection and no objections were raised or were resolved in favor of disclosure by the court of tribunal.
- (9) When required for law enforcement purposes, including for the purpose of identifying or locating a suspect, fugitive, material witness or missing person. Also, when disclosing information about an individual who is or is suspected to be a victim of a crime but only if the individual agrees to the disclosure or the Plan is unable to obtain the individual's agreement because of emergency circumstances. Furthermore, the law enforcement official must represent that the information is not intended to be used against the individual, the immediate law enforcement activity would be materially and adversely affected by waiting to obtain the individual's agreement and disclosure is in the best interest of the individual as determined by the exercise of the Plan's best judgement.
- (10) When required to be given to a coroner or medical examiner for the purpose of identifying a deceased person, determining a cause of death or other duties as authorized by law. Also, disclosure is permitted to funeral directors, consistent with applicable law, as necessary to carry out their duties with respect to the decedent.

(11) When consistent with applicable law and standards of ethical conduct if the Plan, in good faith, believes the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public and the disclosure is to a person reasonably able to prevent or lessen the threat, including the target of the threat

(12) When authorized by and to the extent necessary to comply with workers' compensation or other similar programs established by law.

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

Section 2. Rights of Individuals

Right to Request Restrictions on Uses and Disclosures of PHI

You may request the Plan to restrict the uses and disclosures of your PHI. However, the Plan is not required to agree to your request.

You or your personal representative will be required to submit a written request to exercise this right.

Such requests should be made to the Plan's Privacy Official at: Southwest Service Administrators, Inc., 2400 West Dunlap, Ste. 250, Phoenix, AZ 85021-2811. Telephone: 602-249-3582.

Right to Request Confidential Communications

The Plan will accommodate reasonable requests to receive communications of PHI by alternative means or at alternative locations if necessary to prevent a disclosure that could endanger you.

You or your personal representative will be required to submit a written request to exercise this right.

Such requests should be made to the Plan's Privacy Official at: Southwest Service Administrators, Inc., 2400 West Dunlap, Ste. 250, Phoenix, AZ 85021-2811. Telephone: 602-249-3582.

Right to Amend PHI

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

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

Such requests should be made to the Plan's Privacy Official at: Southwest Service Administrators, Inc., 2400 West Dunlap, Ste. 250, Phoenix, AZ 85021-2811. Telephone: 602-249-3582.

You or your personal representative will be required to submit a written request to request amendment of the PHI in your designated record set.

Right to Receive an Accounting of PHI Disclosures

At your request, the Plan will also provide you an accounting of disclosures by the Plan of your PHI during the six years prior to the date of your request. However, such accounting will not include PHI disclosures made: (1) to carry out treatment, payment or health care operations (including to business associates pursuant to a business associate agreement and to the Trustees as authorized by the Plan or the HIPAA privacy regulations); (2) to individuals about their own PHI; (3) pursuant to your authorization; (4) prior to April 14, 2003; and (5) where otherwise permissible under the law and the Plan's privacy practices. In addition, the Plan need not account for certain incidental disclosures.

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

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

Such requests should be made to the Plan's Privacy Official at: Southwest Service Administrators, Inc., 2400 West Dunlap, Ste. 250, Phoenix, AZ 85021-2811. Telephone: 602-249-3582.

Right to Receive a Paper Copy of This Notice Upon Request

You have the right to obtain a paper copy of this Notice.

Such requests should be made to the Plan's Privacy Official at: Southwest Service Administrators, Inc., 2400 West Dunlap, Ste. 250, Phoenix, AZ 85021-2811. Telephone: 602-249-3582.

A Note About Personal Representatives

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

1. a power of attorney for health care purposes, notarized by a notary public;
2. a court order of appointment of the person as the conservator or guardian of the individual; or
3. an individual who is the parent of an unemancipated minor child may generally act as the child's personal representative (subject to state law).

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

Section 3 The Plan's Duties

The Plan is required by law to maintain the privacy of PHI and to provide individuals (participants and beneficiaries) with notice of the Plan's legal duties and privacy practices.

This Notice is effective April 14, 2004, and the Plan is required to comply with the terms of this Notice. However, the Plan reserves the right to change its privacy practices and to apply the changes to any PHI received or maintained by the Plan prior to that date. If a privacy practice is changed, a revised version of this Notice will be provided to all participants for whom the Plan still maintains PHI. The revised Notice will be distributed in the same manner as the initial Notice was provided or in any other permissible manner.

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

Minimum Necessary Standard

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

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

1. disclosures to or requests by a health care provider for treatment;
2. uses or disclosures made to the individual;
3. disclosures made to the Secretary of the U.S. Department of Health and Human Services;
4. uses or disclosures that are required by law; and
5. uses or disclosures that are required for the Plan's compliance with legal regulations.

De-Identified Information

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

Summary Health Information

The Plan may disclose "summary health information" to the Trustees for obtaining insurance premium bids or modifying, amending or terminating the Plan. "Summary health information" summarizes the claims history, claims expenses or type of claims experienced by participants and excludes identifying information in accordance with HIPAA.

Section 4
Your Right to File a Complaint with the Plan or the HHS Secretary

If you believe that your privacy rights have been violated, you may complain to the Plan. Such complaints should be made to the Plan's Privacy Official at: Southwest Service Administrators, Inc., 2400 West Dunlap, Ste. 250, Phoenix, AZ 85021-2811. Telephone: 602-249-3582.

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

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

Section 5
Whom to Contact at the Plan for More Information

If you have any questions regarding this notice or the subjects addressed in it, you may contact the Plan's Privacy Official. Such questions should be directed to the Plan's Privacy Official at: Southwest Service Administrators, Inc., 2400 West Dunlap, Ste. 250, Phoenix, AZ 85021-2811. Telephone: 602-249-3582.

Conclusion

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

PNTRS-HIPAA NOTICE

HIPAA PRIVACY AMENDMENT
Effective as of: April 14, 2003
(Amended for HIPAA Security as of April 20, 2005)

This amendment is attached to and made a part of the health benefit plan. Except as stated in this amendment, it shall not change any of the terms or provisions of the health benefit plan.

Pursuant to the Health Insurance Portability and Accountability Act ("HIPAA") Privacy Rule, the following language is attached to and becomes part of Your health benefit plan.

DEFINITIONS

Plan Sponsor:

- the employer in the case of an employee benefit plan established or maintained by a single employer;
- the employee organization in the case of a plan established or maintained by an employee organization; or
- the association, committees, joint board of trustees, or other similar group of representatives of the parties who establish or maintain the plan in the case of a plan established or maintained by two or more employers or jointly by one or more employers and one or more employee organizations.

Protected Health Information (PHI): Protected Health Information (PHI) includes individually identifiable health information that is created or received by Your provider, Your health benefit plan or insurer, a data clearinghouse, a health authority, employer, school or university. PHI can be maintained or transmitted in any form or medium. It relates to the past, present, or future:

- condition of Your physical or mental health,
- health care provided to You; or
- payment for the health care provided to You.

PERMITTED/REQUIRED USE AND DISCLOSURE OF YOUR PHI

Your PHI will be used and disclosed for the purpose of routine treatment, payment of Your benefits and health care operations, including plan and benefit administration. Your PHI may also be used or disclosed between Your health plan, plan sponsor and any approved business associates as required or permitted by law, including the HIPAA Privacy Rule.

AMENDMENT PROVISION

The plan sponsor may receive information as to whether individuals are participating in the group health plan, or are enrolled or disenrolled in the plan.

The plan sponsor may also request summary health information for:

- obtaining premium bids from health plans for providing health insurance coverage, or
- modifying, amending or terminating the plan.

Summary health information summarizes claim history, claims expenses or types of claims experienced by individuals under the plan and also contains information which has been de-identified. De-identification deletes PHI and leaves only geographic information.

Your plan sponsor is required by law to:

- not use or disclose to anyone the PHI of any individual covered under this health benefit plan other than as permitted or required by the health benefit plan or by law;
- ensure that any agents, including subcontractor(s), to whom Your plan sponsor provides PHI received from the health benefit plan, agree to the same restrictions and conditions that apply to the plan sponsor with respect to such information;
- not to use or disclose the information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the plan sponsor;
- report to the health benefit plan any use or disclosure of the information that is inconsistent with the uses or disclosures provided for or which Your plan sponsor becomes aware;
- allow You, upon written request, to:
 - access and amend Your PHI;
 - receive an accounting of disclosures of PHI for other than treatment, payment and healthcare operations;

- make its internal practices, books and records relating to the use and disclosure of PHI received from the health benefit plan available to the Secretary of the Office of Civil Rights of HHS for the purposes of determining compliance by the group health plan;
- return or destroy, if feasible, all PHI received from the health benefit plan that Your plan sponsor still maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made; if destruction is not feasible, limit further uses and disclosures to those purposes that made the return or destruction of the information infeasible;
- provide PHI only to those individuals, under the control of the plan sponsor who perform plan administrative functions for the health benefit; (i.e. eligibility, enrollment, payroll deduction, benefit determination; claim reconciliation assistance), and to make clear to such individuals that they are not to use PHI for any reason other than for plan administrative functions nor to release PHI to an unauthorized individual;
- provide PHI only to those entities required to receive the information in order to maintain the health benefit plan (i.e. claim administrator, case management vendor, pharmacy benefit manager, claim subrogation, vendor, claim auditor, network manager, stop loss insurance carrier, insurance broker/consultant, and any other entity subcontracted to assist in administering the health plan); and
- provide an effective mechanism for resolving any issues of noncompliance with regard to the items mentioned in this Amendment.

Your Plan Sponsor may obtain Electronic PHI (also known as ePHI) relative to this health benefit plan. Electronic PHI is that PHI (defined above) which is (i) transmitted by electronic media; (ii) maintained in electronic media; or (iii) transmitted or maintained in any other form or medium.

Relative to this ePHI, your Plan Sponsor is required by law (45 CFR parts 160, 162 and 174) to do the following:

- implement reasonable and appropriate administrative, physical and technical safeguards that protect your ePHI;
- ensure that there are security measures between the Plan Sponsor and those individuals under the control of the Plan Sponsor, who perform plan administrative functions for the health benefit plan;
- ensure that any agent or subcontractor agrees to implement reasonable and appropriate safeguards to protect the information; and
- report to the group health plan any breach of the above that it becomes aware of.

HOW TO FILE A COMPLAINT REGARDING THE USE AND DISCLOSURE OF YOUR PHI

If You believe Your privacy rights have been violated, You may file a complaint with Us or with the Secretary of Health and Human Services. All complaints must be in writing. Please be assured that You may not be retaliated against for filing a complaint.

How to Contact Us

You may contact a representative of Trustmark at the following:

Privacy Officer
 HIPAA Compliance Department
 Trustmark Life Insurance Company
 P.O. Box 7961
 Lake Forest, IL 60045-7961
 Email – HIPAAComplianceDepartment@Trustmarkinsurance.com
 Website – www.trustmarklife.com

2002-24C

FI/MP TL 04-20-05

PLAN AMENDMENT

PHOENIX PAINTING INDUSTRY TRUST FUND

Effective April 14, 2004, the Plan is amended to add a new Section to read as follows:

Privacy. The Plan will use and disclose Protected Health Information (“PHI”) in accordance with the uses and disclosures permitted or required by the privacy regulations issued pursuant to the Health Insurance Portability and Accountability Act of 1996, 45 C.F.R. Parts 160 and 164 (the “Privacy Regulations”). The following provisions address disclosures of PHI to the Plan’s Board of Trustees (the “Trustees”) for Plan administration purposes. If other terms of the Plan conflict with the following provisions, the following provisions shall control. The Privacy Regulations are incorporated herein by reference. Unless defined otherwise in the Plan, all capitalized terms herein have the definition given to them by the Privacy Regulations.

A. Disclosure of PHI to the Trustees.

(1) Disclosures by Plan. The Plan may disclose PHI to the Trustees to the extent necessary for the Trustees to perform Plan administration functions that qualify as Payment or Health Care Operations.

(2) Disclosures by Business Associates. The Plan’s Business Associates may disclose PHI to the Trustees to the extent necessary for the Trustees to perform Plan administration functions that qualify as Payment or Health Care Operations.

(3) Disclosures by Other Covered Entities. A Covered Entity that provides health insurance benefits to Individuals covered by the Plan may disclose PHI to the Trustees to the extent necessary for the Trustees to perform the following Plan administration functions:

(a) the Plan’s Payment activities,

(b) those Health Care Operations designated in 45 C.F.R. section 164.506(c)(4) with respect to the Plan, and

(c) all of the Plan’s Health Care Operations to the extent the Plan and the other Covered Entity are considered an Organized Health Care Arrangement under the Privacy Regulations.

B. Uses and Disclosures of PHI by the Trustees. The Trustees shall use and/or disclose PHI only to the extent necessary to perform administration functions on behalf of the Plan that qualify as Payment or Health Care Operations.

C. Privacy Safeguards. The Trustees agree to:

(1) Not use or further disclose PHI other than as permitted or required under the Plan or as required by law;

(2) Ensure that any subcontractors or agents to whom the Trustees provide PHI agree to the same restrictions and conditions that apply to the Trustees with respect to PHI;

(3) Not use or disclose PHI for employment-related actions and decisions unless authorized by the Individual who is the subject of the PHI;

(4) Not use or disclose PHI in connection with any other employee benefit plan unless authorized by the Individual who is the subject of the PHI or as permitted under the Privacy Regulations;

- (5) Report to the Plan any use or disclosure of PHI of which the Trustees become aware that is inconsistent with the uses or disclosures provided for in the Plan;
- (6) Make PHI available to an Individual in accordance with the Privacy Regulation's access requirements and the Plan's privacy policies and procedures;
- (7) Make PHI available for amendment and incorporate any amendments to PHI in accordance with the Privacy Regulations and the Plan's privacy policies and procedures;
- (8) Make available the information required to provide and accounting of disclosures in accordance with the Privacy Regulations and the Plan's privacy policies and procedures;
- (9) Make internal practices, books and records relating to the use and disclosure of PHI available to the Secretary of the U.S. Department of Health and Human Services for purposes of determining the Plan's compliance with the Privacy Regulations;
- (10) If feasible, return or destroy all PHI that the Trustees maintain in any form, and retain no copies of such PHI when no longer needed for the purpose for which the disclosure was made to the Trustees. If return or destruction is not feasible, the Trustees agree to restrict and limit further uses and disclosures to the purposes that make the return or destruction infeasible and shall maintain the confidentiality of such PHI as long as it is retained; and
- (11) Ensure that adequate separation between the Plan and the Trustees is established, as described below.

D. Adequate Separation. The Trustees may use PHI only for Plan administration activities. The Trustees may not use PHI for employment-related actions or for any purpose unrelated to Plan administration. Any Trustee who uses or discloses PHI in violation of the Plan's privacy policies and procedures or in violation of this Plan provision shall be subject to the Plan's privacy disciplinary procedure.

CONTENTS

PAGE

MANDATORY AMENDMENT GRANDFATHERED GROUP 1

NOTICE OF PRIVACY PRACTICES 4

HIPAA PRIVACY AMENDMENT 14

TABLE OF CONTENTS 18

CONTENTS - INSURING PROVISIONS

PARTICIPANTS 21

- Participants
- Eligibility Date
- Continuing Eligibility
- Contributions
- Effective Date
- Termination

DEPENDENTS 23

- Definition of Dependent
- Exclusions
- Eligibility Date
- Contributions
- Effective Date
- Termination

CONTENTS - INSURING PROVISIONS

MEDICARE 25

WORKMEN'S COMPENSATION 25

CERTIFICATION OF COVERAGE 25

EXTENSION OF BENEFITS 25

CONTENTS – CONTINUATION OF COVERAGE PROVISIONS

Self-Payment Provisions for Employees and Dependents

Employees' Self-Payments 26

- Notice
- Self-Payment Amount – Benefits Available
- Maximum Number of Self-Payments
- Termination of Self-Payment

Dependent Self-Payments 27

- Notice
- Self-Payment Amount – Coverage Available
- Maximum Number of Self-Payments
- Termination of Self-Payments

Payment of Self-Payment Amounts for Employees and Dependents 28

Trustee Rights 28

Persons Whose Eligibility Affected by Multiple Events 28

CONTENTS - SCHEDULE OF BENEFITS

Classification 29

Benefit Amounts 30

All provisions will be found in the policy in the order set forth on this page.

