The Employee Painters' Trust
Active Employees and Non-Medicare-Eligible Retirees

HEALTH AND WELFARE PLAN DOCUMENT

NOVEMBER 2023

844-344-2721

KEY CONTACTS

If you have questions about these topics…	Here's who to contact…
Employee Painters' Trust Health Benefits Benefits Medical and Dental Claims Eligibility COBRA Continuation Coverage Accidental Death & Dismemberment (AD&D) Weekly Disability Benefits	**BeneSys, Inc.—Trust Administrator** Claims, Eligibility, Other: 206-518-9730 or 844-344-2721 (toll-free) Claims Fax: 425-251-1976 Website: www.IUPATWesternBenefits.org Correspondence and payments: 5200 Southcenter Blvd., Suite 205, Tukwila, WA 98188 Claims correspondence (except prescription or vision): P.O. Box 58830, Tukwila, WA 98138
EPT Mobile App	Go to the Apple or Android store and download: IUPATWBenes Mobile App
Treatment Precertification and Care Management Program	**Aetna—In-Network Providers** Phone: 888-632-3862, Option #3 Fax: 888-267-3277 Website: www.aetna.com/health-care-professionals/precertification.html
Disability and Narcotics Review	**Innovative Care Management (ICM)** Phone: 800-862-3338 (toll free) Fax: 503-654-8570 Mail: P.O. Box 22386, Portland, OR 97269
Kaiser Members	**Kaiser Permanente** Customer Service: 800-813-2000 Website: www.kaiserpermanente.org Mail Correspondence: Member Relations Kaiser Foundation Health Plan of the Northwest 500 NE Multnomah St, Suite 100 Portland, OR 97232-2099
Dental PPO	**Careington Maximum Care Network Dental** Provider Search: 800-290-0523 Website: www.careington.com/co/maxcare Provider Relations: 800-441-0380 ext 5202
National PPO	**Aetna** Website: www.aetna.com Phone: 888-632-3862 (toll-free)
Pharmacy Benefits Manager ("PBM") Prescription Drug Plan Benefits Retail Pharmacy Claims Locating a Participating Retail Pharmacy	**Elixir** Phone: 800-361-4542 (toll-free) Go to www.elixirsolutions.com to obtain a list of Participating Pharmacies
Specialty Prescription Drugs	**Archimedes** Phone: 888-504-5563 (toll-free) memberservices@archimedesrx.com
Using the Mail-Order Pharmacy Mail-Order Pharmacy Claims	**Elixir** Website: www.elixirsolutions.com Phone: 866-909-5170 (toll-free) Mail: Elixir Solutions, 2181 East Aurora Road, Suite 201, Twinsburg, OH 44087
Vision Plan Benefits and Claims Locating a VSP Provider	**Vision Service Providers (VSP)** Website: www.vsp.com Phone: 800-877-7195 (toll-free) Mail Correspondence: P.O. Box 997105, Sacramento, CA 95899
Provider Portal	Website: www.memberbenefitsonline.com

ATTENTION

If English is not your primary language, you can receive language assistance, free of charge. Please call the phone number listed on the front page.

NOTICE OF NONDISCRIMINATION

This Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of, or exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

(Espanol/Spanish) ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Por favor, llame al número de la primera página.

(繁體中文/Chinese) 注意：如果您使用繁体中文，您可以免费获得语言援助服务。请致电首页上的电话号码。

(**한국어**/Korean) 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 프론트 페이지 상의 전화번호로 전화해 주십시오.

(**Deutsch /**German**)** ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Bitte verwenden Sie die Rufnummer auf der Vorderseite.

(Français/French) ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Veuillez appeler le numéro inscrit au recto de la page.

(فارسی/Farsi) توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. لطفاً با شماره روی جلد تماس بگیرید.

(**Oroomiffa** /Oromo) HUBACHIISA: YOO AFAAN OROMOO DUBBATTA TAATE; TAJAAJILLI AFAAN HIIKUU TOLATTI SIIF KENNAMA. MAALOO LAKKOBSA BILBILAA FUULA JALQABAA IRRA JIRU BILBILI

(**Srpsko-hrvatski**/ Serbo-Croatian) OBAVEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Molimo vas da nazovete broj na prednjoj strani.

(**Hmoob**/Hmong) LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Thov hu rau tus npawb xovtooj nyob ntawm thawj nplooj ntawv.

(**Polski**/Polish) UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer podany na pierwszej stronie.

(**Tiếng Việt** / Vietnamese) CHÚ Ý: Nếu quý vị nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho quý vị. Vui lòng gọi số điện thoại ở trang trước.

(**Русский** /Russian) ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните по номеру, указанному на главной странице.

(العربية/Arabic) انتبه : اذا كنت تتحدث العربيه فإن خدمات المساعدة اللغوية متاحة لك بالمجان. رجاء الاتصال على الرقم الموجود في الصفحة الأمامية

(日本語 /Japanese) 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。表紙に記載された番号まで、お電話にてご連絡ください。

(**Tagalog**/Filipino) PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Pakitawagan ang numero sa pambungad na pahina.

(Italiano/Italian) ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Si prega di contattare il numero indicato sulla prima pagina.

(**ខ្មែរ /**Cambodian) ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទមកកាន់លេខដែលមាននៅលើទំព័រខាងមុខនេះ។

(**ภาษาไทย/**Thai) เรียน:
ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โปรดโทรศัพท์หาหมายเลขโทรศัพท์ที่ปรากฏอยู่บนหน้าปก

(**ਪੰਜਾਬੀ**/Punjabi) ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। ਕਿਰਪਾ ਕਰਕੇ ਮੁਹਰਲੇ ਸਫ਼ੇ ਉੱਪਰ ਦਿੱਤੇ ਗਏ ਨੰਬਰ ਤੇ ਕਾੱਲ ਕਰੋ।

(**ܣܘܪܝܬ/Assyrian**) ܙܘܗܪܐ: ܐܢ ܐܢܬܘܢ ܟܐ ܡܗܡܙܡܝܬܘܢ ܠܫܢܐ ܐܬܘܪܝܐ، ܡܨܝ ܐܝܬܠܘܟܘܢ ܕܡܫܬܠܒܝܬܘܢ ܥܘܕܪܢܐ ܕܡܬܪܓܡܢܘܬܐ ܒܠܫܢܐ ܡܓܢܐܝܬ. ܩܪܘܢ ܥܠ ܡܢܝܢܐ ܥܠ ܦܐܬܐ.

(Shqip/Albanian) KUJDES: Nëse flisni shqip, për ju kemi shërbime gjuhësore falas. Telefononi në numrin që ndodhet në faqen e përparme.

(**አማርኛ /Amharic)** ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ እባክዎትን በፊት ለፊት ባለው ቁጥር ላይ ይደውሉ።

(ພາສາລາວ/Lao) ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ກະລຸນາໂທຫາເບີໂທທີ່ຢູ່ດ້ານໜ້າ.

(**Ilokano/** Ilocano**)** PAKDAAR: Nu saritaem ti Ilocano, ti serbisyo para ti baddang ti lengguahe nga awanan bayadna, ket sidadaan para kenyam. Awagam ti numero nga adda iti sango a panid.

(**Kreyòl Ayisyen /** French Creole**)** ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Tanpri, rele nimewo ki sou paj devan an.

(**unD/**Karen**)**

ဟ်သူၣ်ဟ်သး– နမ့ၢ်ကတိၤကညီကျိာ်အယိ, တၢ်အိၣ်ဒီးကျိာ်တၢ်မၤစၢၤတၢ်မၤ, လၢတလိ ၣ်ဟ့ၣ်အဘူးအလဲတဖၣ်အိၣ်လၢ နဂီၢ်လီၤ. ကိးလီတဲစိနီၣ်ဂံၢ်လၢအိၣ်လၢတၢ်မဲာ်ညါ တက့ၢ်.

(**اُردُو** / Urdu) توجہ دیں: اگر آپ اردو زبان بولتے ہیں تو، آپ کو زبان سے متعلق اعانت کی خدمات مفت دستیاب ہیں۔ براہ کرم سرورق پر موجود نمبر پر کال کریں۔

(**Igbo asusu/**Ibo**)** NRỤBAMA: Ọ bụrụ na ị asụ Igbo, ọrụ enyemaka asụsụ, n'efu, dịịrị gị. Biko kpọọ nọmba dị n'ihu akwụkwọ ahụ.

(**Ikirundi/**Bantu-Kirundi**)** IKITONDERWA: Niba uvuga Ikirundi, hatangwa ubufasha mururimi kandi kubuntu. Hamagara inimero ya telephone irahabanza kurupapuro

(**Nederlands/**Dutch) AANDACHT: Als u nederlands spreekt, kunt u gratis gebruikmaken van de taalkundige diensten. Bel naar het nummer op de voorste pagina a.u.b.

(Română/Romanian) ATENȚIE: Dacă vorbiți limba română, vă stau la dispoziție servicii de asistență lingvistică, gratuit. Vă rugăm să sunați la numărul de pe prima pagină.

(Português/Portuguese) ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para o número na primeira página.

(**हिंदी**/Hindi) ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। कृपया मुखपृष्ठ पर अंकित नंबर पर कॉल करें।

(**Հայերեն**/Armenian) ՈՒՇԱԴՐՈՒԹՅՈՒՆ՝ Եթե խոսում եք հայերեն, ապա ձեզ անվճար կարող են տրամադրվել լեզվական աջակցության ծառայություններ: Խնդրում ենք զանգահարել առաջին էջում նշված համարով:

(**Українська/**Ukrainian) УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером, вказаним на першій сторінці.

(**বাংলা /**Bengali) লক্ষ্য করুন: যদি আপনি বাংলায় কথা বলতে পারেন, তাহলে নিঃখরচায় ভাষা সহায়তা পরিষেবা উপলব্ধ আছে। অনুগ্রহ করে সামনের পৃষ্ঠায় থাকা নম্বরে ফোন করুন।

(ગુજરાતી/Gujarati) સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો કૃપા કરી પ્રથમ પાના ઉપરના નંબર પર કોલ કરો.

(**Gagana fa'a Sāmoa /** Samoan**)** MO LOU SILAFIA: Afai e te tautala ile Gagana Faa-Samoa, e iai auaunaga fesoasoani e fai fua e leai se totogi mo oe. Faamolemole valaau ane le numera o loo Ile ituau muamua.

(**नेपाली**/Nepali) ध्यान दिनुहोस्: तपाईं नेपाली बोल्नुहुन्छ भने तपाईंका निम्ति भाषा सहायता सेवाहरू निःशुल्क रूपमा उपलब्ध छन् । कृपया अघिल्लो पृष्ठमा दिइएको नम्बरमा फोन गर्नुहोस्।

(èdè Yorùbá/Yoruba**)** AKIYESI: Ti o ba nso ede Yoruba ofe ni iranlowo lori ede wa fun yin o. Jọ̀wọ́ pe nọ́mbà tó wà níwájú ojú-ìwé náà.

(**Tonga/**Tongan**)** FAKATOKANGA: Kapau 'oku ke lea faka-Tonga, 'oku 'i ai 'a e tokoni fakatonulea, ta'e totongi, 'oku faingamālie kiate koe. Kātaki 'o tā ki he fika he peesi 'i mu'a.

(**λληνικά/**Greek**)** ΠΡΟΣΟΧΗ: Αν μιλάτε ελληνικά, στη διάθεσή σας βρίσκονται υπηρεσίες γλωσσικής υποστήριξης, οι οποίες παρέχονται δωρεάν. Παρακαλούμε, καλέστε στον αριθμό που αναγράφεται στην μπροστινή σελίδα.

(ကြမာမ္မ/Burmese)
သင်[မန်မာ(ဗမာ)]လိုပြောတတ်လျှင် : သတိပုရန်
ဘာသာစကားဆိုင်ရာ အကူအညီကို
သင်ငွေကျေန်ကခြေးကျခံစရာမလိုဘဲ ရယူနိုင်ပါသည်။
မျက်နှာဖုံးစာမျက်နှာရှိ နံပါတ်ကိုခေါ်ဆိုပါ။

TAKE ACTION

This Plan Document provides detailed information about your benefit coverage and helps you to make informed decisions for you and your family. To make the most of your benefits:

- Read this Plan Document to understand your benefit coverage.
- Look for "KEY POINTS" and "TAKE ACTION" for important information that you need to know.
- If you have questions, please contact the organization listed in "Key Contacts."
- File this Plan Document in a secure location to use for future reference.

Contents

WELCOME

Welcome to your Employee Painters' Trust Plan ("EPT" or "the Plan"). The Plan intends to provide detailed information about covered services, limitations, and exclusions available through the Plan as of January 1, 2023. The Employee Painters' Trust (the "Trust") is a Taft-Hartley trust fund. Trustees of The Employee Painters' Trust manage the Plan. The Plan explains the benefits available to active employees and certain associates, retirees, and their families with excellent Medical, Prescription Drug, Dental, Vision, Accidental Death and Dismemberment, and Weekly Disability (time loss) benefits. Please note that not all employers provide all benefits; the specific benefits available to you are determined by your collective bargaining agreement ("CBA") or special agreement.

In the event of a conflict with any other Plan documentation predating this document, including Summary of Benefits and Coverage (SBCs), Summaries of Material Modifications (SMMs), or Summary Plan Descriptions (SPDs), the Plan Document will control. SMMs issued after the date of the Plan Document provide notice of Plan Amendments effective after the effective date of the Plan and should be kept with your copy of the Plan for reference. Please note, you can find an electronic copy of the Plan Document on the Trust Administrator's website for EPT members at **www.ourbenefitoffice.com/IUPAT/Benefits/HealthcareDocuments.aspx**.

The Employee Painters' Trust is pleased to provide you with a Mobile App for IOS and Android operating systems. By downloading the Mobile App you will have a tool that provides specific information regarding your coverage and benefits. Key features include benefits and coverage, covered dependents, ID cards, work history, claims history, and more. Go to the Apple or Android store and download the IUPATWBenes Mobile App.

TRUST ADMINISTRATOR AVAILABLE TO ASSIST YOU

If you have any questions about your benefits, please contact the Employee Painters' Trust Administrator (the "Trust Administrator") for assistance. Please note that only the Trust Administrator is authorized to provide information about benefits, eligibility, and other Plan provisions. Participating employers, employer associations, labor organizations, or any individual employed thereby are not authorized to provide this information.

Although the Trust Administrator will answer your questions to the best of their ability when you call, actual eligibility for benefits and benefit payments will be determined only when a claim is submitted to the Trust Administrator.

We encourage you to take the time to read this book to understand your coverage and make the most of the Employee Painters' Trust Plan benefits.

IMPORTANT NOTICES

Preferred Providers. When you utilize a Preferred Provider Hospital, Physician, or Dentist, the costs to the Employee Painters' Trust are reduced. This also reduces your out-of-pocket costs. The Employee Painters' Trust strongly urges you to utilize Preferred Provider services whenever possible. For help locating a Preferred Provider, contact the Trust Administrator or the Preferred Provider Organization (PPO). See Key Contacts for contact information.

Patient Protection Notice. The Plan generally allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the Trust Administrator or the PPO. (See Key Contacts for contact information.)

For children, you may designate a pediatrician as the primary care provider.

You do not need prior authorization from the Plan or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or following procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the Trust Administrator or the PPO. See Key Contacts for contact information.

Utilization Review Treatment and Care Management for inpatient hospital and outpatient services provide support so the patient can receive necessary, appropriate care while avoiding unnecessary expenses. To benefit from these programs, you must receive precertification from Aetna before you receive medical or surgical services. (See Key Contacts for contact information.)

The Board of Trustees' Discretion Retained. The Board of Trustees of the Trust (the "Board") reserves the maximum legal discretionary authority to construe, interpret, and apply the terms, rules, and provisions of the Plan covered in the Plan Document. The Board retains full discretionary authority to make determinations on matters relating to eligibility for benefits, on matters relating to what services, supplies, care, drug therapy, and treatments are experimental and on matters which pertain to participants' rights. The decisions of the claims adjusters, administrator, and the Board as to the facts related to any claim for benefits and the meaning and intent of any provision of the Plan, or application of such to any claim for benefits, shall receive the maximum deference provided by law and will be final and binding on all interested parties.

Amendment and Termination of Benefit Plan. The Board expects to maintain the Plan indefinitely. However, the Board may, in their sole discretion, at any time, amend, suspend, or terminate the Plan, in whole or in part. This includes amending the benefits covered by the Plan, the governing Trust Agreement, and administration policies. If the Plan is terminated, the rights of the participants are limited to benefits accrued before termination. All amendments to the Plan shall become effective as of a date established by the Board. If no effective date is specified by the Board in adopting an amendment, the amendment will take effect on the first day of the plan year following the plan year in which the amendment was adopted.

Nondiscrimination. The Plan complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex, sexual orientation, or gender identity.

ELIGIBILITY

The Plan provides benefits for retirees and bargaining unit employees of contributing employers under certain programs of eligibility and coverage as described further in the Plan. Additionally, certain groups of employees may be subject to a different program of eligibility and coverage as established during collective bargaining (e.g., employees subject to Oregon Kaiser Program coverage or Allied Metal Crafts Program coverage). Separate programs of coverage and eligibility exist for active employees of contributing employers, non-bargaining unit employees of contributing employers (also called Associates), certain Union-affiliated employees, and retirees, as described further in the Plan.

Contributing employers pay a contribution rate for their employees' benefit coverage, as described in the applicable collective bargaining agreement ("CBA") or special agreement. Your eligibility is determined by the program of coverage to which your employer belongs to make these contributions. Briefly, the programs of coverage are:

- Hourly Program
- Flat Rate Program for Owners, Officers, and Non-Bargaining Unit Employees (Associates)
- Oregon Kaiser HMO Program
- Allied Metal Crafts Program

The Plan generally offers health and welfare benefits, including medical, prescription drug, dental, vision, accidental death and dismemberment, and weekly disability wage replacement (time loss) benefits. Some groups also have a basic life benefit. **Not all employers provide all benefits available under the Plan**. Please contact the Trust Administrator to find out if you are eligible for specific benefits.

Individuals belonging to each of the above-listed programs of eligibility and coverage may also be eligible for coverage under the Retiree Benefit Program upon retirement.

! KEY POINT

Your eligibility for the Hourly, Flat Rate, or other Program of benefits is based on your employer's contributions to the Trust. Please contact the Trust Administrator to find out which benefits you are eligible for.

CONTRIBUTING EMPLOYERS

A Bargaining Unit Employee is generally eligible for coverage under the Plan if he or she is an employee of a Contributing Employer or is otherwise eligible for coverage. A Contributing Employer is an employer that is signatory to a labor agreement requiring contributions to the Trust or is otherwise eligible to participate and subscribes in writing to be a participating employer in the Trust.

If you are employed by more than one Contributing Employer, the amount of your benefits under the Plan will not exceed the amount for which you would have been covered if you were employed by only one such Contributing Employer.

Employees of Contributing Employers who do not provide the full contribution rate will have their benefits reduced proportionately.

HOURLY PROGRAM

The provisions below set forth the general eligibility rules for active Bargaining Unit Employees covered under the Hourly Program. Please note that some employees may be subject to special coverage rules depending on the provisions of the applicable collective bargaining agreement (notably, members covered under the Oregon Kaiser HMO Program and the former Allied Metal Crafts Health and Security Program). Every reasonable effort is made to describe all special eligibility rules below. If you have questions about eligibility rules, contact the Trust Administrator.

HOURLY PROGRAM ELIGIBILITY

You will initially become eligible for benefits on the first day of the second calendar month following the calendar month in which you accumulate 300 hours in 12 consecutive months.

For example, if you work 160 hours in January and 160 hours in February, you will become eligible for benefits beginning the first of April. March is the "lag" month. All hours reported on your behalf by contributing employers are credited to your "hour bank."

In order that there is sufficient time for employer reports to be received and processed by the Trust Administrator, a lag month is used in determining eligibility. For example, hours worked in January are reported to the Trust in February, and then the Trust Administrator determines eligibility in February (lag month) for March coverage.

Hourly Plan Continuing Eligibility	Eligibility Method 1	Eligibility Method 2
Local Union or Geographic Region *Depends on bargaining agreement; check with your union office or call the Trust Administrator	10, 55, 66, 77, 159*, 188, 260, 300*, 364*, 427, 567, 740, 1094, 1236, 1237 (Eureka Floors), 1238, 1512, 1959, and DC5 East, Western Washington Painters, Oregon Painters, Las Vegas Material Handlers	159*, 300*, 364*, 1959, Western Washington Drywall, Tapers, Stripers, Floor Coverers, Oregon Drywall, Alaska Stripers
Maximum Hours Accumulation This is the number of hours that may be accumulated after deduction of the 125 hours	450 hours (up to 3 additional months of coverage)	810 hours (up to 6 additional months of coverage)

KEY POINT

Hourly Program employees become eligible for benefits two months after working 300 hours in a 12-consecutive-month period.

HOURLY PROGRAM CONTINUING ELIGIBILITY

Generally, there are two methods by which continuing eligibility is determined for Plan Participants. Your continuing eligibility is based on the contribution rate paid by your employer. Contact the Trust Administrator to determine which method is applicable to you.

Under both continuing eligibility methods, to remain as an Eligible Active Employee after you meet initial eligibility, you will continue to be eligible as long as you have at least 125 hours in your hour bank.

The maximum hours you may accumulate depends on your local union or location, as shown in the table on page 8.

HOURLY PROGRAM CONTINUATION OF COVERAGE

Your coverage ends on the last day of the month following the month when your hour bank accumulation is reduced to less than 125 hours.

When you are not eligible for benefits, you and your dependents may be able to pay for temporary health care coverage through a federal law known as the Consolidated Omnibus Budget Reconciliation Act (COBRA), described later in the Plan Document. Contact the Trust Administrator for more information.

HOURLY PROGRAM REINSTATEMENT OF ELIGIBILITY

If your hour bank has not become inactive by falling below 125 hours for 12 consecutive months, you will be reinstated for eligibility when your hour bank shows at least 125 hours. Such reinstatement will become effective on the first day of the second calendar month following the month in which this requirement is met.

If your hour bank is below 125 hours for more than 12 consecutive months, all credited hours revert to the Trust, and you must again complete the initial eligibility requirement for new employees to become eligible for coverage.

For example, if your coverage terminated January 31 with an hour bank of 90 hours, and then you work at least 35 hours with a contributing employer in October, your eligibility would be reinstated on the first of December.

HOURLY PROGRAM DISABILITY

If you become totally disabled due to an occupational or non-occupational injury or illness while working for a Contributing Employer, your benefits and benefits for your eligible dependents will be continued for up to three months provided the total disability commenced when you were eligible for benefits. Your hour bank will be frozen during that time. If you are still totally disabled after three months, benefits will be continued for you and your dependents until your hour bank is exhausted.

If you are still totally disabled after your hour bank has been exhausted, you may qualify for continuation of coverage under COBRA. Please see information under the headings "Extension of Benefits during Total Disability" on page 19 and Consolidated Omnibus Budget Reconciliation Act (COBRA) Continuation of Coverage on page 19.

If you return to work under a light duty restriction, you are no longer eligible as totally disabled. However, you may still qualify for continuation of coverage under COBRA.

FLAT RATE PROGRAM FOR OWNERS, OFFICERS, AND NON-BARGAINING UNIT EMPLOYEES (ASSOCIATES)

To be covered under the Associates Flat Rate Program, your employer must have signed a collective bargaining agreement calling for contributions to the Trust for Bargaining Unit Employees. All Flat Rate Program employer and employee contributions must be remitted to the Trust Administrator by the first of each month following the month the hours were worked, or at such other time and place as notified in writing by the Trust Administrator.

Your employer may cover owners, officers, and other employees who do not belong to a bargaining unit under a collective bargaining agreement that contributes to the Trust, provided the employer covers 100 percent of all such employees and agrees in writing to continue benefits throughout the life of the Associates Flat Rate agreement. (The spouse of an employer covered under the Associates Flat Rate Program who works for the company is the only exception to this requirement.)

Your employer may only cover employees who work directly for the employer under the rules set forth above. A non-union subsidiary of a Contributing Employer will not be allowed to participate under the Associates Flat Rate Program. Provided the employer meets the rules and procedures established by the Trust, eligible employees may include:

- Office employees
- Maintenance employees
- Superintendents
- Production and industrial employees

Please contact the Trust Administrator for a complete description of Associates Flat Rate Program benefits and rules for participation. Not all employers participating in the Flat Rate Program provide all benefits available under the Plan. Please contact the Trust Administrator for verification of eligibility and benefits.

An employer's participation in the Associates Flat Rate Program requires approval by the Trust's Board. The most current statement of policy governing the Non-Bargaining Employees (Associates) Flat Rate Program is contained in the most recent Flat Rate Plan Eligibility Rules and Procedures. The Board reserves the right to modify the rules of eligibility and to terminate the Associates Flat Rate Program at any time.

ASSOCIATES FLAT RATE PROGRAM ELIGIBILITY

Generally, you are eligible on the first day of the month following the calendar month in which you worked at least 80 hours at your regular job at your customary place of employment.

If you were previously covered as an Eligible Active Employee, eligibility for the Associates Flat Rate Program will not occur until there have been two months in which you worked at least 80 hours but only after a month in which you were not covered as an Eligible Active Employee.

You will remain eligible as long as you continue to be actively employed and work at least 80 hours a month.

KEY POINT

Associates Flat Rate Program employees become eligible for benefits after working 80 hours in one calendar month.

ASSOCIATES FLAT RATE PROGRAM—WHEN COVERAGE ENDS

Your and your dependents' coverage ends:

- On the day the Plan terminates;
- On the first of the month for which no employer contributions are received; or
- On the day before you enter the Armed Forces on "active duty" (except for temporary active duty of two weeks or less) or on the day in which you are no longer eligible under the Plan.

If you are eligible because of your employment, you will no longer be eligible when:

- You resign or retire, but coverage will continue until the last day of the month in which you resign or retire;
- You go on leave of absence or strike;
- You are dismissed, disabled, suspended, laid off, locked out, or not working because of a work stoppage;
- You are no longer in an eligible class; or
- You do not satisfy the requirements for hours worked or any other eligibility conditions in the Plan.

OREGON KAISER HMO PROGRAM

The Trust contracts with Kaiser on an annual basis. Kaiser premiums are subject to change, and coverage is subject to Kaiser's policy in effect at the time of service. Please contact your Kaiser Health office for benefits and eligibility. The information below is controlled by the Plan.

OREGON KAISER HMO PROGRAM CONTINUING ELIGIBILITY

There is one continuing eligibility Kaiser plan in use by members under the Trust. Your continuing eligibility is based on the contribution rate paid by your employer. Contact the Trust Administrator to determine which plan is applicable to you.

Under the Oregon Glaziers eligibility plan, to remain as an Eligible Active Employee, you will continue to be eligible as long as you have at least 125 hours in your hour bank. The maximum hours you may accumulate is 450.

ALLIED METAL CRAFTS PROGRAMS

The Trust maintains coverage for individuals covered under the former Allied Metal Crafts Health and Security Plan (Sheet Metal Workers Local Union 55, Sheet Metal Workers Local Union 66, and Paint Makers Local Union 1094).

Employees under the Allied Metal Crafts' Flat Rate Program must work at least 80 hours for a month of coverage after initial eligibility. The minimum number of hours for a month of coverage under Allied Metal Crafts' Flat Rate Program may be greater than 80 hours per month for some employers according to their agreement.

Employees under the Allied Metal Crafts Residential Metal Workers Program have a dollar bank with a "back-out" amount for a month of coverage after initial eligibility. As of July 1, 2023, the "back-out" amount is $799 for a month of coverage with a maximum dollar bank accumulation of $2,446. ***Rates are subject to change annually.***

SPECIAL RULES FOR ELIGIBILITY—ALLIED METAL CRAFTS FLAT RATE PLAN

For Allied Metal Crafts workers subject to the Allied Metal Crafts Flat Rate Plan, you will initially become eligible for benefits on the first day of the second calendar month following the calendar month in which you accumulate at least 80 hours in each of two consecutive months over a 12- month period.

For example, if your employers' agreement requires 80 hours for a month of coverage and you work 80 hours in January and 80 hours in February, you will become eligible for benefits beginning the first of April. March is the "lag" month.

In order that there is sufficient time for employer reports to be received and processed by the Trust Administrator a lag month is used in determining eligibility. For example, hours worked in January are reported to the Trust in February, and then the Trust Administrator determines eligibility in February (lag month) for March coverage.

SPECIAL RULES FOR CONTINUING COVERAGE—ALLIED METAL CRAFTS FLAT RATE PLAN

For Allied Metal Crafts workers subject to the Allied Metal Crafts Flat Rate Plan, your coverage ends on the last day of the month following any month in which you did not accumulate at least 80 hours.

When you are not eligible for benefits, you and your dependents may be able to pay for temporary health care coverage through a federal law known as Consolidated Omnibus Budget Reconciliation Act (COBRA). Contact the Trust Administrator for more information.

SPECIAL RULES FOR REINSTATEMENT OF ELIGIBILITY—ALLIED METAL CRAFTS FLAT RATE PLAN

For Allied Metal Crafts workers subject to the Allied Metal Crafts Flat Rate Plan, after initial eligibility has been met, if you have had a month of coverage within the last 12 consecutive months, you will be reinstated for eligibility when you work sufficient hours (at least 80) for another month of coverage within that 12-month period. Such reinstatement will become effective on the first day of the second calendar month following the month in which this requirement is met.

If you do not work sufficient hours for another month of coverage for more than 12 consecutive months, all credited hours revert to the Trust, and you must again complete the initial eligibility requirement for new employees to become eligible for coverage.

For example, if your coverage terminated January 31, and then you work at least 80 hours with a contributing employer in October, your eligibility would be reinstated on the first of December.

ALLIED METAL CRAFTS RESIDENTIAL METAL WORKERS PROGRAM ELIGIBILITY

Generally, unless you were eligible for coverage as of the merger effective date between the former Allied Metal Crafts Health and Security Plan and the Plan, you must meet initial eligibility requirements for the Allied Metal Crafts Residential Metal Workers Program. Your employer pays contributions based on the number of hours you work. You will initially become eligible for benefits on the first day of the second calendar month following the calendar month in which you accumulate the current "back-out" amount for a month of eligibility ($799 as of July 1, 2023). At the current rate, you would need to work 145.27 hours for a month of coverage.

SPECIAL RULES FOR CONTINUING COVERAGE—ALLIED METAL CRAFTS RESIDENTIAL METAL WORKERS

For Allied Metal Crafts Residential Metal Workers, your coverage ends on the last day of the month following the month when your dollar bank falls below the threshold for eligibility ($799 as of July 1, 2023).

When you are not eligible for benefits, you and your dependents may be able to pay for temporary health care coverage through a federal law known as COBRA. Contact the Trust Administrator for more information.

SPECIAL RULES FOR REINSTATEMENT OF ELIGIBILITY—ALLIED METAL CRAFTS RESIDENTIAL METAL WORKERS

For Allied Metal Crafts Residential Metal Workers who have a break in coverage, if your dollar bank falls below the threshold for eligibility for up to 12 consecutive months, you will be reinstated for eligibility when your dollar bank rises above the threshold for eligibility. Such reinstatement will become effective on the first day of the second calendar month following the month in which this requirement is met.

If your dollar bank is below the threshold for eligibility for more than 12 consecutive months, all accumulated dollars revert to the Trust, and you must complete the initial eligibility requirement for the Program to become eligible for coverage.

For example, if your coverage terminated August 31, 2023, with $450 accumulated, and then you work the hourly equivalent of $349 with a contributing employer in October 2023, your eligibility would be reinstated on December 1, 2023.

CONTINUITY OF CARE—CONSOLIDATED APPROPRIATION'S ACT

If you are already receiving treatment for a serious and complex condition, pregnant receiving inpatient care, terminally ill, or scheduled for non-elective surgery by an in-network provider, and your individual provider leaves the Plan network, the Plan will continue to cover and process your claims as though they are in-network claims for a period of ninety (90) days following the notice of removal of the provider from the Plan network.

RECIPROCITY

To enable Bargaining Unit Employees to maintain eligibility when they work outside the jurisdiction of the Plan, the Board has entered into reciprocal agreements with certain other health and welfare funds. Under these agreements, if you are temporarily working in the jurisdiction of another local union whose health and welfare fund ("Reciprocal Fund") is signatory to a reciprocal agreement with the Plan, contributions made on your behalf to the Reciprocal Fund can be transferred to the Plan to allow you to maintain your eligibility under the Plan. In such an instance, the Plan would be designated as your Home Fund.

If you are an employee from another local union temporarily working in the jurisdiction of the Plan, and your Home Fund is signatory to a reciprocal agreement with the Plan, you may have your health and welfare contributions sent to your Home Fund in order to maintain eligibility in your Home Fund. Reciprocity is not automatic. You must authorize the transfer to the Plan the health and welfare contributions made by an employer on your behalf. This authorization must be in writing on a form approved by the Board. These forms are available from the Trust Administrator. To find out which other funds are signatory to a reciprocal agreement with the Plan, contact the Trust Administrator.

If you wish to participate in reciprocity, you must designate as your Home Fund a fund with a reciprocal agreement with the Plan that fits one of the following definitions. If you are unable to satisfy the conditions stipulated in either of these two definitions, you will not be eligible to participate in reciprocity.

1. Your Home Fund will be the fund that covers the local union to which you belong, provided that you have been eligible for benefits in that fund for a continuous period of not less than one year prior to your written request to participate in reciprocity; or
2. Your Home Fund is the fund under which you are currently eligible for health and welfare benefits, provided you indicate your intention to return to work under the jurisdiction of the local union to which you belong, as soon as work is available there.

If you have already established eligibility in the Plan, you cannot designate another fund as your Home Fund. If you have any questions regarding reciprocity, contact the Trust Administrator.

If the Plan is your Home Fund and you are working outside the jurisdiction of the Plan, but in the jurisdiction of a Reciprocal Fund and for an employer required to make contributions on your behalf to the Reciprocal Fund, and you have executed the authorization to have contributions transferred to the Plan, but the hourly contribution rate in the Reciprocal Fund is less than the contribution rate then in effect for the Plan, you may be required, at the discretion of the Board of the Plan, to make payment of the difference in the hourly contribution rate (or equivalent) for each hour of covered work you perform. If you are required to pay this difference in contributions but fail to do so, you may lose eligibility in the Plan for yourself and your qualifying dependents.

WITHDRAWAL OR TERMINATION OF BARGAINING UNIT PARTICIPATION

Eligibility for covered benefits is available only to those employees who continue to work for an employer or employers who maintain a labor agreement that requires the payment of contributions to the Trust.

