The Employee Painters' Trust
Active Employees and Retirees

HEALTH AND WELFARE PLAN DOCUMENT

2013

KEY CONTACTS

If you have questions about these topics…	Here's who to contact…
The Employee Painters' Trust Health and Welfare Plan Benefits Medical and Dental Claims Eligibility COBRA Continuation Coverage Accidental Death & Dismemberment (AD&D) Weekly Disability Benefits	**Trust Office—Zenith American Solutions** Claims: 509-534-0265 or 800-566-4455 Claims Fax: 509-328-8623 Eligibility: 509-534-5625 or 800-522-2403 Eligibility Fax: 509-534-5910 Other: 509-534-0265 or 800-566-4455 Website: www.zenith-american.com Mail Correspondence and payments: 111 W. Cataldo, Suite 220, Spokane, WA 99201 Claims (except prescription or vision): P.O. Box 9200, Spokane, WA 99209
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
Hospital Precertification **Care Management Program**	**Innovative Care Management** Phone: 800-862-3338 Fax: 503-654-8570 Mail Correspondence: P.O. Box 22386, Portland, OR 97269
Dental PPO	**Careington Dental** Provider Search: 800-290-0523 Website: www.careington.com/co/maxcare Provider Relations: 800-441-0380 ext 5202
PPO in Washington, Alaska, Idaho, and Montana	**First Choice Health Network (FCHN)** Website: www.fchn.com Phone: 800-231-6935
PPO in Oregon	**Managed Healthcare Northwest (MHN)** Website: www.mhninc.com Phone: 503-413-5800
PPO in Nevada	**Sierra Healthcare Options (SHO)** Website: www.uhcnevada.com Phone: 800-698-4828
Prescription Drug Plan Benefits Retail Pharmacy Claims Locating a Participating Retail Pharmacy	**BeneCard Prescription Benefits Facilitator** Phone: 888-907-0070 Or contact the Trust Office to obtain a list of Participating Pharmacies
Using the Mail-Order Pharmacy Mail-Order Pharmacy Claims	**BeneCard** Website: www.benecardpbf.com Phone: 888-907-0070/TDD 888-907-0020 24/7 Mail Correspondence: 5040 Ritter Road, Mechanicsburg, PA 17055
Vision Plan Benefits and Claims Locating a VSP Provider	**Vision Service Providers (VSP)** Website: www.vsp.com Phone: 800-877-7195 Mail Correspondence: P.O. Box 997105, Sacramento, CA 95899

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WELCOME

The Employee Painters' Trust Health and Welfare Plan provides employees, retirees and their families with excellent Medical, Prescription Drug, Dental, Vision, Accidental Death & Dismemberment and Weekly Disability benefits. (Please note that not all employers provide all benefits; the specific benefits available to you are determined by the bargaining agreement.)

This Plan Document provides detailed information about covered services, limitations and exclusions available through this Plan as of January 2013.

In the event of a conflict with any other Plan documentation, Summary Benefit Comparisons, Summary Material Modifications, or Summary Plan Descriptions, this Plan Document will prevail.

TRUST OFFICE AVAILABLE TO ASSIST YOU

If you have any questions about your benefits, please contact the Trust Office for assistance. Please note that only the Trust Office 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 Office 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 Office.

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

IMPORTANT NOTICES

Preferred Providers: When you utilize a Preferred Provider hospital, Physician, or Dentist, the costs to the Trust are reduced. This also reduces your out-of-pocket costs. The Trust strongly urges you to utilize Preferred Provider services whenever possible. For help locating a Preferred Provider, contact the Trust Office or the PPO in your area (see Key Contacts for contact information).

Utilization Review (hospital precertification) and Care Management for inpatient hospital 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 Innovative Care Management before you receive medical and/or surgical services (see Key Contacts for contact information).

Trustees Discretion Retained: The Board of Trustees reserves the maximum legal discretionary authority to construe, interpret and apply the terms, rules and provisions of the benefit Plan covered in this descriptive booklet. The Trustees retain 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 of Trustees as to the facts related to any claim for benefits and the meaning and intent of any provision of the benefit 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 of Trustees expects to maintain this Benefit Plan indefinitely. However, the Trustees 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 and/or the governing Trust Agreement and administration policies. If the Plan is terminated, the rights of the participants are limited to benefits incurred before termination. All amendments to this Plan shall become effective as of a date established by the Board of Trustees.