CONTENTS - HEALTH INSURANCE

	PAGE
Comprehensive Medical Coverage	35
Hospital Care Sub-Coverage	36
Medical Care Sub-Coverage	37
Surgical Care Sub-Coverage	38
Other Charges Sub-Coverage	39
Home Health Care Sub-Coverage	41

CONTENTS – GENERAL HEALTH PROVISIONS

Application	42
General Health Limitations	42
Governmental Benefits	
Double Coverage	
Non-Obligatory Charges	
Reasonable Charges	
Bodily Injury or Disease	
Occupational Coverage	
Pregnancy	
Miscellaneous	
Notice, Proof of Claims and Payment of Claims	43
Time of Notice	
Forms	
Proof of Loss	
Time of Payment	
To Whom Benefits Payable	
Physician Examination and Autopsy	
Benefits Unpaid at Death; Incompetency	
Legal Action	
Miscellaneous	44
Date of Treatment	
Determination of Insured	
Entire Contract	
Definitions	45
Physician	
Medically Necessary (Medical Necessity)	
Hospital	
Substance Abuse	
Intensive Care Unit	
Coordination of Benefits	47
Effect on Benefits	
Plan	
Principal Plan	
Allowable Expense	
Claim Determination Period	
Anti-duplication Provision	
Order of Benefit Determination	
Right to Information	
Right to Make Payments	
Right to Recover Payments	
Medical Conversion Privilege	50
Dependents	
Conversion Coverage	

All provisions will be found in the policy in the order set forth on this page.

CONTENTS – COVERAGE PROVISIONS FOR LIFE AND AD&D INSURANCE

	PAGE
General Life Provisions	51
Entire Contract	
Statements Not Warranties	
Right To Contest	

CONTENTS – PARTICIPANT LIFE INSURANCE

Participant Life Benefit	52
Benefit	
Beneficiary	
Settlement Options	
Total Disability Extended Benefits	53
Extended Life Insurance Benefit	
Premium Waiver Benefit	
Other Extended Benefits Provisions	
Participant Life Conversion Privilege	54
If Your Eligibility Ends	
If Participant Life Insurance Terminates	
Following Total Disability Extension	
Individual Policy	
Conversion Period	
Notice of Conversion Rights	
Death Benefit During Conversion Period	

CONTENTS – PARTICIPANT AD&D INSURANCE

Benefit	55
Covered Loss	56
Table of Losses and Benefits	
AD&D Exclusions	57
Excluded Charges List	
Proof and Payment of AD&D Claims	57
To Whom Benefits are Payable	
Physical Examination and Autopsy	

NOTICE OF GRIEVANCE PROCEDURES	58
---	-----------

CLAIM REVIEW AND APPEAL RIGHTS UNDER FEDERAL LAW	69
---	-----------

SUMMARY PLAN DESCRIPTION	73
---------------------------------------	-----------

PNTRS

INSURING PROVISIONS - PARTICIPANTS

PARTICIPANTS. Each person who is a participant is eligible for participants insurance under this policy. A participant is an employee of a covered employer who is in a job classification covered under the terms of a collective bargaining agreement between the Painting and Decorating Contractors Association of America, Arizona Chapter No. 1 and Brotherhood of Painters and Decorators and Paperhangers of America, Local Union No.86 and for whom the covered employer is making contributions to the Phoenix Painting Industry Trust Fund.

The term "covered employer" means an employer that subscribes to the trust agreement establishing the Phoenix Painting Industry Trust Fund and that makes contributions on behalf of its employees to that Fund.

ELIGIBILITY DATE - PARTICIPANTS. The Eligibility Date for each person who is eligible as a participant shall be determined from the dates listed below as follows: the Eligibility Date for Initial Participants shall apply to each person who is a participant on the effective date of this policy; the Eligibility Date for Subsequent Participants shall apply to each person who first becomes a participant after the effective date of this policy; and the Eligibility Date for Reinstated Participants shall apply to each person whose eligibility as a participant is reinstated after the person has ceased to be insured under the policy as a participant.

Eligibility Date for Initial Participants: January 1, 2004 if the participant would then have been covered under the prior policy issued to the Policyholder; otherwise the Eligibility Date for Subsequent Participants shall apply.

Eligibility Date for Subsequent Participants: the first day of the second calendar month next following a period of three consecutive months during which the participant completes 360 hours of employment with covered employers.

Lag Month: In order that there will be sufficient time for employer reports to be received and processed by the Administrative Office, a "lag month" will be used in determining your monthly eligibility. The lag month is the month between the payroll period and the month of actual insurance coverage. For example:

You work 120 hours each month during October, November and December. You would become insured on February 1 – in this example, January is the lag month.

Eligibility Date for Reinstated Participants: the first day of the second calendar month next following the month in which a participant's Hour Bank Account shows a total of 120 hours, provided that the participant's coverage is reinstated within four months following the date such coverage terminated; otherwise, the Eligibility Date for Subsequent Participants shall apply, and any hours in the participant's Hour Bank Account shall be forfeited.

INSURING PROVISIONS – PARTICIPANTS *(continued)*

CONTINUING ELIGIBILITY PARTICIPANTS. Each participant who becomes covered under this policy shall have an Hour Bank Account established for that participant. All hours worked by a participant for covered employers shall be credited to the participant's Hour Bank Account. After a participant becomes covered under the policy, 120 hours will be deducted from that participant's Hour Bank Account for each month of insurance coverage. The Hour Bank Account for a participant shall not exceed 360 hours at any time after deduction of 120 hours for that month's coverage. Hour Bank Account hours will be used to continue insurance for a participant if the participant has not completed the required number of hours during a month and the Hour Bank Account shall be debited the number of hours used to continue insurance.

If a participant is disabled and unable to work for a continuous period of at least 31 days, coverage will remain in force and no deductions will be made from the participant's Hour Bank Account until the earlier of (1) the first day of the month following the month in which the disability ends and (2) the first day of the seventh month following the month in which disability commenced.

CONTRIBUTIONS - PARTICIPANTS. Contributions are not required from participants for insurance.

EFFECTIVE DATE - PARTICIPANTS. The participants insurance shall become effective on the participant's Eligibility Date.

TERMINATION - PARTICIPANTS. A participant shall automatically cease to be covered for participants insurance on the earliest of the following dates:

1. the date on which this policy terminates;
2. the date of expiration of the period for which the last required premium payment is made on account of the person's participants insurance;
3. the last day of the month in which the balance of the Participant's Hour Bank Account falls below 120 hours after deduction of 120 hours for that month's coverage; or
4. the date that self payments are not paid on a timely basis.

INSURING PROVISIONS - DEPENDENTS

DEFINITION OF DEPENDENT. The term "dependent" shall include only (1) a participant's wife or husband, and (2) a participant's unmarried child who chiefly depends upon the participant for support and is of an age within the Age Limits for Dependent Children specified below. The word "child" shall also include the participant's step-child, foster child and other child who lives with the participant in a regular parent-child relationship. In no event, however, shall a child be included as a dependent of more than one person.

Age Limits for Dependent Children:

Medical Coverage: under 26 years.

A child pursuant to a court issued qualified medical child support order.

If a dependent, prior to attaining the applicable maximum age for eligible dependents, is chiefly depending upon the participant for support and maintenance and is continuously unable to obtain self-sustaining employment because of physical handicap or mental retardation, the dependent shall remain insured under this policy for the medical coverages provided for dependents until the dependent either recovers from the physical handicap or mental retardation, or no longer chiefly depends upon the participant for support and maintenance.

Proof of such incapacity and dependency shall be furnished to the administrator by the insured within thirty-one days of the child's attainment of the limiting age and subsequently as may be required, but not more frequently than annually after the two year period following the child's attainment of the limiting age.

EXCLUSIONS. The term "dependent" shall not include any person who is a participant under this policy or who is on active duty in the armed forces.

ELIGIBILITY DATE - DEPENDENTS. Each dependent becomes eligible for dependents insurance under this policy on the latest of (1) the participant's Eligibility Date, (2) the date the participant acquires the dependent, or (3) the date on which insuring provisions for dependents become effective under this policy.

CONTRIBUTIONS - DEPENDENTS. Contributions are not required from participants for dependents insurance.

EFFECTIVE DATE - DEPENDENTS. Dependents insurance shall become effective on the later of the dependent's Eligibility Date or the participant's effective date of participant's insurance.

A participant's newborn dependent child, adopted child, regardless of the age at which the child was adopted, or child who has been placed for adoption with the participant shall be covered for any Medical Coverage from the moment of birth, date of adoption or date of adoption placement. Coverage for such newborn dependent child, adopted child or child who has been placed for adoption shall include, to the extent that benefits are provided under the policy, the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities. If contributions are required from the participant for dependents insurance, such dependent must be enrolled within 31 days from the date of such birth, adoption or adoption placement for coverage to continue beyond the 31 day period following such birth.

TERMINATION - DEPENDENTS. A dependent shall automatically cease to be covered for dependents insurance on the earliest of the following dates:

1. the date on which the participant ceases to be covered for participants insurance, except that the insurance for dependents of a deceased participant shall remain in force, without payment of premiums, until the earlier of (a) the end of the twelve month period commencing on the day next following the date of the participant's death, or (b) the date on which the surviving spouse remarries;
2. the date on which the dependent ceases to qualify in accordance with the Definition of Dependent provision;
3. the date of expiration of the period for which the last required premium payment is made on account of the dependent's insurance; or
4. the date that self payments are not paid on a timely basis.

If an employer ceases being a covered employer, the dependents insurance for all dependents of participants who are employed by that employer shall terminate, and their further rights under this policy shall be determined on the same basis as that which would apply if this policy had terminated.

PNTRS

INSURING PROVISIONS *(continued)*

MEDICARE. Medical coverages will not terminate for an insured when he becomes eligible for Medicare, but they will be coordinated with Medicare benefits. See the Coordination of Benefits section for an explanation of how coordination works.

WORKMEN'S COMPENSATION. All benefits provided under this plan are for non-occupational accidents and diseases only. Diseases and accidents which arise out of or in the course of employment are normally covered by Workmen's Compensation Insurance.

CERTIFICATION OF COVERAGE

1. The Administrative Office will provide a "Certificate of Coverage" to each covered person upon termination of coverage under the Plan. The certificate will indicate the period of time each covered person was covered under the Plan and certain additional information that is required by law. If, within 62 days after his coverage under this Plan ends, a covered person becomes eligible for coverage under another group health plan or purchases a health insurance policy, this certificate may be necessary to reduce any exclusion for pre-existing conditions that may apply to such covered person in that group health plan or health insurance policy.
2. The certificate will be sent by first class mail to the covered person's last known address shortly after coverage under this Plan ends. If the covered person elects COBRA self-payment coverage, another certificate will be sent by first class mail shortly after the COBRA self-payment coverage ends for any reason.
3. In addition, a certificate will be provided to any covered person upon receipt of a request for such certificate, if that request is received by the Administrative Office within two years after the later of the date coverage under this Plan ended or the date the COBRA self-payment coverage ended.

EXTENSION OF BENEFITS

If a person whose insurance terminates is totally disabled at the time of the termination, benefits under the Medical Coverages will be payable, to the same extent as if the insurance had not terminated, for covered charges incurred on account of the injury or disease causing that disability and no benefits will be paid for charges incurred after the earliest of the following dates:

1. the date on which the total disability ceases;
2. the end of the calendar year following the calendar year in which the disability began; or
3. the date on which the insured becomes covered under any group or blanket insurance policy; or under any plan, program or coverage which provides benefits similar to those provided to the insured in accordance with the terms of this section.

IP1000

CONTINUATION OF COVERAGE PROVISIONS

Self-Payment Provisions for Employees and Dependents

1. Employees' Self-Payments

If a once-eligible employee loses eligibility under the Hour Bank Eligibility provisions due to a termination of employment or reduction in hours, he and/or his eligible dependents may continue eligibility by making self-payments directly to the Administrative Office.

Notice

It will be the responsibility of each participant to determine his own status of eligibility. The Administrative Office will notify an employee who has lost eligibility under the Hour Bank Eligibility provisions of the Fund. The affected persons will have until the later of 60 days from such notice, or 60 days from the date eligibility is lost, to notify the Administrative Office of their election to continue eligibility by making self-payments. Each participant is responsible for maintaining their correct address at the Administrative Office.

Self-Payment Amount – Benefits Available

The amount of the monthly self-payments will be established by the Board of Trustees and is subject to change in their discretion. The self-payments charged will represent continuation of all health-related benefits provided for employees and dependents by the Fund.

Maximum Number of Self-Payments

The right of an employee and/or his eligible dependents to continue coverage under these provisions shall be continued until the end of the month in which the earliest of the following events occurs:

- a. The Trust Fund ceases providing any benefits to any Participant.
- b. Coverage ceases by reason of the failure of the persons to timely make the self-payments required by the Trustees.
- c. The employee and/or his eligible dependents first become covered, after COBRA election, under any other group health plan.
Note: If the other plan contains limitations or exclusions for any pre-existing conditions, any individual so limited or excluded by the other plan may continue coverage under the Trust Fund until the other plan's limitations or exclusions no longer limit coverage or until otherwise limited by these provisions.
- d. The employee and/or his eligible dependents first become entitled, after COBRA election, to Medicare.
- e. 18 months (24 months for military service) have passed since the end of coverage under the Hour Bank Eligibility provisions. Notwithstanding the foregoing:
 - i. In the event that an employee becomes entitled to Medicare while eligible as an Active Employee, no dependent of such Employee shall be denied the right to continue self-payments to the Fund under this provision until 36 months have passed from the date the employee became entitled to Medicare.
 - ii. In the case of an individual who was totally and permanently disabled for Social Security award purposes on the date of the employment termination of an Active Employee or during the election period, up to 11 additional months of self-payments may be allowed to bridge the gap between these provisions and Medicare. In order to enjoy this additional extension of self-pay rights, the totally disabled individual is required to notify the Administrative Office of the Fund within 60 days of the date of Social Security's determination that he/she was disabled at the time of the termination of employment or during the election period, and before the end of the 18-month period described above. Such individual is also required to notify the Administrative Office within 30 days of any final Social Security determination that he/she is no longer disabled. The additional disability extension of self-payment rights under this subsection 1e will terminate at the end of the month following the month in which a final Social Security determination is made that the individual is no longer disabled.

CONTINUATION OF COVERAGE PROVISIONS *(continued)*

Self-Payment Provisions for Employees and Dependents

- iii effective January 1, 2002, an individual who is age 62 or more, who retires, and who has, at the end of coverage under the Hour Bank Eligibility provisions, a minimum of 15 years of service under the Trust Fund immediately preceding retirement, may self-pay for up to an additional 18 months of health insurance coverage following the end of coverage under these Continuation of Coverage Provisions, but not beyond the end of the month in which the individual reaches age 65.

Termination of Self-Payment

Once an employee fails to make the required self-payment contribution within the specified time, or has made the maximum number of self-payments specified above, he will no longer be permitted to make the self-payments described and must requalify as outlined in the Initial Eligibility provisions or the Reinstatement of Eligibility provisions.

2. Dependent Self-Payments

If any dependent or dependents lose coverage for the benefits of this Trust Fund because of: (a) the death of an eligible employee; (b) the divorce of an eligible employee; (c) the attainment of the entitlement of Medicare by a self-pay employee; or (d) in the case of a dependent child, the failure of the dependent to meet the definition of dependent under the Plan, they may continue eligibility by making self-payments directly to the Administrative Office.