A participant's continuing eligibility under the hour bank eligibility system may be forfeited if:

- His or her employer no longer maintains a labor agreement requiring contributions to the Trust or
- His or her local union bargaining unit withdraws participation in the Trust.

Note that your employer's ability to contribute to the Trust is based on it having a current collective bargaining agreement, being current in contribution requirements, and being accepted as a contributing employer by the Board. The Board retains the right to revoke participation by any delinquent employer to ensure the integrity and financial stability of the Trust. In the event the Board revokes your employer's status, your eligibility may be subject to the below provisions for a "Nonparticipating Employer."

In the event a participant is working for an employer that is delinquent in remitting required contributions to the Trust, the Trust will permit establishment of continuing eligibility for a single, one-month period by submission of pay stub or other evidence demonstrating the employer's obligation to pay required contributions on the participant's behalf. However, this pay stub credit will not apply until the participant's hour or dollar bank has been depleted to the point where a participant will no longer be eligible for continuing coverage as an active participant. A participant may not receive pay stub eligibility more than once for work for any one contributing employer. Pay stub credit does not apply to participants covered under a flat rate or non-bargaining unit participation agreement.

WORKING FOR A NONCONTRIBUTING EMPLOYER

ELIGIBILITY FROZEN

Subject to the limited exception for pay stub eligibility above, a participant who is otherwise eligible for benefits but works in non-covered service (defined below) shall have his or her eligibility suspended subject to the following rules:

- An eligible participant who works in non-covered service shall have his or her eligibility for benefits suspended and frozen effective on the first day of the next eligibility month following notification or information to the Trust that a participant is employed in such non-covered service.
  - Such eligibility and any hour bank reserves shall remain frozen until the second calendar month after he or she returns to employment in work described by and covered by a collective bargaining agreement that requires contributions to the Trust.
  - To reinstate frozen eligibility and hour bank reserves, the participant is required to earn at least the amount of covered hours required by the Plan to maintain continuing eligibility.
- While a participant's eligibility and hour bank reserves are frozen, no benefits or claims are payable with respect to any expenses incurred by the participant or his or her dependents during the period coverage is frozen.
- Unless the participant reinstates participation as described above, the participant's hour bank shall remain frozen for a period of 12 consecutive months. At that time, the account and any hour reserves will be closed and the balance of the account shall be deemed waived and forfeited by the participant.
- Application of this rule shall have no effect upon a participant's or beneficiary's COBRA rights.
- "Non-covered service" is any work as described by and covered by a collective bargaining agreement to which the International Union of Painters and Allied Trades ("IUPAT") or its affiliated local unions are party within the geographic area covered by the Trust but for which no employer contributions are paid to the Trust.

DEPENDENT ELIGIBILITY

When you are eligible for the Plan benefits, your dependents are also eligible for coverage. The Plan covers the following dependents:

- Your lawful spouse (as defined by federal law; the Plan does not cover domestic partners);
- For retirees, your lawful spouse at the time of your retirement, to whom you have been married for 12 months or more;
- Your natural-born or legally adopted child to age 26;
- Your stepchild to age 26;
- A foster child to age 26;

- A child of guardianship as per a Family Court Order or Other Court Order; or
- Your mentally or physically disabled child, at least age 26, who is not capable of self-sustaining employment and is chiefly dependent on you for support (contact the Trust Administrator to obtain an application).

KEY POINT

Your dependents generally become eligible for benefits when you become eligible for benefits. To add a dependent, you must provide the Trust Administrator with a copy of required documents, such as certified birth certificate, Social Security card, certified marriage certificate, court-filed divorce decree, parenting plan, adoption paperwork, and any other legal documentation or evidence the Trust may reasonably require to ascertain or verify eligibility.

ADOPTED CHILD

A minor child, to age 26, placed for adoption with you will be covered from the first day the child is placed in your custody. The child's coverage will continue until the earlier of:

- The day the child is removed from your custody prior to legal adoption; or
- The day benefits would otherwise end in accordance with the Plan provisions.

FOSTER CHILD

A foster child is a child you are raising as your own, who lives in your home, is chiefly dependent on you for support, and for whom you have taken full parental responsibility and control.

A foster child is not a child temporarily living in your home, placed with you in your home by a social service agency which retains control of the child, or a child whose natural parent is in a position to exercise or share parental responsibility and control.

OTHER CHILD DEPENDENT COVERAGE

Other child dependent coverage shall include Family Court Orders of custody, other Court Orders of custody, support, or other guardianship where a participant or spouse have the responsibility or duty to provide such coverage.

DISABLED CHILD

The coverage for a mentally or physically disabled child who attains the limiting age while covered under the Plan may be continued if the child:

- Is chiefly dependent on you for support; and
- Is, by reason of physical impairment or developmental disability, not capable of self-sustaining employment.

The coverage will continue only if you provide proof of the child's disability and proof of financial support no later than 30 days after the child attains the limiting age and thereafter as the Trust requires, but not more often than once every two years.

DEPENDENTS NOT ELIGIBLE

The following are not eligible for dependent coverage:

- Your divorced or legally separated spouse;
- A child who has been legally adopted by another person (coverage ends on the date custody is assumed by the adoptive parents);
- A child who has attained the limiting age, which is the child's 26th birthday; and
- A former stepchild, which means your familial relationship to the stepchild has terminated through divorce from the stepchild's parent.

WHEN DEPENDENT COVERAGE BEGINS

Generally, dependent coverage will begin on the later of:

- The day you are covered; or
- The day you first acquire an eligible dependent.

Please note that you must submit all necessary documentation to add new dependents, such as copies of certified marriage certificates and birth certificates. Failure to supply this documentation within 30 days will delay the Plan's payment of claims for your dependent(s).

Once you have a dependent covered, any newly acquired eligible dependents will be covered automatically with the required documentation.

Any dependent added after the initial 30 days will begin coverage effective as of the first of the month following receipt of a completed enrollment form and all required documentation necessary to enroll the dependent on your coverage.

Newborn children are an exception. Your newborn child, born while you are covered under the Plan, will automatically be covered; but coverage beyond 60 days for a newborn child will be continued only if proper documentation has been provided to the Trust Administrator. If sufficient information is not timely submitted during this 60-day grace period, the Plan will suspend payment of claims until sufficient information is received. If sufficient information is not received more than 1 year after claims are initially presented (36 months in the case of Medicaid-related claims), claims will be administratively denied for lack of dependent eligibility.

WHEN DEPENDENT COVERAGE ENDS

A dependent's coverage will end at midnight on the earliest of:

- The last day of the Plan month in which the dependent is no longer eligible;
- The last day of the Plan month in which the dependent voluntarily disenrolls from coverage under the Plan;
- The day the Plan ends;

- The day before a dependent enters the Armed Forces on active duty (except for temporary active duty of two weeks or less); or
- The day your coverage ends.

Please note an enrolled dependent child cannot be removed from coverage under the Plan until the child reaches age 26 or until proof of other qualifying coverage is supplied to the Trust Administrators, or the dependent child voluntarily disenrolls from coverage under the Plan.

VOLUNTARY DISENROLLMENT OF DEPENDENTS

A dependent enrolled under the Plan may be removed from coverage under the Plan if a request is submitted to the Trust Administrators for approval in the following circumstances:

- In the case of a spouse, if the participant and his or her dependent spouse provide a notarized request for removal and the reason for the request.
- In the case of a child who has reached the age of majority in the child's state of residence, if the child provides a notarized request for removal.
- In the case of a child who has not reached the age of majority in the child's state of residence, you provide a written statement that you have determined that more favorable alternative coverage from another plan, group health insurance, or public program is available only if that child is not covered under the Plan.

The effective date is the first day of the month following the date that the request is approved by the Trust Administrator.

If a dependent is removed under this protection, he or she may only regain coverage under the applicable enrollment if requested by the participant within 60 days of the dependent losing other health insurance coverage. The participant must also provide written consent to reinstatement of coverage from the dependent and demonstrate eligibility of the spouse or child as an eligible dependent under the Plan.

You and your dependents should be advised that there may be adverse tax consequences under the Affordable Care Act if you and your dependents do not maintain qualifying minimum essential coverage. You should consult your tax professional or lawyer for appropriate advice before choosing to voluntarily disenroll from coverage under the Plan.

QUALIFIED MEDICAL CHILD SUPPORT ORDER

If your eligible child is not covered because you did not enroll your child for dependent coverage, such child may be enrolled after the Trust:

- Receives a final medical child support order which requires enrollment; and
- Determines that the order is qualified.

When the Trust receives a proposed or final medical child support order, it will notify you and each child named in the order, at the addresses shown in the order, that the order has been received. The Trust will then review the order to decide if it meets the definition of a Qualified Medical Child Support Order ("QMCSO").

- Within 30 days after the Trust receives the order (or within a reasonable time thereafter), the Trust will give a written notice of its decision to you and each child named in the order.
- The Trust will also send notices to each attorney or other representative who may be named in the order or in other correspondence filed with the Trust.
- If the Trust decides that the order is not qualified, the notice will provide the specific reasons for the decision and the opportunity to correct the order or appeal the decision by contacting the Trust within 30 days.
- If the Trust decides that the order is qualified, the notice will provide instructions for enrolling each child named in the order, and the Plan provisions that apply for other eligible dependents (such as the exceptions for when dependent coverage begins and the rules for determining when dependents coverage ends) will also apply for each child named in the order.

The Trust must receive a *certified* copy of the entire Qualified Medical Child Support ("QMCSO") Order before enrollment can occur.

As part of the Trust's authority to interpret the Plan, the Trust has the discretion and final authority to decide if an order meets or does not meet the definition of a Qualified Medical Child Support Order ("QMCSO") and requires the enrollment of your child as an eligible dependent. The Trust's reasonable decision will be binding and conclusive on all persons.

If, as a result of an order, benefits are paid to reimburse medical expenses paid by a child or the child's custodial parent or legal guardian, these benefits will be paid to the child or the child's custodial parent or legal guardian.

The Plan will treat each child enrolled because of a Qualified Medical Child Support Order ("QMCSO") as a participant for purposes of the reporting and disclosure requirements of a federal law known as Employee Retirement Income Security Act of 1974 ("ERISA"), as amended.

A Qualified Medical Child Support Order ("QMCSO") is defined by Section 609 of ERISA. In general, a Qualified Medical Child Support Order ("QMCSO") means any judgment, decree or order (including approval of a settlement agreement) issued by a court of competent jurisdiction, which:

- Relates to medical benefits under the Plan and provides for your child's support or health benefit coverage pursuant to a state domestic relations law (including a community property law) or enforces a law relating to medical child support described in Section 1908 of the Social Security Act;
- Creates or recognizes the existence of your child's right to be enrolled and receive medical benefits under the Plan;

- States the name and last known mailing address (if any) of you and each child covered by the order;
- Reasonably describes the type of medical insurance to be provided by the Plan to each child, or the manner in which this type of insurance is to be determined;
- States the period to which the order applies;
- States each Plan to which the order applies; and
- Does not require the Plan to provide any type or form of benefit or any option not otherwise provided by the Plan, except to the extent necessary to meet the requirements of Section 1908 of the Social Security Act for medical child support orders.

YOUR OBLIGATION TO NOTIFY THE PLAN OF CHANGES IN DEPENDENT STATUS

You must notify the Trust Administrator in writing if there is a change in the qualifying status of any of your dependents within 60 days of the date on which a change in status occurs. Certain events, called qualifying events, may trigger a change in eligibility status for your dependents. You must inform the Plan of the following qualifying events:

- Divorce or legal separation from your spouse. Include a complete copy of the divorce decree or legal separation order bearing the court's file stamp;
- A child loses dependent status, such as because the child entered active duty military service, divorce, or legal separation from the child's legal parent if you are not also the child's legal parent and the child does not otherwise remain eligible for coverage as set forth above, adoption of your child by another person, or termination of your parental rights.
- A change in Court Order or obligation to provide coverage.

Failure to keep the Plan informed of the status of your dependents is a violation of the Plan's rules, may constitute health care or insurance fraud, and may lead to legal action to recover any wrongfully paid benefits on the part of your ineligible dependents because of your failure to timely notify the Plan.

The Plan may, from time to time, conduct dependent verification audits to ensure your enrolled dependents qualify for coverage under the Plan. You must cooperate with the Plan's efforts to ensure your dependents are qualified for coverage under the Plan. Your failure to do so may result in dependents being dropped from coverage until sufficient verifying information is supplied so the Plan may ensure your dependents are qualified for continued coverage.

TAKE ACTION

You must notify the Trust Administrator in writing within 60 days of any change in the status of any of your dependents that affects the dependent's eligibility for benefits.

RETIREE BENEFIT PROGRAM

RETIREE BENEFIT PROGRAM ELIGIBILITY

Please note that this medical coverage is not free, and Retiree Participants will be required to contribute toward the cost of Retiree Participant's continuing coverage. For information on the current Retiree Participant rates, please contact the Trust Administrator. Also, this medical coverage is not guaranteed for life and may be discontinued. Additionally, special coverage rules may apply for certain merged plans, described later in this section. Consult with the Trust Administrator and/or your Pension Administrator regarding eligibility requirements.

Upon retirement, ALL Retiree Participants MUST:

a) Participate, defer participation, or decline to participate in the Retiree Benefit Program;

b) Notify the Trust Administrator of the selection made above within 60 days of either the Retiree Participant's retirement date or the date the Retiree Participant's hour bank runs out- whichever is later;

c) If the Retiree Participant wishes to defer the start date (e.g., due to other active coverage by Eligible Retiree Participant's spouse insurance or through COBRA after the Eligible Retiree Participant's hour bank is depleted) the Retiree Participant **must notify the Trust Administrator at the time of applying for the Retiree Benefit Program**; and/or

d) Contribute toward the cost of the Retiree Benefit Program –including for all Eligible Dependents;

TAKE ACTION

Retirees must decide upon retirement whether to participate in the Retiree Medical Program and must apply for coverage within 60 days of retirement or when their hour bank runs out, whichever comes later.

The following types of retirees may be eligible for the Retiree Benefit Program: Normal Early Retirees, Disabled Non-Bargaining Participant and/or Union-Affiliated Employee.

Medicare-Eligible Retirees—Must meet ALL of the following requirements:

- Qualify for the Retiree Benefit Program, through a Pension Trust sponsored by the IUPAT, a Local Union, or District Council—which is located in a region covered by the Trust; **and**
- Elect to participate in the Retiree Benefit Program; **and**
- Possess a minimum of 9,000 Covered Hours under the Trust or/or the IUPAT Health and Welfare Trust; **and**
- Have acquired a minimum of 3,000 hours in the last five years under the Trust.

Non-Medicare-Eligible Retiree—Must meet ALL of the following requirements:

- Be at least 55 years of age;
- Qualify for the Retiree Benefit Program, through a Pension Trust sponsored by the IUPAT, a Local Union, or District Council—which is located in a region covered by the Trust **OR** Possess a minimum of 15,000 Covered Hours under the Trust or the IUPAT Health and Welfare Trust; **and**
- Elect to participate in the Retiree Benefit Program; **and**
- Possess a minimum of 15,000 Covered Hours under the Trust; **and**
- Have acquired a minimum of 6,000 hours in the last five years under the Trust.

Disability Retiree—Must meet ALL of the following requirements:

- Qualify for the Retiree Benefit Program, through a Pension Trust sponsored by the IUPAT, a Local Union, or District Council, in a region covered by the Trust; **and**
- Elect to participate in the Retiree Benefit Program; **and**
- Possess a minimum of 10,000 Covered Hours under the Trust; **and**
- Have been awarded Social Security Disability Benefits ("SSDB").

Non-bargaining Participant—Must meet ALL of the following requirements:

- Worked for an employer participating in the Trust for a continuous 10-year period, **and**
- Been covered by the Trust for 5 years immediately before retiring.

Union-affiliated Employees who worked for any District Council or Local Union—Must meet ALL of the following requirements:

- Been an employee of any District Council or Local Union participating in the Trust, **and**
- Been covered by the Trust in the 5 years immediately before retiring.

Union-affiliated Employees who worked for the IUPAT or a direct affiliate—Must meet ALL of the following requirements:

- Been an employee of any District Council or Local Union participating in the Trust, **and**
- Been covered by the Trust in the 5 years immediately before retiring.

Deferred Enrollment. If the Employee Retiree Participant timely meets all of the requirements below, the Employee Retiree Participant may be eligible to defer formal enrollment in the Retiree Benefit Program. Note, enrollment may only be deferred once. The Employee

Retiree Participant may opt to defer enrollment, that is start paying for monthly medical coverage at a later date, only **IF**:

- The Employee Retiree Participant notifies the Trust Administrator of retirement within 60 days of your retirement date; **and**
- The Employee Retiree Participant, or the Employee Retiree Participant's spouse, maintains, or is otherwise covered by, another group health plan under which the Employee Retiree Participant is entitled to participate as an active or dependent participant; **and**
- The Employee Retiree Participant is continuously covered by that other health plan—without any break in monthly coverage; **and**
- The Employee Retiree Participant provides written notice to the Trust Administrator within 30 days of termination of coverage in the other health plan, of the Employee Retiree Participant's intention to enroll in the Retiree Benefit Program; **and**
- Upon such written notice, the Employee Retiree Participant must enroll in the Trust's Retiree Benefit Program; **and**
- If requested, the Employee Retiree Participant must provide the Trust Administrator a Certificate of Creditable Coverage from the other medical plan.

If Employee Retiree Participant dies after the date you defer enrollment but before the date enrollment in the Retiree Benefit Program becomes effective, the Employee Retiree Participant's dependent(s) may elect to enroll in the Retiree Benefit Program—provided all other requirements for coverage are met.

Coverage Availability for Dependents. The Retiree Benefit Program is maintained and administered as a medical plan provided to Employee Retirees formerly covered as Employee Participants (or certain other Eligible Participants) covered by the Trust. The Retiree Benefit Program is subject to the rules of the federal health care legislation known as the Patient Protection and Affordable Care Act, as amended (referred to as PPACA), including the rules covering dependent coverage. The Employee Retiree enrollment and payment of required contributions entitles the Employee Retiree to enroll Non-spouse Dependents until the Non-spouse Dependents reach the age of 26, unless the Dependent(s) otherwise remain qualified for coverage. Additional eligibility requirements are discussed below.

Other than for qualifying retirees, as defined above, coverage under the Retiree Medical Program is available for:

- Your legal spouse at the time of your retirement to whom you have been married for at least 12 months prior to the date of your retirement. Coverage is not available for your spouse to whom you have been married within 12 months prior to the time of your retirement or after the time of your retirement.
- Your natural born child, legally adopted child, stepchild, or foster child, any of whom you have at the time of your retirement and who were eligible for benefits at the time of your retirement.
- A child placed with you for the purpose of legal adoption will be covered from the date of placement, provided you have assumed financial responsibility for the medical expenses of the child.
- In accordance with federal law, coverage under the Retiree Medical Program is available to certain dependent children (called alternate recipients) if directed to do so by a Qualified Medical Child Support Order (QMCSO). Contact the Trust Administrator for details.
- Except for a newborn child born to you and your qualifying spouse, another child otherwise described above who joins your family after the time of your retirement is not eligible for coverage.
- Coverage for a dependent child continues until the child reaches age 26, unless the child otherwise remains eligible as a qualifying dependent (e.g., adult disabled child chiefly dependent on you for support).

Your Cost. Both you and your spouse are required to contribute to participate in the Retiree Benefit Program. Your contributions are periodically determined and adjusted by the Board after study of applicable costs of medical coverage. The Trust does not guarantee that the Retiree Medical Program will continue for your lifetime or indefinitely, and the Board may discontinue, suspend, or otherwise terminate the Retiree Medical Program at any time. Contribution amounts are also dependent upon your age and your enrollment in Medicare. You must cooperate with the Trust Administrator in submission of all documentation concerning your Medicare enrollment.

Contributions are generally payable on or before the 15th day of the month prior to the month for which medical coverage is being provided. For example, your payment for October medical coverage is due and must be received by the Trust no later than September 15. Payments must be made in consecutive months in order to maintain eligibility. The Trust may permit a short grace period extending through the last day of the month prior to the month for which payment is required, but there is no reinstatement of coverage following any termination of coverage for non-payment or late payment. If you do NOT make payment until the month of coverage, you may have issues with obtaining services with the Plan's vendors (prescriptions, vision, dental, etc.).

Enrollment in Medicare Required. You and your spouse or other eligible dependents are required to enroll in Medicare Parts A and B as soon as you are eligible—generally three months before your 65th birthday, or in certain cases earlier (i.e., in the event of End-Stage Renal Disease or qualifying disability)—in order to avoid a gap in coverage. If you leave employment and have not applied for Medicare Part B within three months from the date you turn 65, it may cost you more to enroll in Part B coverage.

Your retiree coverage under the Plan is designed to supplement the coverage you get through Medicare once you or your eligible dependents first become eligible to enroll in Medicare. Accordingly, your monthly costs for Retiree coverage will be reduced when you first become eligible to enroll in Medicare.

Other Rules of Administration. In addition to the above retiree eligibility requirements stated on page 16, the following additional procedures and rules apply:

- Any hour bank balance accrued from active employment will be utilized before the retiree benefits become effective. You must maintain your own records of hour bank coverage available to you. Also, you may exhaust any COBRA benefits available to you before you begin coverage under the Retiree Benefit Program, if you choose.
- The formal written application for retiree benefits (including Dental and Vision option) must be made within 60 days from the date of your retirement or within 60 days of the date your hour bank is exhausted, whichever comes later.
- All Non-Medicare-eligible retirees shall have a second opportunity to apply for dental and vision benefits when they become eligible for Medicare, and must apply for it within 60 days of becoming eligible for Medicare.
- You must contact the Trust Administrator to confirm hour bank eligibility, if any, and to obtain a formal application for retiree benefits with all pertinent information. You may also request a copy of the full retiree eligibility policy.
- Coverage for you will terminate the first of the month for which any premium payment is due and unpaid.

Retiree Eligibility Rules for Merged Plans. Retirees who were covered under the Glaziers, Architectural Metal and Glass Workers Local Union No. 740 Welfare Fund or the Allied Metal Crafts Health and Security Trust Fund (Local Union Nos. 55, 66, 1094) may be subject to different eligibility requirements than those listed above, under the merger agreements merging those funds into the Trust. Please contact the Trust Administrator for more information. Summary eligibility rules are stated below.

- Glaziers, Architectural Metal and Glass Workers Local Union No. 740 Welfare Fund
  - Until January 1, 2019, an eligible employee under the Local 740 Fund may qualify for retiree coverage under the Plan under either the rules of the Local 740 Fund in effect on January 1, 2016, or under the rules of the Plan in effect on January 1, 2016. From January 1, 2019, an eligible employee under the Local 740 Fund must satisfy the requirements of the Plan to obtain retiree coverage.
  - To the extent receipt of pension benefits is required to qualify for retiree coverage, pension benefits from the Western Glaziers Retirement Fund satisfies this requirement.
  - To the extent a certain number of creditable hours of covered work is required to qualify for retiree coverage, hours credited either to the Local 740 Fund or to the Trust qualify and will be credited toward the hour requirement.
- Allied Metal Crafts Health and Security Trust Fund (Local Union Nos. 55, 66, 1094)
  - To the extent receipt of pension benefits is required to qualify for retiree coverage, pension benefits from the Allied Metal Crafts Plan satisfies this requirement.
  - To the extent a certain number of creditable hours of covered work is required to qualify for retiree coverage, hours credited either to the Allied Metal Crafts Security Plan or to the Trust qualify and will be credited toward the hour requirement.

Medicare-eligible Retiree Participants. Medicare-eligible Retiree Participants (including Medicare-eligible spouses) are covered under a fully insured group health plan offered by the Trust for both medical and prescription drug benefits. The Trust is participating in an arrangement with a "Passive PPO" plan—not a traditional HMO plan. Medicare-eligible Retiree Participants may see any provider who both accepts Medicare and is willing to bill the participating provider to receive the preferred benefits; no referral is needed. Contact the Trust Administrator for more information. The benefits provided under the participating provider plan differ from the benefits listed in this document, which are now applicable only to the Trust's non-Medicare-eligible retirees and their qualified dependents.

CONTINUATION COVERAGE

EXTENSION OF BENEFITS DURING TOTAL DISABILITY

If you are totally disabled by an occupational or non-occupational injury or illness on or before the date your eligibility ends, the Plan allows an extension of benefits for covered services as if eligibility had not ended. The Plan will cover up to a maximum of three consecutive months of extended health and welfare benefits, from the date of total disability, until the earlier of:

- The date you or your dependent becomes covered under another group health care plan;
- The three-month extension of benefits period expires;
- Your hour or dollar bank is exhausted after expiration of the three-month extension of benefits period; or
- The date the total disability ends.

Benefits payable are those in effect on the date eligibility ended. Eligibility for extension of benefits coverage during total disability is subject to independent review by the Plan. Coverage will be extended, contingent on establishment of eligibility through independent review, for up to four weeks on the basis of a qualification for coverage letter from your physician or other qualified medical provider.

This three-month extension of benefits coverage period described above does not run concurrently with continuation coverage time periods available to you under COBRA, should you later elect COBRA coverage (see COBRA section below). This three-month extension of benefits coverage period is a lifetime maximum for the covered person.

Under this extension of benefits provision, the Trust extends coverage on your behalf up to three months over your lifetime. If you remain totally disabled after the three-month extension of benefits period expires and your hour or dollar bank is exhausted, premiums for COBRA coverage must be paid by you or your dependent in order to continue coverage under COBRA.

You must make the election for the COBRA coverage when your active eligibility ends (i.e., the three-month extension of benefits has expired and your hour or dollar bank has been exhausted) in order to utilize the COBRA coverage provision. If you do not elect COBRA, COBRA continuation coverage will not be available and coverage will only be available under the extension of benefits. In order to elect COBRA, you must do so at the time your active coverage expires. You will not be able to later elect COBRA coverage.

CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT (COBRA) CONTINUATION OF COVERAGE

If you lose coverage because of a loss of eligibility, you may be able to continue your coverage. Under the circumstances described below, you, your lawful spouse, and eligible dependents each have the independent right to elect to continue your health coverage beyond the time that coverage would ordinarily have ended, under a federal law known as COBRA.

! KEY POINT

COBRA provides certain former employees, retirees, spouses, former spouses, and dependent children the right to temporary continuation of health coverage at group rates, when coverage is lost due to certain specific events. COBRA participants generally pay the entire premium themselves.

QUALIFYING EVENTS

You (as the participating employee) have the right to elect continuation of your health coverage under the Plan if you would otherwise lose eligibility because of a reduction in hours of employment or termination of employment (other than due to gross misconduct).

Your spouse has the right to choose continuation of coverage if he or she would otherwise lose eligibility for any of the following reasons:

- The participating employee's termination of employment or reduction in hours of employment (other than due to gross misconduct);
- Death of the participating employee;
- Divorce or legal separation from the participating employee; or
- The participating employee becoming entitled to Medicare.

A dependent child has the right to elect continuation of coverage if eligibility would otherwise be lost for any of the following reasons:

- The participating employee's termination of employment or reduction in hours of employment; (other than due to gross misconduct);
- Death of the participating employee;
- Divorce or legal separation between the participating employee and the child's legal parent;
- The participating employee becoming entitled to Medicare; or
- The child no longer qualifying as an eligible dependent under the Plan.

YOUR COBRA NOTIFICATION RESPONSIBILITIES

The Trust offers continuation coverage under the Plan only after it has been notified of a qualifying event. You or your eligible dependents have the responsibility to inform the Trust Administrator of a loss of coverage resulting from a divorce or legal separation or from a child losing dependent status.

If you or your eligible dependents have a loss of coverage because of these events, you must notify the Trust Administrator in writing within *60 days* from the latest of:

- The date of the qualifying event;
- The date on which there is a loss of coverage; or

- The date on which the qualified beneficiary is informed of his or her obligation to provide notice and the procedures for providing such notice.

The notice must identify the individual who has experienced the qualifying event, the eligible employee's name, and the qualifying event that occurred. Failure to provide timely notice will result in your coverage ending as it normally would under the terms of the Plan and forfeiture of any COBRA rights that may have otherwise applied.

If your dependent spouse is being voluntarily disenrolled from Plan coverage under the Plan's voluntary disenrollment provisions in anticipation of divorce, you and your dependent spouse must notify the Trust Administrators when your divorce has become final.

Your employer is responsible for informing the Trust if your employment is terminated. The Trust Administrator will determine when the employee's hour or dollar bank falls below the required number of hours. The Board though, reserves the right to determine whether coverage has in fact been lost due to a qualifying event.

TAKE ACTION

You or your eligible dependents have the responsibility to inform the Trust Administrator of a loss of coverage resulting from a divorce or legal separation or from a child losing dependent status.

REQUESTING CONTINUATION COVERAGE

Once the Trust Administrator has received proper notice that a qualifying event has occurred, it will notify you and each of your eligible family members of your rights to elect continuation coverage.

A written request for continuation coverage must be made in writing within *60 days* from the date coverage would otherwise end or *60 days* from the date the notification is received from the Plan, if later.

A request for continuation coverage under the Plan by one family member covers all other eligible members of the same family, provided that such family members are specifically listed on the election form as completed by you or the Trust Administrator. Each person eligible for continuation coverage may separately elect coverage; that is, if one eligible person elects coverage, all other eligible persons do not have to elect coverage.

Submit your request to the Trust Administrator. Failure to request continuation coverage within this *60-day* period will cause eligibility to end as it normally would under the terms of the Plan.

TAKE ACTION

A written election must be made in writing within *60 days* from the date coverage would otherwise end or *60 days* from the date the notification is received from the Trust Administrator, if later.

AVAILABLE COVERAGE

The continuation coverage offered is the same as the coverage provided to the employees of your current employer and an employee's eligible dependents.

ADDING NEW DEPENDENTS

Continuation coverage is only available to individuals who were covered under the Plan at the time of the qualifying event.

If you continue coverage, you may add any new eligible dependents you acquire in keeping with the dependent eligibility provisions of the Plan. To add a new dependent, you must provide written notice to the Trust Administrator within 30 days of acquiring the new dependent.

The written notice must identify the employee, the new dependent, and the date the new dependent was acquired. Mail your notice to the Trust Administrator.

Only newborn dependents are entitled to extend their continuation coverage if a second qualifying event occurs (as discussed below).

CONTINUOUS COVERAGE REQUIRED

Your COBRA continuation coverage must be continuous from the date your coverage under the Plan would have otherwise ended, if you did not choose continuation coverage.

If you initially reject COBRA continuation coverage *before* the end of your 60-day election period, you may change your mind and request COBRA continuation coverage, provided that you submit a completed Election Form by the end of your original 60-day election period.

However, your COBRA continuation coverage will begin on the date you submit the completed Election Form to the Trust Administrator and not on the date of the qualifying event.

COST

A qualified individual must pay the entire cost of the continuation coverage. The Trust uses a composite rate, which means that you pay the same monthly rate if you are covering one person or an entire family.

The cost for the coverage available through the Trust is set annually. If you have a qualifying event, you will be notified of the applicable monthly self-payment premium for the coverage options available to you.

If you are eligible for an extension of coverage as a result of you or a dependent being disabled, the cost of the coverage will be 150 percent of the COBRA self-payment rate for the additional 11 months of coverage provided as a result of your disability.

KEY POINT

If you have a qualifying event, you will be notified of the applicable monthly self-payment premium for the coverage options available to you.

MONTHLY SELF-PAYMENTS REQUIRED

COBRA self-payments are due on the first of each month for that month's coverage. Mail your payment to the Trust Administrator.

The Trust Administrator will terminate coverage if payment is not received within 30 days of the due date. A check that is received and does not clear the bank due to nonsufficient funds is considered a non-payment.

The only exception is that the self-payment for the period preceding the initial election of coverage may be made up to 45 days after the date of election. You lose your right to continuation coverage if your initial payment is not received or bearing a Post Office postmark within 45 days of when you elected continuation coverage. For a person who qualifies for extension of benefits coverage because of total disability, the 45-day grace period applies to the first Participant-funded payment that becomes due after extension of benefits coverage expires.

LENGTH OF CONTINUATION COVERAGE

Continuation of coverage may last for up to 18 months following loss of coverage as a result of a termination of employment or reduction in hours.

For dependent qualifying events (death of employee, divorce or legal separation from employee, employee becoming Medicare entitled, or a child no longer qualifying as a dependent under the Plan) continuation of coverage may last for up to 36 months following the initial 18-month qualifying event date.

However, continuation coverage will end on the last day of the monthly premium payment period if any one of the following occurs before the maximum available continuation period:

- A required self-payment is not paid to the Trust Administrator on a timely basis for the next monthly coverage period;
- You or your eligible dependent become covered under any other group health plan after the date of your COBRA election;
- You or your eligible dependent provide written notice that you wish to terminate your coverage;
- You or your eligible dependent become entitled to Medicare benefits after the date of your COBRA election;
- The date upon which the employer or employee organization ceases to provide any group health plan (including successor plans) to any employee;
- The day the covered person again becomes eligible to be covered under the Plan; or
- The last day of your maximum COBRA coverage period ends (18, 29, or 36 months, as applicable)

LENGTH OF CONTINUATION COVERAGE—DISABLED PARTICIPANTS

If you, your spouse, or any dependent covered under the Plan is determined by the Social Security Administration to be disabled within the first 60 days of continuation coverage, the individuals who have previously elected to receive COBRA coverage can receive an additional 11 months of continuation coverage for up to a maximum of 29 months.

To obtain the additional months of coverage, you must notify the Trust Administrator in writing within 60 days of receipt of your Social Security Disability Determination and prior to the end of your initial 18-month period of continuation coverage.

If the disabled individual is subsequently found to not be disabled, you must notify the Trust Administrator in writing within 30 days of this determination.

LENGTH OF CONTINUATION COVERAGE—SECOND QUALIFYING EVENT

Eligible dependents who are entitled to continuation coverage as the result of the employee's termination of employment or reduction of hours can extend their coverage up to a total of 36 months if a second qualifying event occurs during the initial 18 months of continuation coverage.

Possible second qualifying events are the employee's death, a divorce or legal separation from the employee, a child losing dependent status, or the employee becoming entitled for Medicare during the initial 18 months of continuation coverage.

If an eligible dependent wants extended coverage as a result of a second qualifying event, he or she must notify the Trust Administrator in writing within 60 days of the second qualifying event. Failure to provide timely written notice of a second qualifying event will cause the individual's coverage to end as it normally would under the terms of the Plan. In no event will continuation of coverage extend beyond a total of 36 months.