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.**

ELIGIBILITY

The Employee Painters' Trust Health and Welfare Plan provides benefits for the bargaining unit employees and retirees of contributing employers.

Contributing employers pay a contribution rate for their employees' benefit coverage, as described in the bargaining contract. Your eligibility is determined by which Plan your employer uses to make these contributions:

- Hourly Plan
- Flat Rate Plan

Not all employers provide all benefits available under the Trust. Please contact the Trust Office to find out if you are eligible for specific benefits.

KEY POINT

Your eligibility for the Hourly or Flat Rate Plan is based on your employer's contributions to the Health Trust. Please contact the Trust Office to find out which benefits you are eligible for.

CONTRIBUTING EMPLOYERS

An employee is eligible for this coverage if he/she is an employee of a covered employer. A covered employer is an employer that is signatory to a labor agreement requiring contributions to the Trust Fund or otherwise subscribes in writing to the Employee Painters' 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 PLAN

HOURLY PLAN 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 Office, 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 Office determines eligibility in February (lag month) for March coverage.

KEY POINT

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

HOURLY PLAN CONTINUING ELIGIBILITY

There are two continuing eligibility plans available to members under the Trust. Your continuing eligibility is based on the contribution rate paid by your employer. Contact the Trust Office to determine which plan is applicable to you.

Under both eligibility plans, after you meet the initial eligibility, you will continue to be eligible as long as you have at least 120 hours in your hour bank.

The maximum hours you may accumulate depends on your local union or location, as shown in the chart below.

HOURLY PLAN CONTINUING COVERAGE

Your coverage ends on the last day of the month following the month when your hour bank accumulation is reduced to less than 120 hours.

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

HOURLY PLAN REINSTATEMENT OF ELIGIBILITY

If your hour bank has not become inactive by falling below 120 hours for 12 consecutive months, you will be reinstated for eligibility when your hour bank shows at least 120 hours. Such reinstatement will become effective on the first day of the second calendar month

Hourly Plan Continuing Eligibility	Eligibility Plan 1	Eligibility Plan 2
Local Union or Geographic Region *Depends on bargaining agreement: Check with your Union Office or call the Trust Office	188, 260, 269, 300*, 364, 427, 567, 1236, 1237, 1238, 1922*, 1959, 1964 and DC5 East, Western Washington Painters, Oregon Painters, Las Vegas Material Handlers	159, 300*, 364, 720, 764, 1922*, Western Washington Drywall, Tapers, Stripers, Oregon Drywall
Maximum Hours Accumulation This is the number of hours that may be accumulated after deduction of the 120 hours	450 hours (up to 3 additional months of coverage)	810 hours (up to 6 additional months of coverage)

following the month in which this requirement is met.

If your hour bank is below 120 hours for 12 consecutive months, all credited hours revert to the Trust Fund, 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 30 hours with a contributing employer in October, your eligibility would be reinstated on the first of December.

HOURLY PLAN DISABILITY

If you become totally disabled due to an occupational disability while working for a contributing employer, your benefits and benefits for your eligible dependents will be continued for up to six months provided the disability commenced when you were eligible for benefits. Your hour bank will be frozen during that time. If you are still disabled after six months, benefits will be continued for you and your dependents until your hour bank is exhausted.

If you become totally disabled due to a non-occupational disability, your benefits will be continued until your hour bank is exhausted.

If you are still disabled due to an occupational or a non-occupational disability after your hour bank has been exhausted, you may qualify for an extension of benefits. Please see "Continuation of Coverage during Total Disability" on page 12.

FLAT RATE PLAN

FLAT RATE PLAN ELIGIBILITY

To be covered under the Flat Rate Plan, your employer must have signed a collective bargaining agreement calling for contributions to the Plan. Your employer must cover all employees in that unit. (The spouse of an employer covered under the Flat Rate Plan who works for the company is the *only* exemption to this requirement.) All Flat Rate employer and employee contributions must be remitted to the Trust Office by the first of each month following the month the hours are worked.

Your employer may cover himself and other employees who are not members of a collective bargaining agreement, provided he covers 100% of all such employees and agrees in writing to continue benefits throughout the life of the collective bargaining agreement.