Notice

Dependents whose coverage under this Plan is affected by death, divorce, entitlement to Medicare, or the failure to meet the definition of dependent under the Plan are responsible for notifying the Administrative Office of those facts within 60 days of the affecting event. The Administrative Office will then notify the dependents of their rights under these provisions within 14 days. The dependents will have until the later of 60 days from the date of the notice from the Administrative Office, or 60 days from the date eligibility is lost, to notify the Administrative Office of their election to continue eligibility by making self-payments.

Self-Payment Amount – Coverage Available

The amount of the monthly self-payment for dependents affected by death, divorce, Medicare eligibility or the failure of a dependent to meet the definition of dependent under the Plan will be established by the Board of Trustees and is subject to change in their discretion. The self-payment charged will represent continuation of all dependent health-related benefits.

Maximum Number of Self-Payments

The right of dependents to make self-payments shall be continued until the end of the month in which the earliest of the following events occurs:

- a. The Trust Fund ceases providing any benefits to any participant.
- b. Coverage ceases by reason of the failure of the affected dependents to timely make the self-payments required by the Trustees.
- c. The dependents first become covered, after COBRA election, under any other group health plan.

Note: If the other plan contains limitations or exclusions for any pre-existing conditions, any individual so limited or excluded by the other plan may continue coverage under the Trust Fund until the other plan's limitations or exclusions no longer limit coverage or until otherwise limited by this Section.

- d. The dependents first become entitled, after COBRA election, to Medicare.
- e. 36 months have passed since the end of regular coverage under the provisions of this Plan.

CONTINUATION OF COVERAGE PROVISIONS *(continued)*

Self-Payment Provisions for Employees and Dependents

- f. Notwithstanding the forgoing, effective January 1, 2009, a dependent spouse of an individual who had, at the end of coverage under the Hour Bank or other active employee eligibility provisions, 40 continuous years of participation in the Trust Fund (or, as determined by the trustees in their discretion, 40 continuous years of service to the union organized industry served by the Trust including 10 years of participation in the Trust), may self-pay, upon the death or Medicare eligibility of the employee, for full fund benefits until the dependent spouse becomes entitled to Medicare.

Termination of Self-Payments

Once the affected dependents fail to make the required self-payment contribution within the specified time, or have made the maximum number of self-payments specified above, such dependents will no longer be permitted to make the self-payments described.

3. Payment of Self-Payment Amounts for Employees and Dependents

Initial self-payments (retroactive to the date of loss of eligibility) must be made no later than the 45th day after the date the Administrative Office is notified of the person's election to make self-payments. Each subsequent self-payment is due on the first day of the month for which coverage is intended. Self-payments received at the Administrative Office later than 30 days after the due date will not be accepted and rights to self-payments will terminate. There will be no waivers granted. No cash or personal checks can be accepted by the Administrative Office for self-payment.

4. Trustee Rights

The Board of Trustees reserves the right to request and receive from self-pay employees and self-pay dependents any pertinent information bearing on the eligibility of such persons for the benefits provided under the self-payment provisions of this Trust Fund. The failure of any such person to promptly respond to the Trustees' request for such information may lead to the self-payment rights described being suspended or terminated by the Trustees, in their discretion.

5. Persons Whose Eligibility Affected by Multiple Events

Notwithstanding anything other than Section 1(e)(iii) to the contrary herein, no person may enjoy self-pay coverage extensions under the Trust Fund and plan beyond 36 months from the end of the month in which the first event giving rise to self-payment rights with respect to that person occurred.

CCP1000

SCHEDULE OF BENEFITS

CLASSIFICATION. Each participant shall be covered for the benefits applicable to such participant's insurance classification as follows:

Class Number

1 All participants

SCHEDULE OF BENEFITS *(continued)*

EMPLOYEE LIFE INSURANCE BENEFIT	\$5,000
EMPLOYEE AD&D INSURANCE FULL BENEFIT	\$5,000

SCHEDULE OF BENEFITS *(continued)*

COMPREHENSIVE MEDICAL COVERAGE

Comprehensive Medical Maximum \$1,250,000 per year.

Automatic Restoration Maximum The Automatic Restoration provisions are not in force under this policy.

General Deductible \$350

Accumulated General Deductible Maximum \$700 of covered charges incurred by insured family members and applied toward satisfaction of the General Deductible

The General Deductible applies to all covered medical charges, except (1) covered Surgical Care charges incurred by an insured in the outpatient facility of a hospital or in a freestanding outpatient surgical facility and (2) covered Medical Care charges for second or third surgical opinions.

Special Deductible No Special Deductible applies to coverages provided under this policy.

Covered medical charges incurred in connection with accidental injuries are subject to a Deductible.

Percentage Payable

Medical Care charges for second or third surgical opinions: 100%

Hospital Care charges for inpatient treatment at a Arizona Foundation Point of Service Hospital: 90%

Charges for professional ambulance service: 80%

Covered charges for drugs and medicines (including oral contraceptives): 80% to a maximum of \$100 per retail prescription and a maximum of \$200 per mail order prescription.

- For outpatient prescription drugs and medicines dispensed at a network pharmacy, the cost of the drug or medicine will be discounted.

Covered charges incurred for therapy involving manual manipulation of the musculoskeletal system: 80%

Covered charges by a hospital for emergency outpatient treatment: 80%

Covered charges incurred in connection with inpatient treatment of substance abuse

By preferred providers: 80%

By other providers: 60%

Covered charges incurred in connection with outpatient treatment of substance abuse

By preferred providers: 80%

By other providers: 60%

All other covered charges: 60%*

*For insureds who live outside the Arizona Foundation Physician PPO Network Area: The Percentage Payable is 80%. After an insured has incurred \$5,000 of covered medical charges for which benefits are paid at less than 90%, the percentage payable will increase to 90% for covered medical charges incurred during the remainder of that calendar year.

SCHEDULE OF BENEFITS *(continued)*

*PERCENTAGE PAYABLE INCREASE. After an insured has incurred \$5,000 of covered medical charges during a calendar year for which benefits are paid at less than 80%, the percentage payable will be increased to 80% for the next \$15,000 of covered charges incurred by that insured during that calendar year; thereafter, the percentage payable will be increased to 90% for the remainder of the calendar year.

*PREFERRED PROVIDER BONUS. For covered charges made by a preferred physician and for covered charges made by a preferred hospital, the Percentage Payable is 80%. After an insured has incurred \$5,000 of covered medical charges during a calendar year for which benefits are paid at less than 90%, the percentage payable for covered charges made by a preferred physician and for charges made by a preferred hospital is increased to 90%.

Unit Values	Not Applicable
Covered Charge Maximums	
Hospital Care Daily Benefit	the hospital's average semi-private room rate

SUBSTANCE ABUSE BENEFIT

Covered Substance Abuse Charges. The charges by a hospital or physician that are incurred for the treatment of substance abuse are covered medical charges. Such charges shall be paid same as any other covered charge.

ORTHOTICS BENEFIT

Benefits for charges incurred for orthotics shall not exceed \$300 during any period of 24 consecutive months.

METABOLIC FORMULAS and MODIFIED LOW PROTEIN FOODS BENEFIT

Modified Low Protein Foods and Metabolic Formulas are covered same as for all covered charges (Deductible does not apply).

Metabolic Formulas and Modified Low Protein Foods are foods that are formulated to be consumed entirely under the supervision of a Physician; and processed or formulated to contain less than one gram of protein per unit of serving; and administered for the medical and nutritional management of a person who has a metabolic disorder. Metabolic Formulas and Modified Low Protein Foods does not include a natural food that is naturally low in protein.

OUTPATIENT CONTRACEPTIVE SERVICES

Benefits for charges incurred in connection with Outpatient Contraceptive Services are covered the same as for all covered charges.

Outpatient Contraceptive Services means consultations, examinations, procedures and medical services provided on an outpatient basis and related to the use of United States food and drug prescription contraceptive methods to prevent unintended pregnancies.

PNTRS

SCHEDULE OF BENEFITS *(continued)*

CONTINUOUS HOSPITAL OUTPATIENT AND INDIVIDUAL CASE MANAGEMENT EVALUATION (CHOICE)

All hospitalizations must be certified under the Arizona Foundation for Medical Care Admission Program. Please contact Arizona Foundation for Medical Care at: 602-417-2300 or 1-800-852-8001.

In the event of an emergency, an insured must notify CHOICE of a hospital admission (a) within 48 hours of the admission if it occurs on a day other than a Saturday, Sunday, or holiday, or (b) within 72 hours if it occurs on a Saturday, Sunday, or holiday.

If an insured fails to notify CHOICE, benefits payable in connection with the confinement will be reduced by \$100. No benefits will be paid for charges incurred in connection with any hospital confinement that is not certified or for days of confinement beyond those that are certified.

HEARING CARE BENEFIT

The charges for hearing examinations and hearing aids are covered medical charges. The General Health Limitation that excludes hearing aids does not apply.

The Plan will pay for one hearing examination and hearing aids for each ear during a period of three consecutive calendar years.

SCHEDULE OF BENEFITS *(continued)*

BENEFITS FOR PREGNANCY

Benefits will be payable for the covered medical charges that are incurred for treatment of pregnancy and prenatal care on the same basis as benefits are paid for treatment of a disease.

The charges for well baby care that are listed below are covered medical charges.

- a. The charge of a hospital for routine nursery care furnished to a newborn well baby while the mother is an inpatient.
- b. The charge of a physician for the initial examination of a newborn performed before the child is released from nursery care.
- c. Cost of the birth of a legally adopted child of the Insured if:
 - the child is adopted within one year of birth; and
 - the Insured is legally obligated to pay the costs of birth; and
 - any other policy limitations have been met by the Insured; and
 - the Insured has given us written notice within 60 days after receipt of approval to adopt pursuant to the laws, or within 60 days after a change in insurance plans or companies.

The above benefits will be paid in excess to any other pregnancy coverage the natural mother may have. The individual or agency responsible for arranging the adoption must provide the costs to be paid that are covered under the other coverage; and advise the Insured in writing of the existence and extent of the other coverage without disclosing any confidential information. The Insured must then notify the Company of the extent of the other coverage.

The covered medical charges for pregnancy care, prenatal care, and well baby care described above:

- a. are payable for at least 48 hours of inpatient care following a vaginal delivery, or 96 hours of inpatient care following a Caesarean section; and
- b. are not subject to the requirement that benefits are payable only for a charge that medically necessary.

Pre-certification is not required for inpatient lengths of stay of 48 hours or less following a vaginal delivery, or 96 hours or less following a Caesarean section; otherwise, pre-certification is required.

The term "pregnancy" means any pregnancy, a complication thereof, or the termination of a pregnancy.

WELL CHILD CARE BENEFITS

The charges for well child care that are listed below are covered medical charges. This benefit applies only to a well dependent child who is under 19 years of age. The General Deductible and Percentage Payable apply to this benefit on the same basis that they apply to charges incurred for treatment of a disease. The requirement that benefits be paid only for a charge that is medically necessary and Section C of the General Health Limitations do not apply to this benefit.

Well child care charges include:

1. The charge of a physician for the following routine services:
 - a. Routine physical examinations and check-ups.
 - b. Routine immunizations.
2. The charge for diagnostic X-rays and laboratory tests performed in connection with routine physical examinations and check-ups.

SOB1000

PNTRS

COMPREHENSIVE MEDICAL COVERAGE

Trustmark will pay a Comprehensive Medical Benefit to a participant for covered medical charges the participant incurs for treatment of an insured rendered while the insured is covered under this Coverage.

COMPREHENSIVE MEDICAL BENEFIT. The Comprehensive Medical Benefit will be paid in an amount equal to the Percentage Payable of covered medical charges incurred in excess of the Deductible, up to the Comprehensive Medical Maximum. A Comprehensive Medical Benefit is calculated by subtracting the amount of the applicable Deductible from the covered medical charges incurred and then by multiplying the remaining amount of such charges by the Percentage Payable. The Deductibles, Deductible Periods, Accumulation Periods, Comprehensive Medical Maximum and Percentage Payable are specified in the Schedule of Benefits.

DEDUCTIBLE. All covered charges under this Coverage are subject to the General Deductible unless the Schedule of Benefits indicates otherwise. The Schedule of Benefits will indicate if a Special Deductible applies to any covered charges. No covered charges shall be subject to more than one Deductible. Only covered medical charges subject to a Deductible shall be applied to satisfy such Deductible.

The General Deductible applies separately to each insured during each calendar year and must be accumulated during that calendar year. A Special Deductible shall apply separately to each insured during each Deductible Period and must be accumulated during the Accumulation Period. Covered medical charges that are incurred during the last three months of a calendar year and that are applied to satisfy all or part of the General Deductible of an insured for that year or that are applied to satisfy all or part of any Special Deductible with a calendar year Deductible Period of an insured for that year shall be used to satisfy all or part of that Deductible of that insured for the next calendar year.

When the Accumulated General Deductible Maximum specified in the Schedule of Benefits has been fully satisfied by insureds in the same family during a calendar year, then no additional General Deductible will be applied to any other covered charges incurred thereafter during that calendar year by an insured member of that family. For purposes of this paragraph, "family" means a participant and all the participant's dependents covered under this Coverage.

If the Schedule of Benefits specifies that charges incurred in connection with accidental injuries are not subject to a Deductible, then the General Deductible shall not apply to covered medical charges incurred for accidental injuries, provided that treatment of such injuries commences within ninety days after the date of the accident causing such injuries.

The General Deductible will be applied only once during each calendar year to all covered medical charges incurred as a result of injuries suffered by a participant or any of the participant's dependents covered under this Coverage in a common accident. If greater benefits would be payable without the application of this paragraph, then this paragraph shall not apply.

EXCLUSIONS. Covered medical charges shall not include any charge used to satisfy a Deductible under this policy or under any other coverage provided or supplied by the Policyholder for the benefit of insureds.

LIFETIME MAXIMUM. The total of all Comprehensive Medical Benefits payable on behalf of an insured during a calendar year shall not exceed the Comprehensive Medical Maximum specified in the Schedule of Benefits.

HOSPITAL CARE SUB-COVERAGE

Trustmark will pay a Hospital Benefit for a participant for covered hospital charges the participant incurs for treatment of an insured rendered while the insured is covered under this Sub-Coverage.

COVERED HOSPITAL CHARGES. Covered hospital charges shall include only the following items:

1. The daily service charge of a hospital, up to the Daily Benefit specified in the Schedule of Benefits for each day of confinement of an insured as a registered inpatient.
2. Hospital charges for:
 - a. medical services and supplies provided during confinements of an insured as a registered inpatient, but not including any charge included in sub-paragraph 1 of this paragraph or any charge for private duty nursing;
 - b. medical services and supplies provided by a hospital during outpatient care of an insured;
3. Hospital charges for confinement of an insured in an intensive care unit.
4. The charges for professional ambulance service to transport the insured to or from a local hospital where treatment is given.

Continuous Hospital Outpatient and Individual Case Management Evaluation (CHOICE). The confinement of an insured in a hospital as a registered inpatient must be certified under the terms of CHOICE of the Arizona Foundation for Medical Care.

MEDICAL CARE SUB-COVERAGE

Trustmark will pay a Medical Benefit to a participant for covered medical charges the participant incurs for treatment of an insured rendered while the insured is covered under this Sub-Coverage.

COVERED MEDICAL CHARGES. Covered medical charges shall include only the following items:

1. the charge of a physician for treatment rendered to an insured while the insured is confined in a hospital as a registered inpatient;
2. the charge of a physician for non-psychiatric treatment rendered to an insured in that physician's office;
3. the charge of a physician for non-psychiatric treatment rendered to an insured at a place other than a hospital or physician's office; and
4. the charge of a physician for psychiatric treatment of a mental, nervous or emotional disorder or condition of an insured while the insured is not confined to a hospital.