! KEY POINT

In no event will continuation of coverage extend beyond a total of 36 months.

RELATIONSHIP BETWEEN COBRA AND MEDICARE OR OTHER HEALTH COVERAGE

An individual's COBRA continuation coverage will terminate if he or she becomes entitled to Medicare or other group health coverage. However, if an individual is entitled to Medicare or other group coverage at the time he or she elected COBRA, the individual can be eligible for both types of coverage.

If you have COBRA coverage and you are entitled to Medicare based on age or disability and no longer have current employment status, Medicare will pay first and the Plan will only pay secondary and coordinate with Medicare. Current employment status means you are

still at work or have received short-term disability benefits for less than six months.

If you have Medicare coverage based on end-stage renal disease and have the Plan coverage (COBRA or otherwise), the Trust will pay primary during the 30-month coordination period, provided for by statute. If you have other group health coverage, it will pay primary and the Trust's continuation coverage will be secondary.

EFFECT OF NOT ELECTING CONTINUATION COVERAGE

In considering whether to enroll in COBRA continuation coverage, please be aware that a failure to continue your group health coverage can affect your rights under federal law:

- You should be aware that federal law gives you special enrollment rights. You may have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a spouse's plan) within 30 days after your group health coverage from the Trust ends because of your qualifying event.

You may also have the same special 30-day enrollment right at the end of the maximum continuation coverage period available to you. In order to protect your family's rights, you should keep the Trust Administrator informed of any changes in the address of dependents. You should also keep a copy, for your records, of any notices you send to the Trust Administrator.

! KEY POINT

In considering whether to elect continuation coverage, please be aware that a failure to continue your group health coverage can affect your rights under federal law.

ADDITIONAL INFORMATION

For more information about your rights under ERISA (including COBRA) and other laws affecting group health plans, contact the U.S. Department of Labor's Employee Benefits Security Administration or visit their website at www.dol.gov/ebsa.

SUMMARY OF HEALTH CARE BENEFITS

The tables beginning on page 24 provide a brief overview of the Medical, Prescription Drug, Dental, and Vision Plan benefits.

Keep in mind that Medical Plan payment is based on the allowable expense, which is the Preferred Provider's discounted amount or the Usual, Customary and Reasonable (UCR) rate for Non-Preferred Providers (not the billed amount).

Note: All covered benefits are subject to this "Usual, Customary and Reasonable" clause, except when performed by PPO Providers or as provided by the Outpatient Dialysis provision.

You must satisfy the annual deductible, if required, before the Plan pays benefits.

Note that the Retiree benefits listed below apply only to non-Medicare-eligible retirees and their qualified dependents (including Medicare-eligible spouses); Medicare-eligible retirees are covered under a separate fully insured plan issued by Humana.

PAID MATERNITY LEAVE PROGRAM

The Plan provides eligible Participants with a Paid Maternity Leave benefit. To be eligible for this Benefit Program the following criteria must be met:

- A certification must be submitted by a medical doctor verifying that the Participant is unable to perform the duties of her trade due to physical limitations arising from the pregnancy (for pre-delivery Benefits only);
- At the time the application is made under this Benefit Program the Participant is eligible for coverage under the Plan; and
- The Participant has not used this Benefit within the past twenty-four (24) months.

The Benefit Program is not available to:

- Canadian residents
- Members who are not an active Participant for Plan benefits
- Surrogate-related pregnancies
- Adoption of a child
- Foster care situations
- Dependents of the Participant

AVAILABLE BENEFITS

The Benefit Program provides benefits for pregnancy (pre-delivery/birth) for a maximum of six (6) months and post-delivery/birth for a maximum benefit of six (6) weeks or eight (8) weeks for cesarean birth.

- Pregnancy (pre-delivery/birth) Six (6) month maximum benefit for Paid Maternity

  The Participant must meet the eligibility criteria, but eligibility for this Benefit shall not begin until the onset of the fourth month of pregnancy. This cumulative pre-delivery/birth benefit may be intermittent and may not exceed six (6) months. After six (6) months the Benefits will stop regardless of whether the Participant is able to return to work or not. From time to time, the Plan may require re-certification of continued inability to work by the Participant's medical doctor during pregnancy.

- Post-Delivery/Birth six (6) weeks maximum benefit or eight (8) weeks maximum benefit for cesarean birth.

  Regardless of what was covered under the pre-delivery Benefits, a Participant will be eligible for up to six (6) weeks of paid leave after childbirth with two (2) additional weeks of paid leave Benefits available for cesarean deliveries.

Under this Benefit Program, Benefits are paid weekly and are equal to 66.67% of the Participant's normal weekly earnings to a maximum weekly Benefit of $800. Weekly earnings shall be determined to be the normal hourly wage based on a forty (40) hour work week. Benefit payments under this Benefit Program shall not be considered "other income" for purposes of determining the Participant's eligibility for other Plan benefits.

OTHER BENEFITS AND LIMITATIONS

This Benefit offered through the Plan is in addition to other Plan benefits. However, eligibility and receipt of this Benefit may affect your ability to receive other additional benefits from other sources not related to the Plan.

BENEFITS OVERVIEW TABLES

SUMMARY OF HEALTH CARE BENEFITS OVERVIEW	Standard Benefits	Materials Handlers Benefits	Basic Benefits (Previously Western Washington Residential Painting and Utah Drywall)
Deductible The amount of covered services you pay each calendar year before the Plan pays benefits Note: deductible met in last 3 months of calendar year will carry over to new year.	$300/person $900/family $300/Retiree	$300/person $900/family	$750/person $2,250/family
Medical Out-of-Pocket Limit The maximum you pay in coinsurance each calendar year, after which the Plan pays 100% for most covered services, (exclusive of copays and deductibles)	**$1,000/person $7,300/family Retirees: $2,000/person $7,300/family**	**$3,000/person $7,300/family**	**$3,000/person $5,950/family**
RX Out-of-Pocket Maximum The most you'll pay in copays each calendar year	Standard Benefits: $5,000/person; Material Handlers Benefits: $3,300/person; Basic Benefits: $2,850/person; Retirees: $4,300 Standard, Material Handlers, Basic, and Retirees: $5,000/family		
Combined Out-of-Pocket Limit for Medical and Prescription Plans The maximum you pay each calendar year, after which the Plan pays 100% for most covered services (inclusive of coinsurance, copays, and deductibles)	Standard Benefits: $6,300/person Material Handlers, Basic, and Retirees: $6,600/person Standard, Material Handlers, Basic, and Retirees: $13,200/family		
Annual Maximum The most the Plan will pay for any covered person	**Unlimited**	**Unlimited**	**Unlimited**

		Materials Handlers Benefits		Basic Benefits (Previously Western Washington Residential Painting and Utah Drywall)	
MEDICAL PLAN	**Standard PPO Provider Benefits**	**PPO Providers**	**Non-PPO Providers**	**PPO Providers**	**Non-PPO Providers**
Physician Services Office visits, hospital care, surgery	Plan pays 80%	Plan pays 80%	Plan pays 60%	Plan pays 70%	Plan pays 50%
Preventive Care Routine physical exams, lab and X-ray services; smoking cessation treatment; routine immunizations (according to the CDC); well child care; annual pap test, physician charges, routine mammograms, prostate exams, and any others as required by law	Plan pays 100% (deductible waived)				
Telehealth/Telemedicine Allows for coverage for telephone, internet, or other virtual care consultations where a patient is not physically seen by their physician or other covered visits. Must be for diagnosis and treatment focused via a live, simultaneous telephonic or video exchange with direct participation by the patient and the provider throughout the visit. Missed appointment charges are not covered and are excluded from Plan coverage.					
Hospital Services					
Room and Board Payment based on semiprivate room rate	Plan pays 80%	Plan pays 80%	Plan pays 60%	Plan pays 70%	Plan pays 50%
Intensive Care Unit Payment based on the hospital's ICU charge	Plan pays 80%	Plan pays 80%	Plan pays 60%	Plan pays 70%	Plan pays 50%
Outpatient Services	Plan pays 80%	Plan pays 80%	Plan pays 60%	Plan pays 70%	Plan pays 50%
Emergency Room	Plan pays 80%	Plan pays 80%	Plan pays 60%	Plan pays 70%	Plan pays 50%
Other Services					
Ambulance[1] For emergency transportation to the *nearest* hospital equipped to furnish the services Commercial airline transportation may be covered if medically necessary	Plan pays 80%	Plan pays 80%	Plan pays 60%	Plan pays 70%	Plan pays 50%
Hearing Aids (excluded for retirees) Up to $500/ear every 36 months (does not include battery or other ancillary equipment replacement)	Plan pays 80%	Plan pays 80%	Plan pays 60%	Plan pays 70%	Plan pays 50%
Alternate Providers Acupuncture, Massage Therapy and Naturopathic Care: Up to 24 visits per year for each service	Plan pays 80%	Plan pays 80%	Plan pays 60%	Plan pays 70%	Plan pays 50%
Physical Therapy/Occupational Therapy Up to 60 visits per year	Plan pays 80%	Plan pays 80%	Plan pays 60%	Plan pays 70%	Plan pays 50%

[1]Air Ambulance Services—These services shall be paid as though provided by a Network Provider without balance billing and will count towards deductibles and out of pocket maximums.

		Materials Handlers Benefits		Basic Benefits (Previously Western Washington Residential Painting and Utah Drywall)	
MEDICAL PLAN	**Standard PPO Provider Benefits**	**PPO Providers**	**Non-PPO Providers**	**PPO Providers**	**Non-PPO Providers**
Home Health Care Up to 130 visits per calendar year	Plan pays 80%	Plan pays 80%	Plan pays 60%	Plan pays 70%	Plan pays 50%
Speech Therapy Up to 60 visits per year (must be for restoration of lost speech due to diagnosed injury or illness)	Plan pays 80%	Plan pays 80%	Plan pays 60%	Plan pays 70%	Plan pays 50%
Orthotics Up to $500 per cause	Plan pays 80%	Plan pays 80%	Plan pays 60%	Plan pays 70%	Plan pays 50%
Spinal Manipulations/ Chiropractic Services 24 visits per calendar year	Plan pays 80%	Plan pays 80%	Plan pays 60%	Plan pays 70%	Plan pays 50%
Neurological Initial psychological tests and evaluations	Plan pays 80%	Plan pays 80%	Plan pays 60%	Plan pays 70%	Plan pays 50%
Hospice Care Up to 180 days of inpatient and outpatient services in any covered person's lifetime	Plan pays 100%				
Neurodevelopmental Disorders	Plan pays 80%	Plan pays 80%	Plan pays 60%	Plan pays 70%	Plan pays 50%
Temporomandibular Joint Disorder (TMJ) $5,000 lifetime maximum, regular Plan benefits for jaw surgery if treatment started within 12 months from date of injury Note: TMJ charges will not be counted in accumulating covered charges toward the 100% payment percentage of other charges, nor will these charges be subject to the 100% payment	Plan pays 80%	Plan pays 80%	Plan pays 60%	Plan pays 70%	Plan pays 50%
Pregnancy Employee and spouse only	Plan pays 80%	Plan pays 80%	Plan pays 60%	Plan pays 70%	Plan pays 50%
Organ Transplant and Donor Benefits $350,000 lifetime maximum with $75,000 donor benefits all inclusive	Plan pays 80%	Plan pays 80%	Plan pays 60%	Plan pays 70%	Plan pays 50%
Dialysis Treatment—Outpatient	Plan pays 100% of the Usual and Reasonable Charge after all applicable deductibles and coinsurance. Please refer to Dialysis Treatment—Outpatient description under the Medical Plan, Medical Plan Covered Services				

		Materials Handlers Benefits		Basic Benefits (Previously Western Washington Residential Painting and Utah Drywall)	
MEDICAL PLAN	**Standard PPO Provider Benefits**	**PPO Providers**	**Non-PPO Providers**	**PPO Providers**	**Non-PPO Providers**
Mental Disorders					
Inpatient	Plan pays 80%	Plan pays 80%	Plan pays 60%	Plan pays 70%	Plan pays 50%
Outpatient	Plan pays 80%	Plan pays 80%	Plan pays 60%	Plan pays 70%	Plan pays 50%
Other Behavioral Services					
Substance Abuse/Chemical Dependency (inpatient and outpatient)	Plan pays 80%	Plan pays 80%	Plan pays 60%	Plan pays 70%	Plan pays 50%

PRESCRIPTION DRUG PLAN	**Retail and Specialty Pharmacy**	**Mail-Order Pharmacy**
Out-of-Pocket Maximum The most you'll pay in copays each year	Standard Benefits: $5,000/person Material Handlers Benefits: $3,300/person Basic Benefits: $2,850/person Retirees: $4,300 Standard, Material Handlers, Basic, and Retirees: $5,000/family	
Supply Limit* The maximum supply per refill	30 days**	90 days
Generic Prescriptions	Greater of $5 or 15% copay up to $50, per month	Greater of $12.50 or 15% copay up to $125, per month
Preferred Generic Prescriptions	$0	$0
Formulary Brand Name Prescriptions	Greater of $20 or 25% copay up to $150, per month	Greater of $50 or 25% copay up to $375, per month
Non-Formulary Brand Name Prescriptions	Greater of $20 or 50% copay, per month	Greater of $50 or 50% copay, per month

*Specialty Prescriptions are limited to a 30-day supply per fill. Specialty Drug authorization and Benefits should be processed through Archimedes. Phone: 888-504-5563 (toll-free); **memberservices@archimedesrx.com**

**Generic recurring maintenance medications may be filled for a 90-day supply with 3 monthly copayments ($15 or 15%, whichever is greater, up to $150).

Diabetic supplies purchased with multiple prescriptions at the same time will only incur a single copay. For example, if prescriptions for injectable insulin, test strips, and injection supplies (hypodermic needles and syringes) are presented to the pharmacy for fill on the same day, one retail copay will be applied for all three prescriptions.

DENTAL PLAN* †	Choose Any Licensed Dentist	
Preauthorization is suggested on claims over $300		
Deductible The amount of covered services that you must pay each year before the Plan pays benefits	$25/person	
Maximum Benefit The most the Plan pays per person per calendar year	$2,000/person**	
Covered Services	**In-Network (% of contracted charges)*** **	**Out-of-Network (% of UCR)**
Class I: Diagnostic and Preventive Services Routine oral exams, teeth cleaning and fluoride treatment (up to twice per calendar year) X-rays and sealants (following frequency guidelines)	100%	75%
Class II: Restorative Services Extractions, oral surgery, fillings, periodontic and endodontic procedures, crowns	80%	60%
Class III: Prosthodontic Services Dentures and bridges	60%	50%
Orthodontia Only available to eligible dependent children who have been enrolled in the Dental Plan on the first day of the month following a 9-month period during which you have been eligible for 6 months	Plan pays 15% of the entire cost as down payment when banding occurs and 50% of the monthly adjustment fee $2,000 lifetime maximum/ person***	

*Dental benefits are excluded from Material Handlers and Basic benefits.

†Retirees must elect these benefits at initial enrollment in the Retiree Benefit Program or upon Medicare eligibility.

**Pediatric Dental services through age 12 are not limited to maximum benefit

***Dentists that are contracted with Careington Maximum Care Network cannot charge participants for any amounts over the contracted rate. For Class II and Class III procedures, participants will be responsible for the contracted amount over which the Plan will pay.

VISION PLAN* †		
Covered Expenses (in VSP Network)	**Copay**	**Frequency****
WellVision Exam	$0	Every 12 months
Frame • $170 allowance for a wide selection of frames*** • $190 allowance for featured frame brands*** • 20% savings on the amount over your allowance • $95 allowance at Costco***		Every 24 months
Lenses • Single vision, lined bifocal, and lined trifocal lenses • Polycarbonate lenses for dependent children		Every 12 months
Lens Enhancements • Standard progressive lenses • Premium progressive lenses • Custom progressive lenses Average savings of 30% on other lens enhancements	$0 $95–$105 $150–$175	Every 12 months

VISION PLAN* † continued		
Covered Expenses (in VSP Network)	**Copay**	**Frequency****
Contact Lenses (instead of glasses) • $170 allowance for contacts; copay does not apply*** • Contact lens exam (fitting and evaluation)	Up to $60	Every 12 months
Diabetic Eycare Plus Program Services related to diabetic eye disease, glaucoma, and age-related macular degeneration (AMD). Retinal screening for eligible members with diabetes. Limitations and coordination with medical coverage may apply. Ask your VSP doctor for details	$20	As needed
Prescription or Nonprescription Safety Glasses Single vision, lined bifocal, and lined trifocal lenses. This benefit is available only to the participant and not dependents. Only ProTec brand safety glasses are fully covered and are available from participating VSP providers only.	$0	Lenses every 12 months, frame every 24 months
EXTRA SAVINGS: • **Glasses and Sunglasses:** 20% savings on additional glasses and sunglasses, including lens enhancements, from any VSP doctor within 12 months of your last WellVision Exam. • **Laser Vision Correction:** Save up to $1,000 on Lasik; discounts only available from contracted facilities		
Covered Expenses (Out of VSP Network)		
Complete Eye Exam One exam allowed per calendar year	Plan pays up to $50	
Lenses Two lenses (one pair) allowed each calendar year	Plan pays based on lens type: Single—up to $50 Bifocal—up to $75 Trifocal—up to $91 Progressive—up to $75	
Frames One set of frames allowed every two consecutive calendar years	Plan pays $72	
Contact Lenses The Plan pays benefits for either lenses or contact lenses (not both) each calendar year	Plan pays up to $105	
Prescription or Nonprescription Safety Glasses Single vision, lined bifocal, and lined trifocal lenses (non-ProTec brand safety glasses). This benefit is available only to the participant and not dependents. When safety glasses are obtained from a provider out of the VSP Network or non-ProTec brand safety glasses are obtained (even if in-network), safety glasses are reimbursed at the rates set forth to the right.	Plan pays based on lens type: Single—up to $35 Bifocal—up to $45 Trifocal—up to $60	

* Vision benefits are excluded from Material Handlers and Basic benefits.

†Retirees must elect these benefits at initial enrollment in the Retiree Benefit Program or upon Medicare eligibility.

**Frequency is measured from date of last service.

***Please note that all allowances are subject to change.

MEDICAL PLAN OVERVIEW

HOW BENEFITS ARE PAID

DEDUCTIBLE

The deductible is the amount of covered services you must pay each calendar year before the Plan begins to pay benefits, as listed in the chart beginning on page 24.

The deductible applies to all benefits except Preventive Care and Routine benefits.

There are some exceptions to the deductible requirement:

- **Deductible carry-over**: Expenses applied toward the deductible in the last 90 days of a calendar year will also be applied toward the deductible for the next calendar year.
- **Common accident deductible**: If two or more covered persons of your family are injured in the same accident, only one deductible applies for that accident. This will also apply to any reapplications of the deductible for that accident.

DISCOUNTED CHARGES

The Plan has contractual arrangements with Preferred Providers, other health care providers, provider networks, prescription benefits manager ("PBM"), and other vendors of health care services and supplies ("Providers"). Under these arrangements, certain providers have agreed to discounted charges.

A "discounted charge" is the amount that a provider has agreed to accept as payment in full for covered health care services or supplies. A discounted charge does not include pharmaceutical rebates or any other reductions, fees, or credits a provider may periodically offer. The Trust will retain those amounts that are not discounted charges. However, the Trust has estimated the amount of such rebates, reductions, fees, and credits and has taken those into consideration in setting the premium charged to provide benefits under this Plan.

Claims under the Plan and any deductible, copayment (based upon percentage of charge), coinsurance, and benefit maximums as described in this Plan will be determined based on the discounted charge.

COINSURANCE

Coinsurance means the percentage the Plan pays for covered services. The Plan pays most covered medical services (unless stated otherwise or not listed in the Plan) as follows:

- **Preferred Providers**: The Plan pays 80%
- **Non-Preferred Providers**: The Plan pays 80% **of UCR**
- **Preferred Providers (Material Handlers Only)**: The Plan pays 80%
- **Non-Preferred Providers (Material Handlers Only)**: The Plan pays 60% of UCR
- **Preferred Providers (Basic Only)**: The Plan pays 70%
- **Non-Preferred Providers (Basic Only)**: The Plan pays 50% of UCR

You must first meet the annual deductible before the Plan pays benefits. You pay the remaining percentage until you reach the out-of-pocket limit.

Benefits are payable only for expenses incurred while an individual is covered under the Plan.

ALLOWED AMOUNT

The allowed amount is the amount on which the Plan payment is based. This is equal to:

- **The Preferred Provider's discounted charge**: This is the amount the Preferred Providers agree to accept as full payment for covered health care services or supplies.
- **The Usual, Customary, and Reasonable (UCR) charge**: This is the average charge for a given service or supply, based on geographical location, skill of the provider of service and the complexity of the service performed. The Trust Administrator determines the UCR charge.

When you receive services or supplies from a Non-Preferred Provider, the billed amount may exceed the UCR charge. Keep in mind that you are responsible for 100% of any amount exceeding what the Plan pays.

The "Allowable Charges" for Outpatient Dialysis is the "Usual and Reasonable" amount as that term is defined in the Outpatient Dialysis provision.

! KEY POINT

Any charge in excess of the Usual, Customary, and Reasonable (UCR) charge will be your responsibility.

"NO SURPRISES ACT"— CONSOLIDATED APPROPRIATIONS ACT

Please be aware that in-network providers cannot generally "balance bill" Participants for out-of-network services provided at network facilities. However, if a Participant receives advance notice (72 hours prior) of a possible out-of-network charge and consents to the use of such out-of-network provider services, the Participant may be subject to additional "balanced billing" charges unless there is no network provider for the services available at the network facility.

All emergency services shall be paid as in-network services and no "balance billing" will apply. This includes air ambulance services.

Emergency Medical Condition shall be defined as follows:

A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in a condition described in Emergency Medical Treatment and Active Labor Act (EMTALA), including (1) placing the health of the individual (or, with respect to a pregnant woman, the

health of the woman or her unborn child) in serious jeopardy, (2) serious impairment to bodily functions, or (3) serious dysfunction of any bodily organ or part. This definition includes mental health conditions and substance use disorders.

Consistent with Section 1867 of the Social Security Act, "Emergency Services" shall mean (1) an appropriate medical screening examination that is within the capability of the emergency department of a hospital or of an independent freestanding emergency department, including ancillary services routinely available to the emergency department, to evaluate whether an emergency medical condition exists; and (2) such further medical examination and treatment as may be required to stabilize the individual (regardless of the department of the hospital in which the further medical examination and treatment is furnished) within the capabilities of the staff and facilities available at the hospital or the independent freestanding emergency department.

An "independent freestanding emergency department" is intended to include any health care facility that is geographically separate and distinct from a hospital, and that is licensed by a state to provide emergency services, even if the facility is not licensed under the term "independent freestanding emergency department."

No Surprises Act cost-sharing and balance billing protections continue from the emergency room to post-stabilization services in a hospital or freestanding emergency department until the attending emergency physician or treating provider determines that the participant, beneficiary, or enrollee is able to travel using nonmedical transportation or nonemergency medical transportation to an available participating provider or facility located within a reasonable travel distance, taking into consideration the individual's medical condition. Notice and consent as well as any additional state law requirements must also be met consistent with 45 CFR 149.410(b)(1), 45 CFR 149.410(b)(2), 45 CFR 149.420(c) through (g), 45 CFR 149.410(b)(3) and 45 CFR 149.410(b)(5).

OUT-OF-POCKET LIMIT

Out-of-pocket expenses are costs you pay for covered services as coinsurance or deductible amounts.

The most that you pay in out-of-pocket expenses per year is called the out-of-pocket limit. This amount is $6,300 per person ($6,600 for Material Handlers and Basic Benefits) and $13,200 per family, indexed each calendar year, and is a combined limit for the Medical and Prescription Plans.

! KEY POINT

Once you reach the out-of-pocket limit, the Plan pays 100% of covered expenses for the rest of the calendar year.

The same expense may be used to meet the out-of-pocket limit for Preferred Providers and Non-Preferred Providers.

When you reach this limit, the Plan will pay 100% of covered expenses for the rest of the calendar year.

Expenses for the following may not be used to satisfy the out-of-pocket limit and will not be paid at 100% after the out-of-pocket limit is reached:

- Copays
- Expenses that are excluded, over benefit maximums or exceed the Usual, Customary, and Reasonable (UCR) allowance

BENEFIT MAXIMUM

Under the Affordable Care Act, benefit maximum limits are abolished. Therefore, the benefit maximum is unlimited.

PREFERRED PROVIDER ORGANIZATION (PPO)

! KEY POINT

The Plan pays claims for services provided by PPO Providers directly to the PPO Provider.

When you or your dependents require health care, you may choose any physician, hospital, or other health care provider you wish.

When you choose a provider from a Preferred Provider Organization (PPO), you'll save money. PPO Providers are doctors, facilities, hospitals, labs, etc., who have agreed to provide medical services at discounted fees.

Your Medical Plan is a "coinsurance plan," which means that you pay a percentage of the cost of the services you receive. The actual amount you pay depends on whether you choose a PPO Provider or a Non-PPO Provider.

- **PPO Providers** charge a discounted rate for the services they provide. In most cases, you'll pay 20%-30% of this discounted amount for the services you receive. PPO providers accept the discounted rate as payment in full; that means they won't bill you for a higher amount than the Plan allows.
- **When you choose a Non-PPO Provider**, you'll pay 20% (or 40% for Material Handlers, 50% for Basic) of the UCR charge for most services. The UCR charge is the rate the Plan allows for each covered service. This charge may not be the same as the provider's billed amount; you are responsible for any amount the provider bills that exceeds the Plan's payment.
- **Dental PPO Providers** have agreed to a discounted service fee for covered and non-covered benefits. Using a Dental PPO provider, while still subject to UCR, may result in lower out-of-pocket expenses for you and your family.

LOCATIONS

The Plan participates in national PPO networks for medical, dental, and vision as well as some coalitions. Contact the PPO (see Key Contacts for information) to locate a provider that meets your needs:

- **Aetna PPO**
- **Careington Maximum Care Network Dental** all regions covered by the Trust

- **Nevada Health Services Coalition**
- **Alaska Coalition:**
  - **Alaska Regional Hospital**
  - **Charter North Hospital**
- **VSP**

KEY POINT

You may choose any licensed health care provider; however, when you choose a PPO Provider, you'll save money because PPO Providers charge a discounted rate and the Plan often pays a higher percentage of the covered services.

All Preferred Providers and Non-Preferred Providers are independent contractors; they are not the Plan's employees or agents.

The Plan does not supervise, control, or guarantee the outcome or results of any health care services furnished by any Preferred Provider or Non-Preferred Provider. You and your dependent's relationship with a Preferred Provider or Non-Preferred Provider is that of provider and patient. The Preferred Provider or Non-Preferred Provider is solely responsible for the health care services provided to you and your dependents.

UTILIZATION MANAGEMENT PROVISIONS

"Utilization Management" features are a part of your Medical Plan. The idea behind these features is to emphasize the efficient use of medical services without sacrificing quality care.

KEY POINT

By working together, we can keep costs reasonable so the Plan benefits may continue to provide significant financial protection well into the future.

The starting point for covered benefits under the Plan is whether the services and supplies are eligible health services. See the *Eligible health* services under the Plan and exclusions sections plus the schedule of benefits.

The Plan pays for its share of the expense for eligible health services only if the general requirements are met. They are:

- The eligible health service is medically necessary.
- You or your provider precertifies the eligible health service when required.

This section addresses the medical necessity and precertification requirements.

INFUSION THERAPY / SITE OF CARE

You are prescribed an infusion to treat a chronic condition at a hospital infusion center.

The cost for infusion drugs can vary widely. Where you receive care makes a difference. The cost of a hospital outpatient infusion is often twice the cost of an infusion of the same drug received at a physician's office or home infusion. Aetna's Drug Infusion Site of Care (SOC) Policy requires you to use lower-cost sites for infusions from the beginning of therapy, but also ensures that you have immediate access to care.

During the precertification process, the requested site of care is evaluated.

When you begin therapy at a high-cost site:

- **You get immediate care.** You receive a grace period authorization which may allow you to receive your initial infusion in an outpatient hospital without delay or disruption. Our precertification team issues a short-term authorization based on the clinical criteria.
- **And then,** we direct you to more cost-effective care. A Care Advocate works with the provider and you to transition you to a lower cost setting and updates the short-term authorization to reflect the change.

For select specialty medications you may be required to utilize the most cost-effective site or benefit. You may be required to obtain certain medications covered under the medical benefit at the most cost-effective site of care or setting, such as a home infusion. Likewise, select medications that are administered by a health care professional may be required to be obtained through your pharmacy benefits manager ("PBM"), Elixir.

Infusion in a hospital-based outpatient setting may be considered medically necessary only when:

- The patient has a clinical condition that puts him or her at increased risk of complications for infusions, including any of the following:
  - Known cardiac or pulmonary conditions that increase the risk of an adverse reaction
  - Unstable renal function which decreases the ability to respond to fluids
  - Difficult or unstable vascular access
  - Acute mental status changes or cognitive conditions that impact the safety of infusion therapy
- For the first 90 days to cover:
  - The initial course of infusion of a pharmacologic or biologic agent
  - Re-initiation of an agent after 6 months or longer of non-use
  - The patient has a known history of severe adverse drug reactions and/or anaphylaxis from prior treatment with a related or similar drug
  - Access to care
- There is no outpatient infusion center within 50 miles of the patient's home and there is no contracted home infusion agency that will travel to the home, or a hospital is the only place that offers infusions of the drug.

MEDICALLY NECESSARY; MEDICAL NECESSITY

A medical necessity is a requirement for you to receive a covered benefit under the Plan.

The medical necessity requirements are stated in the Glossary section of the Plan, where we define "medically necessary". That is where we also explain what our medical directors or their physician designees consider when determining if an eligible health service is medically necessary.

PRECERTIFICATION

You need pre-approval from Aetna for some eligible health services. Pre-approval is also called precertification, preauthorization, or prior authorization. **www.aetna.com/health-care-professionals/precertification.html**

IN-NETWORK

Your physician is responsible for obtaining any necessary precertification before you get the care. If your physician does not get a required precertification, the Trust Administrators will not pay the provider who gives you the care. You will not have to pay either if your physician fails to ask Aetna for precertification. If your physician requests precertification and the Trust Administrators refuse it, you can still get the care but the Trust Administrators will not pay for it. You will find details on requirements in the *What the plan pays and what you pay—Important exceptions—when you pay all* section.

OUT-OF-NETWORK

When you go to an out-of-network provider, it is your responsibility to obtain precertification from Aetna for any services and supplies on the precertification list. If you do not precertify, your benefits may be reduced, or the Trust may not pay any benefits. Refer to your schedule of benefits for this information. The list of services and supplies requiring precertification appears later in this section. Also, for any precertification benefit reduction that is applied, see the schedule of benefits in the *Precertification covered benefit reduction* section.

Precertification should be secured within the timeframes specified below. For emergency services, precertification is not required, but you should call within the timeframes provided, and you should notify Aetna within the timeframes listed below. To obtain precertification, call Aetna at the telephone number listed on your ID card. This call must be made:

For non-emergency admissions:	You, your physician or the facility will need to call and request precertification at least 14 days before the date you are scheduled to be admitted.
For an emergency admission:	You, your physician or the facility should call within 48 hours or as soon as reasonably possible after you have been admitted.
For an urgent admission:	You, your physician or the facility will need to call before you are scheduled to be admitted. An urgent admission is a hospital admission by a physician due to the onset of or change in an illness, the diagnosis of an illness, or an injury.
For outpatient non-emergency medical services requiring precertification:	You or your physician must call at least 14 days before the outpatient care is provided, or the treatment or procedure is scheduled.
For outpatient Infusion Therapy	You or your physician must follow all of the requirements and deadlines in this section.
For inpatient Infusion Therapy	You or your physician must follow all of the requirements and deadlines in this section.

Aetna will provide a written notification to you and your physician of the precertification decision, where required by state law. If your precertified services are approved, the approval is valid for 60 days as long as you remain eligible under the Plan.

When you have an inpatient admission to a facility, Aetna will notify you, your physician and the facility about your precertified length of stay. If your physician recommends that your stay be extended, additional days will need to be precertified. You, your physician, or the facility will need to call Aetna at the number on your ID card as soon as reasonably possible, but no later than the final authorized day. Aetna will review and process the request for an extended stay. You and your physician will receive a notification of an approval or denial.

If precertification determines that the stay or services and supplies are not covered benefits, the notification will explain why and how our decision can be appealed. You or your provider may request a review of the precertification decision. See the Claim decisions and appeals procedures section.

WHAT IF YOU DON'T OBTAIN THE REQUIRED PRECERTIFICATION?

If you don't obtain the required precertification:

- Your benefits may be reduced, or the Plan may not pay any benefits. See the schedule of benefits *Precertification covered benefit reduction* section.
- You may be responsible for the unpaid balance of the bills.
- Any additional out-of-pocket expenses incurred will not count toward your out-of-network deductibles or maximum out-of-pocket limits.

WHAT TYPES OF SERVICES REQUIRE PRECERTIFICATION?

Precertification is required for the following types of services and supplies:

Inpatient Services and Supplies	Outpatient Services and Supplies
Stays in hospital	Cosmetic and reconstructive surgery
Stays in a skilled nursing facility	Non-emergency transportation by fixed wing airplane
Stays in a rehabilitation facility	Transcranial magnetic stimulation (TMS)
Stays in a hospice facility	Applied behavior analysis
Stays in a residential treatment facility for treatment of mental disorders and substance abuse	Partial hospitalization treatment—mental disorder and substance abuse diagnoses
Bariatric surgery (obesity)	
Infusion Therapy	Infusion Therapy

Certain prescription drugs are covered under the medical plan when they are given by your doctor or health care facility. The following information applies to these prescription drugs:

For certain drugs, your provider needs to get approval from Aetna before they will cover the drug. The requirement for getting approval in advance guides appropriate use of certain drugs and makes sure they are medically necessary.

Step therapy is a type of precertification where we require you to first try certain drugs to treat your medical condition before we will cover another drug for that condition.

Contact Aetna or go online to get the most up-to-date precertification requirements and list of step therapy drugs.

Sometimes you or your provider may ask for a medical exception for drugs that are not covered or for which coverage was denied. You, someone who represents you, or your provider can contact Aetna. You will need to provide Aetna with clinical documentation. Any exception granted is based upon an individual and is a case-by-case decision that will not apply to other members.