Your employer may only cover employees who work directly for him under the rules set forth above. A non-union subsidiary of a participating employer will not be allowed to participate under the Flat Rate Plan. 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 Office for a complete description of Plan benefits and rules for participation. Not all employers provide all benefits available under the Trust. Please contact the Trust Office for verification of eligibility and benefits.

The contribution required on behalf of flat rate employees will vary, depending upon the number of hours worked by bargaining unit employees in the last year.

KEY POINT

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

FLAT RATE PLAN ELIGIBILITY

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.

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

FLAT RATE PLAN—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 or employee contributions are received
- 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
  - 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
  - You do not satisfy the requirements for hours worked or any other eligibility conditions in this Plan

OREGON KAISER HMO PLAN

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 CONTINUING ELIGIBILITY

There are two continuing eligibility plans in use by members under the Trust. Your continuing eligibility is based on the contribution rate paid by your employer. Contact the Trust Office to determine which plan is applicable to you.

Under the Kaiser Floor Covering eligibility plan, you will continue to be eligible as long as you have at least 120 hours in your hour bank.

Under the Kaiser Painters and Drywall eligibility plan, you will continue to be eligible as long as you have the required premium amount in your dollar bank.

The maximum hours you may accumulate is 450, there is no maximum dollar bank accumulation.

HOURLY PLAN REINSTATEMENT OF ELIGIBILITY

If your hour bank has not become inactive by falling below 120 hours for 12 consecutive months, you will be reinstated for eligibility when your hour bank shows at least 120 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 120 hours for 12 consecutive months, all credited hours revert to the Trust Fund, 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 30 hours with a contributing employer in October, your eligibility would be reinstated on the first of December.

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 supporting contributions to the Employee Painters' Trust.

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

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

Note that your employer's ability to contribute to the Trust is based on their having a current Collective Bargaining Agreement, being current in contribution requirements, and being accepted as a contributing employer by the Board of Trustees. The Trustees retain the right to revoke participation to 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 provisions on the right for a "Non-Bargaining Employer."

WORKING FOR A NONPARTICIPATING EMPLOYER

ELIGIBILITY FROZEN

Notwithstanding any other provision or rule of this Plan, a participant who is eligible for benefits and who 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 Plan 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 Fund.
  - 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 on the left, 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, and its affiliated local unions, are party within the geographic area covered by the Trust but for which no employer contributions are required to be paid to the Plan.

DEPENDENT ELIGIBILITY

When you are eligible for Plan benefits, the following dependents are also eligible for coverage:

- Your lawful spouse as (defined by Federal Law). The Plan does not cover domestic or same sex 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 who is chiefly dependent on you for support
- A foster child to age 26
- Your mentally or physically handicapped child who is not capable of self-sustaining employment and is chiefly dependent on you for support (contact the Trust Office to obtain an application)

KEY POINT

Your dependents become eligible for benefits when you become eligible for benefits. To add a dependent, you must provide the Trust Office with a copy of required documents such as: certified birth certificate, social security card, marriage certificate, divorce decrees, parenting plans, adoption paperwork and any other applicable legal documentation.

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
- 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.

HANDICAPPED CHILD

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

- Is chiefly dependent on you for support
- 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 handicap no later than 31 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

WHEN DEPENDENT COVERAGE BEGINS

Dependent coverage will begin the later of:

- The day you are covered
- 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 will delay the payment of claims for your dependent(s) to the Plan.

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

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 Office.

WHEN DEPENDENT COVERAGE ENDS

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

- The last day of the Plan month the dependent is no longer eligible
- 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)
- The day your coverage ends

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
- 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.

- 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 Order before enrollment can occur. Also, if the cost of each child's benefits is to be deducted from your pay, the Plan must receive proper authorization in the order or otherwise.

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 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 as a participant for purposes of the reporting and disclosure requirements of a federal law known as ERISA.

A Qualified Medical Child Support Order is defined by Section 609 of ERISA. In general, a Qualified Medical Child Support Order 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
- 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

FAMILY AND MEDICAL LEAVE (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
- 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 (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
  - 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
  - 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.

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
- 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 Office 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 on the left (or for any longer period provided in the Plan)
- The employer terminates the Plan

Any coverage for an eligible dependent will also end as provided in the dependents eligibility provision 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 on the left.

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.