The charges for a second surgical opinion are covered medical charges. Charges for a third surgical opinion will also be covered medical charges if the second surgical opinion does not confirm that the surgery is medically necessary. Surgical opinion charges include only:

1. the charge for the professional services of a physician; and
2. the charge for a laboratory test or x-ray examination.

The surgical opinion charges will not be subject to the deductible; the percentage payable will be 100% for these charges.

EXCLUSIONS. Covered medical charges shall not include:

1. diagnostic laboratory or x-ray examinations;
2. the performance of any surgical or radiotherapy procedure or the administration of anesthetic; and
3. any charge for more than one treatment per day.

SURGICAL CARE SUB-COVERAGE

Trustmark will pay a Surgical Benefit for a participant for covered surgical charges the participant incurs for treatment of an insured rendered while the insured is covered under this Sub-Coverage.

COVERED SURGICAL CHARGES. Covered surgical charges shall include only the following items:

1. The charge of the operating physician for professional services rendered to an insured in the performance of a surgical or radiotherapy procedure.
2. The charge of an anesthesiologist for professional services rendered to an insured in the administration of anesthetics in connection with the performance of a surgical operation.

Reduced benefits may be payable for the administration of anesthesia by the operating or assisting physician, but benefits for local infiltration, digital block or topical anesthesia are included in the operating or assisting physician's surgery benefit.

3. The charges shown below that are incurred by a covered person as the result of a mastectomy on one or both breasts, and in a manner determined in consultation between the attending physician and the patient, are covered medical charges, in compliance with state and federal law. Any exclusion of benefits for a procedure performed mainly to improve the appearance of the covered person does not apply to this benefit.

Covered medical charges include:

- a. reconstruction of the breast on which the mastectomy has been performed;
- b. surgery on and reconstruction of the nondiseased breast to produce symmetry between the breasts;
- c. prostheses, including at least two external postoperative prostheses; and
- d. treatment of physical complications, including lymphedemas, at all stages of mastectomy.

Benefits for the attendance of a second physician on the same case at the same time are payable when the attendance is warranted by a need for supplementary skills.

OTHER CHARGES SUB-COVERAGE

Trustmark will pay an Other Charges Benefit to a participant for covered charges the participant incurs for treatment of an insured rendered while the insured is covered under this Sub-Coverage.

COVERED CHARGES. Covered charges shall include only:

1. Charges for drugs and medicines obtainable only by prescription of a physician. This includes off-label prescription drug for the treatment of cancer and medically necessary services associated with the administration of the off-label use prescription drug, if the prescription drug has been recognized as safe and effective for the treatment of that specific cancer in one or more of the following standard medical reference compendia:
 - (a) The American medical association drug evaluations, a publication of the American medical association;
 - (b) The American hospital formulary service drug information, a publication of the American society of health system pharmacists; orDrug information for the health care provider, a publication of the United States pharmacopoeia convention.
2. Charges for rental of a wheel chair, hospital bed, and other similar durable medical equipment.
3. Charges for prosthetic devices, excluding replacements.
4. Charges for casts, splints, and surgical dressings.
5. Charges by a registered nurse or licensed physiotherapist, except charges made by one who normally resides in the insured's home or who is the wife, husband, child, brother, sister, or parent of either the insured or the insured's spouse.
6. Charges of a physician, radiologist, pathologist, or laboratory for a laboratory or x-ray examination of an insured for diagnosis or bodily injury or disease.
7. Charges for oxygen and its administration.
8. Charges incurred for orthotics.
9. Charges incurred for diabetes treatment as described below, in compliance with state law.

Charges incurred for diabetes treatment that are covered medical charges are only those charges shown below. No other charges for diabetes treatment are covered medical charges. The Plan will not pay for treatment unless it is prescribed by the covered person's physician.

Covered medical charges for diabetes treatment include charges for equipment and supplies as follows:

- a. blood glucose monitors, including those for the legally blind;
 - b. test strips for glucose monitors and visual reading, and urine testing strips;
 - c. insulin preparations and glucagon;
 - d. insulin cartridges, including those for the legally blind;
 - e. drawing up devices and monitors for the visually impaired;
 - f. injection aids;
 - g. syringes and lancets including automatic lancing devices;
 - h. prescribed oral agents for controlling blood sugar;
 - i. podiatric appliances for prevention of complications associated with diabetes to the extent coverage is required under Medicare;
 - j. any other device, medication, equipment or supply for which coverage is required under Medicare.
10. In some cases, the radiologist, anesthesiologist, assistant surgeon, emergency room physician, and pathologist who perform services at an In-Network facility are Non-Preferred Providers. We understand that You may not always have the option of selecting these types of providers and, in those instances where You have no choice, benefits will be covered as follows:
- when the radiologist, anesthesiologist, assistant surgeon, emergency room physician, or pathologist services are provided during a covered Preferred Provider facility stay or visit, or when they are provided in connection with covered services ordered by a Preferred Provider, they will be covered at the In-Network level of benefits.
 - when the radiologist, anesthesiologist, assistant surgeon, emergency room physician, or pathologist services are provided during a covered Non-Preferred Provider facility stay or visit, or when they are provided in connection with covered services ordered by a Non-Preferred Provider, they will be covered at the Out-of-Network level of benefits.

OTHER CHARGES SUB-COVERAGE *(continued)*

Patient Costs, that are directly associated with a cancer clinical trial offered in Arizona and in which the Covered Person participates voluntarily.

A "cancer clinical trial" is a course of treatment in which all of the following apply:

- The treatment is part of a scientific study of a new therapy or intervention that is being conducted at an institution in Arizona, that is for the treatment or prevention of cancer and includes the following:
 - Specific goals.
 - A rationale and background for the study.
 - Criteria for patient selection.
 - Specific directions for administering the therapy and monitoring patients.
 - A definition of quantitative measures for determining treatment response.
 - Methods for documenting and treating adverse reactions.
- The treatment is being provided as part of a study being conducted in a Phase I, II, III or IV cancer clinical trial.
- The treatment is being provided as part of a study being conducted in accordance with a clinical trial approved by at least one of the following:
 - One of the National Institutes of Health.
 - A National Institutes of Health Cooperative Group or Center.
 - The United States Food and Drug Administration in the form of an investigational new drug application.
 - The United States Department of Defense.
 - The United States Department of Veterans Affairs.
 - A qualified research entity that meets the criteria established by the National Institutes of Health for grant eligibility.
 - A panel of qualified recognized experts in clinical research within academic health institutions in this state.
- The proposed treatment or study has been reviewed and approved by an Institutional Review Board of an institution in Arizona.
- The personnel providing the treatment or conducting the study:
 - Are acting within the scope of practice, experience and training and are capable of providing the treatment because of their experience, training and volume of patients treated to maintain expertise.
 - Agree to accept reimbursement as payment in full from Us at the rates that are established by Us and that are not more than the level of reimbursement applicable to other similar services provided by health care providers with the provider network.
- There is no clearly superior, noninvestigational treatment alternative.
- The available clinical or preclinical data provide a reasonable expectation that the treatment will be at least as efficacious as any noninvestigational alternative.

HOME HEALTH CARE SUB-COVERAGE

Trustmark will pay a Home Health Care Benefit to a participant for covered home health care charges the participant incurs for treatment of an insured rendered while the insured is covered under this Sub-Coverage. Trustmark will not pay for home health care unless: (1) the plan of home health care is drawn up, or approved, by the insured's physician; and (2) Trustmark validates the physician's certification that:

- a. the home health care is medically necessary; and
- b. in the absence of the home health care, the insured would be a registered inpatient at a hospital.

Covered home health care charges include only the following items:

1. The charge for the professional services of a registered nurse, a licensed practical nurse, or a licensed vocational nurse on a part-time or intermittent basis.
2. The charge for the services of a home health aide on a part-time or intermittent basis.
3. The charge for physical, occupational or speech therapy.
4. Subject to the terms of the Medical Care Sub-Coverage, the charge for psychiatric treatment of a mental, nervous or emotional disorder or condition by a licensed social worker who is: (a) practicing within the scope of the license; and (b) under the direct supervision of a physician or psychologist.
5. The charge for medical supplies, drugs and medicines prescribed by a physician and laboratory services, to the extent such charge would have been covered under the policy if the insured had been a registered inpatient at a hospital when the charge was incurred.

Charges for home health care will not be subject to any term or limit that applies to charges for outpatient treatment but that does not apply to charges for inpatient treatment. Any term or limit that applies to charges for inpatient treatment will apply to charges for home health care.

No benefits will be paid: (1) under any other coverage or sub-coverage of this policy for a charge for a service or supply that is a covered home health care charge; and (2) for a service that is rendered:

- a. by a person who ordinarily lives in the insured's home; or
- b. by a spouse, child, parent, or sibling of the insured or of the insured's spouse.

Home Health Care. "Home health care" is medical care that is furnished by or through a home health agency to an insured in the insured's home.

Home Health Agency. A "home health agency" is an agency that: (1) meets any legal licensing required by the state or other locality in which it is located; or (2) qualifies as a participating home health agency under Medicare.

CM1000

GENERAL HEALTH PROVISIONS

APPLICATION

These General Health Provisions shall apply to all health insurance coverages in force under this policy. The health insurance coverages which may be in force under this policy include but are not limited to: Accidental Death and Dismemberment Coverage and Medical Coverages. The medical coverages in force may be one or more of the following: the sub-coverages indicated in the Table of Contents as the Basic Medical Coverage, Major Medical Coverage and Comprehensive Medical Coverage.

GENERAL HEALTH LIMITATIONS

1. **GOVERNMENTAL BENEFITS.** If, with respect to a bodily injury or disease, an insured is entitled, or could have been entitled if proper application had been made, to any medical, dental or disability benefit paid by, reimbursed by or provided by or under the authority of any government or any governmental agency, such benefit shall discharge the obligation of Trustmark as though and to the extent such benefit had been paid hereunder, except that
 - a. no claim will be denied solely because treatment or services are rendered in a hospital owned or operated by a State or a political subdivision thereof, and
 - b. eligibility for medical assistance pursuant to title XIX of the Federal Social Security Act will not be considered when determining eligibility for coverage or calculating payments under this plan
2. **DOUBLE COVERAGE.** Unless specifically provided otherwise, no benefits are provided for any charge under more than one coverage or sub-coverage, or more than once under any single coverage or subcoverage.
3. **NON-OBLIGATORY CHARGES.** No benefits are provided under this policy if the insured is not obligated to pay, is not billed or would not have been billed except for the fact that the person was insured.
4. **REASONABLE CHARGES.** No benefits are provided under this policy for charges in connection with any treatment unless that treatment is generally accepted medical practice and then only to the extent that the charge for that treatment is usual, customary and reasonable in amount. In addition, no benefits are provided for treatment, services or supplies which are not Medically Necessary, experimental, investigational, educational, or primarily for the purpose of medical or other research, not required for the Sickness or Injury and not prescribed by a Physician as required to treat the Sickness or Injury. A charge equivalent to that made for a comparable workmen's compensation case in the same geographical area shall be considered reasonable.
5. **BODILY INJURY OR DISEASE.** No benefits are provided under this policy for any charge for any medical service or supply unless such service or supply is provided for the treatment or diagnosis of a bodily injury or disease and is prescribed by, or made at the direction of, a physician.
6. **OCCUPATIONAL COVERAGE.** No benefits are provided under this policy for or in connection with any bodily injury or disease resulting from and arising out of any employment or occupation for compensation or profit except only as may be expressly provided in any Weekly Disability Coverage, any Long Term Disability Coverage and any Accidental Death and Dismemberment Coverage.
7. **PREGNANCY.** The benefits provided under this policy in connection with pregnancy are described in the Schedule of Benefits.

GENERAL HEALTH PROVISIONS *(continued)*

8. MISCELLANEOUS. No benefits are provided under this policy for or in connection with any
- a. hearing aid or the fitting thereof;
 - b. cosmetic surgery except only for repair of damage resulting from an accident and incurred within one year from the date of the accident;
 - c. treatment of substance abuse, except as specified in the Schedule of Benefits;
 - d. non-surgical treatment of feet;
 - e. bodily injury or disease resulting from any act of war;
 - f. bodily injury or disease resulting from any release of nuclear energy, except only when being used solely for medical treatment of a disease or bodily injury of the insured under direction and prescription of a physician;
 - g. bodily injury or disease intentionally self-inflicted, if the injury or disease is not the result of a medical condition;
 - h. bodily injury or disease resulting from or occurring during the commission of a crime by an insured;
 - i. replacement or repair of any prosthetic device, except as may be provided under any Dental Coverage or SubCoverage or any Major Medical Coverage; and
 - j. Eye Refractions.

NOTICE, PROOF OF CLAIMS, AND PAYMENT OF CLAIMS

TIME OF NOTICE. Written notice of any claim under a health insurance coverage in force under this policy must be given to Trustmark at its Home Office, or to any authorized agent of Trustmark within twenty days' after the occurrence or commencement of a covered expense or loss, or as soon thereafter as is reasonably possible.

FORMS. Within fifteen days after receipt of written notice of a claim, Trustmark shall furnish to the claimant its usual form for submitting proof of loss. If such form is not furnished within fifteen days, the claimant shall be deemed to have complied with the requirements of this policy as to proof of loss upon submitting within the time set in the next paragraph written proof regarding the occurrence, 'character and extent of the expense or loss for which claim is made.

PROOF OF LOSS. In the case of a claim for expense or loss for which a health insurance coverage in force under this policy provides a periodic payment which is contingent upon continuing loss, written proof of loss must be submitted to Trustmark at its Home Office within ninety days after expiration of each week, or each month for which Trustmark is liable. In the case of a claim for any other expense or loss under any health insurance coverage in force under this policy, written proof of loss must be submitted within ninety days after the date the expense or loss was incurred. Failure to submit such proof within the time required shall not invalidate or reduce any claim if it was not reasonably possible to give proof within such time, provided that such proof is submitted as soon as reasonably possible and in no event, except in absence of legal capacity, later than one year after the date proof is otherwise required.

TIME OF PAYMENT. Amounts payable under any health insurance coverage in force under this policy for any expense or loss, other than one for which a periodic payment is provided, will be paid immediately upon receipt of written proof of loss. Subject to receipt of written proof of loss, all amounts payable for expense or loss for which a health insurance coverage in force under this policy provides periodic payment will be paid as they accrue, but not less frequently than once each month, and any balance remaining unpaid at the termination of the period of liability will be paid immediately upon receipt of written proof of loss.

TO WHOM BENEFITS PAYABLE. Amounts payable for loss of life will be payable in accordance with the beneficiary designation and provisions of the General Provisions of this contract effective at the time of payment. Subject to the Benefits Unpaid at Death, Incompetency provision below, any other accrued amounts unpaid at the participant's death may at the option of Trustmark be paid either to such beneficiary or to the estate of such participant. All other amounts will be payable to the participant.

PHYSICAL EXAMINATION AND AUTOPSY. Trustmark at its own expense shall have the right and opportunity to examine the person of any individual whose injury or sickness is the basis of claim when and as often as it may reasonably require during the pendency of a claim hereunder and in the case of death, to make an autopsy where not forbidden by law.

GENERAL HEALTH PROVISIONS *(continued)*

BENEFITS UNPAID AT DEATH; INCOMPETENCY. If any benefits remain unpaid or become payable at the death of the insured, or are payable to a participant or beneficiary who is a minor or is incompetent or incapable of executing a valid release and for whom no guardian has been appointed, Trustmark may pay up to \$500 of any such benefit to any person or institution, or to the husband or wife or any relative by blood of the insured or beneficiary who is determined by Trustmark to be equitably entitled thereto. Any payment in accordance with this paragraph shall fully discharge any obligation of Trustmark under this policy to the extent of such payment.