CARE MANAGEMENT PROGRAM

The Care Management Program, while voluntary, helps you, your representative, your doctor, and hospital to take certain steps when your doctor recommends an inpatient hospital confinement.

What does the Care Management Program do for you?

- The program acts as a patient advocate.
- It helps you work with your doctor or other health care providers to ensure that your medical services are medically necessary under the terms of the Plan.
- It will assist in your hospital discharge planning and see that you receive appropriate medical support services following your discharge, when necessary.
- It allows the Plan to manage health care services and costs more efficiently to ensure that your high level of benefits can continue.

HOSPITAL PRECERTIFICATION

To help ensure participants receive necessary hospital care in the most cost-effective manner participants are required to precertify all inpatient hospital stays. Precertification is a review process that simply determines the medical necessity of your inpatient treatment and length of stay.

To precertify an inpatient hospital stay, simply call Aetna (please see inside front cover for contact information)**:**

- For prescheduled hospitalizations, call as soon as you know you are going to be hospitalized.
- For emergency admissions, call within two business days or as soon as reasonably possible.
- Precertification is not required for emergency care and childbirth (unless the stay is for greater than 48 hours for normal delivery or 96 hours for Caesarean).

You are responsible for making sure the hospital stay is precertified. However, you, your representative, or your doctor may call Aetna to request precertification.

Aetna also provides the Care Management Program, which helps to ensure that you receive appropriate care for your condition. The program informs your doctor about alternatives to hospitalization, such as home care services, which may promote an earlier discharge and recovery at home.

Precertification of a hospital confinement through the utilization review process does not necessarily mean that benefits are payable. Please review the General Exclusions and Limitations section for possible non-covered services. Confirmation of a covered person's eligibility for the Plan coverage for a particular service or supply and fulfillment of all other Plan requirements are also necessary for benefits to be payable.

Aetna will make a determination regarding the medical necessity of your inpatient treatment and mail you a letter indicating the number of hospital days certified.

Also, unless you have a medical emergency, you should make the call yourself and not rely on your doctor or the hospital to precertify your hospital stay for you.

Prior authorization is also required for outpatient procedures.

! KEY POINT

You, not your physician, are responsible for making sure precertification occurs. However, you, your representative, or your physician may initiate the precertification.

MEDICAL REVIEW WHILE HOSPITALIZED

During an approved hospitalization, the Trust will monitor the confinement to assure that continued general hospital care is medically necessary and that the services being provided are appropriate to the condition being treated. Your doctor will be advised of alternatives to hospitalization, such as home care services, which may promote an earlier discharge and recovery at home.

QUESTIONS ABOUT THE CARE MANAGEMENT PROGRAM

Call Aetna if you, your doctor or the hospital, have questions regarding the Care Management Program.

If you have questions regarding the Plan, call the Trust Administrator. When calling, please identify yourself as a participant in the Trust.

REQUEST FOR AN APPEAL OF THE UTILIZATION REVIEW DECISION

You, your representative, or your provider of health care, have the right to request an appeal regarding the utilization review decision. (Please see the Appeals section of the Plan for details.) You may call Aetna for additional information regarding the appeal.

Submit the request in writing (see mailing address on inside front cover) and include any additional information that may have been omitted from the review or that should be considered by Aetna.

PRECERTIFICATION EXCEPTIONS

Precertification is not required when the covered person:

- Has Medicare coverage which has primary responsibility for the covered person's claims and which must pay its full benefits before the Plan benefits are paid in accordance with the coordination of benefits provision;
- Has other group medical coverage which has primary responsibility for the covered person's claims and which must pay its full benefits before the Plan benefits are paid in accordance with the coordination of benefits provision; or
- Receives services or supplies outside of the United States, Mexico, Canada, or any state, district, province, territory, or possession thereof.

MEDICAL PLAN

MEDICAL PLAN COVERED SERVICES

COVERED HOSPITAL SERVICES

The Plan benefits pay for incurred covered services received for each hospital confinement.

- Hospital room and board, up to the room limit:
  - Semiprivate Room: The semiprivate room charge of the hospital where the covered person is confined.
  - Ward Accommodation: The ward accommodation charge of the hospital where the covered person is confined.
  - Private Room: The average semiprivate room charge of the hospital where the covered person is confined.
  - Intensive Care Unit/Cardiac Care Unit: The intensive care unit/cardiac care unit charge of the hospital where the covered person is confined.
- Hospital services and supplies used during covered hospital confinement.
- Hospital outpatient services in connection with:
  - A surgical operation
  - Emergency treatment within 24 hours after an accident
- Preadmission tests for surgery.

PHYSICIAN SERVICES

Covered services include:

- Hospital outpatient services
- Physician's services for medical care
- Active services of an assisting surgeon
- Biofeedback
- Services of a registered graduate nurse (RN) for private duty nursing care, or of a licensed physiotherapist; but the Plan does not pay for services provided by a person who lives with you in your home or is a part of your family
- The following services and supplies:
  - Formulas necessary for the treatment of phenylketonuria (PKU);
  - Diagnostic x-ray and laboratory service;
  - Oxygen and the rental of equipment for its administration;
  - Blood or blood plasma and its administration;
  - Radium, radioactive isotopes and x-ray therapy;
  - The Plan will allow 3 nerve blocks/steroid injections in a 6-month period with no earlier repeat procedures within a 2-month period and not more than 2 joint injections per level. Physical therapy, home exercise and medication management must be utilized with these procedures when approved as medically necessary;
  - Local professional ambulance service;
  - Transportation by professional ambulance, air ambulance or a regularly scheduled flight on a commercial airline for non-emergency care when:
    - Special and unique covered hospital services are required which are not provided by a local hospital; and
    - Transportation is medically necessary.

    Transportation benefits during any plan year for a condition that cannot be treated locally are limited to:
    - One visit and follow-up visit for a condition requiring therapeutic treatment or surgery;
    - One visit for prenatal or postnatal maternity care and one visit for the actual maternity delivery;
    - One pre- or post-surgical visit and one visit for the surgical procedure; and
    - One visit for each allergic condition.

    Transportation coverage applies only to the person receiving treatment, unless the transportation of a caregiver is medically necessary and has been pre-approved.

    If preoperative testing and surgery more than 100 miles from your home is medically necessary, food and lodging expenses outside of the hospital are covered during the preoperative testing period, but only if pre-approved.
- Transportation is to the nearest hospital equipped to furnish the services;
- Casts, splints, braces, trusses, and crutches;
- Durable medical equipment used for the treatment of a covered injury or illness;
- Artificial limbs and eyes to replace natural limbs and eyes;
- Initial placement of contact lenses required because of cataract surgery;
- Dental services by a physician or dentist for the treatment of a dental injury to sound natural teeth, (including the initial replacement of the injured teeth and any necessary dental x-rays), provided the expense is incurred within one year after the injury;
- Dental services by a physician or dentist for dental treatment caused or resulting from medical treatment or services covered by the Trust, provided the expense is pre-authorized as medically necessary;
- Sterilization procedures and elective abortions for employees and spouses;
- Infusion Therapy; and
- Medically necessary medications administered under the supervision of a physician. NOTE: If you or your dependent are Medicare eligible and are enrolled in a Medicare Part D prescrip-

tion drug plan, outpatient prescription drug benefits will not be provided under the Plan.

HOME HEALTH CARE BENEFITS

The Plan pays benefits for covered expenses for home health care as follows:

- Major medical benefits at 100% in lieu of hospitalization for other covered services
- Major medical benefits at 80% if **not** in lieu of hospitalization
- Not to exceed 130 visits in any calendar year for the services listed below.

Each visit by a member of the home health care team will be considered one home health care visit.

COVERED HOME HEALTH CARE SERVICES

- Skilled nursing care provided on a part-time basis (no more than an eight-hour shift) by:
  - A registered nurse
  - A licensed practical nurse (LPN)
- Physical therapy, occupational therapy, inhalation therapy or speech therapy provided by a licensed therapist
- Home health aide services are not covered under the Plan because they do not provide skilled services and are considered custodial care
- The following equipment and supplies, which are ordered or prescribed by a physician and would be covered as a hospital inpatient expense:
  - Drugs and medicines requiring a physician's written prescription;
  - Medical supplies such as oxygen, catheters, syringes, dressings, antiseptics, irrigation solutions, and intravenous fluids;
  - Prosthetic devices, casts, splints, trusses, crutches, and braces; and
  - Rental (up to the purchase price) of a wheelchair, hospital bed for patient care, or other durable medical equipment.

HOSPICE CARE BENEFITS FOR A TERMINALLY ILL PERSON

The Plan pays benefits for covered expenses for hospice care as follows:

- Major medical benefits at 100%
- Not to exceed 6 months of inpatient and outpatient hospice care services combined while covered under the Plan
- Any hospital, skilled nursing care facility, or convalescent home which is associated with the hospice (or, if none, which is located nearest the hospice)
- Medical social services provided by a licensed social worker with a master's degree in social work
- Payment of hospice care benefits is not in lieu of hospital or medical benefits under the Plan; but the Plan will not pay duplicate benefits for the same services and supplies or the same days of confinement

Exceptions—the Plan will not pay for:

- Services and supplies which are not covered under this home health care benefit and hospice care benefit
- Services by a person who lives in your home or is a member of your family
- Services which consist mainly of housekeeping, companionship, or sitting
- Services which are not directly related to the covered person's medical condition, including (but not limited to):
  - Estate planning, drafting of wills, or other legal services
  - Pastoral counseling, funeral arrangements, or services
  - Nutritional guidance or food services such as "meals on wheels"
  - Transportation services (except as provided above)
- Expense for which benefits are paid under any other provision of the Plan
- Any requirement that hospice care be part of an active plan of medical treatment which is reasonably expected to reduce the disability will not apply

MENTAL DISORDER BENEFITS

The Plan pays benefits for covered expenses for the treatment of a mental disorder, including treatment by:

- A physician
- A provider licensed in the state to provide mental health care
- A community mental health agency
- A state hospital

Subject to such providers being licensed by the proper authority of the state in which they are located.

If an employee or dependent incurs covered charges because of a mental disorder, the benefits for any inpatient or outpatient medically necessary treatment and supporting services will be paid in the same manner as any other injury or illness.

Pursuant to the requirements of the Mental Health Parity and Addiction Equity Act ("MHPAEA"), autism and neurological disorders will be covered under the Plan in the same fashion as any other covered claim. The MHPAEA requires that there be no stricter requirements for coverage of these disorders, and other mental disorders, than any other covered medical treatments.

JAW TREATMENT

The Plan pays limited benefits for surgical and non-surgical treatment by a physician or a dentist for:

- Temporomandibular joint (TMJ) dysfunction

- Myofascial pain dysfunction (MPD)
- Jaw surgeries of any nature, including skeletal deformities, except treatments relating to tumors, or malignancies

Coverage includes:

- Diagnosis
- X-rays
- Hospitalization
- Surgery
- Physical therapy
- Splints
- Guards

The Plan pays benefits in the same manner as any other injury or illness for covered charges up to a maximum of $5,000 while covered under the Plan. Charges in excess of these benefits do not apply to the annual "out-of-pocket" maximum.

Regular Plan benefits will apply to jaw surgery or repair if the required treatment is for an injury resulting from an accident. These benefits require treatment to be started within the 12 months immediately following the accident. Failure to commence treatment within this time shall not invalidate any claim if it can be shown that it was not reasonably possible to commence the treatment within the 12-month period, and the treatment was commenced as soon as reasonably possible.

SPINAL TREATMENT

The Plan will pay for 24 visits per calendar year. X-rays are paid the same as any other condition.

- The Plan allows an initial office visit only
- Further office visits are allowed if a new condition or new onset has occurred

AMBULANCE

- Local professional emergency ambulance service
- Transportation by professional ambulance, air ambulance, or a regularly scheduled flight on a commercial airline for non-emergency care when:
  - Special and unique covered hospital services are required which are not provided by a local hospital; and
  - Transportation is medically necessary.
- Transportation benefits during any plan year for a condition that cannot be treated locally are limited to:
  - One visit and follow-up visit for a condition requiring therapeutic treatment or surgery;
  - One visit for prenatal or postnatal maternity care and one visit for the actual maternity delivery;
  - One pre- or post-surgical visit and one visit for the surgical procedure; and
  - One visit for each allergic condition.

Transportation coverage applies only to the person receiving treatment, unless the transportation of a caregiver is medically necessary and has been pre-approved.

If preoperative testing and surgery more than 100 miles from your home is medically necessary, food and lodging expenses outside of the hospital are covered during the preoperative testing period, but only if pre-approved.

EMERGENCY ROOM

$100 copay waived if within 24 hours of covered injury for life threatening conditions or if patient is admitted to hospital. Life threatening conditions and treatment when urgent care is unavailable or not accessible are determined on a case-by-case basis. Conditions may include shortness of breath, broken bones, high fever, dehydration, severe pain, etc. A cough, sore throat, or other common cold related symptoms may not be life threatening.

DURABLE MEDICAL EQUIPMENT (DME)

Durable medical equipment used for the treatment of a covered injury or illness are covered, with rentals covered up to the purchase price of the equipment.

PHYSICAL THERAPY/OCCUPATIONAL THERAPY

Limited to 60 visits per calendar year.

SPEECH THERAPY

Limited to 60 visits per calendar year (must be for restoration of lost speech due to injury or illness).

FOOT ORTHOTICS

Foot Orthotics are covered as medically necessary up to $500 per cause. The $500 maximum is limited to foot orthotics.

CHEMICAL DEPENDENCY

Medically necessary, with respect to chemical dependency coverage, means the treatment is indicated in the most recent ASAM PPC-2R: ASAM Patient Placement Criteria for the Treatment of Substance Abuse-Related Disorders as published by the American Society of Addiction Medicine.

Chemical dependency means, for the purposes of an illness characterized by a physiological or psychological dependency or both, on a controlled substance or alcoholic beverage. It is further characterized by a frequent or intense pattern of pathological use to the extent the user exhibits a loss of self-control over the amount and circumstances of use; develops symptoms of tolerance or physiological and/or psychological withdrawal if use of the controlled substance or alcoholic beverage is reduced or discontinued; and the user's health is substantially impaired or endangered or his or her social or economic function is substantially disrupted.

- If you or your covered dependent requires medically necessary detoxification in a hospital or other licensed facility as a result of

chemical dependency, the Plan will pay the expense incurred in the same manner and subject to the same conditions and limitations as any other illness if such detoxification care is considered medically necessary under the Plan.

- If you or your covered dependent enrolls in a state-approved treatment program, for the medically necessary treatment of chemical dependency, the Plan will pay the expense incurred, including supporting services, in the same manner and subject to the same conditions and limitations as any other illness.

Court-ordered chemical dependency treatment is not covered under this provision unless it is medically necessary. In situations where a covered person is under court order to undergo a chemical dependency assessment or treatment, such as:

- Is related to deferral of prosecution
- Is related to deferral of sentencing or suspended sentencing
- Pertains to motor vehicle driving rights

The Plan will require, at the covered person's expense, and no less than 10, nor more than 30 working days, before treatment is to begin, an initial assessment of the need for chemical dependency treatment and a treatment plan made by a certified chemical dependency counselor of the covered person's choice who is employed by a state-approved treatment program. This will enable the Plan to make a determination that the scheduled treatment is medically necessary.

ALTERNATE PROVIDERS

If a participant incurs expense for a covered service because of an injury or illness for:

- Naturopath
- Acupuncturist
- Massage Therapist

The Plan pays up to 24 visits each per calendar year.

HEARING AIDS

(for active participants and their dependents only; Retirees are excluded)

If you or your dependent incurs expense by a physician or a certified or licensed audiologist for covered hearing aid services, the Plan will pay for the expense in the same manner as any other illness, disorder, or other covered condition, up to $500 per each ear in any period of 36 consecutive months. This benefit is payable after the deductible has been satisfied at the applicable coinsurance percentage.

The Plan will pay expenses for the following:

- An otologic examination made by a physician
- An audiologic examination made by a certified or licensed audiologist and the expense for one follow-up visit
- The purchase or repair of a hearing aid device (monaural or binaural) prescribed as a result of such examinations, but only if the examining physician or audiologist certifies that the covered person has a hearing loss that may be lessened by the use of a hearing aid device. These charges include the expense for:
  - The actual hearing aid device
  - Ear mold(s)
  - The initial batteries, cords, and other necessary ancillary equipment
  - A warranty
  - A follow-up visit within 30 days after the delivery of the hearing aid device

Exceptions—the Plan will not pay for:

- Replacement of a hearing aid more than once during any period of 36 consecutive calendar months, regardless of the reason
- Batteries or other ancillary equipment, except those purchased with the hearing aid device
- A hearing aid device that exceeds the specifications of the prescription
- Service or supply that is not necessary or that does not meet professionally recognized standards
- Anything excluded under the General Exclusions and Limitations

Extension of Hearing Aid Benefits

The Plan will not pay benefits for expenses incurred after the date a covered person's coverage ends, other than expense for a hearing aid device that was ordered or repaired, prior to and delivered within 30 days after, the termination date.

PHENYLKETONURIA (PKU) TREATMENT

Formulas necessary for the treatment of phenylketonuria (PKU) are payable as any other covered service.

NEURODEVELOPMENTAL THERAPIES

If a dependent child incurs expense for neurodevelopmental therapies services, the Plan will pay benefits in the same manner and subject to the same conditions and limitations as any other covered service

Exceptions the Plan will not pay for:

- Any expense which is paid under any other provision of the Plan

PREVENTIVE CARE

If you or your dependent incurs expense for the following services, the Plan will pay 100% of the expense incurred, during the calendar year for all routine preventive care services combined. Any deductible shown in the Plan will not apply.

Covered services include:

- Routine physical exams (for covered persons age 24 months or older) performed in a hospital outpatient department or a

physician's office or clinic. Covered services include any related routine immunizations, laboratory and x-ray charges for the routine physical exam.

- Routine cancer screening benefits
- Any services defined and required as preventive under federal law in effect at the time of service.

SMOKING CESSATION

The Plan pays for smoking cessation treatment received in conjunction with tobacco usage, including chewing, provided:

- The nicotine patch or other smoking deterrent used is in conjunction with a behavioral modification program
- The Plan receives the physician's written certification that the program was completed

Prescriptions must be obtained through the prescription benefit. Covered services include:

- Nicotine patches or any other smoking deterrent, which requires a physician's written prescription
- A behavioral modification program (other than hypnosis) attended in conjunction with the nicotine patch or other smoking deterrent

WELL CHILD CARE

(for dependent children through the age of 24 months)

If your dependent child incurs well child expense for the following services, the Plan will pay 100% of the covered expense incurred in the first two years of the child's life.

Covered services include:

- A physician's preventive health care services performed in a hospital outpatient department, physician's office or clinic
- Preventive inoculations, which include but are not limited to:
  - Inoculations for diphtheria, tetanus, pertussis, measles, mumps, and rubella
  - Oral polio vaccine
  - Tests for tuberculosis
- Services required and defined by federal law at the time of service

Exceptions—the Plan will not pay for:

- A routine physician exam performed while the covered person is confined as a resident patient in a hospital
- Preventive health care services performed while a dependent child is confined as a resident patient in a hospital
- Any expense which is paid under any other provision of the Plan

OFF-LABEL DRUG USE

If you or your dependent incurs expense for drugs, including their administration, which have not been approved by the Food and Drug Administration ("FDA") for a particular indication, the Plan will pay the expense incurred on the same basis as any other covered drug, provided the drug is recognized as effective for treatment of such indication:

- In one of the standard reference compendia
- In the majority of relevant peer-reviewed medical literature if not recognized in one of the standard reference compendia
- By the Federal Secretary of Health and Human Services

Exceptions—Unless otherwise required by law for approved clinical trials under 42 U.S.C. § 300gg-8, the Plan will not pay for:

- Any drug when the Food and Drug Administration ("FDA") has determined its use to be contraindicated
- Experimental drugs not otherwise approved for any indication by the Food and Drug Administration ("FDA")
- Anything excluded under the General Exclusions and Limitations; however, any exclusion that is in conflict with the benefits provided by this provision will not apply

PRENATAL TESTING FOR CONGENITAL DISORDERS

If a female participant incurs expense for prenatal diagnosis of congenital disorders of the fetus by means of screening and diagnostic procedures, benefits will be payable under the Plan in the same manner as for any other illness.

MATERNITY

If a participant is confined to a hospital as a resident inpatient for childbirth, including any post-delivery follow-up care, the Plan will pay benefits in the same manner and subject to the same conditions and limitations as any other covered service.

Benefits will be in accordance with accepted medical practice as recommended by the attending physician (including a licensed nurse midwife, a licensed physician's assistant, or a licensed advanced registered nurse-practitioner), in consultation with the mother.

Post-delivery follow-up care includes, but is not limited to, visits by a licensed home health agency or by a licensed registered nurse.

The newborn child will be insured automatically for 60 days following birth, even if the newborn child is admitted separately to the hospital. Following such 60-day period, the newborn child will be insured in accordance with the dependent eligibility provisions of the Plan.

Benefits will be payable only if the covered person's pregnancy is insured under the Plan.

DIABETES

If you or your dependent is a person with diabetes and incurs expense for the following diabetes equipment and supplies for the treatment of diabetes, benefits will be paid in the same manner and subject to the same conditions and limitations as any other covered service.

Diabetes equipment and supplies includes but is not limited to:

- Blood glucose monitors
- Test strips for blood glucose monitors (limited to 6 test strips per day), visual reading and urine test strips
- Insulin
- Injection aids
- Syringes
- Insulin pumps and accessories to the pumps
- Insulin infusion devices
- Prescriptive oral agents for controlling blood sugar levels
- Foot care appliances for prevention of complications associated with diabetes
- Glucagon emergency kits
- If you or your dependent incurs expense for diabetes outpatient self-management training and education, including medical nutrition therapy, benefits will be paid in the same manner and subject to the same conditions and limitations as any other covered service

Exceptions—the Plan will not pay for:

- Any expense not recommended or prescribed by a physician or other licensed health care provider
- Any expense which is paid under any other provision of the Plan
- Anything excluded under the General Exclusions and Limitations; except that any podiatric appliance listed above will not be excluded

BODY ORGAN TRANSPLANTS

Please note: organ transplants require preauthorization. Please contact the Trust Administrator for additional information.

WEIGHT LOSS (BARIATRIC) SURGERY

The Plan covers medically necessary (as determined by the Plan) weight loss surgery only when preauthorized. Approval is based on specific criteria adopted by the Plan and its provider network; please contact the Trust Administrator for those criteria. The most recent Bariatric Surgery Policy approved July 29, 2022, sets forth the Plan's detailed criteria for approval of bariatric or weight loss surgery, is available from the Trust Administrator. The Plan's Board reserves the right to change the criteria contained in the Bariatric Surgery Policy at any time.

BREAST REDUCTION SURGERY

Please note: Breast reduction surgery requires preauthorization.

The Plan provides benefits for breast reduction surgery; for details on the program, benefits, and requirements, please contact the Trust Administrator for a copy of the breast reduction policy of the National PPO provider.

MASTECTOMY

The Women's Health and Cancer Rights Act of 1998 requires that the Plan provide benefits for mastectomy-related services due to disease or cancer, including reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from the mastectomy, including lymphedema.

The Plan provides coverage for prophylactic mastectomies when medically indicated. The Plan applies medical necessity criteria to judge whether a prophylactic mastectomy is medically indicated. Contact the Trust Administrator for a copy of the current criteria.

MEDICAL EMERGENCY

If you or your dependent requires emergency services for a medical emergency, the Plan will pay the expense incurred in the same manner and subject to the same conditions and limitations as any other covered service.

- Non-medical emergency services rendered in a hospital setting maybe subject to $100 copay

CONTRACEPTIVES

Contraceptive drugs or devices mean drugs or devices that prevent unwanted pregnancy including, but not limited to:

- Oral contraceptives
- IUDs
- Contraceptive implants
- Any similar drug, device, or method

If a participant receives contraceptive drugs or devices, including any services associated with the use of such drug or device, the Plan will pay the expense incurred in the same manner and subject to the same conditions and limitations as any other covered service.

The contraceptive drug or device:

- Requires a physician's written prescription
- Must be approved by the Food and Drug Administration ("FDA") for use as a contraceptive
- Removal of an IUD is subject to medical necessity review

Removal of such devices will only be covered if medically indicated. The Plan complies with the Women's Health Services portion of the Patient Protection and Affordable Care Act, where required.

SEX TRANSFORMATION SURGERY

Please note: Sex Transformation Surgery requires preauthorization.

The Plan provides benefits for sex transformation surgery for participants over eighteen (18) years of age; for details on the program, benefits, and requirements, please contact the Trust Administrator for a copy of the sex transformation surgery policy of the National PPO provider.

Note: The Plan coverage for sex transformation surgery is limited to one such surgery in a participant's lifetime.

TREATMENT FOR SEXUAL DYSFUNCTION

Please note: Treatment for Sexual Dysfunction requires preauthorization.

The Plan provides benefits for sexual dysfunction and erectile dysfunction for participants over eighteen (18) years of age; for details on the program, benefits, and requirements, please contact the Trust Administrator for a copy of the treatment for sexual dysfunction policy of the National PPO provider.

DIALYSIS TREATMENT—OUTPATIENT

This Section describes the Plan's Dialysis Benefit Preservation Program (the "Dialysis Program"). The Dialysis Program shall be the exclusive means for determining the amount of the Plan benefits to be provided to Covered Persons and for managing cases and claims involving dialysis services and supplies, regardless of the condition causing the need for dialysis.

A. Reasons for the Dialysis Program. The Dialysis Program has been established for the following reasons:

1. The concentration of dialysis providers in the market in which the Plan members reside may allow such providers to exercise control over prices for dialysis-related products and services,
2. The potential for discrimination by dialysis providers against the Plan because it is a non-governmental and non-commercial health plan, which discrimination may lead to increased prices for dialysis-related products and services charged to Plan members,
3. Evidence of (i) significant inflation of the prices charged to the Plan members by dialysis providers, (ii) the use of revenues from claims paid on behalf of the Plan members to subsidize reduced prices to other types of payers as incentives, and (iii) the specific targeting of the Plan and other non-governmental and non-commercial plans by the dialysis providers as profit centers, and
4. The fiduciary obligation to preserve the Plan assets against charges which (i) exceed reasonable value due to factors not beneficial to the Plan members, such as market concentration and discrimination in charges, and (ii) are used by the dialysis providers for purposes contrary to the Plan members' interests, such as subsidies for other plans and discriminatory profit-taking.

B. Dialysis Program Components. The components of the Dialysis Program are as follows:

1. *Application*. The Dialysis Program shall apply to all claims filed by, or on behalf of, the Plan members for reimbursement of products and services provided for purposes of outpatient dialysis, regardless of the condition causing the need for dialysis ("dialysis-related claims").
2. *Claims Affected*. The Dialysis Program shall apply to all dialysis-related claims received by the Plan on or after November 1, 2017, regardless when the expenses related to such claim were incurred or when the initial claim for such products or services was received by the Plan with respect to the Plan member.
3. *Mandated Cost Review*. All dialysis-related claims will be subject to cost review by the Trust Administrator to determine whether the charges indicate the effects of market concentration or discrimination in charges. In making this determination the Trust Administrator shall consider factors including:
   i. *Market concentration*: The Trust Administrator shall consider whether the market for outpatient dialysis products and services is sufficiently concentrated to permit providers to exercise control over charges due to limited competition, based on reasonably available data and authorities. For purposes of this consideration multiple dialysis facilities under common ownership or control shall be counted as a single provider.
   ii. *Discrimination in charges*: The Trust Administrator shall consider whether the claims reflect potential discrimination against the Plan, by comparison of the charges in such claims against reasonably available data about payments to outpatient dialysis providers by governmental and commercial plans for the same or materially comparable goods and services.
4. In the event that the Trust Administrator's charge review indicates a reasonable probability that market concentration and/or discrimination in charges have been a material factor resulting in an increase of the charges for outpatient dialysis products and/or services for the dialysis-related claims under review, the Trust Administrator may, in its sole discretion, determine that there is a reasonable probability that the charges exceed the reasonable value of the goods and/or services. Based upon such a determination, the Trust Administrator may subject the claims and all future claims for outpatient dialysis goods and services from the same provider with respect to the Plan member, to the following payment limitations, under the following conditions:
   i. Where the Trust Administrator deems it appropriate in order to minimize disruption and administrative burdens for the Plan member, dialysis-related claims received prior to the cost review determination may, but are not required to be, paid at the face or otherwise applicable rate.
   ii. Where the provider is or has been a participating provider under a Preferred Provider Organization (PPO) available to the Plan's members, upon the Trust Administrator's determination that payment limitations should be implemented, the rate payable to such provider shall be subject to the limitations of this Section.
   iii. *Maximum Benefit*. The maximum the Plan benefit payable to dialysis-related claims subject to the payment limitation shall be the Usual and Reasonable Charge for covered services and/or supplies, after deduction of all amounts payable by coinsurance or deductibles.
   iv. *Usual and Reasonable Charge*. With respect to dialysis-related claims, the Trust Administrator shall determine the Usual and Reasonable Charge based upon the average payment actually made for reasonably comparable services and/or supplies to all providers of the same services and/or supplies by all types of

plans in the applicable market during the preceding calendar year, based upon reasonably available data, adjusted for the national Consumer Price Index medical care rate of inflation. The Trust Administrator may increase or decrease the payment based upon factors concerning the nature and severity of the condition being treated.

v. *Additional Information Related to Value of Dialysis-Related Services and Supplies*. The Plan member, or where the right to the Plan benefits has been properly assigned to the provider, may provide information with respect to the reasonable value of the supplies and/or services, for which payment is claimed, on appeal of the denial of any claim or claims. In the event the Trust Administrator, in its sole discretion, determines that such information demonstrates that the payment for the claim or claims did not reflect the reasonable value, the Trust Administrator shall increase or decrease the payments (as applicable) to the amount of the reasonable value, as determined by the Trust Administrator based upon credible information from identified sources. The Plan Administrator may, but is not required to, review additional information from third-party sources in making this determination.

vi. All charges must be billed by a provider in accordance with generally accepted industry standards.

5. *Provider Agreements*. Where appropriate, and a willing appropriate provider acceptable to the Plan member is available, the Trust Administrator may enter into an agreement establishing the rates payable for outpatient dialysis goods and/or services with the provider, provided that such agreement must identify this Section of the Plan and clearly state that such agreement is intended to supersede this Section.

6. *Discretion*. The Trust Administrator shall have full authority and discretion to interpret, administer, and apply this Section, to the greatest extent permitted by law.

GENERAL EXCLUSIONS AND LIMITATIONS

The Plan will not pay benefits for the following exclusions and limitations:

- Any injury or illness which arises out of or in the course of any employment with any employer or for which the covered person is entitled to benefits under any workers' compensation or occupational disease law, or receives any settlement from a workers' compensation carrier or other third-party source (reference subrogation provisions below),but this exclusion does not apply to any Accidental Death and Dismemberment ("AD&D") benefits or weekly disability (time loss) benefits provision
- Any expense which is in excess of the usual, customary, and reasonable global charges
- Any expense for genetic testing, except for genetic testing required as a preventive service under the Affordable Care Act
- Any expense or charge for services or supplies not medically necessary
- Any expense incurred after coverage ends (except as specifically provided under any extended benefits provisions in the Plan)
- Any expense which is not the result of an injury or illness as defined in the definitions section of the Plan, except as otherwise specifically covered under the Plan (this exception applies only to any Accidental Death and Dismemberment (AD&D)
- Any loss, expense, or charge resulting from the covered person's participation in a riot or in the commission of a felony
- Any expense or charge which a beneficiary does not have to pay
- Any treatment, service, or supply unless it is shown as a covered service
- Contact lenses, except as specifically provided under the Vision Plan
- Eye refractions or the fitting or cost of visual aids or surgery to correct visual acuity; routine eye care will be allowed for services involving diseases of the eye including but not limited to diabetes, cataracts, and macular degeneration
- The fitting or cost of hearing aids, except as specifically provided
- Alcohol and drug abuse, except as provided under the chemical dependency benefit
- Mental disorder, except as provided under the mental disorder benefit
- Any expense or charge for failure to appear for an appointment as scheduled, or for completion of claim form or for additional information as requested for claims processing
- Any expense or charge for medicines, vitamins, or any other supplements not prescribed for an illness except as specifically provided
- Any expense or charge which is older than 12 months from the date of service
- Services and supplies which are for conditions related to behavioral health, learning disability, pervasive developmental disability, communication delay, perceptual disorder, hospitalization for environmental change, or mental retardation, any of which are not otherwise covered under the mental disorder benefit or other benefit
- Services or supplies by a provider who normally resides in your home or is related to you by blood or marriage
- Spinal treatment, except as specifically provided under the spinal treatment benefit
- Any expense or charge for custodial care or developmental care
- Any expense which results from reconstructive surgery, except
  - For an injury

- For repair of defects which result from surgery
- For the reconstructive (not cosmetic) repair of a congenital defect which materially corrects a bodily malfunction

- Any expense which results from cosmetic surgery
- Any loss, expense, or charge which results from appetite control, food addictions, eating disorders (except for documented cases of bulimia, anorexia, or other eating disorders that meet standard diagnostic criteria as determined by us, and present significant symptomatic medical problems, or are otherwise recognized as a mental disorder) or any treatment of obesity (including surgery to treat morbid obesity) not covered under the bariatric surgery benefit and as deemed medically necessary
- Any expense or charge for orthopedic shoes, orthotics, or other supportive devices for the feet, except as specifically provided in the Plan
- Any expense or charge in connection with dental work, dental surgery, or oral surgery (unless the charges are usual, customary, and reasonable as part of a medically necessary procedure specifically provided or required by law), including:
  - Treatment or replacement of any tooth or tooth structure, alveolar process, abscess, or disease of the periodontal or gingival tissue; or surgery or splinting to adjust dental occlusion
  - Any expense or charge for treatment of jaw joint disorders (unless specifically provided)
- Any loss, expense, or charge related to mental disorders which are classified as sexual deviations or disorders, except as otherwise required by nondiscrimination provisions of the Affordable Care Act
- Any expense or charge for the diagnosis or treatment of fertility or infertility or promotion of fertility including (but not limited to):
  - Fertility tests and procedures
  - Reversal of surgical sterilization
  - Any attempts to cause pregnancy by hormone therapy, artificial insemination, in vitro fertilization and embryo transfer or any treatment or method
- Chelation therapy except for acute arsenic, gold, mercury, or lead poisoning;
- Any expense or charge for services or supplies which are not provided in accordance with generally accepted professional standards on a national basis;
- Unless required under 42 U.S.C. § 300gg-8 as part of an approved clinical trial (such as for routine patient costs), any expense or charge for services or supplies which:
  - Are considered experimental or investigational drugs, devices, treatments or procedures
  - Result from or relate to the application of such experimental or investigational drugs, devices, treatments or procedures
- Any expense or charge which is primarily for education, training, or development of skills needed to cope with an injury or illness, unless specifically provided in the Plan
- Any expense or charge which is primarily for the participant's convenience or comfort or that of the participant's family, caretaker, physician, or other medical provider
- Any expense or charge for telephone calls to or from a physician, hospital, or other medical provider
- Any loss, expense, or charge which results from services for a pervasive developmental disability, unless covered under the mental disorder benefit. (When the Trust, medical staff, or a qualified party or entity selected by the Trust determines that a confinement or visit is mainly for developmental disability, some services such as prescription drugs, x-rays and lab tests may still be covered if medically necessary and otherwise covered by the Plan. All bills should be routinely submitted for consideration.)
- Any expense or charge for services or supplies which are provided or paid for by federal government or its agencies; except for:
  - The Veterans Administration, when services are provided to a veteran for a disability which is non service-connected
  - A military hospital or facility, when services are provided to a retiree (or dependent of a retiree) from the armed services
  - A group health plan established by a government for its own civilian employees and their dependents
- Any loss, expense, or charge which results from an act of declared or undeclared war
- Any loss, expense, or charge:
  - Which is incurred while the covered person is on active duty or training in the armed forces, national guard, or reserves of any state or country
  - For which any governmental body or its agencies are liable
- Maternity for dependent children
- Marriage or family counseling
- Any expense or charge for injury or illness caused by the act or omission of another person (known as a third-party) for which there is a potential opportunity to recover from the third-party, the third-party's insurer, or any other liability policy including but not limited to an automobile policy, commercial premises policy, homeowner's policy, medical malpractice policy, renter's policy, or any other liability policy, including first-party uninsured or underinsured motorist policy. The Plan may agree to advance benefits if the participant agrees to reimburse the Plan as set forth in the Plan's Reimbursement Procedure.