RETIREE PLAN

RETIREE PLAN ELIGIBILITY

Upon retirement, retirees need to choose to participate, defer participation, or not participate in the Plan's Retiree Benefit. You must notify the Trust Office of your choice. If you are otherwise eligible as described in the following rules, you must complete an application to enroll in the Trust's Retiree Medical Plan. Please note that **this medical coverage is not free and you will be required to contribute toward the cost of your continuing coverage. For information on the current Retiree rates, please contact the Trust Office. Also, this medical coverage is not guaranteed for your lifetime and may be discontinued.**

CONTRIBUTE TOWARD THE COST OF THE PLAN

Submit a Retiree Plan application to the Trust Office within 60 days of your retirement date or from when your ***active*** hour bank runs out

Advise the Trust Office if you wish to defer your start date (due to other active coverage by your spouse's insurance or through COBRA after your hour bank is depleted) **at the time of application**

TAKE ACTION

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

You may be eligible for these benefits if you are a normal, early or disabled retiree, or a non-bargaining participant.

Normal retiree—You must meet all of the following:

- Qualified and elected retirement benefits from a Pension Trust sponsored by the IUPAT, a Local, or District Council, in a region covered by the Plan, **and**
- Have 9,000 covered hours under this Trust or the IUPAT Health and Welfare Trust, **and**
- Have 3,000 hours in the last five years in this Trust

Early retiree—You must meet all of the following:

- Age 55 or older, qualified and elected retirement benefits from a Pension Trust sponsored by the IUPAT, a Local, or District Council, in a region covered by the Plan **or** you have earned 15,000 covered hours under this Trust or the IUPAT Health and Welfare Trust, **and**
- Have 15,000 covered hours under this Trust, **and**
- Have 6,000 hours in the last five years in this Trust

Disability retiree—You must meet all the requirements:

- Qualified and elected retirement benefits from a Pension Trust sponsored by the IUPAT, a Local, or District Council, in a region covered by the Plan
- Have 10,000 hours under this Trust
- Have been awarded Social Security disability benefits

Non-bargaining participant and have:

- Worked for a participating employer for 10 years
- Been covered by this Trust for 5 years immediately before retiring

Union-Affiliated Employees:

- Employee of any District Council or Local Union Participating in the Trust
- Been covered by this Trust in the 5 years immediately before retiring

OR

- An IUPAT employee or direct affiliate
- Been covered by this Trust for 5 consecutive years at some point in the past
- Been covered under the IUPAT Health and Welfare Trust fund immediately before retiring

Deferred Enrollment. It is possible for you to defer formal enrollment in the Retiree Medical Plan. On a one-time basis only, you may opt to defer enrollment and start paying for monthly medical coverage at a later date IF:

- You notify the Trust Office of your retirement within 60 days of your retirement date; and
- You or your spouse maintains or is otherwise covered by another group health plan under which you are entitled to participate as an active or dependent participant; and
- You are continuously covered by that other medical plan without any break in monthly coverage; and
- You provide written notice to the Trust Office, within 30 days of termination of your coverage in the other plan, of your intention to activate your enrollment in the Retiree Medical Plan; and
- Upon such written notification of your desire to activate your enrollment in the Trust's Retiree Medical Plan, you provide a Certificate of Creditable Coverage from the other medical plan.

If you meet the requirements for deferred enrollment, you may make such election just once.

Untimely notification of any of the above events will result in denial of enrollment.

Coverage Availability for Family Members. The Retiree Medical Plan is maintained and administered as a medical plan provided to participants formerly covered as active employees covered by the Trust. The Retiree Plan 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. Your enrollment and payment of required contributions entitles you to enroll your dependents until they reach the age of 26.

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

Contributions are generally payable on or before the 10th day of the month for which medical coverage is being provided. For example, your payment for September medical coverage is due and must be received by the Trust no later than September 10. 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 for which payment required, however 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.)

Other Rules of Administration. In addition to the eligibility requirements on page 10, the following additional procedures/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 Plan, 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.
- You must contact the Trust Office 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.

CONTINUATION COVERAGE

CONTINUATION OF COVERAGE DURING TOTAL DISABILITY

If you are totally disabled by injury or illness on or before the date eligibility ends, the Plan allows an extension of benefits for covered services as if eligibility had not ended for up to a maximum of 12 consecutive months from the date active eligibility ends or, if earlier:

- The date you or your dependent becomes covered under another group health care plan
- The date the total disability ends

Benefits payable are those in effect on the date eligibility ended.

