SOUTHERN PAINTERS WELFARE FUND

SUMMARY OF SCHEDULE OF BENEFITS

Deductible:
- Individual $400
- Family......$1,200

Plan Benefit Percentage:......75%

Total Maximum Out-of-Pocket:
- Individual $5,000
- Family......$10,000

Office/Clinic/Urgent Care Visits:
- Retail Clinic Visits:......100% after $30 copayment
- Primary Care Provider Office Visits......100% after $30 copayment
- Specialist Office & Virtual Visits......100% after $60 copayment
- Urgent Care Center Visits......100% after $75 copayment
- Telemedicine Service......100% after $0 copayment

Preventive Care Benefits......100%

Hospital Inpatient......75% after $100 copayment
Hospital Outpatient......75% after deductible
Maternity......75% after deductible
Medical Care/Surgical Expenses......75% after deductible

Emergency Room Services....75% after deductible, $500 copayment (waived if admitted)
Ambulance......75% after deductible

Mental Health/Substance Abuse:
- Inpatient...... 75% after deductible
- Inpatient Detoxification/Rehabilitation......75% after deductible
- Outpatient......100% after $30 copayment

Prescription Drug Benefit
- Individual Calendar Year Deductible......$100
- Rx Out-of-Pocket Maximum Per Calendar Year
  - Per Individual......$1,500
- Per Family......$3,000

Continued on Reverse

Retail (Up to 31-day supply) Copayment

Benefit	Amount
Generic Rx	$10
Brand Name Rx with No Generic Equivalent	Lesser of $25 or 30%
Brand Name Rx With Generic Equivalent	Generic copayment plus difference Between generic and brand name cost

Mail Order (up to 90-day supply) Copayment

Benefit	Amount
Generic Rx	$20
Brand Name Rx with No Generic Equivalent	Lesser of $50 or 30%
Brand Name Rx With Generic Equivalent	Generic copayment plus difference Between generic and brand name cost

Vision Benefit (Reimbursement)

Benefit	Amount
Eye Exam (per 12 month period)	$40

Lenses (per 12 month period)

Benefit	Amount
Single Vision	$40
Bi-Focal Rx	$50
Tri-Focal	$65
Lenticular	$85
Contacts	$90

Benefit	Amount
Frames (per 24 month period)	$50

Dental Benefit

Benefit	Amount
Individual Calendar Year Deductible	$50
Calendar Year Maximum	$750*
Percent Payable by Plan (Coinsurance)	50%

Benefit	Amount
Weekly Accident and Sickness Benefit (Employee Only)	$200
Maximum Period for any one period of Total Disability	13 weeks

Benefit	Amount
Life Insurance (Employee Only)	$10,000
Accidental Death and Dismemberment Insurance (Employee Only)	$10,000

*Calendar Year Maximum for Dental Benefits is $1,500 for eligible employees with employer contributions paid at or over $7.50 per hour.