PRESCRIPTION DRUG PLAN

FOR ACTIVE PARTICIPANTS AND THEIR DEPENDENTS

The Prescription Drug Plan covers most medically necessary medications that are prescribed by a qualified health care provider. The Plan is completely separate from the Medical Plan, which means you do not have to pay the annual deductible before Prescription Drug benefits are payable.

When you need a prescription filled (or refilled), except as otherwise provided below, you have three options:

1. **Go to a Participating Pharmacy.** Participating pharmacies charge a discounted rate, so you'll usually save money. Simply present your Prescription Plan ID card, pay your copay, and the pharmacy will submit a claim to the Plan for the remainder. To locate a Participating Pharmacy, call the Trust Administrator or Elixir, the pharmacy benefits manager ("PBM"). (See contact information on page 1.)
2. **Go to a Non-Participating Retail Pharmacy.** You must pay the full charge at the time of purchase and then submit a claim to be reimbursed for only the discounted (Participating Pharmacy) rate, less the copay. Only the copay amount will be applied to the out-of-pocket maximum.
3. **Use the Mail-Order Pharmacy.** This option is for ongoing prescriptions that you take regularly, for example, blood pressure or cholesterol lowering medications. You pay your copay when you place your order and the mail-order pharmacy submits a claim to the Plan for the remainder.

NOTE: If you or your dependent are Medicare eligible and are enrolled in a Medicare Part D prescription drug plan, outpatient prescription drug benefits will not be provided under the Plan.

! KEY POINT

The Plan covers medically necessary prescription drugs and does not require a deductible before benefits begin.

PRIOR AUTHORIZATION REQUIRED; CERTAIN OPIOID MEDICATIONS NOT COVERED

Elixir, the PBM, will require prior authorization for all compound medications and chemicals. In addition, no compound medication in excess of $75 will be allowed, and specific ingredients that are being used outside the FDA approved label for that medication or are not approved for human use will be excluded.

Elixir, the PBM, will require prior authorization for many medications that have been shown to have a significant amount of off-label use as well as all medications in excess of $1,000 at a retail pharmacy or $2,000 via mail order pharmacy.

Elixir, the PBM, will require prior authorization for narcotic drugs that have the potential for abuse. All opioid medications are subject to prior authorization to ensure they are being used appropriately.

PRESCRIPTION DRUG BENEFITS SUMMARY

Overview	Retail and Specialty Pharmacy	Mail-Order Pharmacy
Deductible	None required	
Out-of-Pocket Maximum The most you'll pay in copays each year, after which copays are waived for the remainder of the year	**Standard Benefits: $5,000/person** **Material Handlers Benefits: $3,300/person** **Basic Benefits: $2,850/person** **Retirees: $4,300** **Standard, Material Handlers, Basic, and Retirees: $5,000/family**	
Supply Limit The maximum supply per refill*	30 days**	90 days
Preferred Generic Prescriptions	$0	$0
Generic Prescriptions	$5 or 15% copay up to $50, whichever is greater, per month	$12.50 or 15% copay up to $125, whichever is greater, per month
Formulary Brand Name Prescriptions	$20 or 25% copay up to $150, whichever is greater, per month	$50 or 25% copay up to $375, whichever is greater, per month
Non-Formulary Brand Name Prescriptions	$20 or 50% copay, whichever is greater, per month	$50 or 50% copay, whichever is greater, per month

*Specialty Prescriptions are limited to a 30-day supply. Erectile dysfunction medication is subject to a quantity limit of 10 pills for 30 days.

**Generic recurring maintenance medications may be filled for a 90-day supply with 3 monthly copayments ($15 or 15%, whichever is greater, up to $150).

Additionally, several high potency narcotic drugs, including Zohydro, Fentanyl, and Actiq, are subject to prior authorization, which will need to be renewed every three months instead of the standard 12-month period.

OxyContin and derivative forms (including oxycodone-based medications) and certain other related opioid medications are covered only for treatment of a terminal illness, end-of-life pain management, and for no more than 7 days for post-surgery pain management. Otherwise, the Plan does not cover these medications.

DISPENSE AS WRITTEN PENALTY

A "Dispense as Written" (DAW) penalty will apply unless requested by the prescribing doctor. The penalty is the highest tier coinsurance plus ingredient cost difference when requested by the patient/member at the pharmacy.

DAYS' SUPPLY LIMITATIONS

- The maximum days' supply allowable at retail pharmacies is 30 days for Brand Name medications and 90 days for Generic medications.
- The maximum allowable days' supply at the mail-order pharmacy is 90 days.
- The maximum allowable days' supply for Specialty Prescriptions is 30 days.

If purchasing more than these amounts for a drug on the same day, the Plan will not cover any expense exceeding the supply limit.

The Plan covers prescription refills only when no more than 25% of the days' supply remains, based on the physician's written order.

COORDINATION OF BENEFITS

This Prescription Drug Plan does not coordinate benefits with any other benefit coverage.

PARTICIPATING PHARMACIES

The Trust will publish an updated list of participating pharmacies periodically. For the current list of participating pharmacies, see inside front cover for contact information. The Trust will also provide prescription ID cards for participants.

The Trust does not supervise, control, or guarantee the services of any Participating Pharmacy or other providers. Please make sure that you are obtaining medications from a participating pharmacy.

NONPARTICIPATING PHARMACIES

When you choose a Nonparticipating Pharmacy, you must pay the pharmacy the full charge at the time of purchase and then submit a Nonparticipating Drug Claim Form as directed inside the front cover.

The Plan will reimburse you at the negotiated Participating Pharmacy rate, less the appropriate copay. This usually means you will pay more for the prescription than if you choose a Participating Pharmacy.

Only your copays will be applied toward the $5,000 annual maximum out of pocket costs. The difference between the reimbursement plus the copay and the actual charge for the prescription will not be applied to the annual maximum out of pocket amount.

MAIL-ORDER PHARMACY

Enjoy the convenience of home delivery by using mail-order. There is no cost for delivery and you can refill a 90-day supply, saving you trips to the pharmacy. Follow the steps below to get started.

The mail-order pharmacy automatically fills your prescriptions with a generic drug whenever possible. If your physician specifies a brand-name drug and writes "dispense as written" (DAW) on the prescription, the pharmacist will fill your prescription with the brand-name drug rather than filling it with a generic drug. However, the pharmacist may call your physician to request approval of filling your prescription with a generic drug.

Call the number listed inside the front cover:

- For information about placing your first order
- To order refills
- For consultation with an emergency pharmacist - seven days a week, 24 hours a day

GETTING STARTED WITH MAIL-ORDER

1. Request a Patient Profile questionnaire and an envelope, from the Trust Administrator or your local union office.
2. Complete a Patient Profile questionnaire for each family member who will use this program. The questionnaire asks for information about each participant's medical history, blood type, allergies, and any other drugs they are taking (prescription and over the counter). This information is kept on file, and checked with every prescription. You may update your profile as you like by including any health condition changes with your prescription. Our group number/name is: **PAINTER**.
3. Complete the information requested on the form/envelope. Be sure to include all required information, including the physician's name.
4. If you are getting a new prescription filled, ask your physician to prescribe up to a 90-day supply of the maintenance drug with the appropriate number of refills.
5. If you are requesting a refill, place your refill order at least two weeks before your prescription runs out. With each prescription, a notice showing how many refills you have left will be included. Be sure to contact your physician for a new prescription when you request your last refill.
6. Send your prescription (and questionnaire if it is your first order or request for a refill) and the appropriate copay in the envelope. Call to get an estimate of your copay amount. You may pay by check, money order, MasterCard, Visa or Discover card; if you use a credit card, include the card number and expiration date. Do not send cash.
7. Your prescription will be delivered at your home within two weeks by United Parcel Service (UPS) or U.S. Mail. With each prescription, you'll receive a postage-paid envelope to use to order refills.

SPECIALTY PHARMACY DRUGS AND MEDICINES

Specialty drugs and medicines are normally high-cost drugs which are specially formulated to treat complex conditions. Often these drugs require special handling and are administered via injection. The Trust requires preauthorization to determine medical necessity on many of these drugs. For information about specific drugs and conditions, contact Archimedes, the Specialty PBM. Please note that Specialty medications are limited to a 30-day supply. Specialty medications may also be subject to Prior Authorization and Step Therapy. Specialty prescriptions must be filled through Archimedes.

Prescriptions for the treatment of Hepatitis C must be filled through Archimedes. This includes but is not limited to Harvoni, Sovaldi, and Viekira.

Additionally, in order to permit the Plan to take more full advantage of available manufacturer-funded copay assistance, copays for certain Specialty medications may be increased to the maximum of either the current plan design (based on whether the particular specialty medication is classified by the Plan as a brand or generic, formulary, or non-formulary medication) or the copayment amount set for any available manufacturer-funded copay assistance. However, in no case will true out-of-pocket costs to the participant be greater than the maximum copayment published above. Finally, manufacturer-funded copay assistance received will not be considered to be or credited as a true out-of-pocket cost for participants and will not apply toward deductibles and out-of-pocket maximums.

STEP THERAPY

Step therapy requires starting treatment with the most cost-effective and safest drug therapy and progressing to other, more costly therapies only if medically necessary and approved through the Prior Authorization process.

Certain medications, including the therapy classes listed below, are subject to Step Therapy.

Therapy Class	Condition
ARBs	Heart and High Blood Pressure
Cox II	Inflammation/Pain
SSRI/SNRI	Depression
PPI	Stomach Acid
Statins	Cholesterol
NSAIDs	Prescription Pain Relief
Gout	Gout

If you have questions about this process or want to know more about the specific medications affected by Step Therapy, please call Archimedes Customer Service at (888) 504-5563.

OVER-THE-COUNTER MEDICATIONS

The Prescription Drug Plan covers certain over-the-counter ("OTC") medications when you have a doctor's written prescription:

- Proton-Pump Inhibitors (e.g., Prevacid OTC, generic equivalents)
- Non-Sedating Antihistamines (e.g., Zyrtec, Zyrtec-D, Claritin, Claritin-D, and their generic equivalents)
- Cough Syrup with Codeine

OTC medications covered by the Plan are processed like any other medication you purchase under the Plan. You must present your Prescription Drug Plan ID card to the pharmacy when you purchase these OTC drugs.

PRESCRIPTION DRUG PLAN EXCLUSIONS

The Prescription Drug Plan excludes (does not cover) the following items:

- Syringes, other than for use with insulin
- Fertility drugs
- Obesity drugs
- Over the counter items (unless otherwise provided for by the Plan)
- Hair growth items (e.g., Rogaine)
- Drugs that have been determined under the internal standards of the Food and Drug Administration ("FDA") to be "less-than-effective" in accordance with the Drug Efficacy Study Implementation ("DESI")
- Prescription drugs that are also available over the counter
- Any prescription or refill which, considered individually or cumulatively within a timeframe, authorizes dosages which exceed the FDA's or manufacturer's recommendations
- Any drug used for a purpose which is deemed to be not medically necessary
- Drugs dispensed directly to the participant by physician, even if the physician charges separately for them
- Drugs dispensed directly to a participant while a patient in a hospital, skilled nursing facility, nursing home, or other health care institution
- Non-drug items, such as mechanical contraceptives, immunization agents, nose drops, gamma globulin, appliances, non-drug items, or injectable drugs normally administered by a physician or nurse;
- Drugs dispensed prior to the participant's coverage becoming effective or after the participant's coverage has terminated
- Prescription vitamins
- Anything excluded under the General Exclusions and Limitations section in the Medical Plan section of the Plan.

DENTAL PLAN

The Plan has contractual arrangements with Preferred Providers. Under these arrangements, certain providers have agreed to discounted charges.

A "discounted charge" is the amount that a provider has agreed to accept as payment in full for covered health care services or supplies.

Claims under the Plan and any deductible, copayment (based upon percentage of charge), coinsurance and benefit maximums as described in the Plan will be determined based on the discounted charge.

You may choose any licensed dentist to provide services. The Plan pays up to a specific amount for covered services, as listed in the Dental Schedule of Covered Services (available upon request from the Trust Administrator or on the www.IUPATWesternBenefits.org website.)

Many dentists will submit a claim for you when you present your Health Plan identification card. However, you may be required to pay the full amount and then submit a claim to the Plan for reimbursement. If you're utilizing a PPO Dentist, the Plan will pay the benefit at the applicable coinsurance level up to the PPO allowed amount, and you may be responsible for the remaining charge.

You must first meet the annual deductible before the Plan pays benefits. The Plan then pays the dentist's charges up to the amount shown in the Dental Schedule of Allowances, available from the Trust Administrator or on the www.IUPATWesternBenefits.org website.

Dental Plan participation is based on the bargaining agreement with each employer, or which plan you retired under; please contact the Trust Administrator to confirm your participation.

Dental Plan participation is based on the bargaining agreement with each employer or under which you retired; please contact the Trust Administrator to confirm your participation. Dental benefits are excluded from Material Handlers and Basic Plan benefits. Retirees must elect these benefits at initial enrollment in the Retiree Benefit Program or 60 days prior to becoming Medicare-eligible, if desired and not previously elected.

DENTAL BENEFITS SUMMARY

Overview		
Deductible The amount of covered services that you must pay each year before the Plan pays benefits	$25/person	
Maximum Benefit The most the Plan pays per person per calendar year	$2,000/person	
Covered Services	**In-Network (% of contracted charges)***	**Out-of-Network (% of UCR)**
Class I: Diagnostic and Preventive Services Routine oral exams, teeth cleaning and fluoride treatment (up to twice per calendar year) X-rays and sealants (following frequency guidelines)	100%	75%
Class II: Restorative Services Extractions, oral surgery, fillings, periodontics and endodontic procedures, crowns	80%	60%
Class III: Prosthodontic Services Dentures and bridges	60%	50%
Orthodontia Only available to eligible dependent children up to age 26 who have been enrolled in the Dental Plan on the first day of the month following a 9-month period during which you have been eligible for 6 months	Plan pays 15% of the entire cost as down payment when banding occurs and 50% of the monthly adjustment fee $2,000 lifetime maximum/person	
Personal Protective Equipment (PPE) Personal Protective Equipment will be considered as a Covered Dental Benefit, effective March, 1, 2020.	Plan will cover PPE at 100% of billed charges up to a maximum of $10/visit	

*Dentists that are contracted with Careington Maximum Care Network cannot charge participants for any amounts over the contracted rate. For Class II and Class III procedures, participants will be responsible for the contracted amount over what the Plan will pay.

COVERED DENTAL SERVICES

DIAGNOSTIC AND PREVENTIVE SERVICES

- Routine oral examinations, but not more than twice in a calendar year
- Routine prophylaxis (cleaning and scaling of teeth) by a dentist or dental hygienist, but not more than twice in a calendar year
- Fluoride treatment by a dentist or dental hygienist, but not more than twice in a calendar year
- Dental x-rays, but not more than:
  - One panoramic x-ray in any period of three consecutive calendar years
  - One full-mouth series of x-rays in any period of three consecutive calendar years
  - Four supplemental bite-wing x-rays in a calendar year
- Space maintainers
- Dental sealants applied to the first and second permanent molars, but only:
  - For your dependent who is less than age 16
  - When the teeth have not been treated with sealants for at least four years

RESTORATIVE SERVICES

- Extractions
- Oral surgery
- Fillings
- Periodontic procedures (treatment of the area around the tooth)
- Endodontic procedures (treatment of the dental pulp, for example root canals)
- Emergency treatment for the relief of dental pain
- Crowns and the replacement of a crown restoration when the original crown was placed more than five years prior to the replacement
- General anesthesia given in connection with covered dental services

NOTE: Crowns and inlays of gold or non-precious metals are covered if usual filling materials are not satisfactory.

If you elect to have a crown or inlay in lieu of a filling, the Plan pays as if you had an amalgam restoration.

PROSTHODONTIC SERVICES

- The first placement of full or partial removable dentures, temporary dentures, or fixed bridgework (including adjustments during the six-month period following placement)
- The placement must be needed as a result of the extraction of one or more natural teeth. The denture or bridgework must include the replacement of the extracted teeth; the Plan will not pay for replacement of third molars (wisdom teeth)
- The replacement or alteration of full or partial dentures or fixed bridgework that is necessary because of oral surgery:
  - Resulting from an accident
  - For the repositioning of muscle attachments
  - For the removal of tumor, cyst, torus, or redundant tissue
- The surgery must be performed while you or your dependent is covered; the replacement or alteration must be completed within 12 months from the day of surgery
- The replacement of a full denture that is necessary because of:
  - Structural change within the mouth and when more than five years have gone by since the prior placement
  - The first placement of an opposing full denture when the placement takes place after the individual has been covered under this provision for two years or more
  - The prior placement of an immediate or temporary denture when the replacement occurs within 12 months of the initial placement
- Addition of teeth to, or replacement of, an existing partial or full removable denture or fixed bridgework when:
  - The replacement or addition is needed to replace one or more additional natural teeth
  - The existing denture or bridgework was put in at least five years prior to its replacement
- Inlays and precision attachments for dentures
- Repair or recementing of crowns, inlays, bridgework, or dentures, including the rebasing or relining of dentures

ORTHODONTIA

(for dependent children only)

Orthodontia benefits are only available to eligible dependent children up to age 26 who have been enrolled in the Dental Plan on the first day of the month following a 9-month period during which you have been eligible for 6 months. Covered services include initial and subsequent installations of orthodontic appliances, and all orthodontic treatments for reduction or elimination of malocclusion and attendant sequelae through correction of malpositioned teeth.

Orthodontia benefits are payable if all of the following conditions are met:

- Before treatment begins, the dentist diagnoses the need for the treatment and submits to the Trust a plan of treatment indicating a condition of handicapping malocclusion that is correctable
- The Plan gives its authorization for the dentist's plan of treatment
- One of the following diagnoses applies:
  - Extreme buccolingual version of teeth
  - Protrusion of maxillary anterior teeth is more than 4mm
  - Maxillary or mandibular arc is in protrusive or retrusive relation to a cusp
  - Malalignment of teeth interferes with function or creates marked facial deformity
- The dentist acquires and maintains records, including x-rays, photographs, and models, adequate to show the patient's oral condition before and after treatment and available at the Plan's request, to verify the diagnosis and that the orthodontic needs and treatment are within the scope of these orthodontia provisions.

Orthodontic benefits do not include coverage for:

- Orthodontia performed exclusively on primary teeth
- Replacement or repair of any appliance furnished in connection with treatment
- Any service for which a benefit is provided under other provisions of the Dental Plan
- Consultation or planning of treatment, except planning in connection with treatment authorized by the Trust under these provisions
- Any broken appointment
- Expenses incurred after coverage for orthodontia benefits terminates
- Expenses incurred after the termination of the orthodontia provisions under the Plan

NOTE: To determine benefits for treatment in progress when coverage begins or terminates, expenses for a service are considered to be incurred on the date the service is performed

PREAUTHORIZATION OF EXTENSIVE DENTAL SERVICES

Preauthorization of benefits helps you determine your out-of-pocket expense before you receive extensive dental services. Ask your dentist to submit a claim form, indicating all procedures needed to fully complete treatment, including the fee for each procedure.

The Plan will then confirm your eligibility and determine the benefits for the procedures, so you will know how much the Plan will pay—and what your out-of-pocket expenses will be.

When the Plan returns the form to your dentist, your dentist will contact you to make arrangements for treatment. Treatment must be completed within 60 days from the date the preauthorization is received.

OUTPATIENT HOSPITAL FOR DENTAL WORK

The Plan covers outpatient hospital and anesthesia under some instances when a child up to age 11 undergoes extensive dental work.

CONDITIONS

Dental services must be performed by a licensed dentist and includes any required supplies. Before the Plan pays any benefits, the Plan may request:

- Supporting proofs of loss
- Clinical reports;
- Charts
- X-rays

DENTAL PLAN EXCLUSIONS

The Plan will not pay for:

- Any treatment, service, or supply not included in the list of covered dental services above
- Treatment of the teeth or gums for cosmetic purposes, including realignment of teeth
- Expense incurred after coverage ends; however, the Plan pays for prosthetics, including bridges and crowns, which were fitted and ordered prior to the date coverage ends and received within 30 days after the coverage ends
- Prosthetics, including bridges and crowns, started or under way prior to the date you or your dependent became covered under the Plan; for prosthetics, the incurred date will be the initial "prep date"
- Rebasing or relining of a denture less than six months after the first placements, and not more than one rebasing or relining in any two-year period
- Analgesia/nitrous oxide
- Replacement of lost or stolen prosthetics
- Replacement of prosthetics less than five years after a previous placement, except as specifically provided in prosthodontic services section
- A new denture or bridgework if the existing denture or bridgework can be made serviceable
- Charges you or your dependent are not required to pay, including charges for services furnished by any hospital or organization which normally makes no charge if the patient has no hospital, surgical, medical, or dental coverage

- Any hospital charges
- Procedures, restorations, and appliances to change vertical dimension or to restore occlusion (proper contact between opposing teeth)
- Any expense paid in whole or in part by the Medical Plan
- Sealants (except as previously indicated)
- Appliances (night guards) except for bruxism
- Charges incurred for temporomandibular joint disorder (TMJ)
- Any expense or charge paid in whole or in part by any other provision of the Medical Plan, including:
  - Treatment or replacement of any tooth or tooth structure, alveolar process, abscess, or disease of the periodontal or gingival tissue; or surgery or splinting to adjust dental occlusion.

VISION PLAN

You may choose any provider from the Vision Service Provider (VSP) network. Covered expenses include eye exams performed by a legally qualified ophthalmologist or optometrist and prescribed lenses or frames required for prescription lenses.

VSP Providers agree to a discounted rate, which saves you money and keeps costs down for the Trust. In most cases, you will be asked to pay any amount exceeding the Plan's benefit at the time you receive services.

Vision Plan participation is based on the bargaining agreement with each employer or under which you retired; please contact the Trust Administrator to confirm your participation. Vision benefits are excluded from Material Handlers and Basic (previously Western Washington Residential Painting and Utah Drywall) benefits. Retirees must elect these benefits at initial enrollment in the Retiree Benefit Program or 60 days prior to becoming eligible for Medicare, if desired and not previously elected.

! KEY POINT

You may choose any provider from the Vision Service Provider (VSP) network. VSP Providers agree to a discounted rate, which saves you money and keeps costs down for the Trust.

COVERED VISION SERVICES

- Eye exam: The charges for an eye exam, including refraction, performed by a legally qualified ophthalmologist or optometrist
- Lenses: The charge for prescribed lenses
- Frames: The charge for frames required for prescription lenses
- Benefits are provided for one eye exam and two lenses each calendar year, and one set of frames each two consecutive calendar years
- Either lenses or contacts allowed per year
- Prescription or Nonprescription Safety Glasses: Single vision, lined bifocal, and lined trifocal lenses. This benefit is available only to the participant and not dependents. Only ProTec brand safety glasses are fully covered and must be obtained from participating VSP providers. When non-ProTec brand safety glasses are obtained from a provider in or out of the VSP Network, safety glasses are reimbursed at the rates set forth in the chart as previously noted.

VISION PLAN EXCLUSIONS

The Plan will not pay for:

- Visual field charting
- Orthoptics or vision training
- Subnormal vision aids
- Aniseikonic lenses
- Tinted lenses or sunglasses
- Nonprescription lenses, except under the safety glasses benefit
- More than the allowance for a standard prescription when multi-focal hard resin lenses, coated lenses, or no-line bifocals (blended type) are chosen
- Medical or surgical treatment of the eyes
- Services and supplies that are payable under a workers' compensation occupational disease law
- Any expense that results from an act of declared or undeclared war or armed aggression
- Any expense that you or your dependent does not have to pay
- Any eye examination required as a condition of employment
- More than one exam for any covered individual during any calendar year
- More than two lenses for any covered individual during any calendar year
- More than one set of frames for any covered individual during any two consecutive calendar years
- Any expense paid in whole or part by any other provision of the Medical Plan
- Anything excluded under the General Exclusions and Limitations section in the Medical Plan section of the Plan

HOW TO FILE A CLAIM

Only claims incurred on or after the effective date of your coverage will be processed. To receive prompt payment for your claims, follow these procedures:

1. Obtain a claim form from VSP.
2. Complete your portion by inserting all of the information requested. Be sure to sign the claim form where indicated.
3. Mail the completed claim form and your itemized bills to VSP.
4. Claims may also be submitted online at www.vsp.com.

VISION BENEFITS SUMMARY

Covered Expenses (in VSP Network)	Copay	Frequency*
WellVision Exam	$0	Every 12 months
Frame • $170 allowance for a wide selection of frames** • $190 allowance for featured frames • 20% savings on the amount over your allowance** • $95 allowance at Costco**		Every 24 months
Lenses • Single vision, lined bifocal, and lined trifocal lenses • Polycarbonate lenses for dependent children • Anti-reflective lens coating (Covered in full after a $40 copay)		Every 12 months
Lens Enhancements • Standard progressive lenses • Premium progressive lenses • Custom progressive lenses • Average savings of 30% on other lens enhancements	$0 $95–$105 $150–$175	Every 12 months
Contact Lenses (instead of glasses) • $170 allowance for contacts; copay does not apply** • Contact lens exam (fitting and evaluation)	Up to $60	Every 12 months
Diabetic Eyecare Plus Program Services related to diabetic eye disease, glaucoma, and age-related macular degeneration (AMD). Retinal screening for eligible members with diabetes. Limitations and coordination with medical coverage may apply. Ask your VSP doctor for details	$20	As needed
Prescription or Nonprescription Safety Glasses** Single vision, lined bifocal, and lined trifocal lenses. This benefit is available only to the participant and not dependents. Only ProTec brand safety glasses are fully covered and are available from participating VSP providers only.	$0	Lenses every 12 months, frame every 24 months

EXTRA SAVINGS: Glasses and Sunglasses: 20% savings on additional glasses and sunglasses, including lens enhancements, from any VSP doctor within 12 months of your last WellVision Exam. **Laser Vision Correction:** Save up to $1,000 on Lasik; discounts only available from contracted facilities

Covered Expenses (Out of VSP Network)	
Complete Eye Exam One exam allowed per calendar year	Plan pays up to $50
Lenses Two lenses (one pair) allowed each calendar year	Plan pays based on lens type: Single—up to $50 • Bifocal—up to $75 Trifocal—up to $91 • Progressive—up to $75
Frames One set of frames allowed every two consecutive calendar years	Plan pays $72
Contact Lenses The Plan pays benefits for either lenses or contact lenses (not both) each calendar year	Plan pays up to $105
Prescription or Nonprescription Safety Glasses Single vision, lined bifocal, and lined trifocal lenses (non-ProTec brand safety glasses). This benefit is available only to the participant and not dependents. When safety glasses are obtained from a provider out of the VSP Network or non-ProTec brand safety glasses are obtained (even if in-network), safety glasses are reimbursed at the rates set forth to the right..	Plan pays based on lens type: Single—up to $35 Bifocal—up to $45 Trifocal—up to $60

*Frequency is measured from the date of last service. **Please note that all allowances listed are subject to change.

ACCIDENTAL DEATH & DISMEMBERMENT (AD&D) BENEFITS

The Plan provides AD&D coverage for all active participants, which provides financial help for you and your family in the event of your serious injury or loss of life. The Plan pays benefits only if the active member is accidentally injured or killed.

The Plan pays benefits to you for any injury and to your beneficiary in the event of your death, in the amounts shown in the table below.

! KEY POINT

Accidental Death & Dismemberment (AD&D) coverage provides financial help for your family in the event of your serious injury or loss of life.

AD&D BENEFITS SUMMARY

Loss	Benefit Amount
Life	$10,000
Both hands, both feet, or both eyes	$10,000
One hand and one foot, one hand and one eye, or one foot and one eye	$10,000
One hand, one foot, or one eye	$5,000
Thumb and index finger of same hand	$2,500

INJURY DEFINITIONS

- Loss of a hand means the severance at or above the wrist joint.
- Loss of a foot means the severance at or above the ankle joint.
- Loss of thumb and index finger means the severance of two or more phalanges of both the thumb and the index finger.
- Loss of an eye means the total loss of sight in that eye.

If the injury causes more than one loss, the Plan pays only the largest benefit.

BENEFICIARY

The Plan will pay benefits payable because of your death to the beneficiary you name. To designate a beneficiary, please contact the Trust Administrator to request a Beneficiary Designation form.

If you have not named a beneficiary, or if your named beneficiary does not survive you, the Plan will pay benefits to the person or persons in the following order of priority:

1. Spouse
2. Natural or adopted child or children
3. Parent or parents
4. Brothers or sisters
5. Your estate

The Plan will pay benefits equally among surviving beneficiaries unless you have requested otherwise in writing.

PAYMENT METHOD

The Plan pays benefits in a lump sum; however, you may request a different mode of payment for death benefits. You must make this request in writing to the Trust Administrator.

When the Trust Administrator records and acknowledges your request, the change will take effect on the date the request is signed. However, the change will not apply to any payments or other action taken before the Trust Administrator acknowledges your request.

You may change your beneficiary or mode of payment at any time, unless you have given up this right.

AD&D PLAN EXCLUSIONS

The Plan will not pay benefits for any loss which:

- Is not permanent;
- Occurs more than 365 days after the injury;
- Is caused by voluntary carbon monoxide poisoning;
- Results from injuries you receive in any aircraft other than while:
  - Riding as a passenger in a commercial aircraft on a regularly scheduled flight (or while operating, boarding, or leaving)
  - You are traveling on business of the Plan (any trip you make on assignment for or with authorization of the Plan for the purpose of furthering the business of the Plan), provided the aircraft:
    - Has a current and valid FAA (Federal Aviation Administration of the United States) standard airworthiness certificate
    - Is operated by a person holding a current and valid FAA pilot's certificate of rating authorizing him or her to operate the aircraft;
- Results from injuries you receive while riding in any aircraft engaged in racing or acrobatic or stunt flying;
- Is caused by bodily or mental infirmity, ptomaines, bacterial infections (except pyogenic infections sustained accidentally) or which is caused by any other kind of disease; and/or
- Is excluded under the General Exclusions and Limitations section in the Medical Plan section of the Plan.

WEEKLY DISABILITY (TIME LOSS) BENEFITS

The Plan provides Weekly Disability (time loss) coverage for active members, which can help you meet your financial responsibilities if you become totally disabled because of injury or illness and are not able to work.

The Plan pays benefits while you remain totally disabled, as long as you are under a physician's care and are not receiving compensation from any other sources.

! KEY POINT

Weekly Disability can help you meet your financial responsibilities if you become disabled because of injury or illness and are not able to work.

WEEKLY DISABILITY BENEFITS SUMMARY

Overview	Coverage Details
Weekly Benefit Your actual benefit amount is based on the bargaining agreement with your employer	$350 or $750 per week, subject to an 80-percent cap discussed below.
When Benefits Begin	First day of disability due to an accident Eighth day of disability due to illness
Maximum Weeks Payable For each period of disability	26 weeks

CAP ON BENEFIT

The Weekly Disability (time loss) benefit provided is capped at 80 percent of your gross weekly wage (based on a 40-hour work week). For example, if the benefit level for which you are eligible is $750, and if your gross weekly wage is $800, then your benefit is capped at $640.

DISABILITY PERIODS

A new period of disability begins:

- When you become disabled after you have been back to work full-time for at least 6 consecutive months since the previous disability
- When you become disabled due to a cause not related to any cause of the previous disability, and the new disability begins after you have been back to work full-time for at least one day

No extension options are available for this benefit.

WEEKLY DISABILITY PLAN EXCLUSIONS

The Plan will not pay benefits for:

- Any disability during which you are not under the regular care of a Physician
- Anything excluded under the General Exclusions and Limitations section in the Medical Plan section of the Plan
- Any disability that begins while you are on COBRA

TAXATION OF BENEFITS

Benefits paid by the Plan are subject to Social Security (FICA) taxation. The Plan is required by federal law to withhold and deposit with the appropriate depository your share of the tax from each weekly disability benefit payment.

Weekly disability benefits provided by the Plan are also subject to federal income tax. You have the option of having the Trust withhold federal income taxes from your weekly benefit. At year-end, the Plan will send you a W-2 form so that you will be able to file your federal income taxes.

If you want to have federal income taxes withheld, contact the Trust Administrator and request Form W-4S.