This extension of benefits coverage period described above shall run concurrently with continuation coverage time periods available to you under COBRA if you elect the COBRA coverage (see COBRA section).

Under this extension of benefits provision, the Trust Fund shall pay on your behalf the first 12 months of COBRA continuation premiums that are required to be paid for COBRA coverage. The election of COBRA will continue full eligibility for benefits for you and your dependents. Premium for COBRA coverage which continues after the expiration of the 12-month period must be paid by you or your dependent.

You must make the election for the COBRA coverage when your active eligibility ends in order to utilize the COBRA coverage provision and for the Trust to make the COBRA payments on your behalf. If you do not elect COBRA, no COBRA payment will be made by the Trust and coverage will only be available under the extension of benefits. You will not be able to later elect COBRA coverage.

CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT (COBRA)

If you lose coverage because of a loss of eligibility, you may be able to continue your coverage. Under the circumstances described on the right, you, your lawful spouse, and eligible dependents each have the independent right to elect to continue your Trust 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 from the Trust 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
- 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
- The child no longer qualifying as an eligible dependent under the Plan

YOUR COBRA NOTIFICATION RESPONSIBILITIES

The Trust offers continuation coverage only after it has been notified of a qualifying event. You or your eligible dependents have the responsibility to inform the Trust Office of a loss of coverage resulting from a divorce, legal separation or 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 Office 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
- 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.

Your employer is responsible for informing the Trust if your employment is terminated. The Trust Office will determine when the employee's hour bank falls below the required number of hours. The Board of Trustees, 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 Office of a loss of coverage resulting from a divorce, or a child losing dependent status.

REQUESTING CONTINUATION COVERAGE

Once the Trust Office 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 Trust, if later.

A request for continuation coverage under the Trust 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 Office.

Submit your request to the Trust Office. 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 Office, if later.

AVAILABLE COVERAGE

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

The continuation coverage offered is the same as the Trust paid coverage provided to the employees of your current employer and the 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 Office within 31 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 Office.

Only newborn dependents are entitled to extend their continuation coverage if a second qualifying event occurs (as discussed on page 14).

CONTINUOUS COVERAGE REQUIRED

Your COBRA continuation coverage must be continuous from the date your Trust coverage 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 Office, 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% 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 Office.

The Trust Office 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 insufficient funds is considered 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 postmarked within 45 days of when you elected continuation coverage.

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 Office 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 (unless the other group health plan limits or excludes coverage for a preexisting condition of the individual seeking continuation coverage)
- 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 Trust Plan
- 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 by the Trust is determined by the Social Security Administration to be disabled within the first 60 days of continuation coverage, the individuals who have previously been 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 Office 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 not be disabled, you must notify the Trust Office 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 Office 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 Trust 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 Trust 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 can lose the right to avoid having preexisting condition exclusions apply to you under a future group health plan if you have more than a 63-day gap in health coverage. Electing continuation coverage may help you avoid such a gap.
- You can lose the right to purchase guaranteed individual health coverage that does not impose preexisting condition exclusions if you do not obtain continuation coverage for the maximum time available to you.

- 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 Office informed of any changes in the address of family members. You should also keep a copy, for your records, of any notices you send to the Trust Office.

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 following chart provides 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 and Customary" clause, except when performed by PPO Providers**

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

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.

- Individual deductible: $300/$750
- Family deductible: $900/$2,250 (After you pay this amount in covered expenses incurred by you and your dependents in a calendar year, no other individual deductible will be required that year.)

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 Trust has contractual arrangements with Preferred Providers, other health care providers, provider networks, pharmacy benefit managers, and other vendors of health care services and supplies ("Providers"). In accordance with 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 Document 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 this Plan Document) as follows:

- **Preferred Providers**: The Plan pays 80%
- **Non-Preferred Providers**: The Plan pays 80%
- **Preferred Providers**: The Plan pays 80% (Material Handlers Only)
- **Non-Preferred Providers**: The Plan pays 60% (Material Handlers Only)
- **Preferred Providers**: The Plan pays 70% (Residential Painting Only)
- **Non-Preferred Providers:** The Plan pays 50% (Residential Painting Only)

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 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 Office 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.