LEGAL ACTION. No action at law or in equity shall be brought to recover under any health insurance coverage in force under this policy prior to the expiration of sixty days after written proof of loss has been submitted in accordance with the requirements of this section. No such action shall be brought after the expiration of three years after the time written proof of loss is required to be submitted.

MISCELLANEOUS

DATE OF TREATMENT. The charge for any examination, hospitalization, treatment, service, supply or procedure for which a benefit is payable under this policy shall be deemed to have been incurred on the day it is rendered or furnished to the insured.

DETERMINATION OF INSURED. If the Schedule of Benefits provides separate benefit amounts for participants and dependents, then the amount payable under the policy shall be the amount applicable to the insured undergoing the treatment.

ENTIRE CONTRACT. This policy, the application of the Policyholder, if any, and the individual applications, if any, of participants constitute the entire contract between the parties, and any statement made by the Policyholder or any participant shall, in the absence of fraud, be deemed a representation and not a warranty. No such statement shall avoid the insurance or reduce the benefits under the health insurance coverages or be used in defense to a claim hereunder unless it is contained in a written application, nor shall any such statement of the Policyholder, except a fraudulent misstatement, be used to avoid the health insurance coverages after they have been in force for two years from the date of issue; nor shall any such statement of a person eligible for coverage under this policy, except a fraudulent misstatement, be used at all in defense to a claim for loss incurred or disability commencing after the coverage, with respect to which claim is made, has been in effect for two years from the date it became effective; nor shall any such statement of a person eligible for coverage under this policy be used in defense to a claim hereunder unless a copy of the application or applications containing the statement is or has been furnished to such person.

GENERAL HEALTH PROVISIONS *(continued)*

DEFINITIONS

PHYSICIAN. The term "physician" means only a person who is licensed or certified to practice and who is practicing within the scope of the license or certification as: a Doctor of Medicine or a Doctor of Osteopathy or, to the extent that benefits are provided, as a Doctor of Dentistry, Doctor of Podiatry, Doctor of Optometry, Doctor of Chiropractic, Licensed Optician or Psychologist.

MEDICALLY NECESSARY (MEDICAL NECESSITY). A service, supply, or drug that is necessary and appropriate for the diagnosis or treatment of a Sickness or Injury in accordance with generally accepted standards of medical practice in the United States at the time it is provided. When specifically applied to a confinement it means that the diagnosis or treatment of symptoms or a condition cannot be safely provided on an outpatient basis.

A service, drug, or supply shall not be considered as Medically Necessary if it:

1. is Experimental, investigational, or furnished in connection with medical research;
2. is provided solely for the convenience of the patient, the patient's family, Physician, Hospital or any other provider;
3. exceeds in scope, duration, or intensity that level of care that is needed to provide safe, adequate, and appropriate diagnosis or treatment;
4. could have been omitted without adversely affecting the person's condition or the quality of medical care;
5. involves the use of a medical device, drug, or substance not formally approved by the United States Food and Drug Administration; or
6. involves a service, supply or drug not considered reasonable and necessary by the Health Care Financing Administration Medicare Coverage Issues Manual.

We retain the right to determine whether a service, supply, or drug is Medically Necessary.

HOSPITAL. The term "hospital" means only an institution which meets all the following tests:

1. it is primarily engaged in providing medical treatment to sick and injured persons as registered in-patients;
2. it maintains facilities for diagnosis of injury and disease;
3. it provides treatment to patients only by or under the supervision of a staff of physicians;
4. it continuously provides 24-hour-a-day nursing care by professional registered nurses;
5. it maintains permanent facilities for surgery;
6. it maintains a daily medical record for each patient;
7. it complies with all licensing and other legal requirements; and
8. it is not, other than incidentally, a place of rest, a place for custodial care, a place for the aged, a place for the care of senile or mentally deficient persons, a nursing home, a hotel or a similar institution.

For the purposes of the hospital benefits provided under this policy for treatment of mental, nervous or emotional disorders or conditions, or substance abuse, the terms of sub-paragraph 5 above shall not apply.

SUBSTANCE ABUSE. The term "substance abuse" means only an addictive relationship an insured has with a drug or alcohol agent. It does not include addiction to, or dependence on, tobacco, tobacco products or food.

GENERAL HEALTH PROVISIONS *(continued)*

INTENSIVE CARE UNIT. The term "intensive care unit" means only a separate, clearly designated service area which is maintained within a hospital and which meets all the following tests:

1. it is solely for the treatment of patients who require special medical attention because of their critical condition;
2. it provides within such area special nursing care and observation of a continuous and constant nature not available in the regular rooms and wards of the hospital;
3. it provides a concentration of special life-saving equipment immediately available at all times for the treatment of patients confined within such area;
4. it contains at least two beds for the accommodation of critically ill patients; and
5. it provides at least one professional registered nurse who continuously and constantly attends the patient confined in such area on a 24-hour-a-day basis.

Medical Coverages. With respect to Medical Coverages, "total disability" for a participant who is an active employee means the complete inability of the participant due solely to disease or bodily injury to perform the regular and customary work of such participant; total disability for a participant who is a retired employee or for a dependent means the complete inability due solely to disease or bodily injury to engage in the normal activities of a person of like sex and age.

GENERAL HEALTH PROVISIONS *(continued)*

The Coordination of Benefits provisions apply: (a) to each insured (b) to any insurance for medical or vision care under the group policy.

Effect on Benefits

When an insured is entitled to medical, dental, or vision care benefits or services under more than one plan, the rules shown in the Order of Benefit Determination section below will be used to decide which plan is the principal plan. If the group policy:

1. is the principal plan among all of the plans that cover the insured, then its benefits will be determined without taking into account the benefits or services of any other plan.
2. is not the principal plan, then its benefits may be reduced by Trustmark. They will be reduced so that all of the benefits and services provided by all of the plans during each claim determination period will not be more than 100% of the allowable expenses incurred by the insured. The benefits provided by a plan include those that would have been provided if a claim had been duly made.

The benefits of the group policy will never be greater than the sum of the benefits that would have been paid if there were no other plan covering the insured.

Plan. The term "plan" means a plan that provides benefits or services for medical, dental, or vision care by or through any:

1. group insurance;
2. group practice or prepayment coverage;
3. group service plan;
4. method of coverage for persons in a group other than as shown in items 1, 2, and 3; or
5. coverage that is required or provided by law.

The term "plan" shall also include "no-fault" motor vehicle insurance where the law does not forbid it.

Principal Plan. With respect to any two plans that cover an insured on whose expenses a claim is based, the "principal plan" is the plan under which benefits will be determined first.

Allowable Expense. The term "allowable expense" means any necessary, reasonable, and customary item of expense that is, at least in part, a covered expense under one or more of the plans that cover the insured. When a plan provides a service, the service will be deemed to be both an allowable expense and a benefit paid.

Claim Determination Period. The term "claim determination period" means a calendar year.

Anti-duplication Provision. An "anti-duplication provision" is a provision that reserves to a plan the right to consider the benefits or services of other plans in determining its benefits.

GENERAL HEALTH PROVISIONS *(continued)*

Order of Benefit Determination

Medicare and Other Statutory Plans. If an insured is eligible for Medicare, Medicare will be the principal plan except:

1. when the law requires an insurer to be the principal plan; or
2. when, to fulfill an employer's obligation under the law, Trustmark's agreement with the Policyholder is to provide the principal plan.

When Medicare is the principal plan, its benefits will be taken into account in determining any benefits to be paid under the group policy as follows:

- a. The benefits of Medicare Part A will be taken into account whether or not the insured has enrolled for Part A.
- b. The benefits of Medicare Part B will be taken into account only if the insured has enrolled for Part B.

Any other plan that is required or provided by law, including a "no-fault" plan, will be the principal plan unless the law forbids such plan to be the principal plan.

Plans Without Anti-duplication Provisions. When one of any two plans does not include an anti-duplication provision, then that plan will be the principal plan. If any part of a plan is not subject to an anti-duplication provision, then that part will be deemed to be a separate plan and will be the principal plan.

Plans With Anti-duplication Provisions. These rules will be used to decide which of any two plans is the principal plan when both contain an anti-duplication provision. The first rule listed that describes one, but not both, of the plans will identify the principal plan.

1. The plan that covers the insured other than as a dependent.
2. The plan that covers the insured as a dependent of the parent whose birthday occurs earlier in a calendar year. If both parents have the same birthday, the plan that has covered the parent for the longer period of time. The rule of the other plan will be used in place of this rule when: (a) the rule of the other plan is not based on the birthday of the parent; and (b) the result of using this rule is that the plans do not agree on which plan is the principal plan.
3. The plan that covers the insured through present employment instead of a plan that covers the insured through prior employment. Through prior employment means as a laid off or retired employee or as a dependent of a laid off or retired employee. This rule will not be used when: (a) the other plan does not include a similar rule; and (b) the result of using this rule is that the plans do not agree on which plan is the principal plan.
4. The plan that has covered the insured for the longer period of time.

Exception to Rule 2. If the insured is a dependent child of parents who are divorced or separated, then the following rules will be used in place of rule 2:

- a. The plan of the parent who has been assigned the financial duty for the child's health care by a court decree.
- b. The plan of the parent who has custody of the child.
- c. The plan of the stepparent who is married to the parent with custody of the child.
- d. The plan of the parent who does not have custody of the child.

GENERAL HEALTH PROVISIONS *(continued)*

Right to Information, Payment, and Recovery of Payment

To meet the intent of the Coordination of Benefits provisions or an anti-duplication provision of any other plan:

1. Trustmark may, in a way allowed by law, give or get any information that is needed to decide the benefits that are payable. An insured must declare coverage under any other plans and give to Trustmark the information Trustmark needs to meet the intent of this provision.
2. Trustmark shall have the right to pay to any organization the amount that organization has paid that should have been paid by Trustmark. An amount so paid will be deemed to be a benefit paid under the group policy. To the extent of the payment, Trustmark will have no more liability under the group policy.

If Trustmark has paid more than it should have paid to meet the intent of this provision, Trustmark may recover the excess amount from one or more of the following, as Trustmark may decide:

1. any person to, or for, or with respect to whom the payment was made;
2. any other insurance company; or
3. any other organization.

RIGHT TO INFORMATION. For the purposes of determining the applicability of and implementing the terms of this section of this plan or any provision of similar purpose of any other plan, Trustmark may, without the consent of or notice to any person, release to or obtain from any other insurance company or other organization or person any information, with respect to any person, which Trustmark deems to be necessary for such purposes. Any person claiming benefits under this plan shall furnish to Trustmark such information as may be necessary to implement this section.

RIGHT TO MAKE PAYMENTS. Whenever payments which should have been made under this plan in accordance with these provisions have been made under any other plan, Trustmark shall have the right, exercisable alone and in its sole discretion, to pay over to any organizations making such other payments any amounts it shall determine to be warranted in order to satisfy the intent of this section, and amounts so paid shall be deemed to be benefits paid under this plan and, to the extent of such payments, Trustmark shall be fully discharged from liability under this plan.

RIGHT TO RECOVER PAYMENTS. Whenever payments have been made by Trustmark with respect to allowable expenses in a total amount, at any time, in excess of the maximum amount of payment necessary at that time to satisfy the intent of these provisions, Trustmark shall have the right to recover such payment, to the extent of such excess, from among one or more of the following as Trustmark shall determine:

1. any persons to, or for, or with respect to whom such payments were made;
2. any other insurance companies; or
3. any other organizations.

GENERAL HEALTH PROVISIONS *(continued)*

MEDICAL CONVERSION PRIVILEGE

You are entitled to the Medical Conversion Privilege if your group Comprehensive Medical Coverage terminates because your employment or your membership in an eligible class of participants terminates.

You will be entitled to medical conversion coverage for yourself and your dependents, without evidence of insurability, under a policy of sickness and accident insurance issued by Trustmark. You must make application and pay the first premium to Trustmark within a 31-day period immediately following the termination of your insurance coverage.

You are not eligible for the conversion privilege if your coverage under the policy terminates: (1) because the policy terminates or the medical coverage under the policy terminates; or (2) because you have received maximum medical benefits under the group policy.

The conversion coverage is not available to an insured if: (1) the insured is or becomes eligible for coverage under any governmental plan of medical benefits, except that this provision does not apply to Medicare coverage; (2) the insured is or becomes eligible for coverage under any other group plan of medical benefits; or (3) the insured is in or enters full-time service in the armed forces.

Dependents

Only your eligible dependents who were covered under the group policy can be covered under the conversion coverage.

The conversion coverage is available to your eligible dependents if their group medical coverage terminates because of your death. It is also available to a dependent spouse who ceases to be a dependent spouse because of termination of marriage. If a dependent attains the policy limiting age, the conversion coverage is available to that dependent. Your dependents' conversion privilege is subject to the same time limits for application and the first premium payment as those for your own conversion privilege.

Conversion Coverage

Any conversion coverage provided under the Medical Conversion Privilege shall become effective on the day following the termination date of the group medical coverage and shall be on a form then customarily issued by Trustmark for the conversion of group medical insurance.

GHP1000

COVERAGE PROVISIONS FOR LIFE INSURANCE AND AD&D INSURANCE

Second person pronouns are used in these provisions to address the insured employees. Where they appear, the terms "you" and "your" refer only to an insured employee. The term "employee" and the term "covered person" mean a participant who is insured under the group policy.

GENERAL LIFE PROVISIONS

Entire Contract

The entire contract will be made up of: (1) the group policy; (2) the application of the Policyholder, a copy of which is attached to the group policy; and (3) the applications, if any, of the employees.

Statements Not Warranties

Life Insurance. All statements made by the Policyholder or by an insured employee will be deemed representations and not warranties. No statement made by the Policyholder or by the employee to obtain insurance will be used to avoid or reduce the insurance unless it is made in writing and is signed by the Policyholder or the employee and a copy is sent to the Policyholder, the employee, or his beneficiary.

Right to Contest

After the group policy has been in force for two years, Trustmark has no right to contest its validity except for non-payment of premiums. Trustmark has no right to contest the insurance of an employee on the basis of any statement made by the employee after the employee's insurance has been in force for two years during his lifetime; and before then only if the statement was in writing on a form signed by the employee and a copy of it is given to the employee or his beneficiary.

PARTICIPANT LIFE INSURANCE

Trustmark will pay a Participant Life Benefit if you die while insured for the Participant Life Insurance.

PARTICIPANT LIFE BENEFIT

Benefit

An "Participant Life Benefit" is the benefit that will be paid if you die. The amount of the Participant Life Benefit is the amount determined from the Schedule of Benefits. The Participant Life Benefit will be paid to your beneficiary in one sum unless a settlement option is in effect.

Beneficiary

A "beneficiary" is the person, or one of the persons, you designate to receive any benefit to be paid under the group policy for the loss of your life.

Beneficiary Designation. By written request to Trustmark at its Home Office:

1. you may designate anyone as your beneficiary; and
2. you may change your beneficiary designation at any time.

The consent of a beneficiary is not required. Trustmark shall not be held liable for a payment made to another person before your written request is received at Trustmark's Home Office.

More Than One Beneficiary. Benefits will be paid in equal shares to your beneficiaries unless you state otherwise in your beneficiary designation. The share of a beneficiary who does not live to receive payment will pass equally to those who survive unless you state otherwise in your beneficiary designation.

Beneficiary Not Designated. If you do not designate a beneficiary or if no beneficiary lives to receive payment, then the benefits shall be paid to the person or persons who appear first in the list below and who live to receive payment:

1. your spouse;
2. your children;
3. your parents;
4. your siblings.

If none of these lives to receive payment, then the benefit will be paid to your estate.

Settlement Options

A "settlement option" is an option to have your Participant Life Benefit paid in installments rather than in one sum. With the written consent of Trustmark:

1. you may elect a settlement option of your choice;
2. you may change the terms of a settlement option; and
3. your beneficiary may elect a settlement option if none is in effect at the time of your death.