CLAIMS AND APPEALS

FILING CLAIMS

SUBMITTING A CLAIM

The Plan will only process claims incurred on or after the effective date of your coverage. In order for you to receive prompt payment of your claims, follow the procedures listed below as closely as possible:

- **For physician's services**, provide an itemized copy of your physician's bill.
- **For hospital services**, provide an itemized copy of the hospital bill, which lists all services and supplies received.
- **For weekly disability (time loss) benefits or other disability benefits**, you and your physician must complete the form. (Contact the Trust Administrator to obtain a copy of the form.)
- **For ALL expenses incurred as a result of an accident**, you must submit complete accident details to the Plan for payment.

ANTI-ASSIGNMENT CLAUSE

You choose how the Plan should pay approved claims:

- You may assign payment of benefits by signing the authorization on the claim form or by filling out one of the provider's own assignment forms. (If the provider's form purports to assign more than a Beneficiary's right to payment, only the right to payment will actually be transferred.) If you do assign payment of your benefits, the payment will be sent directly to the provider of service (payments for Preferred Providers are automatically paid to the provider). A Beneficiary cannot assign any of the following:
  - Beneficiary's right to negotiate, litigate, or otherwise debate, coverage, benefits, and or claims;
  - Beneficiary's right to benefit payment(s);
  - Beneficiary's right to seek legal recourse, including but not limited to filing or bringing:
    - A claim for benefits;
    - A claim for breach of fiduciary duty;
    - A claim for Employee Retirement Income Security Act (ERISA) violation(s);
    - A lawsuit;
    - Any other right to act on behalf of Beneficiary; and/or
    - Any other claim related to, involving, or arising out of the Plan or any provision(s) of the Plan.
- Or, you may pay the bill directly, in which case the benefit checks will be made payable to you.

DESIGNATION OF AUTHORIZED REPRESENTATIVE

Except for claims involving urgent care, a Beneficiary may designate one Authorized Representative to assist in obtaining Plan benefits at any time. The designation must:

- Be in writing;
- Be signed by the Beneficiary;
- Be dated;
- Expressly state which claim(s) the Authorized Representative is designated to assist with; and
- Specifically state the Authorized Representative is authorized to submit claims and appeals, receive documents, and communicate with the Plan on behalf of the Beneficiary.

Submit your claim and all bills connected with it to the Trust Administrator within 90 days following the date expenses are incurred or as soon as reasonably possible, and no later than 12 months after loss occurs, unless the claimant is not legally capable.

Please remember, the Plan only processes claims incurred on or after the effective date of your coverage.

! KEY POINT

To receive timely payment, submit claims as soon as possible after you incur services, following the instructions above. Be sure to include itemized bills and sign your claim form.

THE PLAN'S RESPONSE TO CLAIMS

Once the Plan receives information necessary to evaluate a claim, the Plan will make an initial review decision of the benefits payable within the timeframes shown below:

If an extension is necessary due to matters beyond the Plan's control, the Plan will notify the person submitting the claim of the extension and the circumstances requiring the extension.

Except where you voluntarily agree to provide the Plan with additional time, extensions are limited as shown above.

URGENT CARE

A claim or request involving urgent care means any claim or request for a benefit for medical care or treatment for which the time allowed for making non-urgent care determinations:

- Could seriously jeopardize the life or health of the covered person or the ability of the covered person to regain maximum function
- Or, in the opinion of a physician with knowledge of the covered person's medical condition, would subject the covered person to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim

Additionally, if a physician with knowledge of the covered person's medical condition determines that a claim is a claim or request involving urgent care, the claim shall automatically be treated as a claim or request involving urgent care for the purposes of this provision.

THE PLAN'S RESPONSE TO CLAIMS			
Type of Benefit	**Initial Review Decision**	**Extension Period**	**Maximum Number of Extensions**
Urgent Care	72 hours	N/A	
Benefits and Claims NOT Requiring Precertification	30 days	15 days	1
Benefits and Claims REQUIRING Precertification	15 days	15 days	1
Accidental Death & Dismemberment	45 days	30 days	2
Weekly Disability	45 days	30 days	2

ADDITIONAL INFORMATION			
Type of Benefit	**Plan Notification—Additional Info Needed (after receiving claim)**	**Submit Additional Info By (after the date notified)**	**Plan's Decision (after additional info received)**
Urgent Care	24 hours	48 hours	48 hours
Benefits and Claims NOT Requiring Precertification	30 days	45 days	15 days
Benefits and Claims Requiring Precertification	5 days	45 days	15 days
Accidental Death & Dismemberment	45 days	45 days	30 days (or 60 days, if a second extension is period required)
Weekly Disability	45 days	45 days	30 days (or 60 days, if a second extension period is required)

ADDITIONAL INFORMATION

The Plan will notify the person submitting the claim if it needs additional information in order to make a decision.

- The person submitting the claim will then have a specified amount of time (see below) to submit the additional information to the Plan.
- If the Plan does not receive the additional information within the specified time, the Plan will make a decision based on the available information.

The Plan may contact the person submitting the claim at any time for additional details about the processing of the claim. Likewise, you may contact the Trust Administrator at any time for additional details about the processing of your claim.

CLAIM DENIALS

If a claim is denied or partially denied, the person submitting the claim will receive a written or electronic notice of the denial which will include:

- The specific reason(s) for the denial;
- Reference to the Plan-specific provisions on which the denial is based;
- If applicable, a description of any additional material or information necessary to complete the claim and the reason the Plan needs the material or information;
- A description of the appeal procedures and the time limits applicable to such procedures, including the right to request an appeal and the right to external review, and including a statement of the claimant's right to bring a civil action under Section 502(a) of the Employee Retirement Income Security Act (ERISA), as amended;
- Instructions on how and where to submit a request for an appeal; and
- Any other information that may be required under state or federal laws and regulations.

ADVERSE BENEFIT DETERMINATION: MEDICAL BENEFITS

An adverse benefit determination for Medical benefits means a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part), for a benefit, including, without limitation, any such denial, reduction, termination of, or failure to provide or make payment that is based upon:

- The covered person's ineligibility for benefits under the Plan
- The Plan's determination that the treatment or service is not a covered service under the Plan
- A utilization review determination
- The Plan's determination that the treatment or service is considered an experimental or investigational drug or treatment
- The Plan's determination that the treatment is not medically necessary

You will receive a statement of your right to receive, upon request and free of charge, any internal rule, guideline, protocol, or other similar criterion the Plan used in making an adverse benefit determination.

The Plan will include a statement that an explanation of the scientific or clinical judgment be provided to you upon request, free of charge, if the Plan makes an adverse benefit determination based upon its determination that the treatment or service is considered an experimental or investigational drug or treatment or is not medically necessary.

ADVERSE BENEFIT DETERMINATION: ONGOING TREATMENT

The Plan will notify you of an adverse benefit determination regarding a previously approved ongoing course of treatment or number of treatments sufficiently in advance to allow you to request an appeal of the adverse benefits determination and obtain a determination of your appeal before the ongoing treatment is terminated or reduced.

If you submit a request to extend the course of treatment beyond the period of time or number of treatments that the Plan originally approved…

…and your request is a claim involving urgent care, the Plan will notify you of its determination within 24 hours of receiving your request, provided that the Plan receives your request for extension at least 24 hours prior to the expiration of the prescribed period of time or number of treatments. However, if the Plan does not receive your request within the 24-hour period, the Plan will treat your request as a claim involving urgent care.

…and your request is *not* a claim involving urgent care, the Plan will treat your request as a "claim for benefits requiring precertification" or "claim for benefits *not* requiring precertification," whichever is applicable to the request.

ADVERSE BENEFIT DETERMINATION: ACCIDENTAL DEATH & DISMEMBERMENT (AD&D), WEEKLY DISABILITY (TIME LOSS) BENEFITS, AND DISABILITY CLAIMS

An adverse benefit determination for Accidental Death & Dismemberment (AD&D), Weekly Disability (time loss), or other Disability benefits means a denial, reduction, or termination of, or a failure to provide or to make payment (in whole or in part) for a benefit. This may include any such denial, reduction, termination of, or failure to provide or make payment (in whole or in part) that is based upon:

- The covered person's ineligibility for benefits under the Plan;
- The Plan's determination that the treatment or service is not a covered service under the Plan;
- A utilization review determination;
- The Plan's determination that the treatment or service is considered an experimental or investigational drug or treatment; or
- The Plan's determination that the treatment is not medically necessary.

In the case of disability claims, the term adverse benefit determination also means any rescission of disability coverage with respect to a participant or beneficiary (whether or not, in connection with the rescission, there is an adverse effect on any particular benefit at that time). For this purpose, the term "rescission" means a cancellation or discontinuance of coverage that has retroactive effect, except to the extent it is attributable to a failure to timely pay required premiums or contributions towards the cost of coverage.

You will receive a statement that an explanation of the scientific or clinical judgment will be provided to you upon request, free of charge, if the Plan makes an adverse benefit determination based upon its determination that the treatment or service is considered an experimental or investigational drug or treatment or is not medically necessary. You will also receive a statement of your right to receive, upon request and free of charge, any internal rule, guideline, protocol, or other similar criterion the Plan used in making an adverse benefit determination. You will also receive a statement of your right to receive, upon request and free of charge, access to or copies of all documents, records, and other information relevant to the claimant's claim for benefits.

The Plan will also include a discussion of the decision, including an explanation of the basis for disagreeing with or not following:

- The views presented by the claimant to the Plan of health care professionals treating the claimant and vocational professionals who evaluated the claimant;
- The views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a claimant's adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination; and
- A disability determination regarding the claimant presented by the claimant to the Plan made by the Social Security Administration.

ADVERSE BENEFIT DETERMINATION—OUT-OF-NETWORK CLAIMS—CONSOLIDATED APPROPRIATIONS ACT

In the event of a dispute between the Plan and a beneficiary over claims and payment to an out-of-network provider, a Participant has the option under the Consolidated Appropriations Act to resolve the dispute via binding arbitration. The request for arbitration must be made within thirty (30) days after the initial payment or denial of payment of the claims.

Arbitration under this provision will be binding arbitration and "baseball" style arbitration with the Arbitrators required to choose one side's proposal or the other side's proposal and the loser of the arbitration required to pay all arbitration costs.

Only one such request for arbitration on the same type of services may be made each ninety (90) days and the Arbitrator is required to consider the median in-network rate of services for the same services excluding UCR, Medicare rates, or billed services.

APPEAL RIGHTS AND PROCEDURES

In the event a claim for benefits or a precertification request is denied, or any participant or beneficiary feels he or she is adversely affected by the operation of the Plan, that person or his or her representative is entitled to a review of the decision.

The Board will conduct a full and fair review of the precertification and claim review decisions in keeping with the Plan's procedures for hearing, researching, recoding, and resolving any appeal.

The Board suggests you begin by contacting the Trust Administrator before invoking the hearing procedures outlined below. A phone call may resolve any problems and thereby save you considerable time and trouble.

! KEY POINT

It's a good idea to contact the Trust Administrator before submitting a request for an appeal. The Trust Administrator may be able to resolve the issue or clarify the benefit decision for you.

BOARD HEARING

Any participating employee or beneficiary of a participating employee who applies for benefits and…

- Is ruled ineligible by the Board (or by a committee of the Board, an administrative agent, insurance carrier, or other organization acting for the Board)
- Believes he or she did not receive the full amount of benefits to which he or she is entitled
- Is otherwise adversely affected by any action of the Board

…has the right to submit a request for an appeal, asking that the Board conduct a hearing in the matter. You must make this request within the timeframe required for each type of claim (see below) after being apprised of, or learning of, the action.

The Board shall then conduct a hearing at which the participant or beneficiary shall be entitled to present his or her position and any evidence in support thereof. The participant or beneficiary may be represented at any such hearing by an attorney or by any other representative of his or her choosing. Thereafter, the Board shall issue a written decision affirming, modifying, or setting aside the former action.

The written decision of the Board shall include the specific reasons for the decision as well as specific reference to the Plan-pertinent provision(s) on which the decision is based and shall be written in a manner calculated to be understood by the claimant. If the claimant's position is denied, the denial will include steps for requesting an External Review.

SUBMITTING A REQUEST FOR AN APPEAL

The person submitting a claim may request an appeal of the Board's initial claim denial or precertification decision. This request may be submitted in writing, electronically, or orally and should include any additional information you believe may have been omitted from the Board's review or that should be considered by the Board.

The Board provides the person submitting the request:

- The opportunity to submit written comments, documents, records, and other information relating to the claim
- Reasonable access to and copies of documents, records, and other information relevant to the claim (upon request and free of charge)

Submit the request for an appeal within 180 days after receiving notification of the adverse benefit determination.

Include the following in your request for an appeal:

- The name of the patient or the person for whom the claim has been submitted;
- The name of the person filing the appeal;
- The member number;
- The nature of the appeal; and
- The names of all individuals, facilities, and services involved with the appeal.

In reviewing the appeal, the Board will consider all comments, documents, records, and other information relating to the claim, without regard to whether such information was submitted or considered in the initial claim decision.

By requesting an appeal, you authorize the Board, or anyone designated by the Board, to review all records (including, but not limited to, your medical records) which the Board determines may be relevant to your appeal.

DISABILITY CLAIMS

Before the Board provides an adverse benefit determination on review on a disability benefit claim, the claimant is entitled to be provided by the Trust Administrator, free of charge, any new or additional evidence considered, relied upon, or generated by the Plan,

insurer, or other person making the benefit determination (or at the direction of the Plan, insurer, or such other person) in connection with the claim; such evidence must be provided as soon as possible and sufficiently in advance of the date on which the notice of adverse benefit determination on review is required to be provided to the claimant to give the claimant a reasonable opportunity to respond prior to that date.

Before issuing an adverse benefit determination on review on a disability benefit claim based on new or additional rationale, the Trust Administrator shall provide the claimant, free of charge, with the rationale; the rationale must be provided as soon as possible and sufficiently in advance of the date on which the notice of adverse benefit determination on review is required to be provided to the claimant to give the claimant a reasonable opportunity to respond prior to that date.

RESPONSE TO APPEALS

Along with the Board's decision regarding your appeal, you will receive:

- Information regarding their decision
- Information regarding external review appeal rights
- A statement of the claimant's right to bring an action under Section 502(a) of the Employee Retirement Income Security Act (ERISA), as amended; and
- In the case of a claim for disability benefits, the statement of the claimant's right to bring an action under Section 502(a) of the Employee Retirement Income Security Act (ERISA) shall also describe any applicable contractual limitations period that applies to the claimant's right to bring such an action, including the calendar date on which the contractual limitations period expires for the claim.

ADVERSE BENEFIT DETERMINATION ON REVIEW

In the case of an adverse benefit determination, the notification shall set forth, in a manner calculated to be understood by the claimant—

- The specific reason or reasons for the adverse determination;
- Reference to the Plan-specific provisions on which the benefit determination is based;
- A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits;
- A statement describing any voluntary appeal procedures offered by the Plan and the claimant's right to obtain the information about such procedures, and a statement of the claimant's right to bring an action under Section 502(a) of the Employee Retirement Income Security Act (ERISA), as amended; and
- In the case of a plan providing disability benefits, in addition to the information described above, a statement of the claimant's right to bring an action under Section 502(a) of the Employee Retirement Income Security Act (ERISA) shall also describe any applicable contractual limitations period that applies to the claimant's right to bring such an action, including the calendar date on which the contractual limitations period expires for the claim.

If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge to the claimant upon request.

RESPONSE TO APPEALS

Once the Board receives your request for an appeal, the following timeframes apply:

Type of Benefit	Plan's Decision	Extension Period	Maximum Number of Extensions
Urgent Care	72 hours	60 days	1
Benefits and Claims NOT Requiring Precertification	60 days	60 days	1
Benefits and Claims Requiring Precertification	30 days	N/A	
Experimental and Investigational Services	14 days	Any extension requires the informed written consent of the covered person	
Accidental Death & Dismemberment	45 days	45 days	1
Disability	45 days	45 days	1

If additional information is requested, the extension periods noted above apply.

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

The following statement: "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."

ADVERSE BENEFIT DETERMINATION ON REVIEW: DISABILITY BENEFITS

In the case of an adverse benefit decision with respect to disability benefits, a discussion of the decision, including an explanation of the basis for disagreeing with or not following:

- The views presented by the claimant to the plan of health care professionals treating the claimant and vocational professionals who evaluated the claimant;
- The views of medical or vocational experts whose advice was obtained on behalf of the plan in connection with a claimant's adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination; and
- A disability determination regarding the claimant presented by the claimant to the plan made by the Social Security Administration.

If the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of change upon request; and

Either the specific internal rules, guidelines, protocols, standards, or other similar criteria of the plan relied upon in making the adverse determination or, alternatively, a statement that such rules, guidelines, protocols, standards, or other similar criteria of the plan do not exist.

BOARD'S DISCRETION RETAINED

The Board reserves the maximum legal discretionary authority to construe, interpret, and apply the terms, rules, and provisions of the Plan's coverage.

The Board retains full discretionary authority to make determinations on matters relating to eligibility for benefits, on matters relating to what services, supplies, care, drug therapy and treatments are experimental, and on matters which pertain to participant's rights.

The decisions of the claims adjusters, administrator, and Board as to the facts related to any claim for benefits and the meaning and intent of any provision of the Plan, or application of such to any claim for benefits, shall receive the maximum deference provided by law and will be final and binding on all interested parties.

The Trust Administrator has the discretionary authority to decide whether a charge is Usual and Reasonable, with respect to dialysis-related claims, and Usual, Reasonable and Customary (URC), with respect to all other claims. Benefits under the Plan shall be paid only if the Trust Administrator decides in its discretion that a Covered Person is entitled to them.

REQUEST FOR EXTERNAL REVIEW

The Plan has an internal claim appeal process (described previously above) that must be exhausted before external or judicial review can be sought. Once the internal claim appeal process is exhausted, an individual has four months from the date of the Plan's final adverse benefit determination to file a request for an external review. Failure to request an external review within four months from the date of the Plan's final adverse benefit determination will end the individual's ability to seek external review.

An individual may request external review only for appeals involving medical judgment, including but not limited to, those based on the Plan's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit, or a determination that a treatment is experimental or investigational, or the rescission of a benefit. The Independent Review Organization (IRO) will determine whether a denial involves a medical judgment.

Requests for external reviews under the Plan should be sent to:

Employee Painters' Trust
c/o BeneSys, Inc.
PO Box 58830
Tukwila, WA 98138
(206) 518-9730 or (844) 344-2721
www.IUPATWesternBenefits.org

PRELIMINARY REVIEW OF EXTERNAL REVIEW REQUEST

Within five business days of receipt of a request for external review, the Plan or the Trust Administrator will complete a preliminary review of the external review request. Within one business day after completion of this preliminary review, the Plan will notify the individual of its decision. If the request is not eligible for external review, the Plan will notify the individual, explain the reason, and provide any other information required under applicable federal regulations. If the request for external review is incomplete, the Plan will identify what is needed and the individual will have the longer of 48 hours or the remaining portion of the four-month external review request period to provide the information. If the external review request is complete and eligible for external review, the Plan will refer the matter to an IRO.

REVIEW BY INDEPENDENT REVIEW ORGANIZATION (IRO)

When a properly filed request for external review is referred, the Plan will provide the IRO the required documentation in the time required by applicable federal regulations. The IRO will provide a decision to the

individual within 45 days after it has received the request to review.

If the IRO directs that benefits be paid, the Plan shall provide benefits under the Plan in accordance with the decision.

REVIEW OF URGENT CLAIMS AND URGENT CLAIM APPEALS

The Plan's existing claim appeal procedures provide for an expedited review of an urgent claim if the time period for completion of the regular appeal process would seriously jeopardize the life or health of the individual, would jeopardize the individual's ability to regain maximum function, or the appeal involves a determination concerning an admission, availability of care, continued stay, or health care services for which the individual received Emergency Services but has not been discharged from the facility providing the care. For urgent claims, the initial determination on an urgent claim will be made within 72 hours of the receipt of an urgent claim and necessary supporting information. An appeal of the denial of an urgent claim will be made within 72 hours of the receipt of an urgent claim appeal.

Similarly, if an urgent appeal is submitted to an IRO, a decision will be made within 72 hours or the expedited timeframe provided in the final applicable federal regulations.

CONTRACTUAL LIMITATIONS PERIOD—DEADLINE TO FILE A LAWSUIT

If a decision continues to be adverse, an individual has the right to bring a civil action pursuant to Section 502(a) of ERISA, 29 U.S.C. § 1132(a). Any legal action for benefits seeking to overturn a denial or other decision that has adversely impacted an individual's claim for benefits must be brought within 180 days of the latest of the following events: An initial denial by the Trust Administrator for which no appeal has been requested; the Plan's final adverse benefit determination on review or appeal; or a denial by an IRO on external review.

YOUR RIGHTS UNDER HIPAA

PRIVACY NOTICE

The Trust is required by law (Health Insurance Portability and Accountability Act—HIPAA) to maintain the privacy of your health information. The Trust must provide you with this notice of legal duties and privacy practices with respect to your health information. The Trust is also required to abide by the terms of this notice, which may be amended from time to time.

The Trust reserves the right to change the terms of this notice at any time in the future and to make the new provisions effective for all health information that it maintains. The Trust will promptly revise this notice and distribute it to all of the Plan participants, whenever material changes are made to privacy policies and procedures. Until then, the Trust is required by law to comply with the current version of this notice.

! KEY POINT

The Trust is required by law to maintain the privacy of your health information and has strict policies in place to protect your confidential information.

HOW THE TRUST MAY USE OR DISCLOSE YOUR HEALTH INFORMATION

The Trust is permitted by law to use or disclose your health information to conduct activities necessary for payment and health care operations.

There are other purposes for which the Trust may use or disclose your health information, but these two are the main ones. For each of these primary purposes, examples are listed below of these kinds of uses and disclosures. These are only examples and are not intended to be a complete list of all the ways the Trust may use or disclose your health information within each of these two categories.

- **Payment**: The Trust may use or disclose health information about you for purposes within the definition of payment. These include, but are not limited to, the following purposes and examples:
  - Determining your eligibility for Plan benefits. For example, the Trust may use information obtained from your employer to determine whether you have satisfied the Plan's requirements for active eligibility.
  - Obtaining contributions from you or your employer. For example, the Trust may send your employer a request for payment of contributions on your behalf, and the Trust may send you information about premiums for COBRA continuation coverage.
  - Precertifying or pre-authorizing health care services. For example, the Trust may consider a request from you or your physician to verify coverage for a specific hospital admission or surgical procedure.
  - Determining and fulfilling the Plan's responsibility for benefits. For example, the Trust may review health care claims to determine if specific services that were provided by your physician are covered by the Plan.
  - Providing reimbursement for the treatment and services you received from health care providers. For example, the Trust may send your physician a payment with an explanation of how the amount of the payment was determined.
  - Subrogating health claim benefits for which a third party is liable. For example, the Trust may exchange information about an accidental injury with your attorney who is pursuing reimbursement from another party.
  - Coordinating benefits with other plans under which you have health coverage. For example, the Trust may disclose information about the Plan benefits to another group health plan in which you participate.
  - Obtaining payment under a contract of reinsurance. For example, if the total amount of your claims exceeds a certain amount the Trust may disclose information about your claims to our stop-loss insurance carrier.
- **Health Care Operations**: The Trust may use and disclose health information about you for purposes within the definition of health care operations. These purposes include, but are not limited to:
  - Conducting quality assessment and improvement activities. For example, a supervisor or quality specialist may review health care claims to determine the accuracy of a processor's work.
  - Case management and care coordination. For example, a case manager may contact home health agencies to determine their ability to provide the specific services you need.
  - Contacting you regarding treatment alternatives or other benefits and services that may be of interest to you. For example, a case manager may contact you to give you information about alternative treatments which are neither included nor excluded in the Plan's documentation of benefits, but which may nevertheless be available in your situation.
  - Contacting health care providers with information about treatment alternatives. For example, a case manager may contact your physician to discuss moving you from an acute care facility to a more appropriate care setting.
  - Employee training. For example, training of new claims processors may include processing of claims for health benefits under close supervision.
  - Accreditation, certification, licensing, or credentialing activities. For example, a company that provides professional services to the Plan may disclose your health information to an auditor that is determining or verifying its compliances with standards for professional accreditation.
  - Securing or placing a contract for reinsurance of risk relating to claims for health care. For example, your demographic

information (such as age and sex) may be disclosed to carriers of stop-loss insurance to obtain premium quotes.

- Conducting or arranging for legal and auditing services. For example, your health information may be disclosed to an auditor who is auditing the accuracy of claim adjudications.
- Management activities relating to compliance with privacy regulations. For example, the Privacy Officer may use your health information while investigating a complaint regarding a reported or suspected violation of your privacy.
- Resolution of internal grievances. For example, your health information may be used in the process of settling a dispute about whether or not a violation of our privacy policies and procedures actually occurred.
- Sale, transfer, merger, or consolidation. For example, your health information may be disclosed if the Plan merges with another health plan.
- De-identification of health information. The Trust may use or disclose your health information for the purpose of creating health information that is no longer identifiable as pertaining to you. Such de-identified health data may then be used for purposes that are not described in this notice as either permitted or required.
- Creation of a limited data set. The Trust may use your health information to create a limited data set which excludes most identifiers but may include partial addresses (city, state, and ZIP code), dates of birth and death, and other dates that pertain to your health care treatment. Such a limited data set may be disclosed for purposes of research, public health, or health care operations.

- **Disclosures to providers and to other health plans for their own activities related to your health care**. The Trust may disclose information to providers and to other health plans if it is intended to be used for their own purposes, as described below.
  - Treatment. A health care provider may obtain your health information from us for the purpose of providing health care treatment. For example, the Trust may disclose the identity of your primary care physician to emergency medical staff if requested for treatment purposes.
  - Payment. A health care provider or another health plan may obtain your health information from us for purposes related to payment for health care. For example, if you have secondary coverage with another health plan the Trust may disclose information to that other plan regarding our payments for your health care.
  - Health care operations. A health care provider or another health plan may obtain your health information from us for some purposes related to health care operations, but only if the provider or the Plan has a relationship with you and the information pertains to that relationship. The purposes for which such disclosures are permitted include, but are not limited to, quality improvement, case management, performance evaluation, training, and credentialing.
- **Other uses and disclosures**. Other ways that the Trust may use and disclose your health information are described below. Not every potential use or disclosure in each category will be listed, and those that are listed may never actually occur.
  - Disclosures to you. The Trust is permitted, and in some circumstances required, to disclose your health information to you. Your rights are described below under "Your Health Information Privacy Rights."
  - Disclosures to your personal representative. Anyone with legal standing to act as your personal representative may, depending on the terms of the legal authority, have any or all of the same rights that you have with regard to obtaining or controlling your health information. For example, state law determines the extent to which a parent may act on behalf of a minor with regard to the child's health information. Someone who is legally responsible for your affairs after your death may also act as your Personal Representative.
  - Involvement in payment. With your agreement, the Trust may disclose your health information to a relative, friend, or other person designated by you as being involved in payment for your health care. For example, if the Trust is discussing your health benefits with you, and you wish to include your spouse or child in the conversation, the Trust may disclose information to that person during the course of the conversation.
  - Disclosures required by law. The Trust will disclose your health information when required to do so by federal, state, or local law. For example, the Trust may disclose your information to a representative of the U.S. Department of Health and Human Services who is conducting a privacy regulation compliance review. The Trust may also use and disclose your health information for purposes described below under "Your Health Information Privacy Rights".
  - Public health. As permitted by law, the Trust may disclose your health information as described below:
    - To an authorized public health authority, for purposes of preventing or controlling disease, injury, or disability;
    - To a government entity authorized to receive reports of child abuse or neglect; or
    - To a person under the jurisdiction of the Food and Drug Administration, for activities related to the quality, safety, or effectiveness of FDA-regulated products.
  - Health oversight activities. The Trust may disclose your health information to health agencies during the course of audits, investigations, inspections, licensure, and other proceedings related to oversight of the health care system or of compliance with civil rights laws. However, this permission to disclose your

health information does not apply to any investigation of you or which is directly related to your health care.

- Judicial and administrative proceedings. The Trust may disclose your health information in the course of any administrative or judicial proceeding:
  - In response to an order of a court or administrative tribunal, or
  - In response to a subpoena, discovery request, or other lawful process.
  - Specific circumstances may require us to make reasonable efforts to notify you about the request or to obtain a court order protecting your health information.
- Law enforcement. The Trust may disclose your health information to a law enforcement official for various purposes, such as identifying or locating a suspect, fugitive, material witness, or missing person.
- Coroners, medical examiners, and funeral directors. The Trust may disclose your health information to coroners, medical examiners, and funeral directors. For example, this may be necessary to identify a deceased person or determine the cause of death.
- Organ and tissue donation. The Trust may disclose your health information to organizations involved in procuring, banking, or transplanting organs and tissues.
- Disclosures to Trust Administrator. In addition to the circumstances and examples described above, there are three types of health information about you that the Trust may disclose to the Board.

  The Trust may disclose to the Board whether or not you have enrolled in, are participating in, or have dis-enrolled from the Plan.

  The Trust may provide the Board with "summary health information", which includes claims totals without any personal identification except your ZIP code, for these two purposes:
  - To obtain health insurance premium bids from other health plans, or
  - To consider modifying, amending, or terminating the Plan.

  The Trust may disclose your health information to the Board for purposes of administering benefits under the Plan. These purposes may include, but are not limited to:
  - Reviewing and making determinations regarding an appeal of a denial or reduction of benefits;
  - Evaluating situations involving suspected or actual fraudulent claims; or
  - Monitoring benefit claims that may or do involve stop-loss insurance
- Business associates. Business Associates are individuals and companies who need access to the personal health information for which the Trust are responsible in order to act on our behalf or to provide us with services. Examples of business associates include third party administrators, prescription benefits managers ("PBMs"), attorneys, consultants, and auditors. The Trust may disclose your health information to our business associates, and the Trust may authorize them to use or disclose your health information for any or all of the same purposes for which the Trust is permitted to use or disclose it ourselves, as well as for their own administrative purposes. Our business associates are contractually required not to use or disclose your health information for any other purposes.

HOW THE TRUST MAY NOT USE OR DISCLOSE YOUR HEALTH INFORMATION

The Trust may not use or disclose your health information without written authorization from you (except as described above).

If you have authorized the Trust to use or disclose your health information for another purpose, you may revoke your authorization in writing at any time. If you revoke your authorization, the Trust will no longer be able to use or disclose health information about you for the reasons covered by your written authorization. However, the Trust will be unable to take back any disclosures the Trust has already made with your permission. Requests to revoke a prior authorization must be submitted in writing to the Privacy Contact Person.

PRIVACY CONTACT PERSON

To obtain a more detailed explanation of your health information privacy rights, or if you would like to exercise one or more of these rights, contact:

Employee Painters' Trust
c/o BeneSys, Inc.
Attn Privacy Contact Person
PO Box 58830
Tukwila, WA 98138
(206) 518-9730 or (844) 344-2721
www.IUPATWesternBenefits.org

Please contact the Privacy Contact Person if you have questions about any part of this notice or the privacy practices at the Trust.

YOUR HEALTH INFORMATION PRIVACY RIGHTS

You have the following rights concerning your health information:

- **Right to Request Restrictions**: You have the right to request restrictions on certain uses and disclosures of your health information. The Trust is not required to agree to restrictions that you request. If you would like to make a request for restrictions, you must submit your request in writing to the Privacy Contact Person.
- **Right to Request Confidential Communications**: You have the right to ask the Trust to communicate with you using an alternative means or at an alternative location. Requests for confidential communications must be submitted in writing to the Privacy Contact Person. The Trust is not required to agree to your request unless disclosure of your health information could endanger you.
- **Right to Inspect and Copy**: You have the right to inspect and copy health information about you that may be used to make decisions about the Plan benefits. To inspect or copy such information, you must submit your request in writing to the Privacy Contact Person. If you request a copy of the information, the Trust may charge you a reasonable fee to cover expenses associated with your request.
- **Right to Request Amendment**: If you believe that the Trust possesses health information about you that is incorrect or incomplete, you have a right to ask us to amend it. To request an amendment of health records, you must make your request in writing to the Privacy Contact Person. Your request must include a reason for the request. The Trust is not required to change your health information. If your request is denied, the Trust will provide you with information about our denial and how you can disagree with the denial.
- **Right to Accounting of Disclosures**: You have the right to receive a list or "accounting" of disclosures of your health information made by us. However, the Trust does not have to account for disclosures that were:
  - Made to you or were authorized by you, or
  - For purposes of payment functions or health care operations.

  Requests for an accounting of disclosures must be submitted in writing to the Privacy Contact Person. Your request should specify a time period within the last six years. The Trust will provide one free list per twelve-month period, but the Trust may charge you for additional lists.
- **Right to Paper Copy**: You have a right to receive a paper copy of this Notice of Privacy Practices at any time. To obtain a paper copy of this notice, contact the Privacy Contact Person.

COMPLAINTS

If you believe that your privacy rights have been violated by the Trust or by anyone acting on the Trust's behalf, you may send a written complaint to the Privacy Contact Person.

You may also file a written complaint with the United States Department of Health and Human Services by writing to the Secretary at 200 Independence Avenue SW, Washington, DC 20201.

Complaints about the Trust must refer to the Employee Painters' Trust by name and must describe what the Trust did or failed to do that violated federal regulations regarding health information privacy.

Complaints to the Secretary or to the Trust must be filed within 180 days after you first knew or should have known about the privacy violation that is the subject of your complaint. The Trust will not retaliate against you in any way for filing a complaint.

YOUR RIGHTS UNDER THE FAMILY AND MEDICAL LEAVE ACT (FMLA)

A federal law called the Family and Medical Leave Act of 1993 (FMLA) may allow your benefits to be continued on the same basis as if you were an actively at-work employee during an eligible leave of absence to:

- Care for your child after the birth or placement of a child with you for adoption or foster care;
- Care for your spouse, child or parent who has a serious health condition; and/or
- For your own serious health condition, as stated in the FMLA.

In the event you and your spouse are both insured as employees of the Plan, the continued coverage to care for a newborn or newly placed child may not exceed a combined total of 12 weeks. In addition, if the leave is taken to care for a parent with a serious health condition, the continued coverage may not exceed a combined total of 12 weeks.

KEY POINT

The Family Medical Leave Act (FMLA) is a federal law requiring that employers of 50 or more employees (and public employers of any size) allow employees to take leave to care for ill family members and to return to substantially similar employment conditions following the leave. The Act also allows eligible employees to maintain their health care coverage during an FMLA leave on a self-pay basis.