PARTICIPANT LIFE INSURANCE *(continued)*

TOTAL DISABILITY EXTENDED BENEFITS

The Extended Life Insurance Benefit and Premium Waiver Benefit are referred to here as the "Extended Benefits". Trustmark will provide the Extended Benefits, as set forth below, if you become totally disabled while you are under age 60 and while you are insured for the Participant Life Insurance.

The Extended Life Insurance Benefit applies during the period of your total disability before Trustmark determines whether or not you qualify for the Premium Waiver Benefit.

Extended Life Insurance Benefit

If your Participant Life Insurance ends while you are totally disabled and you die before you qualify for the Premium Waiver Benefit, Trustmark will pay the Extended Benefit Amount to your beneficiary provided:

1. you became totally disabled while you were insured for the Participant Life Insurance;
2. you were under 60 years of age when you became totally disabled;
3. you die within 12 months of the date your total disability started; and
4. you stayed totally disabled from the date your total disability started until the date of your death.

The Extended Benefit Amount shall be paid in place of the Participant Life Benefit.

Premium Waiver Benefit

Waiver. Trustmark will keep in force or reinstate your Participant Life Insurance and waive the payment of premiums for it during the premium waiver period described below if:

1. you become totally disabled while you are insured for the Participant Life Insurance;
2. you are under 60 years of age when you become totally disabled;
3. you stay totally disabled for nine consecutive months;
4. you give written proof of your total disability to Trustmark, at no cost to Trustmark, during the last three months of the 12 month period that follows the start of your total disability.

During the premium waiver period, you will be insured for an Extended Benefit Amount in place of the Participant Life Benefit.

Premium Waiver Period. A premium waiver period begins on the later of: (a) the first day of the tenth consecutive month of your total disability; and (b) the date Trustmark approves the proof of your total disability.

The premium waiver period continues only while you stay totally disabled. You must give written proof to Trustmark, at no cost to Trustmark, that you are still totally disabled. That proof must be submitted during the last three months of each 12 month period during which the total disability continues. If, for any reason, you do not give that proof to Trustmark, the premium waiver period will end as stated below. During the premium waiver period, Trustmark has the right to have a physician of its choice examine you, at Trustmark's cost, whenever Trustmark may reasonably require it. If, for any reason, you fail to have an examination that is asked for by Trustmark, the premium waiver period will end as stated below.

PARTICIPANT LIFE INSURANCE *(continued)*

The premium waiver period will end on the earliest of the dates that follow:

1. The date you stop being totally disabled.
2. The date Trustmark requests proof of your total disability, if you fail to furnish the proof.
3. The date Trustmark requests that you have an examination, if you fail to have the examination.
4. The date you convert your Participant Life Insurance under the terms of the Participant Life Conversion Privilege.

Other Extended Benefits Provisions

Extended Benefit Amount. The "Extended Benefit Amount" is the amount of the Participant Life Benefit for which you were insured when you became totally disabled.

Total Disability. As used here, "total disability" and "totally disabled" mean that you are unable, due to disease or injury, to perform the substantial and material duties of any gainful occupation for which you are reasonably fitted by education, training, or experience.

Effect of Life Conversion Privilege. If you die during the conversion period a Participant Life Benefit will be provided as stated in the Participant Life Conversion Privilege. If you convert your Participant Life Insurance under the terms of the Participant Life Conversion Privilege:

1. the Extended Benefits will not apply to you; and
2. any coverage that may be in force under the Extended Benefits will end on the date your Participant Life Insurance is converted.

The Extended Benefits will again apply to you if you are still eligible for them and your individual policy is surrendered to Trustmark without any claim for benefits.

Coverage When Extended Benefits End. When your total disability and your coverage under these Extended Benefits end:

1. you may again be insured for the Participant Life Benefit that applies to your insurance class if you are then eligible; or
2. your rights under the Participant Life Conversion Privilege will apply if you are not then eligible.

Written Notice of Death. No Extended Benefit Amount will be paid unless written notice of your death is given to Trustmark at its Home Office within 12 months of the date you die.

PARTICIPANT LIFE CONVERSION PRIVILEGE

You can convert to an individual policy of life insurance if your Participant Life Insurance ends under the conditions set forth below. You must apply and pay the first premium to Trustmark within the conversion period.

If Your Eligibility Ends

If your Participant Life Insurance ends because:

1. your employment ends; or
2. you are no longer in an eligible class of employees for a reason other than: (a) termination of the group policy; (b) termination of the Participant Life Insurance; or (c) your employer ceasing to be a covered employer;

then you can convert to an individual policy of life insurance. In this event, the individual policy will be for an amount equal to the amount that ended, unless Trustmark agrees to convert a lesser amount.

If Participant Life Insurance Terminates

You can also convert to an individual policy of life insurance if you have been insured for the Participant Life Insurance for at least five consecutive years and your insurance ends because:

1. the group policy terminates;
2. the Participant Life Insurance terminates for the eligible class of employees you are in; or
3. your employer is no longer a covered employer.

PARTICIPANT LIFE INSURANCE *(continued)*

In this event, the amount of the individual policy will not be more than the lesser of:

- a. \$2,000; or
- b. the amount of Participant Life Insurance that terminated, reduced by the amount of life insurance for which you are or become eligible under a group policy issued or reissued by Trustmark or by any other insurer during the conversion period.

Following Total Disability Extension

You can convert to an individual policy of life insurance if:

1. you qualified for the Total Disability Extended Benefits;
2. your Extended Benefits end; and
3. you are not then in an eligible class of employees.

In this event, the individual policy will be for an amount equal to the Extended Benefit Amount that ended, unless Trustmark agrees to convert a lesser amount.

Individual Policy

The individual policy of life insurance:

1. will not require evidence of insurability from you for its issue;
2. may be in any one of the forms, except term insurance, chosen by you from the forms customarily issued by Trustmark at the age and amount applied for;
3. will not have any disability or supplementary benefits; and
4. will be in exchange for all of your rights under the Participant Life Insurance, except as stated in the Total Disability Extended Benefits provisions.

The premium charged for the individual policy will be Trustmark's customary rate that then applies: (a) to the form and amount of that policy; and (b) to your age and class of risk on the effective date of that policy.

Conversion Period

As used here, a "conversion period" is the period of 31 days that follows: (a) the date your Participant Life Insurance ends; or (b) the date your Total Disability Extended Benefits end.

Notice of Conversion Rights

If you do not receive notice of the right to convert at least 15 days before the end of the conversion period, then you will have an additional period to apply. This additional period:

1. will be the period of 15 days that follows the date you are given such notice, but will in no case extend beyond 60 days after the end of the conversion period; and
2. will in no case be deemed a part of the conversion period.

Notice in writing that is given to you in person or that is mailed to your last known address by Trustmark or by the Policyholder will constitute notice for the purposes of this conversion privilege.

Death Benefit During Conversion Period

The amount of life insurance you are entitled to convert will be paid by Trustmark under the Participant Life Insurance:

1. if you die during the conversion period and before the effective date of the individual policy; and
2. whether or not you have applied and paid the first premium for the individual policy.

LI1000

PARTICIPANT AD&D INSURANCE

Trustmark will pay an Accidental Death and Dismemberment (AD&D) Benefit for a covered loss due to an injury you sustain in an accident that occurs while you are insured for the Participant AD&D Insurance.

Benefit

An "AD&D Benefit" is the benefit that will be paid for the covered losses you sustain. The AD&D Benefit for a covered loss is the Full Benefit or one half the Full Benefit, as shown in the Table of Losses and Benefits below. Trustmark will not pay more than the Full Benefit for all covered losses from one accident. The amount of the Full Benefit is shown in the Schedule of Benefits.

The AD&D Benefit for loss of life will be paid to your beneficiary as stated in the Beneficiary provision of the Participant Life Insurance. All other AD&D Benefits will be paid to you.

Covered Loss

A "covered loss" is a loss:

1. that is shown in the Table of Losses and Benefits;
2. that results, directly and independently of all other causes, from an injury you sustain in an accident that occurs while you are insured for the Participant AD&D Insurance;
3. that results within 90 days from the date of the accident; and
4. that is not excluded by the AD&D Exclusions or the General Health Limitations.

Accident. The term "accident" means an event that: (a) caused a physical injury; (b) was caused by a sudden, violent, and external force; (c) was not expected and could not have been reasonably foreseen; and (d) could not have been avoided.

Table of Losses and Benefits

Loss of:

Life.....	Full Benefit
Both Hands	Full Benefit
Both Feet.....	Full Benefit
Both Eyes.....	Full Benefit
A Hand & a Foot.....	Full Benefit
A Hand & an Eye.....	Full Benefit
A Foot & an Eye	Full Benefit
A Hand	Half the Full Benefit
A Foot.....	Half the Full Benefit
An Eye.....	Half the Full Benefit

Loss of a hand or foot means the complete and permanent severance of the hand or foot at or above the wrist or ankle joint. Loss of an eye means the entire and permanent loss of the sight of that eye.

PARTICIPANT AD&D INSURANCE *(continued)*

AD&D Exclusions

No AD&D Benefit will be paid for a loss that is caused or contributed to by any:

1. disease;
2. voluntarily taken drugs, except those prescribed by a physician and taken in accordance with the directions of that physician, voluntarily taken chemical or poison, or voluntarily inhaled gas;
3. injury that is sustained:
 - a. in the course of any medical or dental diagnosis or treatment, including the therapeutic use of nuclear energy;
 - b. while you are in or upon any aircraft, unless you are a fare-paying passenger on a regularly scheduled flight.

Excluded Charges List

No benefit will be paid for or in connection with any injury or disease:

1. that is intentionally self-inflicted while sane or that is self-inflicted while insane;
2. that results from: (a) any act of war; (b) the participant's commission of a crime; or (c) nontherapeutic release of nuclear energy.

PROOF AND PAYMENT OF AD&D CLAIMS

To Whom Benefits Are Payable

Any health benefits payable for loss of your life will be paid to the beneficiary you have designated to receive such benefits. Any other benefits that have not been paid when you die may be paid, at the option of Trustmark, either to your beneficiary or to your estate. All other amounts will be paid to you.

Physical Examination and Autopsy

Trustmark shall have the right and opportunity to have a covered person examined by a physician of its choice to determine the extent of any sickness or injury for which you have made a claim. This right may be used as often as it is reasonable to do so. If a covered person dies, Trustmark may require an autopsy where the law does not forbid it. Such an examination or autopsy shall be made at Trustmark's expense.

ADD1000

Trustmark Life Insurance Company

CAREFULLY READ THE INFORMATION IN THIS PACKET AND KEEP IT FOR FUTURE REFERENCE. IT HAS IMPORTANT INFORMATION ABOUT HOW TO APPEAL DECISIONS WE MAKE ABOUT YOUR HEALTH CARE.

Getting Information About the Health Care Appeals Process

Help in Filing an Appeal: Standardized Forms and Consumer Assistance From the Department of Insurance

We must send you a copy of this information packet when you first receive your policy, and within 5 business days after we receive your request for an appeal. When your insurance coverage is renewed, we must also send you a separate statement to remind you that you can request another copy of this packet. We will also send a copy of this packet to you or your treating provider at any time upon request. Just call our customer/member services number at 1-800-396-2960 to ask.

At the back of this packet, you will find forms you can use for your appeal. The Arizona Insurance Department ("the Department") developed these forms to help people who want to file a health care appeal. You are not required to use them. We cannot reject your appeal if you do not use them. If you need help in filing an appeal, or you have questions about the appeals process, you may call the Department's Consumer Assistance Office at (602) 364-2499 or 1-(800) 325-2548 or call us at 1-800-396-2960.

How to Know When You Can Appeal

When we do not authorize or approve a service or pay for a claim, we must notify you of your right to appeal that decision. Your notice may come directly from us, or through your treating provider.

Decisions You Can Appeal

You can appeal the following decisions:

1. We do not approve a service that you or your treating provider has requested.
2. We do not pay for a service that you have already received.
3. We do not authorize a service or pay for a claim because we say that it is not "medically necessary."
4. We do not authorize a service or pay for a claim because we say that it is not covered under your insurance policy, and you believe it is covered.
5. We do not notify you, within 10 business days of receiving your request, whether or not we will authorize a requested service.
6. We do not authorize a referral to a specialist.

Decisions You Cannot Appeal

You cannot appeal the following decisions:

1. You disagree with our decision as to the amount of "usual and customary charges."
2. You disagree with how we are coordinating benefits when you have health insurance with more than one insurer.
3. You disagree with how we have applied your claims or services to your plan deductible.
4. You disagree with the amount of coinsurance or copayments that you paid.
5. You disagree with our decision to issue or not issue a policy to you.
6. You are dissatisfied with any rate increases you may receive under your insurance policy.
7. You believe we have violated any other parts of the Arizona Insurance Code.

If you disagree with a decision that is not appealable according to this list, you may still file a complaint with the Arizona Department of Insurance, Consumer Affairs Division, 2910 N. 44th, Second Floor, Phoenix, AZ 85018.

Either you or your treating provider can file an appeal on your behalf. At the end of this packet is a form that you may use for filing your appeal. You are not required to use this form, and can send us a letter with the same information. If you decide to appeal our decision to deny authorization for a service, you should tell your treating provider so the provider can help you with the information you need to present your case.

Description of the Appeals Process

There are two types of appeals: an **expedited appeal** for urgent matters, and a **standard appeal**. Each type of appeal has 3 levels. The appeals operate in a similar fashion, except that expedited appeals are processed much faster because of the patient's condition.

Expedited Appeals

(for urgently needed services you have not yet received)

Level 1. Expedited Medical Review

Level 2 Expedited Appeal

Level 3 Expedited External Independent Medical Review

Standard Appeals

(for non-urgent services or denied claims)

Informal Reconsideration 1

Formal Appeal

External Independent Medical Review

We make the decisions at Level 1 and Level 2. An outside reviewer, who is completely independent from our company, makes Level 3 decisions. You are not responsible to pay the costs of the external review if you choose to appeal to Level 3.

EXPEDITED APPEAL PROCESS FOR URGENTLY NEEDED SERVICES NOT YET PROVIDED

Level 1. Expedited Medical Review

Your request: You may obtain Expedited Medical Review of your denied request for a service that has not already been provided if:

- You have coverage with us,
- We denied your request for a covered service, and
- Your treating provider certifies in writing and provides supporting documentation that the time required to process your request through the Informal Reconsideration and Formal Appeal process (about 60 days) is likely to cause a significant negative change in your medical condition. (At the end of this packet is a form that your provider may use for this purpose. Your provider could also send a letter or make up a form with similar information.) Your treating provider must send the certification and documentation to:

Name: Polly Johnson
Title: Director, Benefits Division
Address: 8324 South Avenue
Boardman, OH 44512
Phone: 800-544-7312
Fax: 1-330-965-7599

Our decision: We have 1 business day after we receive the information from the treating provider to decide whether we should change our decision and authorize your requested service. Within that same business day, we must call and tell you and your treating provider, and mail you our decision in writing. The written decision must explain the reasons for our decision and tell you the documents on which we based our decision.

If we deny your request: You may immediately appeal to Level 2.

If we grant your request: We will authorize the service and the appeal is over.

If we refer your case to Level 3: We may decide to skip Level 1 and Level 2 and send your case straight to an independent reviewer at Level 3.

Level 2: Expedited Appeal

Your request: If we deny your request at Level 1, you may request an Expedited Appeal. After you receive our Level 1 denial, your treating provider **must immediately** send us a written request (to the same person and address listed above under Level 1) to tell us you are appealing to Level 2.

To help your appeal, your provider should also send us any more information (that the provider hasn't already sent us) to show why you need the requested service.

Our decision: We have 3 business days after we receive the request to make our decision.

If we deny your request: You may immediately appeal to Level 3.

If we grant your request: We will authorize the service and the appeal is over.

If we refer your case to Level 3: We may decide to skip Level 2 and send your case straight to an independent reviewer at Level 3.

Level 3: Expedited External, Independent Review

Your request: You may appeal to Level 3 only after you have appealed through Levels 1 and 2. You have only 5 business days after you receive our Level 2 decision to send us your written request for Expedited External Independent Review. Send your request and any more supporting information to:

Name: Pilly Johnson
Title: Director, Benefits Division
Address: 8324 South Avenue
Boardman, OH 44512
Phone: 800-544-7312
Fax: 1-330-965-7599

Neither you nor your treating provider is responsible for the cost of any external independent review.

The process: There are two types of Level 3 appeals, depending on the issues in your case:

(1) Medical necessity

These are cases where we have decided not to authorize a service because we think the services you (or your treating provider) are asking for, are not medically necessary to treat your problem. For medical necessity cases, the independent reviewer is a provider retained by an outside independent review organization (IRO), that is procured by the Arizona Insurance Department, and not connected with our company. The IRO provider must be a provider who typically manages the condition under review.

(2) Contract coverage

These are cases where we have denied coverage because we believe the requested service is not covered under your insurance policy. For contract coverage cases, the Arizona Insurance Department is the independent reviewer.

Medical Necessity Cases

Within 1 business day of receiving your request, we must:

1. Mail a written acknowledgement of the request to the Director of Insurance, you, and your treating provider.
2. Send the Director of Insurance: the request for review; your policy, evidence of coverage or similar document; all medical records and supporting documentation used to render our decision; a summary of the applicable issues including a statement of our decision; the criteria used and clinical reasons for our decision; and the relevant portions of our utilization review guidelines. We must also include the name and credentials of the health care provider who reviewed and upheld the denial at the earlier appeal levels.

Within 2 business days of receiving our information, the Insurance Director must send all the submitted information to an external independent reviewer organization (the "IRO").

Within 5 business days of receiving the information, the IRO must make a decision and send the decision to the Insurance Director.

Within 1 business day of receiving the IRO's decision, the Insurance Director must mail a notice of the decision to us, you, and your treating provider.

The decision (medical necessity): If the IRO decides that we should provide the service, we must authorize the service. If the IRO agrees with our decision to deny the service, the appeal is over. Your only further option is to pursue your claim in Superior Court.

Contract Coverage Cases:

Within 1 business day of receiving your request, we must:

1. Mail a written acknowledgement of your request to the Insurance Director, you, and your treating provider.
2. Send the Director of Insurance: the request for review, your policy, evidence of coverage or similar document, all medical records and supporting documentation used to render our decision, a summary of the applicable issues including a statement of our decision, the criteria used and any clinical reasons for our decision and the relevant portions of our utilization review guidelines.

Within 2 business days of receiving this information, the Insurance Director must determine if the service or claim is covered, issue a decision, and send a notice to us, you, and your treating provider.

Referral to the IRO for contract coverage cases: The Insurance Director is sometimes unable to determine issues of coverage. If this occurs, the Insurance Director will forward your case to an IRO. The IRO will have 5 business days to make a decision and send it to the Insurance Director. The Insurance Director will have 1 business day after receiving the IRO's decision to send the decision to us, you, and your treating provider.

The decision (contract coverage): If you disagree with Insurance Director's final decision on a contract coverage issue, you may request a hearing with the Office of Administrative Hearings ("OAH"). If we disagree with the Director's final decision, we may also request a hearing before OAH. A hearing must be requested within 30 days of receiving the Director's decision. OAH must promptly schedule and complete a hearing for appeals from expedited Level 3 decisions.

STANDARD APPEAL PROCESS FOR NON-URGENT SERVICES AND DENIED CLAIMS

Level 1. Informal Reconsideration

Your request: You may obtain Informal Reconsideration of your denied request for a service if:

- You have coverage with us,
- We denied your request for a covered service,
- You do not qualify for an expedited appeal, and
- You or your treating provider asks for Informal Reconsideration within 2 years of the date we first deny the requested service by calling, writing, or faxing your request to:

Name: Polly Johnson
Title: Director, Benefits Division
Address: 8324 South Avenue
Boardman, OH 44512
Phone: 800-544-7312
Fax: 1-330-965-7599

Claim for a covered service already provided but not paid for: You may not obtain Informal Reconsideration of your denied request for the payment of a covered service. Instead, you may start the review process by seeking Formal Appeal.

Our acknowledgement: We have 5 business days after we receive your request for Informal Reconsideration ("the receipt date") to send you and your treating provider a notice that we got your request.

Our decision: We have 30 days after the receipt date to decide whether we should change our decision and authorize your requested service. Within that same 30 days, we must send you and your treating provider our written decision. The written decision must explain the reasons for our decision and tell you the documents on which we based our decision.

If we deny your request: You have 60 days to appeal to Level 2.

If we grant your request: The decision will authorize the service and the appeal is over.

If we refer your case to Level 3: We may decide to skip Level 1 and Level 2 and send your case straight to an independent reviewer at Level 3.

Level 2. Formal Appeal

Your request: You may request Formal Appeal if: (1) we deny your request at Level 1, or (2) you have an unpaid claim and we did not provide a Level 1 review. After you receive our Level 1 denial, you or your treating provider must send us a written request within 60 days to tell us you are appealing to Level 2. If we did not provide a Level 1 review of your denied claim, you have 2 years from our first denial notice to request Formal Appeal. To help us make a decision on your appeal, you or your provider should also send us any more information (that you haven't already sent us) to show why we should authorize the requested service or pay the claim. Send your appeal request and information to:

Name: Polly Johnson
Title: Director, Benefits Division
Address: 8324 South Avenue
Boardman, OH 44512
Phone: 800-544-7312
Fax: 1-330-965-7599

Our acknowledgement: We have 5 business days after we receive your request for Formal Appeal ("the receipt date") to send you and your treating provider a notice that we got your request.

Our decision: For a denied service that you have not yet received, we have 30 days after the receipt date to decide whether we should change our decision and authorize your requested service. For denied claims, we have 60 days to decide whether we should change our decision and pay your claim. We will send you and your treating provider our decision in writing. The written decision must explain the reasons for our decision and tell you the documents on which we based our decision.

If we deny your request or claim: You have 30 days to appeal to Level 3.

If we grant your request: We will authorize the service or pay the claim and the appeal is over.

If we refer your case to Level 3: We may decide to skip Level 2 and send your case straight to an independent reviewer at Level 3.

Level 3: External, Independent Review

Your request: You may appeal to Level 3 only after you have appealed through Levels 1 and 2. You have 30 days after you receive our Level 2 decision to send us your written request for External Independent Review. Send your request and any more supporting information to:

Name: Polly Johnson
Title: Director, Benefits Division
Address: 8324 South Avenue
Boardman, OH 44512
Phone: 800-544-7312
Fax: 1-330-965-7599

Neither you nor your treating provider is responsible for the cost of any external independent review.

The process: There are two types of Level 3 appeals, depending on the issues in your case:

(1) Medical necessity

These are cases where we have decided not to authorize a service because we think the services you (or your treating provider) are asking for, are not medically necessary to treat your problem. For medical necessity cases, the independent reviewer is a provider retained by an outside independent review organization (IRO), procured by the Arizona Insurance Department, and not connected with our company. For medical necessity cases, the provider must be a provider who typically manages the condition under review.

(2) Contract coverage

These are cases where we have denied coverage because we believe the requested service is not covered under your insurance policy. For contract coverage cases, the Arizona Insurance Department is the independent reviewer.

Medical Necessity Cases

Within 5 business days of receiving your request, we must:

1. Mail a written acknowledgement of the request to the Director of Insurance, you, and your treating provider.
2. Send the Director of Insurance: the request for review; your policy, evidence of coverage or similar document; all medical records and supporting documentation used to render our decision; a summary of the applicable issues including a statement of our decision; the criteria used and clinical reasons for our decision; and the relevant portions of our utilization review guidelines. We must also include the name and credentials of the health care provider who reviewed and upheld the denial at the earlier appeal levels.

Within 5 days of receiving our information, the Insurance Director must send all the submitted information to an external independent review organization (the "IRO").

Within 21 days of receiving the information the IRO must make a decision and send the decision to the Insurance Director.

Within 5 business days of receiving the IRO's decision, the Insurance Director must mail a notice of the decision to us, you, and your treating provider.

The decision (medical necessity): If the IRO decides that we should provide the service or pay the claim, we must authorize the service or pay the claim. If the IRO agrees with our decision to deny the service or payment, the appeal is over. Your only further option is to pursue your claim in Superior Court.

Contract Coverage Cases

Within 5 business days of receiving your request, we must:

1. Mail a written acknowledgement of your request to the Insurance Director, you, and your treating provider.
2. Send the Director of Insurance: the request for review; your policy, evidence of coverage or similar document; all medical records and supporting documentation used to render our decision; a summary of the applicable issues including a statement of our decision; the criteria used and any clinical reasons for our decision; and the relevant portions of our utilization review guidelines.

Within 15 business days of receiving this information, the Insurance Director must determine if the service or claim is covered, issue a decision, and send a notice to us, you, and your treating provider. If the Director decides that we should provide the service or pay the claim, we must do so.

Determine issues of coverage. If this occurs, the Insurance Director will forward your case to an IRO. The IRO will have 21 days to make a decision and send it to the Insurance Director. The Insurance Director will have 5 business days after receiving the IRO's decision to send the decision to us, you, and your treating provider.

The decision (contract coverage): If you disagree with the Insurance Director's final decision on a coverage issue, you may request a hearing with the Office of Administrative Hearings ("OAH"). If we disagree with the Director's determination of coverage issues, we may also request a hearing at OAH. Hearings must be requested within 30 days of receiving the coverage issue determination. OAH has rules that govern the conduct of their hearing proceedings.

Obtaining Medical Records

Arizona law (A.R.S. §12-2293) permits you to ask for a copy of your medical records. Your request must be in writing and must specify who you want to receive the records. The health care provider who has your records will provide you or the person you specified with a copy of your records.

Designated Decision-Maker: If you have a designated health care decision-maker, that person must send a written request for access to or copies of your medical records. The medical records must be provided to your health care decision-maker or a person designated in writing by your health care decision-maker unless you limit access to your medical records only to yourself or your health care decision-maker.

Confidentiality: Medical records disclosed under A.R.S. §12-2293 remain confidential. If you participate in the appeal process, the relevant portions of your medical records may be disclosed only to people authorized to participate in the review process for the medical condition under review. These people may not disclose your medical information to any other people.

Documentation for an Appeal

If you decide to file an appeal, you must give us any material justification or documentation for the appeal at the time the appeal is filed. If you gather new information during the course of your appeal, you should give it to us as soon as you get it. You must also give us the address and phone number where you can be contacted. If the appeal is already at Level 3, you should also send the information to the Department.

The Role of the Director of Insurance

Arizona law (A.R.S. §20-2533(F)) requires "any member who files a complaint with the Department relating to an adverse decision to pursue the review process prescribed" by law. This means, that for appealable decisions, you must pursue the health care appeals process before the Insurance Director can investigate a complaint you may have against our company based on the decision at issue in the appeal.

The appeal process requires the Director to:

1. Oversee the appeals process.
2. Maintain copies of each utilization review plan submitted by insurers.
3. Receive, process, and act on requests from an insurer for External, Independent Review.
4. Enforce the decisions of insurers.
5. Review decisions of insurers.
6. Report to the Legislature.
7. Send, when necessary, a record of the proceedings of an appeal to Superior Court or to the Office of Administrative Hearings (OAH).
8. Issue a final administrative decision on coverage issues, including the notice of the right to request a hearing at OAH.

Receipt of Documents

Any written notice, acknowledgment, request, decision or other written document required to be mailed is deemed received by the person to whom the document is properly addressed on the fifth business day after being mailed. "Properly addressed" means your last known address.

HEALTH CARE APPEAL REQUEST FORM

You may use this form to tell your insurer you want to appeal a denial decision.

Covered Person's Name _____ Member ID # _____

Name of representative pursuing appeal, if different from above _____

Mailing Address _____

Phone # _____

City _____ State _____ Zip Code _____

Type of Denial: Denied Claim or Denied Service Not Yet Received (CIRCLE ONE)

Name of Insurer that denied the claim/service: _____

If you are appealing your insurer's decision to deny a service you have not yet received, will a 30 to 60 day delay in receiving the service likely cause a significant negative change in your health?

Yes or No (CIRCLE ONE)

If your answer is "Yes," you may be entitled to an expedited appeal. Your treating provider must sign and send a certification and documentation supporting the need for an expedited appeal.

What decision are you appealing?

(Explain what you want your insurer to authorize or pay for.)

Explain why you believe the claim or service should be covered:

(Attach additional sheets of paper, if needed.)

If you have questions about the appeals process or need help to prepare your appeal, you may call the Department of Insurance Consumer Assistance number (602) 364-2499 or 1-(800) 325-2548, or Trustmark Life Insurance Company at 1-800-396-2960.

Make sure to attach everything that shows why you believe your insurer should cover your claim or authorize a service, including: Medical records and Supporting documentation (letter from your doctor, brochures, notes, receipts, etc.) ****Also attach the certification from your treating provider if you are seeking expedited review.**

Signature of insured or authorized representative

Date

PROVIDER CERTIFICATION FORM FOR EXPEDITED MEDICAL REVIEWS
(You and your provider may use this form when requesting an expedited appeal.)

A patient who is denied authorization for a covered service is entitled to an expedited appeal if the treating provider certifies and provides supporting documentation that the time period for the standard appeal process (about 60 days) "is likely to cause a significant negative change in the patient's medical condition at issue."

PROVIDER INFORMATION

Treating Physician/Provider _____
Phone # _____ FAX # _____
Address _____
City _____ State _____ Zip Code _____

PATIENT INFORMATION

Patient's Name _____ Member ID # _____
Phone # _____
Address _____
City _____ State _____ Zip Code _____

INSURER INFORMATION

Insurer Name _____
Phone # _____ FAX # _____
Address _____
City _____ State _____ Zip Code _____

Is the appeal for a service that the patient has already received? Yes No

If "Yes," the patient must pursue the standard appeals process and cannot use the expedited appeals process. If "No," continue with this form.

What service denial is the patient appealing?

Explain why you believe the patient needs the requested service and why the time for the standard appeal process will harm the patient.

Attach additional sheets if needed, and include: Medical records and Supporting documentation.

If you have questions about the appeals process or need help regarding this certification, you may call the Department of Insurance Consumer Assistance number (602) 364-2499 or 1(800) 325-2548. You may also call Trustmark Life Insurance Company at 1-800-396-2960.

I certify, as the patient's treating provider, that delaying the patient's care for the time period needed for the informal reconsideration and formal appeal processes (about 60 days) is likely to cause a significant negative change in the patient's medical condition at issue.

Provider's Signature _____ Date _____

STATE OF ARIZONA HEALTH CARE APPEALS TRANSMITTAL FORM

Is this an Expedited External Independent Review Request? Yes No (Circle One)

This case is a denial based on: Lack of medical necessity A coverage issue (Circle One)

Insured Member's Name _____

Mailing Address _____

City, State, Zip Code _____

Insured's Telephone # _____ Member I.D. # _____

Insurer's Name _____

Insurer NAIC # _____

Insurer's Street Address _____

City, State, Zip Code _____

Telephone # _____ FAX # _____

Contact Person Name and Phone no. _____

Treating Provider's Name _____

Office Address _____

Mailing Address, if different than above: _____

City, State, Zip Code _____

Provider's Telephone # _____ FAX # _____

Treating Provider's Medical Specialty _____

(If multiple providers, please list other providers on reverse)

Utilization Review Agent _____

UR Agent's Street Address _____

City, State, Zip Code _____

UR Agent Telephone # _____ FAX # _____

Contact Person _____

External Review requested by: insured member insurer UR Agent AZ D O I (Circle One)

Date External Review requested _____ Date of Level 2 Decision _____

Decision to deny or not authorize service or claim was made by:

Insurance Company Health Care Services Org. UR Agent (Circle One)

For medical necessity cases: Name(s) and credentials of provider(s) issuing the level 1 & 2 decisions:

With this form, transmit all items listed below. **For medical necessity cases, submit 2 copies** of all items.