CONDITIONS

- If, on the day your coverage is to begin, you are already on an FMLA leave of absence, you will be considered actively at-work. Coverage for you and any eligible dependents will begin in accordance with the terms of the Plan.
  - However, if your leave of absence is due to your own or any eligible dependent's serious health condition, benefits for that condition will not be payable to the extent benefits are payable under any prior group plan.
- You are eligible to continue benefits under FMLA if all of the following conditions are met:
  - You have worked for your employer for at least one year;
  - You have worked at least 1,250 hours over the previous 12 months;
  - Your employer employs at least 50 employees within 75 miles from your worksite; and
  - You continue to pay any required premium for yourself and any eligible dependents in a manner determined by your employer.
- In the event you choose not to pay any required premium during your leave, your coverage will not be continued during the leave. You will be able to reinstate your coverage on the day you return to work, subject to any changes that may have occurred in the Plan during the time you were not insured. You and any insured dependents will not be subject to any evidence of good health requirement provided under the Plan. Any partially satisfied waiting periods, including any limitations for a preexisting condition, which are interrupted during the period of time premium was not paid will continue to be applied once coverage is reinstated.
- You and your dependents are subject to all conditions and limitations of the Plan during your leave, except that anything in conflict with the provisions of the FMLA will be construed in accordance with the FMLA.
- If requested by the Plan, you or your employer must submit acceptable proof that your leave is in accordance with FMLA.
- This FMLA continuation is concurrent with any other continuation option except for COBRA, if applicable. You may be eligible to elect any COBRA continuation available under the Plan following the day your FMLA continuation ends.
- FMLA continuation ends on the earliest of:
  - The day you return to work;
  - The day you notify your employer that you are not returning to work;
  - The day your coverage would otherwise end under the Plan; or
  - The day coverage has been continued for 12 weeks.

Contact your employer as soon as you think you are eligible for a family or medical leave, since the law requires you to give 30 days' notice, or tell your employer immediately if your leave is caused by a sudden, unexpected event. Your employer can tell you of your other obligations under FMLA.

YOUR RIGHTS UNDER THE UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT (USERRA)

If your health coverage ends because of your service in the uniformed services, you may continue your coverage and your dependent(s) coverage, until the earlier of:

- The end of the period during which you are eligible to apply for reemployment in accordance with USERRA, or
- 24 consecutive months after coverage ends.

To continue coverage, you or your dependent must pay the required premium (including your former employer's share and any retroactive premium), unless your service in the uniformed service is for fewer than 31 days, in which event you must pay your share, if any, of the premium. The Trust Administrator will inform you or your dependent of procedures to pay premiums.

The continuation under USERRA will end at midnight on the earlier of the day:

- Your former employer ceases to provide any group health plan to any employee;
- Any premium is due and unpaid;
- A covered person again becomes covered under the Plan;
- Your coverage has been continued for the period of time stated above (or for any longer period provided in the Plan); or
- The employer terminates the Plan.

Any coverage for an eligible dependent will also end as provided in the dependent eligibility provisions of the Plan.

! KEY POINT

The Uniformed Services Employment and Reemployment Rights Act (USERRA) provides reemployment protection and other benefits for veterans and employees who perform military service.

OTHER CONTINUATION PROVISIONS

In the event coverage is continued under any other continuation provision of the Plan, the periods of continued coverage will run concurrently. If another continuation provision provides a shorter continuation period for which premium is paid in whole or in part by your employer, then the premium you are required to pay may increase for the remainder of the period provided above.

REEMPLOYMENT

(following service in the uniformed services)

Following your discharge from such service, you may be eligible to apply for reemployment with your former employer in accordance with USERRA. Such reemployment includes your right to elect reinstatement in any then-existing health coverage provided by your employer.

Your employer's leave of absence policy will determine your right to participate in any group life or other benefits.

After reemployment, credit will be given, if applicable, for the period of such service, if required to determine your benefit amounts, eligibility or costs.

In the event of a conflict between this provision and USERRA, the provisions of USERRA, as interpreted by your employer or former employer, will apply.

YOUR RIGHTS UNDER THE EMPLOYEE RETIREMENT INCOME SECURITY ACT (ERISA)

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

- Receive information about the Plan and benefits.
- Examine, without charge, at the Trust Administrator and at other specified locations, such as worksites and union halls, all documents governing the Plan, including 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.
- Obtain, upon written request to the Trust Administrator, copies of documents governing the operation of the Plan, including contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 series) and updated Plan. The Trust Administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report. The Trust Administrators are required by law to furnish each participant with a copy of this summary annual report.
- Continue group health Plan 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 the Plan and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.
- Reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health Plan, if you have creditable coverage from another Plan. You should be provided a certificate of creditable coverage, free of charge, from your group health Plan or the Trust when you lose coverage under the Plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion period after your enrollment date in your coverage.

! KEY POINT

The Employee Retirement Income Security Act (ERISA) is a federal law that regulates the majority of private pension and welfare group benefit plans in the United States.

PRUDENT ACTIONS BY THE PLAN FIDUCIARIES (WHO ARE THE "FIDUCIARIES" OR PLAN OPERATORS?)

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

ENFORCE YOUR RIGHTS

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of the Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Trust 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 Trust Administrator.

If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in federal court.

If it should happen that the 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 the Plan, you should contact the Trust 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 Trust Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

GENETIC INFORMATION NON-DISCRIMINATION ACT (GINA)

The Genetic Information Nondiscrimination Act of 2008 enacted May 21, 2008, is designed to prohibit the use of genetic information in health insurance and employment. The Act prohibits group health plans and health insurers from denying coverage to a healthy individual or charging that person higher premiums based solely on a genetic predisposition to developing a disease in the future. The legislation also bars employers from using individuals' genetic information when making hiring, firing, job placement, or promotion decisions.

NONDISCRIMINATION NOTICE UNDER SECTION 1557 OF THE AFFORDABLE CARE ACT (ACA)

DISCRIMINATION IS AGAINST THE LAW

The Plan complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex, sexual orientation, or gender identity. The Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, sex, sexual orientation, or gender identity.

The Plan:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact the Trust Administrator.

If you believe that the Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, sex, sexual orientation, or gender identity, you can file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at **www.hhs.gov/ocr/office/file/index.html**.

PLAN COMMUNICATIONS

The Plan will endeavor to communicate with participants and beneficiaries in a culturally and linguistically appropriate manner. This means the Plan will:

- Provide oral language services (such as a telephone customer assistance hotline) that include answering questions in any applicable non-English language and providing assistance with filing claims and appeals in any applicable non-English language;
- Provide, upon request, a notice in any applicable non-English language; and
- Include in the English versions of all notices, a statement prominently displayed in any applicable non-English language clearly indicating how to access the language services provided by the Plan.

With respect to an address in any United States county to which a notice is sent, a non-English language is an applicable non-English language if ten percent or more of the population residing in the county is literate only in the same non-English language, as determined in guidance published by the Secretary of Labor.

PLAN ADMINISTRATION

STANDARD PROVISIONS

CHANGE IN PLAN BENEFITS

Plan benefits may be changed (including reducing or terminating benefits or increasing contributions) at any time. A change in the Plan benefits:

- Does not require the consent of any covered person or beneficiary, and
- Must be in writing.

A change may affect any class of covered persons, including retirees.

APPLICATIONS

Any application of a covered person may be used to contest the validity of coverage, reduce coverage, or deny a claim.

The Plan must first furnish you or your beneficiary with a copy of that application. A person's application may not be used to contest or reduce coverage which has been in force for two years or more during that person's lifetime.

However, if you or your dependents are not eligible for coverage, there is no time limit on the Plan's right to contest coverage or deny a claim. Statements in an application are treated as representations, not as warranties.

RELEASE OF MEDICAL INFORMATION

As a condition of receiving benefits under the Plan, you and your dependents authorize:

- Any provider to disclose to the Trust Administrator any medical information it requests;
- The Trust Administrator to examine your medical records at the offices of any provider;
- The Trust Administrator to release to or obtain from any person or organization any information necessary to administer your benefits or your dependent's benefits; and
- The Trust Administrator to examine your employment records in order to verify your eligibility.

The Plan will keep such information confidential whenever possible, but under certain circumstances it may be disclosed without specific authorization.

PLAN DISCLOSURES

You or your dependents are entitled to request from the Trust Administrator, without charge, information applicable to the Plan's benefits and procedures. In addition, this book includes, as applicable, a description of:

- Qualified Medical Child Support Orders (QMCSO)
- Any cost-sharing provisions, including premiums, deductibles, coinsurance and copayments, maximums, details about the level of benefits, providers, preauthorization and utilization review rules, coverage for medical tests, devices and procedures, out-of-network coverage, limits on emergency care, and/or coverage of existing and new drugs
- Employee and dependent eligibility requirements
- Any participating provider requirements (a current listing of such providers is available online and can be furnished as a separate document)
- When coverage ends
- When benefits may be denied or reduced, including subrogation or reimbursement, and coordination of benefits provisions
- Federal continuation rights
- Claims procedures (additional details shall be furnished upon request)
- Maternity hospitalization for the mother and newborn infant

COORDINATION OF BENEFITS (COB)

If the claimant is covered by another plan or plans, the benefits under the plan and the other plan(s) will be coordinated. This means that one plan pays its full benefits first, then the other plan(s) pay(s).

- "Primary plan" means a plan whose benefits for a person's health care coverage must be determined without taking the existence of any other plan into consideration (e.g., employee, member, non-dependent participant). The primary plan (which is the plan that pays benefits first) pays the benefits that would be payable under its terms in the absence of this provision.
- "Secondary plan" means a plan that is not a primary plan. The secondary plan (which is the plan that pays benefits after the primary plan) will limit the benefits it pays so that the sum of its benefit and all other benefits paid by the primary plan will not exceed 100% of total covered expense, exclusive of copayments, deductibles, and other cost-sharing arrangements.

The order of benefit determination paragraph below explains the order in which plans must pay. If the covered person is covered by Medicare, then the order of benefit determination for Medicare applies.

This COB provision will not apply to a claim when the covered expense for a claim period is $50 or less, but if both of these conditions apply, this COB provision will apply to the total amount of the claim:

- Additional expense is incurred during the claim period, and
- The total covered expense exceeds $50.

Coordination of benefits does not apply to prescription drugs.

! KEY POINT

Coordination of Benefits (COB) is a term to describe the process by which benefits paid under multiple health plans are coordinated to determine in what order benefits are paid and how much each plan should pay.

ORDER OF BENEFIT DETERMINATION

When another plan does not have a COB provision, that plan must determine benefits first. When another plan does have a COB provision, the first of the following rules that applies governs:

- If a plan covers the claimant as an employee, member, or nondependent, then that plan will pay its benefits first
- If the claimant is a dependent child whose parents are not divorced or separated, then the plan of the parent whose birthday anniversary is earlier in the calendar year will pay first, except:
  - If both parents' birthdays are on the same day, the rule below will apply, or
  - If another plan does not include this COB rule based on the parents' birthdays, but instead has a rule based on the gender of the parent, then that plan's COB rule will determine the order of benefits.
- If the claimant is a dependent child whose parents are divorced or separated, then the following rules apply:
  - A plan that covers a child as a dependent of a parent who by court decree must provide health coverage will pay first, or
  - When there is no court decree that requires a parent to provide health coverage to a dependent child, the following rules will apply:
    - When the parent who has custody of the child has not remarried, that parent's plan will pay first, or
    - When the parent who has custody of the child has remarried, then benefits will be determined by that parent's plan first, by the stepparent's plan second, and by the plan of the parent without custody third.
- If none of the rules above apply, the plan that has covered the claimant for the longer period of time will pay its benefits first, except when:
  - One plan covers the claimant as a laid-off or retired employee (or a dependent of such an employee)
  - The other plan includes this COB rule for laid-off or retired employees (or is issued in a state that requires this COB rule by law)

Then the plan that covers the claimant as **other than** a laid-off or retired employee (or a dependent of such an employee) will pay first.

Where part of a plan coordinates benefits and a part does not, each part will be treated like a separate plan.

ORDER OF BENEFIT DETERMINATION FOR MEDICARE

For you: The Plan is the primary plan for your claims, if all of the following apply:

- You are age 65 or older
- You are covered by Medicare solely because of age
- You are actively employed by an ADEA employer (subject to the U.S. Age Discrimination in Employment Act (ADEA), which pays all or part of the Plan premium

The Plan is the secondary plan for your claims when you are covered by Medicare because of age, if you are not actively employed by an ADEA Employer which pays all or part of the Plan premium.

For your dependent spouse: The Plan is the primary plan for your dependent spouse's claims, if all of the following apply:

- Your spouse is age 65 or older;
- Your spouse is covered by Medicare solely because of age; and
- You are actively employed by an ADEA employer which pays all or part of the plan premium.

The Plan is the secondary plan for your dependent spouse's claims when he or she is covered by Medicare because of age, if you are not actively employed by an ADEA employer which pays all or part of the Plan premium.

For a disabled person: The Plan is the primary plan for the claims of a covered person:

- Who is covered for primary Medicare benefits because he or she is disabled and has received Social Security disability benefits for 24 months in a row
- Whose employer normally employed 100 or more employees on a typical business day during the previous calendar year.

The Plan is the secondary plan for the claims of a covered person, even if he or she is also covered by Medicare because of age.

For a covered person with end-stage renal disease: The Plan is the secondary plan for the claims of a covered person:

- Who is covered for primary Medicare Benefits because of end-stage renal disease;
- Even if he or she is also covered by Medicare because of age.

The Plan is the primary plan for the claims of a covered person who is covered for secondary Medicare benefits solely because of end-stage renal disease.

During the first 30 months, coverage through the Plan is primary and Medicare is secondary. After 30 months, Medicare becomes primary.

IMPORTANT INFORMATION ABOUT MEDICARE

Medicare may affect the Plan benefits; therefore, you may want to contact your local Social Security office for information about Medicare. This should be done before your or your spouse's 65th birthday.

CREDIT SAVINGS

Where the Plan does not have to pay its full benefits because of COB, the savings will be credited to the claimant for the claim period. These savings would be applied to any unpaid covered expense during the claim period.

HOW COB AFFECTS PLAN BENEFIT LIMITS

If COB reduces the benefits payable under more than one plan provision, each benefit will be reduced proportionately. Only the reduced amount will be charged against any benefit limit in those plan provisions.

RIGHT TO COLLECT AND RELEASE NEEDED INFORMATION

In order to receive benefits, the claimant must give the Trust Administrator any information that is needed to coordinate benefits. With the claimant's consent, the Plan may release to or collect from any person or organization any needed information about the claimant.

FACILITY OF PAYMENT

If benefits which the Plan should have paid are instead paid by another plan, the Plan may reimburse the other plan. Amounts reimbursed are Plan benefits and are treated like other Plan benefits in satisfying Plan liability.

RIGHT OF RECOVERY

If the Plan pays more for a covered expense than is required by this provision, the excess payment may be recovered from:

- The claimant
- Any person to whom the payment was made
- Any insurance company, service plan, or any other organization which should have made payment
- Any provider

The Plan has the right to offset future payment of benefits against an amount owed to the Plan.

SUBMITTING CLAIMS

If a claimant is covered under more than one plan, it is recommended that the claim be submitted to all plans at the same time. In that way, the proper coordinated benefits may be most quickly determined and paid.

THIRD PARTY REIMBURSEMENT AND/OR SUBROGATION

You may have a claim against another person or party for payment of medical and other charges, if you or your dependent incur medical or other charges:

- Related to injuries or illness caused by the act or omission of another person or;
- That another person may be liable or legally responsible to pay

The Trust will advance payment of covered expenses incurred as a result of the accidental injury/condition for which a third party is liable, on the condition that the employee, his/her dependent and your attorney (if applicable) complete and sign the Plan's Reimbursement Agreement to reimburse the Trust and assign to the Trust any recovery by settlement or judgment up to the amount of the benefits paid by the Trust. Reimbursement rights means the Plan's right to be reimbursed if:

- The Plan pays benefits for you or your dependent because of an injury or illness caused by a third party's act or omission; and
- You, your dependent, or any legal representative recovers an amount from the third party, the third party's insurer, an uninsured or underinsured motorist insurer, or from any other source or person by reason of the third party's act or omission. This recovery may be the result of a lawsuit, a settlement, or some other act. The Plan is entitled to be paid out of any recovery, up to the amount of Plan benefits the Plan pays, regardless of attorney's fees, costs or other charges.

Subrogation rights means the Plan's right to enforce its recovery of any Plan benefits paid for you or your dependent because of an injury or illness caused by a third party's act or omission. The Plan is entitled to be paid out of the gross amount of any recovery, up to the amount of Plan benefits it pays.

! KEY POINT

Subrogation means that the Plan, after paying your claim, may "step into your shoes" and seek reimbursement from another entity on your behalf. Subrogation permits the Plan to take direct legal action against a responsible party.

REIMBURSEMENT RIGHTS AND SUBROGATION RIGHTS

If you or your dependent has an injury or illness caused or alleged to be caused by a third party's act or omission:

- The Plan will pay benefits for that injury or illness subject to its reimbursement rights and subrogation rights and on condition that you or your dependent (or the legal representative of you or your dependent):
  - Will not take any action which would prejudice the Plan's reimbursement rights or subrogation rights
  - Complete and sign the Plan's Reimbursement Agreement.
  - Will cooperate in doing what is reasonably necessary to assist the Plan in enforcing its reimbursement rights or subrogation rights
  - Will not negotiate or enter into any agreement with a third party that would undermine the assignment, subrogation, or reimbursement rights of the Plan. All such agreements will be deemed unenforceable and will be ignored for purposes of determining and enforcing the rights of the Plan.
  - The Plan's reimbursement or subrogation rights will not be reduced because:
    - The recovery does not fully compensate you or your dependent for all losses sustained or alleged
    - The recovery is not described as being related to medical costs or loss of income

- The Plan may enforce its reimbursement rights or subrogation rights by filing a lien with the third party, the third party's insurer or another insurer, a court having jurisdiction in this matter, or any other appropriate party. The Plan also may claim a lien upon funds held by any person, including your attorney or other party who has or who had before disbursement custody of such funds.
- The Plan shall be entitled to a court order barring you and any representative from spending or transferring any portion of any recovery you obtain until any dispute between the Plan and you (or a representative) is finally resolved, or until a court issues a final decision regarding the Plan's rights.
- The amount of the Plan's reimbursement will not be reduced by legal fees or court costs incurred in seeking the recovery, unless the Trust Administrator agrees otherwise in writing.
- The Plan may elect to charge any reimbursement due under this provision against any further benefit payments for you or your dependent under the Plan. This will not reduce the Plan's right to be paid out of any recovery up to the amount of Plan benefits not yet reimbursed.
- When you retain an attorney to assist you in the claim against the third party who caused your injury or illness, the attorney must sign the reimbursement rights and subrogation rights agreement as a condition of payment of benefits.
  - Your attorney must also acknowledge in writing that the Plan precludes the operation of equitable defenses to the Plan's rights, including the "make whole" and "common funds" doctrines.
  - The Plan will not pay your attorney's fees or costs associated with recovery of funds, nor will the Plan reduce its reimbursement pro rata for payment of any attorney's fees and costs. Any attorney's fees will be payable out of the recovery only after the Plan has received full reimbursement.
  - You and your attorney who receives any recovery, whether by judgment, settlement, compromise, or otherwise, has an absolute obligation to immediately tender the recovery or recoveries to the Plan. If any recovery or funds received are not immediately tendered to the Plan, you, your attorney, or any other person possessing the recovery will be deemed to hold the recovery in constructive trust for the Plan.
  - The Plan will have the right to collect monies owed under this provision from your attorney using federal law and applicable state laws and rules. The Plan's right to collect from your attorney is separate from and in addition to its right to collect from you.
- When the Plan's third-party reimbursement and/or subrogation rights are applicable, the claimant and the claimant's attorney, as applicable, must complete and return to the Trust Office that reimbursement rights and subrogation rights agreement within **180 days** of the date the Plan initially sent the agreement to the claimant. If the agreement and all necessary supporting documentation is not received by the Plan by the date that is **180 days** after the Plan sent the agreement to the claimant, the Plan will deny all claims subject to the Plan's third party reimbursement rights or subrogation rights. The Plan may apply principles of equitable tolling with respect to this deadline to extend the deadline if the claimant can demonstrate that the claimant was incapacitated such that it was not possible for the claimant or the claimant's representative to complete the necessary paperwork.

! KEY POINT

If the agreement and all necessary supporting documentation is not received by the Plan by the date that is 180 days after the Plan sent the agreement to the claimant, the Plan will deny all claims subject to the Plan's third party reimbursement rights or subrogation rights.

ANTI-FRAUD POLICY

The Plan has adopted vigorous anti-fraud policies and procedures, which include:

- The Plan will not knowingly permit any person or entity to perpetrate a fraud upon the Plan for purposes of obtaining benefits or payments to which he, she, or it are not legitimately entitled. The Plan may terminate a covered person's coverage if the person is found to have engaged in fraudulent conduct against the Plan.
- The Plan's internal procedures actively investigate any circumstances which might involve intentional misrepresentation or deception by a service provider, beneficiary, contributing employer, or covered participant or beneficiary.
- The Plan actively investigates circumstances involving unacceptable practices that impose increased costs upon the Plan.
- The Plan seeks to identify all persons and entities who have made any untrue representations, to obtain recovery of any benefits or other services thereby improperly awarded, and to refer all such circumstances to other offices of authority.

If you know of any circumstances involving potentially fraudulent conduct perpetrated against the Plan, please inform the Trust Administrator. The Board is grateful for all assistance provided in reducing costs by preventing payment of unauthorized benefits.

If the Plan has to take legal action or incur legal fees to seek recovery of funds from you or your dependents, you shall be responsible for all possible liability for interest on improperly obtained benefits or payments and attorney's fees and costs incurred by the Plan for collection of those funds, regardless of payment under fraudulent circumstances or misrepresentations by you or your dependents.

DEFINITIONS/GLOSSARY

Unless the context otherwise requires, the terms below have the following definitions when used in this book.

Acupuncture means the practice of insertion of needles into specific exterior body locations to:

- Relieve pain
- Induce surgical anesthesia
- For therapeutic purposes

ADEA Employer means an employer which:

- Is subject to the U.S. Age Discrimination in Employment Act (ADEA)
- Has 20 or more employees each working day in 20 or more calendar weeks during the current or preceding calendar year

Administrator or Trust Administrator means BeneSys, Inc.

Adverse Benefit Determination means a denial, reduction or termination of, or a failure to provide or to make payment (in whole or in part) for a benefit, including any such denial, reduction, termination of, or failure to provide or make payment (in whole or in part) that is based upon the covered person's ineligibility for benefits under the Plan.

Age 65 (as used in the Coordination of Benefits provision) means the age attained at 12:01 a.m. on the first day of the month in which the covered person's 65th birthday occurs.

Bargaining Unit Employee means a person:

- In good standing in the International Union of Painters and Allied Trades, residing within commuting distance and available for work within the jurisdictional area of a Union local accepted by the Trust as a participating Union local; and
- With respect to a Contributing Employer, under the terms of a collective bargaining agreement, making contributions to the Trust for each hour worked by such employee for the purchase of health and welfare benefits, exclusive of any retirement benefits.

Body Organ means any of the following:

- Kidney
- Heart
- Heart/Lung
- Liver
- Pancreas (when the condition is not treatable by use of insulin therapy)
- Bone marrow
- Cornea

Brand Name Drug means a covered proprietary drug approved by the Food and Drug Administration.

Calendar Year is January 1 to December 31 of the same year.

Claimant means the person, participant or beneficiary for whom the claim is made.

Claim Period means part or all of a calendar year during which the claimant is insured under the Plan.

COBRA means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

Community Mental Health Agency means an agency which:

- Is licensed as such by the proper authority of the state in which it is located
- Has in effect a plan for quality assurance and peer review
- Provides treatment under the supervision of a physician or a licensed psychologist

Contributing Employer means any person or entity who, pursuant to a collective bargaining agreement, is making payments to the Trust for the purchase of health and welfare benefits for employees in job classifications covered by such bargaining agreement.

Copayment means an amount which the covered person must pay before benefits are payable, and which is incurred on the date the covered drug or service is received. Copayments may not be used to satisfy any deductible or the major medical stop-loss limit.

Cosmetic Surgery means any surgical procedure performed primarily:

- To improve physical appearance without materially correcting a bodily malfunction
- To prevent or treat a mental illness through a change in bodily form

Covered Drug means:

- A drug or medicine which requires a physician's written prescription
- Insulin and certain diabetic supplies (needles, syringes, test tablets, sticks, tapes, strips and lancets)
- Contraceptive drugs which require a physician's written prescription

Covered Expense means the Usual and Customary Charge for any medically necessary health care service or supply, which is covered at least in part by the Plan or other plans (for Coordination of Benefits purposes).

Covered Person means you and your dependents who are covered under the Plan.

Custodial Care means services or supplies, regardless of where or by whom they are provided which:

- A person without medical skills or background could provide or could be trained to provide;
- Are provided mainly to help the covered person with daily living activities, including (but not limited to):
  - Walking, getting in or out of bed, exercising and moving the covered person

- Bathing, using the toilet, administering enemas, dressing and assisting with any other physical or oral hygiene needs
- Assistance with eating by utensil, tube or gastrostomy
- Homemaking, such as preparation of meals or special diets, and house cleaning
- Acting as a companion or sitter
- Supervising the administration of medications which can usually be self-administered, including reminders of when to take such medications

- Provide a protective environment;
- Are part of a maintenance treatment plan or are not part of an active treatment plan intended to or reasonably expected to improve the covered person's illness, injury or functional ability; or
- Are provided for the convenience of the covered person or the caregiver or are provided because the covered person's own home arrangements are not appropriate or adequate.

The Plan will determine what services or supplies are custodial care. When a confinement in a facility or a visit to a physician is found to be mainly for custodial care, some services (such as prescription drugs, x-rays and lab tests) may still be covered if medically necessary and otherwise covered. All bills should be routinely submitted for consideration.

Day(s) means calendar day(s).

Dental Injury means an injury to sound natural teeth caused by an external force such as a blow or fall. It does not include tooth breakage while chewing.

Dentist means a person who is licensed to practice in the state where the dental procedure is performed, operating within the scope of his or her license and performing a service which is payable under the Plan.

- Where required to be covered by law, dentist means any other licensed practitioner who is acting within the scope of his or her license and performing a service which is payable under the Plan when performed by a dentist.
- A dentist does not include a person who lives with you or is part of your family (you; your spouse; or a child, brother, sister or parent of you or your spouse).

Developmental Care means services or supplies, regardless of where or by whom they are provided which:

- Are provided to a covered person who has not previously reached the level of development expected for the covered person's age in the following areas of major life activity:
  - Intellectual
  - Physical
  - Receptive and expressive language
  - Learning
  - Mobility
  - Self-direction
  - Capacity for independent living
  - Economic self-sufficiency
- Are not rehabilitative in nature (restoring fully developed skills that were lost or impaired due to injury or illness)
- Are educational in nature

The Plan will determine what service or supplies are developmental care. When a confinement, visit or other service or supply is found to be primarily for developmental care, some services or supplies (such as prescription drugs, x-rays and lab tests) may still be covered if medically necessary and otherwise covered. All bills should be routinely submitted for consideration.

Drug means any substance prescribed by a physician taken by mouth; injected into a muscle, the skin, a blood vessel or a cavity of the body, or applied to the skin to treat or prevent a disease, and specifically includes drugs or biologicals used in an anticancer chemotherapeutic regimen for a medically accepted indication or for the treatment of people with HIV or AIDS.

Durable Medical Equipment means equipment which:

- Can stand repeated use
- Is mainly and customarily used for a medical purpose
- Is not generally useful to a person in the absence of an injury or illness
- Is suited for use in the home

It does not include equipment with a non-medical use, such as sun or heat lamps, heating pads, whirlpool baths, exercise devices, ramps or handrails, or air conditioners, purifiers, humidifiers, waterpiks or commodes.

Eligible Active Employee means an employee working for a contributing employer who meets the initial eligibility requirements and maintains sufficient hours or premium amounts for continuing eligibility, according to the terms of the applicable coverage plans.

Emergency Services means otherwise-covered health care services medically necessary to evaluate and treat a medical emergency condition, provided in a hospital emergency department.

ERISA means the Employee Retirement Income Security Act of 1974, as amended, a federal statute that, together with other federal laws and regulations, governs the administration of the Trust and the Plan.

Expense means the expense incurred for a covered service or supply which has been ordered or prescribed by a physician. Expense is considered incurred on the date the service or supply is received. Expense does not include any charge:

- For a service or supply which is not medically necessary
- Which is in excess of the usual and customary global charge for a service or supply

Experimental or Investigational Drug, Device and Treatment or Procedure means a:

- Drug or device which cannot be lawfully marketed without approval of the U.S. Food and Drug Administration, and which has not been so approved for marketing at the time the drug or device is furnished
- Drug, device, treatment or procedure which was reviewed and approved (or which is required by federal law to be reviewed and approved) by the treating facility's institutional review board or other body serving a similar function, or a drug, device, treatment or procedure which is used with a patient informed consent document which was reviewed and approved (or which is required by federal law to be reviewed and approved) by the treating facility's institutional review board or other body serving a similar function
- Drug, device, treatment, or procedure which reliable evidence shows is the subject of ongoing phase I, II or III clinical trials or is under study to determine its maximum tolerated dose, toxicity, safety, or efficacy as compared with a standard means of treatment or diagnosis
- Drug, device, treatment or procedure for which the prevailing opinion among experts, as shown by reliable evidence, is that further studies or clinical trials are necessary to determine its maximum tolerated dose, toxicity, safety, or efficacy as compared with a standard means of treatment or diagnosis

Generic Drug means a covered drug, regardless of the manufacturer, which is bioequivalent to a brand name drug and which is approved by the Food and Drug Administration. Not all brand name drugs have a generic equivalent.

Global Charge means the single expense incurred for the combination of all necessary medical services normally furnished by a physician or other covered provider (or multiple physicians or other covered providers) before, during and after the principal medical service. The global charge will be based on a complete description of the covered medical service, rather than a fragmented description of that service. The global charge will not exceed the usual and customary charge allowed by us. The Plan will determine what is included in the global charge.

Health Coverage means hospital, surgical, medical, dental, vision or prescription drug benefits provided under the Plan. Health Plan eligibility and benefits are subject to change as a result of open enrollments or Plan modifications.

Home Health Agency means a public or private agency or organization which:

- Administers and provides home health care services
- And is either:
  - Certified as such by the State Department of Social and Health Services; or
  - Licensed or certified as such by the state where the services are rendered

Home Health Care Plan means a plan of continued care and treatment of a covered person:

- Who is under the care of a physician
- Whose physician certifies that, without the home health care, confinement in a hospital or skilled nursing care facility would be needed

The home health care plan must be:

- Established by a physician within 14 days after the home health care begins
- Certified by a physician every 30 days after the home health care begins

Home Health Care Services means the services and supplies listed above, which are furnished:

- By a home health agency
- In the covered person's home
- In accordance with a home health care plan

Hospice Agency means a public or private agency or organization which:

- Administers and provides hospice care and is:
  - Certified as such by the State Department of Social and Health Services;
  - Licensed or certified as such by the state where services are rendered;
  - Certified to participate as such under Medicare; or
  - Accredited as such by the Joint Commission on the Accreditation of Hospitals or the National Hospice Organization.

Hospice Care Plan means a plan of continued care of a terminally ill covered person who is under the care of a physician:

- Which is established by a physician within 14 days after the hospice care begins
- Which is certified by a physician every 30 days after the hospice care begins

Hospice Care Services means palliative (pain controlling) and supportive medical, nursing, and other health services provided:

- By a hospice agency
- In the covered person's home or in an inpatient hospice unit or facility
- In accordance with a hospice care plan

Hospital means any of the following facilities which are licensed by the proper authority in the area in which they are located:

- A place which is licensed as a general hospital

- A place which:
  - Is operated for the care and treatment of resident inpatients
  - Has a registered graduate nurse (RN) always on duty
  - Has a laboratory and X-ray facility
  - Has a place where major surgical operations are performed
- A facility which is accredited by the Joint Commission on the Accreditation of Healthcare Organizations, American Osteopathic Association or the Commission on the Accreditation of Rehabilitative Facilities, if the function of such facility is primarily of a rehabilitative nature, provided such rehabilitation is specifically for treatment of a physical disability. Such facility need not have major surgical facilities.
- When treatment is needed for Mental Disorder/Alcohol and Drug Abuse or Substance Abuse, Hospital can also mean a place which meets these requirements:
  - Has rooms for resident inpatients
  - Is equipped to treat mental disorders/alcohol and drug abuse or substance abuse
  - Has a resident physician on duty or on call at all times
  - As a regular practice, charges the patient for the expense of confinement
  - Is licensed by the proper authority of the area in which it is located
- A hospital does not include a hospital or institution or part of a hospital or institution which is licensed or used principally as a convalescent home, rest home, nursing home, home for the aged, halfway house onboard and care facility, residential treatment center (except as required under chemical dependency benefits), "wilderness" program, treatment group home or "boot camp."

Hospital Confinement means a medically necessary hospital stay of 24 consecutive hours or more in any single or multiple departments or parts of a hospital for the purpose of receiving any type of medical service. These requirements apply even if the hospital does not charge for daily room and board. How the hospital classified the stay is irrelevant as well.

Any hospital confinement satisfying this definition will be subject to all Plan provisions relating to inpatient hospital services or admissions, including any applicable preadmission review requirements. Hospital stays or services not satisfying this definition will be considered under the Plan provisions for outpatient services.

Illness means a disease, disorder or condition which requires treatment by a physician.

- For a female employee and dependent spouses, illness includes childbirth or pregnancy
- For a dependent child, illness does not include normal pregnancy or normal childbirth, but it does include complications of pregnancy

Injury means an accidental bodily injury which is the direct result of a sudden, unexpected and unintended external force or element, such as a blow or fall that requires treatment by a physician. It must be independent of illness or any other cause, including, but not limited to, complications from medical care.

Jaw Joint Disorder means any misalignment, dysfunction or other disorder of the jaw joint (or of the complex of muscles, nerves and tissues related to that joint). It includes:

- Temporomandibular joint dysfunction (TMJ), arthritis or arthrosis
- Other craniomandibular joint disorders
- Myofacial or orofacial pain syndrome
- It does not include a fracture or dislocation which results from an injury

Maintenance Drug means a covered drug which is prescribed for a chronic condition requiring continued medication on a regular or long-term basis.

Massage Therapy is the manipulation of the soft tissue of the body through stroking, rubbing, kneading or tapping to increase circulation, to improve muscle tone and to promote relaxation.

Mastectomy means the removal of all or part of the breast for medically necessary reasons.