1. Copy of the insured's policy, certificate, evidence of coverage or similar document
2. All medical records
3. Supporting documentation used to render the decision
4. Summary description of the applicable issues
5. A statement of the utilization review agent's or insurer's decision
6. The utilization review agent's or insurer's criteria used and the clinical reasons for the decision
7. The relevant portions of the utilization review agent's utilization review plan
8. The insured's or provider's letter or appeal form requesting the appeal, and all pertinent correspondence between the member/enrollee and the insurer.

Form P-1098 Rev. 10/00

NOTICE: CLAIM REVIEW AND APPEAL RIGHTS UNDER FEDERAL LAW - THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974 (ERISA)

Department of Labor Regulation 29 CFR 2560.503-1 establishes new claim and appeal procedures for employer-sponsored employee benefit plans.

Preemption of state law for insured coverages: The Federal provisions described below will coordinate with any state claim and appeal review procedures contained within Your Certificate. None of the procedures described below supersedes any state insurance law regulating Your coverage, except to the extent that such law prevents the application of the Federal procedures.

Definitions:

- **Adverse Benefit Determination** - a denial, reduction or termination of benefits, or a failure to otherwise make benefits available.
- **Pre-service Claim** - a claim for medical services that have not yet been rendered and require pre-authorization and/or pre-certification. There are two (2) categories of Pre-service Claims:
 - Urgent Pre-service Claim – any Pre-service Claim for medical care that, if treated as a Non-Urgent Pre-service Claim, could seriously jeopardize the life or health of the claimant, or the ability of the claimant to regain maximum function, or would subject the claimant to severe pain.
 - Non-Urgent Pre-service Claim – a Pre-service Claim that is neither an Urgent Pre-Service Claim nor a Concurrent Care Claim.
- **Concurrent Care Claim** - a claim for a previously approved, ongoing course of medical treatment. There are two (2) categories of Concurrent Care Claims:
 - Urgent Concurrent Care Claim – a claim for ongoing medical care that, if treated as a Non-Urgent Concurrent Care Claim, could seriously jeopardize the life or health of the claimant, or the ability of the claimant to regain maximum function, or would subject the claimant to severe pain.
 - Non-Urgent Concurrent Care Claim – a claim for ongoing medical care that is not an Urgent Concurrent Care Claim.
- **Post-service Claim** - a claim for medical services that have already been rendered that is not a Concurrent Care Claim.

Timing of Claim Determinations for Pre-service Claims and Concurrent Care Claims:

- Pre-service Claims:
 - Urgent Pre-service Claim – Notification will be provided within 72 hours after receipt, unless additional information is necessary. You will be notified within 24 hours if additional information is needed, and You will have 48 hours to submit the information. A determination will be made within 48 hours after receipt of the additional information. If the requested information is not received, a determination will be made based upon the information available.
 - Non-Urgent Pre-service Claim – Notification will be provided within 15 days after receipt, unless additional information is requested. You will be notified within 5 days if additional information is needed, and You will be given 45 days to submit the additional information. A determination will be made within 15 days of the receipt of the additional information. If the requested information is not received, a determination will be made based upon the information available.
- Concurrent Claims:
 - You will be notified of an Adverse Benefit Determination regarding a previously approved ongoing course of treatment sufficiently in advance to allow You to appeal the adverse determination. If, at least 24 hours before the end of a course of previously approved ongoing treatment, You request an extension for that treatment, then a determination will be made within 24 hours of receipt of Your request.
 - If Your request is received less than 24 hours before the end of the course of treatment, the Urgent Pre-service Claim procedures described above will be followed.

Timing for Claim Determinations for Post-service Claims:

Notice of benefit determination will be provided within:

- 30 days of receipt of a Post-service Medical claim.

If a determination cannot be made within that timeframe due to circumstances beyond our control, an extension of:

- 15 days for a Medical claim
may be requested.

You will be notified within that timeframe of any additional information needed for a benefit determination. You will have 45 days from receipt of our request to submit the information.

Content of Notice of Adverse Benefit Determination:

Any notice of Adverse Benefit Determination on a Pre-service, Concurrent Care or Post-service Claim will include:

- The specific reasons for any adverse determination, and reference to the specific Certificate provision(s) on which determination is based.
- A description of any additional information needed.
- A description of Your Certificate's appeal procedures and applicable time limits.
- A statement of right to bring civil action under section 502(a) of ERISA regarding Adverse Benefit Determinations upheld on appeal.

In addition, if the Adverse Benefit Determination was rendered on a claim for Medical benefits, the Notice of Adverse Determination will include a statement that any internal rule, guideline, protocol or other similar criteria used in the determination will be provided upon request at no charge. If the adverse determination on a Medical claim was based on medical judgment, the Notice of Adverse Determination will include a statement that an explanation of medical judgment will be provided upon written request at no charge.

If a Pre-service, Concurrent or Post-service Claim is denied or partly denied, You shall have a reasonable opportunity for an appeal and a right to a full and fair review. Please refer to the Appeal Rights provision below.

APPEAL RIGHTS UNDER ERISA -

Opportunity to Request an Appeal

You have the right to appeal an Adverse Benefit Determination rendered on a Pre-service, Concurrent Care or Post-service Claim. Appeal of an Urgent Pre-service Claim or an Urgent Concurrent Care Claim may be requested verbally; all other appeal requests must be in writing. You will have 180 days to appeal a Medical claim denial.

You will be provided a full and fair review taking into account all comments, documents, records and other information relevant to your claim whether it was used or submitted with the initial claim determination or not. The reviewer on appeal will be someone other than the person who made the original determination and will not be a subordinate employee of that person.

If the determination is based in whole or in part on a medical judgment, the reviewer must consult with a health care professional with appropriate training and experience. The professional consulted will be someone other than the person who made the original determination and will not be a subordinate employee of that person. Upon written request, You will be provided reasonable access to information relevant to the claim.

Timing for Appeal Determinations:

Once Your request for an appeal is received, You will receive a determination on Your appeal no later than:

- Pre-service and Concurrent Care claims involving Urgent Care: 72 hours.
- Pre-service and Concurrent Care claims involving Non-Urgent Care: 15 days for Plans requiring two Levels of Appeal and 30 days for Plans requiring one Level of Appeal.
- Post-service Medical claims: 30 days for Plans requiring two Levels of Appeal and 60 days for Plans requiring one Level of Appeal.

Content of Notice of Adverse Benefit Determinations Upheld on Appeal:

The Notice of an Adverse Benefit Determination upheld on appeal will include all of the information required to be included in the initial Notice of Adverse Benefit Determination, and:

- A statement describing any voluntary appeal procedures offered by the Plan, including any appeal rights mandated by state insurance law.
- A statement as follows: "You and your 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."

REV APP DOL

THE FOLLOWING PAGES ENTITLED "SUMMARY PLAN DESCRIPTION" ARE NOT PART OF THE CERTIFICATE FURNISHED THROUGH TRUSTMARK LIFE INSURANCE COMPANY.

THE INFORMATION CONTAINED THEREIN IS BEING PROVIDED BY THE POLICYHOLDER

THE PAGES CONTAIN ADDITIONAL INFORMATION REGARDING IMPORTANT INFORMATION ABOUT THIS PLAN; THE BENEFITS PROVIDED; COBRA CONTINUATION, AND YOUR RIGHTS AS PROVIDED UNDER ERISA (EMPLOYEE RETIREMENT INCOME SECURITY ACT).

**INFORMATION REQUIRED BY ERISA
EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974**

The following information concerning the Welfare Plan is being provided to you in accordance with Government regulations:

A. The name and type of administration of the Plan.

The Phoenix Painting Industry Health and Welfare Trust Fund is a welfare benefit plan providing medical expense, and life and accidental death and dismemberment benefits to participants and beneficiaries. It is administered by a joint Board of Trustees, consisting of four Union representatives and three Employer representatives.

B. The name and address of the Plan Administrator is:

Board of Trustees

Phoenix Painting Industry Health and Welfare Trust Fund
Southwest Service Administrators, Inc.
2400 West Dunlap Avenue, Suite 250
Phoenix, Arizona 85021
Phone: (602) 249-3582

The Trustees have engaged the independent contractor named below to perform the routine administration of the Trust:

Southwest Service Administrators, Inc.
2400 West Dunlap Avenue, Suite 250
Phoenix, Arizona 85021
Phone: (602) 249-3582

C. The names and business addresses of the Trustees are:

Employer Trustees

K.W. Lunsford
P.O. Box 26795
Phoenix, AZ 85068-6795

William Moder
P.O. Box 37289
Phoenix, AZ 85069-7289

Scott Maki
430 E. Watkins Rd.
Phoenix, AZ 85004

Fred Cohill
21240 N. 22nd Street
Phoenix, AZ 85024

Union Trustees

Lonnie Tinder
1841 N. 24th St.
Phoenix, AZ 85008

H.B. (Sonny) Williams
2131 W. Mulbery Dr.
Chandler, AZ 85248-1776

Garnet Kingsland
2473 E. Nathan Way
Chandler, AZ 85225-2813

- D. **In addition to the Board of Trustees, the following person has been designated as agent for the service of legal process:**

David L. Niederdeppe, Esq.
107 N. Cortez Street, Ste. 201
Prescott, AZ 86301

- E. **The Employer Identification Number assigned by Internal Revenue Service to the Board of Trustees is 86-6051048. The Plan Number assigned by the Board of Trustees is 501.**

- F. **For purposes of maintaining the Fund's fiscal records, the year-end date is December 31.**

- G. **Funding Medium:**

Benefits are provided from the Fund's assets which are accumulated under the provisions of the Collective Bargaining Agreement and the Trust Agreement and held in a Trust Fund for the purpose of providing benefits to covered participants and defraying reasonable administrative expenses.

The life and accidental death and dismemberment and medical benefits are fully insured under policy JE882 underwritten by Trustmark Insurance Company.

Financial Information

- H. **Contribution Source:**

All contributions to the Plan are made by Employers in accordance with collective bargaining agreements between The Painting and Decorating Contractors of America, Central Arizona Chapter No. 3, and Brotherhood of Painters and Decorators and Paperhangers of America, Local Union No. 86, and Employers in the Industry.

The collective bargaining agreements require contributions to the Plan at a fixed rate per hour worked.

The Administrative Office will provide you, upon written request, information as to whether a particular Employer is contributing to this Plan on behalf of Participants working under the collective bargaining agreement.

See the section entitled "Plan Documents" if you wish to obtain additional information about the collective bargaining agreement.

- I. **Organizations Accumulating Fund Assets:**

The Fund's assets and reserves are held in custody by Wells Fargo Bank.

See the section entitled "Plan Documents" if you wish to obtain additional information concerning the Fund's investment of assets and checking accounts.

Plan Information

- J. **Eligibility:**

The Plan's requirements with respect to eligibility as well as circumstances that may result in disqualification, ineligibility, or denial or loss of any benefits are fully described in this booklet.

K. Plan Regulations:

All of the types of benefits provided by the Plan are set forth in this booklet.

L. Statement of ERISA Rights:

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

RECEIVE INFORMATION ABOUT YOUR PLAN AND BENEFITS

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 Employee Benefits Security Administration (formerly known as the Pension and Welfare Benefits Administration).

Obtain, upon written request to the plan administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.

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 GROUP HEALTH PLAN COVERAGE

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.

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

USERRA- UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT OF 1994

The Uniformed Services Employment and Reemployment Rights Act of 1994, provides that upon notification by the employee/service member to the Employer of pending active military service, such employee has the right to elect to continue existing personal and/or dependent coverage subject to the following conditions:

- the maximum period of coverage for an employee and his/her covered dependents shall be the lessor of 24 months, beginning on the date the absence from employment begins, or the day after the date on which the person is required to apply for or return to a position of employment as specified under the USERRA Act;
- an employee and/or covered dependents who elect to continue health plan coverage may be required to pay up to 102% of the full cost under the Plan, except that a person on active duty for 31 days or less cannot be required to pay more than the Employee's share, if any, for the coverage; and

- continuation of coverage under the USERRA Act applies to health coverage only. Health Coverage includes Comprehensive Medical, Prescription Drugs and Dental benefits, if such benefits are provided through the Employer's Plan. It does not include Group Life or Accidental Death and Dismemberment Insurance if such benefits are provided by the Employer.

An Employee, who applies for reemployment within the time limit specified under the USERRA Act, will have coverage reinstated in the Employer's health plan without imposition of any waiting period or exclusion. Except that an exclusion or waiting period can be applied to any injury or illness determined by the Secretary of Veterans Affairs to have been incurred or aggravated during the performance of military service.

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 the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the 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 domestic relations order or a medical child support order, you may file suit in Federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

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 (formerly known as the Pension and Welfare Benefits Administration), U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration (formerly known as the Pension and Welfare Benefits Administration), U.S. Department of Labor, 200 Constitution Avenue NW, 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 (formerly known as the Pension and Welfare Benefits Administration).

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 plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours). Of course, a longer stay will be allowed if the needs are such that a longer stay is medically necessary.

Under the Women's Health and Cancer Rights Act of 1998, group health plans that provide medical and surgical benefits in connection with a mastectomy must provide benefits for certain reconstructive surgery. This covers:

- Reconstruction of the breast on which the mastectomy was performed;
- Surgery on the other breast to produce a symmetrical appearance;
- Prosthesis and physical complications of all stages of mastectomy, including lymphedemas.

This coverage is subject to the Plan's normal co-payments, annual deductibles and coinsurance provisions.

M. Claim Procedures:

The procedures to follow for filing a claim for benefits are set forth in this booklet. All claims for benefits must be submitted on claim forms made available by the Administrative Office or other provider. Claims submitted must be accompanied by any information or proof requested and reasonably required to process such claims.

N. Review and Appeals Procedures:

The procedures to follow for appealing an adverse claim determination are also set forth in this booklet.

O. Plan Documents and Reports:

You may examine the following documents at the Administrative Office during regular business hours, Monday through Friday, except holidays:

1. Trust Agreement;
2. Collective Bargaining Agreement;
3. Plan Documents, policies and all amendments;
4. Form 5500 or full Annual Report filed with the Internal Revenue Service and Department of Labor; and
5. List of Contributing Employers.

You may also obtain copies of the documents by writing for them and paying the reasonable cost of duplication. You should find out what the charges will be before requesting copies. If you prefer, you can arrange to examine these reports, during business hours, at your Union Office.

To make such arrangements, call or write the Administrator at the Administrative Office. A summary of the annual report which gives details of the financial information about the Fund's operation is furnished free of charge to all Participants.

P. Spanish Language Assistance:

Pongase en contacto con la oficina de administracion si no entiende los beneficios del Plan al numero (602) 249-3582.

This booklet contains a summary in English of your Plan rights and benefits under the Plan. If you have difficulty understanding any part of this booklet, contact the Administrative office at Southwest Service Administrators, Inc., 2400 West Dunlap Avenue, Suite 250, Phoenix, Arizona 85021..

The office hours are from 8:30 a.m. to 5:00 p.m., MST, Monday through Friday. You may also call the Administrative office at (602) 249-3582 for assistance.

Nothing in this booklet is meant to interpret or extend or change in any way the provisions expressed in the Rules and Regulations of the Health and Welfare Plan. The Trustees reserve the right to amend, modify or discontinue all or part of this Plan whenever, in their judgment, conditions so warrant.

Administrative Office

SOUTHWEST SERVICE ADMINISTRATORS
2400 W. Dunlap
Suite 250
Phoenix, AZ 85021-3582

Consultants and Actuaries

THE SEGAL COMPANY

Underwritten by

TRUSTMARK LIFE INSURANCE COMPANY