Medical Emergency means the emergency and acute onset of a symptom or symptoms, including severe pain, that would lead a prudent layperson acting reasonably to believe that a health condition exists that requires immediate medical attention, if failure to provide medical attention would result in:

- Serious impairment to bodily functions
- Serious dysfunction of a bodily organ or part
- Placing the person's health in serious jeopardy
- The patient's portion of the difference between the cost sharing amounts for the use of Preferred vs. Nonpreferred Providers services will not exceed $50
- If a non-participating hospital emergency department provides emergency services, benefits will be payable at the Preferred Provider level, when:
  - Due to circumstances beyond the covered person's control, he or she was unable to go to a participating hospital in a timely fashion without serious impairment to his or her health
  - A prudent layperson possessing an average knowledge of health and medicine would have reasonably believed that he or she would be unable to go to a participating hospital in a timely fashion without serious impairment to his or her health

A **Medically Necessary** service or supply means one which is ordered by a physician and which the Plan determines is:

- Provided for the diagnosis or direct treatment of an injury or illness

- Appropriate and consistent with the symptoms and findings or diagnosis and treatment of the covered person's injury or illness
- Provided in accordance with generally accepted medical practice on a national basis
- The most appropriate supply or level of service which can be provided on a cost effective basis (including, but not limited to, inpatient vs. outpatient care, electric vs. manual wheelchair, surgical vs. medical or other types of care)

The fact that the covered person's physician prescribes services or supplies does not automatically mean such services or supplies are medically necessary and covered by the Plan.

Medicare Benefits means benefits for services and supplies which the covered person receives or is eligible for under Medicare.

Mental Disorder/Alcohol and Drug Abuse or Substance Abuse means any condition or disease, regardless of its cause, listed in the most recent edition of the International Classification of Diseases as a mental disorder. Not included in this definition are conditions or diseases specifically excluded.

The Plan may include special benefits for any one or more of the conditions included in this definition. If the Plan does, only those special benefits relating to those conditions are available for that condition.

Naturopathic Care means a system of therapeutics in which neither surgical nor medical agents are used, dependent on being placed on natural (non-medical) forces, such as:

- Natural foods
- Light
- Warmth
- Massage
- Fresh air
- Regular exercise
- The avoidance of medications

Neurodevelopmental Therapies Services include services of those authorized to deliver occupational therapy, speech therapy and physical therapy. Such services shall be:

- For the maintenance of a dependent child in cases where significant deterioration in the patient's condition would result without the service
- To restore and improve function
- Periodically reviewed by a physician

Nonpreferred Providers means a provider who does not have a contract with your health insurer or plan to provide services to you.

Normal pregnancy or normal childbirth means pregnancy or childbirth that is free of complications of pregnancy.

Complications of pregnancy means:

- Any condition resulting in hospital confinement, the diagnosis of which is distinct from pregnancy, but is adversely affected or caused by pregnancy
- A non-elective cesarean section, an ectopic pregnancy which is terminated, a spontaneous termination of pregnancy when a viable birth is not possible, a puerperal infection, eclampsia and toxemia
- False labor, occasional spotting, physician prescribed rest, morning illness, hyperemesis gravidarum, preeclampsia and similar conditions associated with a difficult pregnancy are not complications of pregnancy

Occupational Therapy means treatment, when you or your dependent is physically disabled, by means of constructive activities designed and adapted to promote the restoration of the ability to accomplish satisfactorily the ordinary tasks of daily living and those required by the particular occupational role of you or your dependent.

Off-Label means the prescribed use of a drug which is other than that stated in its Federal Drug Administration approved labeling.

Other Provider means a provider of covered services who:

- Is not participating in the Preferred Provider option
- Is not shown on our current list of members in that option
- The payments to Other Providers will be based on the Usual and Customary Charges
- The Plan does not supervise, control or guarantee the health care services of any Preferred Provider or Other Provider

Our, We, or Us means the Employee Painters' Trust.

Out-of-Pocket Expense means expense which the covered person incurs for covered services during the calendar year and must pay out-of-pocket:

- To satisfy the deductible
- As coinsurance (the percentage the covered person must pay in accordance with the percentage payable provision)

PBM means Prescription Benefits Manager Elixir

Peer-Reviewed Medical Literature means scientific studies printed in journals or other publications in which original manuscripts are published only after having been critically reviewed for scientific accuracy, validity, and reliability by unbiased independent experts. Peer-Reviewed Medical Literature does not include in-house publications of pharmaceutical manufacturing companies.

Person with Diabetes means a person diagnosed by a health care provider as having insulin-using diabetes, noninsulin-using diabetes or elevated blood glucose levels induced by pregnancy.

Physical Therapy means treatment by:

- Manual manipulation or other physical means
- Hydrotherapy
- Heat
- Physical agents
- Biomechanical and neurophysiological principles and devices; used to:
  - Relieve pain
  - Restore maximum bodily function
  - Prevent disability arising from injury or illness
- Physical therapy shall not include cardiac rehabilitation

Physician means any of the following licensed practitioners who perform a service payable under the Plan:

- A doctor of medicine (MD), osteopathy (DO), podiatry (DPM) or chiropractic (DC)
- A licensed doctoral clinical psychologist
- A master's level counselor and licensed or certified social worker
- A licensed physician's assistant (PA)
- Where required to cover by law, any other licensed practitioner who:
  - Is acting within the scope of his/her license
  - Performs a service which is payable under the Plan when performed by an MD
- A physician does not include a person who lives with you or is part of your family (you; your spouse; or a child, brother, sister or parent of you or your spouse).

Placed for Adoption means assumption and retention by the covered person of a legal obligation for total or partial support of such child in anticipation of adoption of such child.

Plan means the provisions and benefits described in the Plan, as well as any of the following coverages which provide benefits payments or services to a covered person for hospital, medical, surgical, prescription drug, dental or vision care:

- Group or blanket insurance (except student accident insurance)
- Group Blue Cross and/or Blue Shield and other prepayment coverage on a group basis, including HMOs (health maintenance organizations)
- Coverage under a labor-management trust plan, a union welfare plan, an employer organization plan or an employee benefits plan
- Coverage under government programs, other than Medicaid, and any other coverage required or provided by law
- Other arrangements of insured or self-insured group coverage

If any of these coverages include group and group-type hospital indemnity coverage, Plan also means that amount of indemnity benefits which exceeds $200 a day.

Precertification, Preauthorization, Prior Authorization means you need pre-approval from Aetna for some eligible health services. Pre-approval is also called precertification, preauthorization, or prior authorization.

Preferred Provider means a provider of covered services who:

- Is participating in our Preferred Provider option
- Is shown on our current list of participating providers in that option

The payments to Preferred Providers will be based on arrangements with providers who participate in the Preferred Provider option.

Prescription Drug means a drug requiring a prescription by federal or state law will be provided when dispensed by a licensed pharmacist to treat a condition covered under the Plan. Antigen and allergy vaccine and insulin dispensed by a physician or certified laboratory will also be provided. Any other drug or medication furnished by the physician or any drug not requiring a prescription will not be provided unless otherwise allowed by the Plan. Mail order drug purchases are generally limited to a 90-day supply.

Prior Group Plan means the group plan providing similar benefits (whether insured or self-insured, including HMOs and other prepayment plans provided by the Plan) in effect immediately prior to the effective date of the Plan.

Reconstructive Surgery means any surgical procedure which repairs an abnormal body structure.

Reimbursement Rights means the Trust's or the Plan's right to be reimbursed if:

- The Plan pays benefits for you or your dependent because of an injury or illness caused by a third party's act or omission
- You, your dependent or the legal representative recovers an amount from the third party, the third party's insurer, an uninsured motorist insurer or from any other source or person by reason of the third party's act or omission. This recovery may be the result of a lawsuit, a settlement or some other act. The Trust is entitled to be paid out of any recovery, up to the amount of benefits the Plan pays, regardless of attorney's fees, costs or other charges.

Reliable Evidence means only published reports and articles in the authoritative medical and scientific literature; the written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same drug, device, treatment or procedure; or the written informed consent used by the treating facility or by another facility studying substantially the same drug, device, treatment or procedure.

Serious Health Condition is defined as stated in the Family and Medical Leave Act (FMLA).

Service in the Uniformed Services means the performance of duty on a voluntary or involuntary basis in a uniformed service under competent authority and includes active duty, active duty for training, initial active duty for training, inactive duty training, full-time National Guard duty and a period for which a person is absent from a position of employment for the purpose of an examination to determine the fitness of the person to perform any such duty.

Smoking Cessation Treatment means treatment received in conjunction with tobacco usage, including chewing.

Speech Therapy means treatment for the correction of a speech impairment resulting from an injury, illness or surgery, or such treatment following surgery to correct congenital and developmental anomalies. Speech therapy is covered only if there is a physician's recommendation that speech therapy is required for a covered person. Speech therapy which is educational in nature, such as for treatment of a learning disability, is not covered.

Sound Natural Teeth means teeth which:

- Are whole or properly restored
- Are without impairment or periodontal disease
- Are not in need of the treatment provided for reasons other than dental injury

Spinal Treatment means detection or correction to remove nerve interference or its effects (by manual or mechanical means) of:

- Structural imbalance
- Distortion
- Subluxation in the body
- The interference must be the result of or related to distortion, misalignment or subluxation of or in the vertebral column

Standard Reference Compendia means:

- The American Hospital Formulary, Service-Drug Information
- The American Medical Association Drug Evaluation
- The United States Pharmacopoeia-Drug Information
- Other authoritative compendia as identified time to time by the Federal Secretary of Health and Human Services or the insurance commissioner

Stepchild means a child of the eligible participant's spouse if the participant is not the parent, natural or through adoption, of the child, and the participant and spouse are both eligible for benefits under the Plan.

Subrogation Rights means the Trust's right to enforce recovery of the Plan benefits paid for you or your dependent because of an injury or illness caused by a third party's act or omission. The Trust is entitled to be paid out of any recovery, up to the amount of benefits the Plan pays.

Terminally Ill means:

- Determined by a physician to have a terminal illness with no reasonable prospect of cure
- Expected by a Physician to have less than six months to live

Third Party means another person or organization.

Total Disability, Totally Disabled or Disabled means that because of an injury or illness:

- You are completely and continuously unable to perform the material and substantial duties of your regular occupation and are not engaging in any work or occupation for wages or profit
- Your dependent is:
  - Either physically or mentally unable to perform all of the usual and customary duties and activities (the "normal activities") of a person of the same age and sex who is in good health
  - Not engaged in any work or occupation for wages or profit

Uniformed Service means the United States Armed Forces, the Army National Guard and the Air National Guard when engaged in active duty for training, inactive duty training, or full-time National Guard duty, the commissioned corps of the Public Health Service, and any other category of persons designated by the President in time of war or emergency.

Union means the International Union of Painters and Allied Trades and any other local union affiliated with the International Union of Painters and Allied Trades which may be added from time to time by mutual agreement between the Trust and the Union, and any other union whose collective bargaining agreement requires contributions be made to the Trust.

USERRA means the Uniformed Services Employment and Reemployment Rights Act of 1994 (including any amendments to such Act and any interpretive regulations or rulings).

Usual and Customary Charge means a charge by a professional service provider for a covered service which is no higher than the 90th percentile identified on the healthcare charges database (HCD).

- When there is, in the Plan's determination, minimal data available from the HCD for a covered service, the Plan will determine the usual and customary charge by calculating the unit cost for the applicable service category using HCD, and multiplying that by the relative value of the covered service assigned by the Medicare resource based relative value scale (supplemented with a commercially available relative value scale selected by us where one is not available from Medicare).
- In the event of an unusually complex covered service, a covered service that is a new procedure or a covered service that otherwise does not have a relative value that is in our determination applicable, the Plan will assign one.

- In no event will the usual and customary charge exceed the amount billed by the professional service provider or the amount for which the covered person is responsible. The term "usual and customary charge" may not reflect the actual charges of the professional service provider and does not take into account the professional service provider's training, experience or category of licensure.
- Usual and Customary Charge is not the same as "Usual and Reasonable" as defined in the Outpatient Dialysis provision.

You means eligible collective bargaining employee, officers, non-bargaining unit employees, and associates.

PLAN INFORMATION

SUMMARY PLAN DESCRIPTION

The Employee Retirement Income Security Act of 1974 (ERISA) requires that certain information be furnished to eligible participants in an employee benefits plan. The employee benefits plan maintained by the Trust shall be referred to herein as the Plan.

The Plan is known as the Employee Painters' Trust Plan. The Trust through which the Plan is provided is known as the Employee Painters' Trust.

The Plan covers certain classes of employees who, in general, work for participating employers who are required to make contributions under various collective bargaining agreements to the Trust.

THE BOARD

This Plan is sponsored and administered by a joint labor-management Board, the name, address, and telephone number of which is:

The Board of the Employee Painters' Trust
c/o BeneSys, Inc.
5200 Southcenter Blvd., Suite 205
Tukwila, WA 98188
Phone: 206-518-9730 or 844-344-2721
Fax: 425-251-1976

TYPE OF ADMINISTRATION

The Plan is administered by the Board with the assistance of a Third-Party Administrator to provide services for routine plan administration. The name and address of the agent for the service of legal process that the Board has designated is:

BeneSys, Inc.
5200 Southcenter Blvd., Suite 205
Tukwila, WA 98188

Service of legal process may also be made upon any member of the Board.

THE BOARD

Jonathan Holca Long Painting Company 21414 68th Avenue South Kent, WA 98032	Dave Winkler IUPAT District Council No. 5 11105 NE Sandy Blvd. Portland, OR 97220
Stacey Grund Grund & Company, Inc. 1115 N 97th Seattle, WA 98103	Robert Williams IUPAT District Council No. 16 2705 Constitution Drive Livermore, CA 94551
Steve Malcolm Eastside Glass 20205 114th Ave NE, Suite 100 Woodinville, WA 98072	Todd Springer IUPAT District Council No. 5 5200 Southcenter Blvd., Suite 200 Tukwila, WA 98188
Harold Daly Southern Nevada PDCA 1701 Whitney Mesa Drive, Suite 104 Henderson, NV 89014	Keith Markland IUPAT District Council No. 16 1701 Whitney Mesa Drive, Suite 105 Henderson, NV 89014
Jeremy Gibson BNBuilders 2601 4th Ave, Suite 350 Seattle, WA 98121	Lisa DeRosia IUPAT District Council No. 5 5200 Southcenter Blvd., Suite 200 Tukwila, WA 98188

The Board's membership as of October 2021.

IDENTIFICATION NUMBER

The identification number (EIN) assigned to the Plan by the Internal Revenue Service is 91- 0597991, Plan number 501.

PLAN YEAR

The plan year for the Plan ends on July 31 of each year. Each 12-month period ending on such date consists of an entire plan year for the purposes of accounting and all other reports to the U.S. Department of Labor and other appropriate regulatory bodies.

TYPE OF PLAN

The Plan can be described as a health and welfare plan, which provides major medical, disability, accidental death and dismemberment, and prescription drug benefits.

DESCRIPTION OF COLLECTIVE BARGAINING AGREEMENT

The Plan is maintained pursuant to more than one collective bargaining agreement. A copy of such agreements may be obtained by participants and beneficiaries upon written request to the Board. Additionally, a list of employers, employer organizations, and unions sponsoring the Plan is available upon request.

Such agreements are also available for examination by participants and beneficiaries from the Trust Administrator or at local union offices upon 10 days' advance written request.

The Board may impose a reasonable charge to cover the cost of furnishing copies. Participants and beneficiaries may wish to inquire as to the amount of charges before requesting copies.

SOURCE OF CONTRIBUTIONS

These agreements generally provide that the employers who are parties thereto will make monthly contributions to the Trust for the purpose of enabling the employees working under such agreements to participate in the Plan. In addition, employee self-payments are also permitted for retiree coverage and to continue employee and dependent coverage. Contributions are calculated based upon the provisions set out in the various collective bargaining agreements under which the Plan is maintained.

ENTITIES USED FOR ACCUMULATION OF ASSETS AND PAYMENT OF BENEFITS

The employer contributions or employee self-payments are received and held in trust by the Board pending the payment of claims or benefits and administrative expenses. The balance is invested by the Board and held as Trust reserves.

Presently, the Accidental Death & Dismemberment (AD&D) benefits are administered by Mutual of Omaha. Weekly Disability, major Medical, retail Prescription Drug benefits, Dental and Vision benefits are self-funded and paid directly from the Trust's assets.

PARTICIPATION, ELIGIBILITY, AND BENEFITS

Employees are entitled to participate in the Plan if they work under one of the collective bargaining agreements (CBAs) described in the above paragraph entitled "Description of Collective Bargaining Agreements," and if their employer makes contributions to the Trust on their behalf.

CIRCUMSTANCES WHICH MAY RESULT IN INELIGIBILITY OR DENIAL OF BENEFITS

An employee or beneficiary who is eligible for benefits may become ineligible as a result of one or more of the following circumstances:

- The employee's failure to work required hours to maintain eligibility; and
- Beneficiaries who are dependents of eligible employees may become ineligible if:
  - The employee becomes ineligible
  - They are no longer dependents
  - They have attained the disqualifying age
- An employee or beneficiary who is eligible may be denied benefits for one or more of the following reasons:
  - Failure of the employee or beneficiary to file a claim for benefits within 12 months of the date they incurred the expense for which benefits are payable
  - Failure of the employee to file a complete and truthful benefit application

Any person who knowingly presents a false or fraudulent claim for payment, or prepares or makes any false or fraudulent account, certification, or other document or writing with intent that it be presented or used in support of such claim, may be guilty of a crime. Civil penalties, including interest, costs, and attorney's fees, may also be assessed on all false or fraudulent claims.

Where the employee or beneficiary has other group coverage, benefits under the Plan may be reduced or denied due to the Coordination of Benefits provision.

CHANGE OR DISCONTINUANCE OF THE PLAN

It is hoped the Plan will be continued indefinitely but, as with any group benefit plan, the right of change or discontinuance by the Board at any time must be reserved.

MEDICAL PLAN DISCLOSURES

You or your dependent(s) are entitled to request from the Trust Administrator, without charge, information applicable to the Plan's benefits and procedures. In addition, the Plan includes, as applicable, a description of:

- Qualified Medical Support Orders
- Any cost-sharing provisions, including premiums, deductibles, coinsurance and copayments, maximums, details about the level of benefits, providers, preauthorization and utilization review rules, coverage for medical tests, devices and procedures, out-of-network coverage, limits on emergency care, coverage of existing and new drugs
- Employee and dependent eligibility requirements
- Any participating provider requirements; a current listing of such providers is available online and can be furnished as a separate document
- When coverage ends
- When benefits may be denied or reduced, including subrogation or reimbursement, and Coordination of Benefits provisions
- State or federal continuation rights
- Claims procedures; additional details shall be furnished upon request
- Maternity hospitalization for the mother and newborn infant

ACCIDENTAL DEATH & DISMEMBERMENT AND WEEKLY DISABILITY DISCLOSURES

You or your dependent(s) are entitled to request from the Trust Administrator, without charge, information applicable to the Plan's benefits and procedures. In addition, this book includes, as applicable, a description of:

- Employee and dependent eligibility requirements
- When coverage ends
- State or federal continuation rights
- Claims procedures; additional details shall be furnished upon request

THE NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT (NMHPA) NOTICE

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 insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

PLAN CHANGES

The persons with authority to change, including the authority to terminate, the Plan on behalf of the Plan are the Plan's Board or other governing body, or any person or persons authorized by resolution of the Board or other governing body to take such action.

Please refer to the information in the Trustees' Discretion section for additional information about how the Plan can be changed. The Board and the Trust Administrator are authorized to apply for and accept the Plan and any changes to the Plan.

LANGUAGE ASSISTANCE

The Plan contains a summary in English of your plan rights and benefits under the Plan. If you have difficulty understanding any part of this book, contact the Trust Administrator at 844-344-2721.

FORMS

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EMPLOYEE PAINTERS' TRUST

ENROLLMENT FORM

Event Date:_____
Effective Date: _____

CHECK ALL THAT APPLY:

☐ **New Enrollment** ☐ **Add Dependent** ☐ **Remove Dependent** ☐ **Plan Change** ☐ **Address Change**

EMPLOYEE'S FULL LEGAL NAME:_____ SSN:_____

ADDRESS:_____

CITY:_____ STATE:_____ ZIP:_____ GENDER: (Circle One) Male Female

DATE OF BIRTH:_____ PHONE NUMBER: (_____)_____ EMAIL: _____

MARITAL STATUS: ☐ Married (Date of Marriage) _____ ☐ Single ☐ Divorced (Date of Divorce) _____

EMPLOYER_____ DATE OF HIRE:_____ LOCAL UNION #_____

MEDICAL PLAN: (Provided By)	**DENTAL PLAN: (Provided By)**	**VISION PLAN: (Provided By)**
AETNA	CAREINGTON DENTAL **	VISION SERVICE PLAN (VSP)**
**** Dental and Vision benefits excluded from Material Handlers and Residential Painting benefits**		

NOTE: IF YOU ARE ADDING ANY DEPENDENTS WHO ARE ON MEDICARE, PLEASE INCLUDE A COPY OF THEIR MEDICARE CARD.

DEPENDENTS - (Including Spouse)

YOU MUST ATTACH LEGAL DOCUMENTATION THAT APPLIES TO ADD YOUR DEPENDENTS:
Birth Certificate(s) for children, Marriage Certificate for spouse, Legal Adoption papers, Legal Guardianship papers

FULL NAME	SSN	GENDER	DATE OF BIRTH	RELATIONSHIP

I agree to notify the Trust Office within 30 days of any changes to the above information. Further, I declare all the above information to be complete and correct. I understand that it is a crime to knowingly provide false, incomplete, or misleading information for the purpose of defrauding obtaining plan coverage. Penalties may include imprisonment, fines, and denial of benefits.

EMPLOYEE SIGNATURE_____ **DATE** _____

5200 Southcenter Blvd, Suite 205, Tukwila, WA 98188 • P O Box 58830 • Tukwila, WA 98138
Phone (206) 518-9730 • Toll Free (844) 344-2721 • Fax (425) 251-1976
www.IUPATWesternBenefits.org

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Coordination of Benefits

Member's Name: _____ Member ID #: _____ Date of Birth: _____

Address: _____

☐ ***If you and/or spouse/dependents DO NOT have any other insurance coverage, please check this box turn over and sign/date the bottom of the next page (under "Member Statement").***

INCOMPLETE DOCUMENTATION WILL RESULT IN POSSIBLE DELAYS IN CLAIMS PROCESSING

A MEMBER HEALTH COVERAGE INFORMATION

Does this plan include **Medical** Coverage? □ Yes or □ No If yes, is this plan an: □ HMO or □ PPO

Name of Medical Carrier: _____ Policyholder name: _____ Policy Number: _____

Effective Date: _____ Termination Date (if applicable): _____ Group Number: _____

Does this plan include **Dental** Coverage? □ Yes or □ No If yes, is this plan an: □ HMO or □ PPO

Name of Dental Carrier: _____ Policyholder name: _____Policy Number: _____

Effective Date: _____ Termination Date (if applicable): _____ Group Number: _____

Does this plan include **Vision** Coverage? □ Yes or □ No If yes, is this plan an: □ HMO or □ PPO

Name of Vision Carrier: _____ Policyholder name: _____Policy Number: _____

Effective Date: _____ Termination Date (if applicable): _____ Group Number: _____

Medicare: Policyholder name: _____ Policy Number: _____

Is coverage because of? □ Age □ Disability □ ESRD

Part: A □ B □ C □ D □ Effective Date: A) _____ B) _____ C) _____ D) _____

B SPOUSE AND DEPENDENTS HEALTH COVERAGE INFORMATION

Does this plan include **Medical** Coverage? □ Yes or □ No If yes, is this plan an: □ HMO or □ PPO

Name of Medical Carrier: _____ Policyholder name: _____ Policy Number: _____

Effective Date: _____ Termination Date (if applicable): _____ Group Number: _____

Does this plan include **Dental** Coverage? □ Yes or □ No If yes, is this plan an: □ HMO or □ PPO

Name of Dental Carrier: _____ Policyholder name: _____Policy Number: _____

Effective Date: _____ Termination Date (if applicable): _____ Group Number: _____

Does this plan include **Vision** Coverage? □ Yes or □ No If yes, is this plan an: □ HMO or □ PPO

Name of Vision Carrier: _____ Policyholder name: _____Policy Number: _____

Effective Date: _____ Termination Date (if applicable): _____Group Number: _____

Medicare: Policyholder name: _____ Policy Number: _____

Is coverage because of? □ Age □ Disability □ ESRD

Part: A □ B □ C □ D □ Effective Date: A) _____ B) _____ C) _____ D) _____

1.) Dependent: _____

☐ **Medical** Effective Date: _____ ☐ **Dental** Effective Date: _____ ☐ **Vision** Effective Date: _____

- Name of **Medical** Carrier: _____ Policyholder name: _____ Policy Number: _____
- Name of **Dental** Carrier: _____ Policyholder name: _____ Policy Number: _____
- Name of **Vision** Carrier: _____ Policyholder name: _____ Policy Number: _____

2.) Dependent: _____

☐ **Medical** Effective Date: _____ ☐ **Dental** Effective Date: _____ ☐ **Vision** Effective Date: _____

- Name of **Medical** Carrier: _____ Policyholder name: _____ Policy Number: _____
- Name of **Dental** Carrier: _____ Policyholder name: _____ Policy Number: _____
- Name of **Vision** Carrier: _____ Policyholder name: _____ Policy Number: _____

Continuation on other Side

For additional dependents, ATTACH A SEPARATE sheet with employee's name at top. (Last, First, MI)

3.) Dependent: _____

☐ **Medical** Effective Date: _____ ☐ **Dental** Effective Date: _____ ☐ **Vision** Effective Date: _____

- Name of **Medical** Carrier: _____ Policyholder name: _____ Policy Number: _____
- Name of **Dental** Carrier: _____ Policyholder name: _____ Policy Number: _____
- Name of **Vision** Carrier: _____ Policyholder name: _____ Policy Number: _____

4.) Dependent: _____

☐ **Medical** Effective Date: _____ ☐ **Dental** Effective Date: _____ ☐ **Vision** Effective Date: _____

- Name of **Medical** Carrier: _____ Policyholder name: _____ Policy Number: _____
- Name of **Dental** Carrier: _____ Policyholder name: _____ Policy Number: _____
- Name of **Vision** Carrier: _____ Policyholder name: _____ Policy Number: _____

C

FILL OUT THIS SECTION ONLY IF YOUR CHILD(REN) HAVE ADDITIONAL HEALTHCARE COVERAGE DUE TO •DIVORCE •SEPARATION •COURT ORDER •MEDICARE OR •OTHER FEDERAL-STATE HEALTH INSURANCE PROGRAMS.

*****(Indicate which child by marking appropriate circle) *****

1.) Is child(ren) covered by Medicare or other Federal-State coverage? □ Yes or □ No (If yes which child)? ○1 ○ 2 ○ 3 ○ 4

Medicare: Policyholder name: _____ Policy Number: _____

Is coverage because of? □ Age □ Disability □ ESRD

Part: A □ B □ C □ D □ Effective Date: A) _____ B) _____ C) _____ D) _____

Medi-Cal/Medicaid: Policyholder name: _____ Policy Number: _____

2.) Does one parent/guardian have full custody of the child(ren): □ Yes or □ No (If yes which child)? ○1 ○ 2 ○ 3 ○ 4

Parent: _____ **Date:** _____

3.) Is one parent required by court decree to provide health insurance for child(ren): □ Yes or □ No ○1 ○ 2 ○ 3 ○ 4

Parent: _____ **Date:** _____

Name of person responsible for child's healthcare coverage? _____

Employer: _____ Date of Birth: _____

Insurance Company name: _____ Insurance Company City & State: _____

Insurance Company Phone Number: _____ Enrollee ID/ policy number: _____

Group Number: _____ Effective date: _____ Cancellation date (if applicable): _____

******If court decree is present please PROVIDE A COPY of the court documents** ****

Member Statement: The above information is true and accurate to the best of my knowledge and belief. I am also aware of the fact that I must notify the Fund Office immediately should any of the dependents listed on my coverage become eligible for any other coverage. Any materials submitted by myself or on behalf of any eligible person that contains a material alteration or forged or false information, including signatures, will be rejected. The Trustees reserve the right to refer such matters to Fund Legal Counsel for appropriate action. This will not limit the right of the Fund to recover any losses it suffers because of such material in any matter.

Signature: _____ **Phone #:** _____ **Date:** _____

Instructions for completing the

Authorization for Release of Protected Health Information

There is a section for the Member/Retiree, Spouse and if applicable, a section for a dependent child(ren) over the age of 18.

Member Section /Retiree Section

1. Fill in your name and social security number.
2. **If you are married** and you want to give your spouse authority to inquire about your health information, please enter his/her name and relationship (spouse) –or-
   If you are not married or **you want to give someone other than your spouse** authority to inquire about your health information, please enter his/her name and relationship (mother, father, friend, etc.).
3. **If you are giving someone else authority, please sign and date form.**

   OR

   If you do not want to give anyone other than yourself authority to inquire about your health information, then place an "X" in the box where it says "I do not want my Health Information released to anyone but myself". **Please sign and date below the box**.

Spouse Section

1. Fill in your name and social security number.
2. **If you want to give your spouse (member/retiree)** authority to inquire about your health information, please enter his/her name and relationship (spouse).
   If you want to give someone other than your spouse authority to inquire about your health information, please enter his/her name and relationship (mother, father, friend, etc.), **please sign and date form.**

   OR

   If you do not want to give anyone other than yourself authority to inquire about your health information, then place an "X" in the box where it says "I do not want my Health Information released to anyone but myself".
3. **Please sign and date form below the box**.

Dependent(s) over the age of 18 Section

1. Fill in your name and social security number.
2. **If you want to give your parents** authority to inquire about your health information, please enter their name and relationship (father, mother).
   If want to give someone other than your parents authority to inquire about your health information, please enter his/her name and relationship (mother, father, friend, etc.) **please sign and date form.**

   OR

   If you do not want to give anyone other than yourself authority to inquire about your health information, then place an "X" in the box where it says "I do not want my Health Information released to anyone but myself".
3. **Please sign and date form below the box**.

Authorization for Release of Protected Health Information

MEMBER/RETIREE SECTION

I, (print your name and Social Security number) _____ **authorize the Employee Painters' Trust (the "Plan"), and its business associates, to disclose claims, payment, eligibility and other related health information about me to the following persons (select 1-2 persons if desired), at the request of such persons:**

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I understand that this authorization will expire upon termination of my enrollment in the Plan, unless I revoke it sooner. I understand that I have the right to revoke it at any time, except to the extent that it has already been relied upon. I understand that if I decide to revoke this authorization, I must give notice of my decision in writing and send it to:

Employee Painters' Trust
5200 Southcenter Blvd., Suite 205
Tukwila, WA 98188
P O Box 58830 • Tukwila, WA 98138
Phone 206-518-9730 • Toll Free 844-344-2721 • www.IUPATWesternBenefits.org

I understand that my health information that is disclosed pursuant to this authorization may be re-disclosed by the persons I have identified above, and the Plan cannot prevent or protect such re-disclosures, AND I understand that I am not required to sign this form to receive my health care benefits (enrollment, treatment or payment).

Signature of Member_____ **Date Signed:** _____

-OR- ☐ I do not want my Health Information released to anyone but myself.

Signature of Member_____ **Date Signed**: _____

SPOUSE SECTION

I, the **spouse** (**Name, Please Print**) _____, (**Spouse's Social Security #**) _____of the above named member, have also read, understand, and authorize the Plan to disclose claims, payment, eligibility and other related health information about me to the following persons (select 1-2 persons if desired) for the reasons and with the explanations listed above, at the request of such persons:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Signature of Spouse_____ **Date Signed**: _____

-OR- ☐ I do not want my Health Information released to anyone but myself.

Signature of Spouse_____ **Date Signed**: _____

DEPENDENT(S) OVER THE AGE OF 18 SECTION

I, the **dependent child(ren)** over the age of 18 (**Name, Please Print)**_____,**(Social Security #)** _____have also read, understand, and authorize the Plan to disclose claims, payment, eligibility and other related health information about me to the following persons (select 1-2 persons if desired) for the reasons and with the explanations listed above, except at the request of such persons:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Signature of Dependent_____**Date Signed**: _____

OR- ☐ I do not want my Health Information released to anyone but myself.

Signature of Dependent_____**Date Signed**: _____

NOTE: If there is more than one dependent over the age of 18, please copy, complete and sign the appropriate number of additional Authorization Forms and return to the Benefit Office.

EMPLOYEE PAINTERS' TRUST

Beneficiary Designation Form
Accidental Death & Dismemberment Benefits

Member's Name: _____ **Social Security Number:** _____

DESIGNATED BENEFICIARY NAME: (Primary Beneficiary)		Date of Birth:		SSN	
Relationship		Percentage of Benefit to be Received			
Phone		Address:			

BENEFICIARY NAME:		Date of Birth:		SSN	
Relationship		Percentage of Benefit to be Received			
Phone		Address:			

BENEFICIARY NAME:		Date of Birth:		SSN	
Relationship		Percentage of Benefit to be Received			
Phone		Address:			

CONTINGENT BENEFICIARY NAME (Secondary Beneficiary)		Date of Birth:		SSN	
Relationship		Percentage of Benefit to be Received			
Phone		Address:			

Custodial Designation

If my above named beneficiary is a minor, I hereby designate (print full name)_____ to act as Custodian to receive such benefits on behalf of such child (or children). I understand that I may change this Custodial Designation at any time. I also understand that if I fail to name a Custodian, then the natural parent(s) of the minor will automatically be designated as Custodian. I also understand that if the amount of the benefit is more than $10,000, and I fail to name a Custodian, the benefit cannot be paid until a Custodian is appointed by the Superior Court.

CUSTODIAN NAME:		Date of Birth		SSN	
Relationship		Address:			
Phone					

*If you designate more than one Beneficiary, benefits will be paid to them in equal shares, unless you fill in a different percentage to be received where indicated on this form. For example, if you name two beneficiaries you may state that one will receive 75% and the other 25%. Benefits will be paid to the person you list as a Secondary Beneficiary only in the event your designated Beneficiaries have died. If you fail to designate a Beneficiary or if all of your designated Beneficiaries have died, the benefits will be paid in accordance with Trust rules.

Member's Signature: _____ **Date:** _____

5200 Southcenter Blvd., Suite 205, Tukwila, WA 98188 • P O Box 58830 • Tukwila, WA 98138
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