! KEY POINT

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

Overview	Standard Benefits	Materials Handlers Benefits	Residential Painting Benefits
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
Out-of-Pocket Limit The maximum you pay in coinsurance each calendar year, after which the Plan pays 100% for most covered services	$1,300/person (includes deductible) Retirees: $2,300/person	$1,300/person Retirees: N/A	$3,000/person (does not include deductible or copays)
Annual Maximum The most the Plan will pay for any covered person	$1,500,000 Retirees: $1,250,000	$1,500,000	$1,500,000

Medical Plan	Standard PPO Provider Benefits	Materials Handlers		Residential Painting	
		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 baby care; annual Pap test, physician charges, routine mammograms, prostate exams and any others as required by law	Plan pays 100% (deductible waived)				
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%
Medical Plan					
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%
Out-patient 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%
Ambulance 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 $350/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%

Medical Plan, continued	Standard PPO Provider Benefits	Materials Handlers		Residential Painting	
		PPO Providers	Non-PPO Providers	PPO Providers	Non-PPO Providers
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%
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 30 visits per year (must be for restoration of lost speech due to diagnosed illness or injury)	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 Limited to dependents age 6 and under	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%
Mental Disorders					
Inpatient Up to 10 inpatient hospital days per calendar year	Plan pays 80%	Plan pays 80%	Plan pays 60%	Plan pays 70%	Plan pays 50%
Outpatient Up to 20 visits per calendar year	Plan pays 80%	Plan pays 80%	Plan pays 60%	Plan pays 70%	Plan pays 50%
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 Pharmacy	Mail-Order Pharmacy
Out-of-Pocket Maximum The most you'll pay in copays each year	$5,000/year/family	
Supply Limit* The maximum supply per refill	30 days	90 days
Generic Drug	Greater of $5 or 15% co-pay up to $50	Greater of $12.50 or 15% copay up to $125
Brand Name Drug (when no generic is available)	Greater of $20 or 25% co-pay up to $150	Greater of $50 or 25% co-pay up to $375
Brand Name Drug (when a generic is available)	Greater of $20 or 50% co-pay	Greater of $50 or 50% co-pay

*Specialty Prescriptions are limited to a 30-day supply per fill. Diabetic Supplies purchase 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.

Vision Plan **	Choose Any VSP Provider
Complete Eye Exam Exam allowed once per 12 months from your last date of service	Plan pays $72
Lenses Two lenses (one pair) allowed once per 12 months from your last date of service	Plan pays based on lens type: Single—$74 Bifocal—$94 Trifocal—$104 Lenticular—$109
Frames Frames allowed every 24 months from your last date of service.	Plan pays $72
Contact Lenses Once every 12 months from your last date of service. The Plan pays benefits for either lenses and a frame, or contact lenses (not both)	Plan pays $104

**Dental and Vision benefits are excluded from Material Handlers and Residential Painting benefits, Retirees must elect these benefits at initial enrollment in the Retiree Plan.

Dental Plan**	Choose Any Licensed Dentist
Pre-authorization 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	$1,500/person*
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)	Plan pays the lesser of amount listed in the Schedule of Covered Services (available from the Trust Office or online at www.zenith-american.com) or 100% of billed PPO Charges
Restorative Services Extractions, oral surgery, fillings, periodontic and endodontic procedures, crowns	Plan pays the lesser of amount listed in the Schedule of Covered Services (available from the Trust Office or online at www.zenith-american.com) or 100% of billed PPO Charges
Prosthodontic Services Dentures and bridges	Plan pays the lesser of amount listed in the Schedule of Covered Services (available from the Trust Office or online at www.zenith-american.com) or 100% of billed PPO Charges
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 subject to a $2,000 lifetime maximum/ person
Restorative Services Extractions, oral surgery, fillings, periodontic and endodontic procedures, crowns	Plan pays the lesser of amount listed in the Schedule of Covered Services (available from the Trust Office or online at www.zenith-american.com) or 100% of billed PPO Charges

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

**Dental and Vision benefits are excluded from Material Handlers and Residential Painting benefits, Retirees must elect these benefits at initial enrollment in the Retiree Plan.

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 $1,300 per person ($2,300 for retirees, $3,000 for Residential Painting.)

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
- Mental and nervous disorders
- Expenses that are excluded, over benefit maximums or exceed the UCR allowance

BENEFIT MAXIMUM

The maximum amount the Plan will pay in covered services for any individual is $1,500,000 ($1,000,000 for retirees) annually.

Benefits are payable only for expenses incurred while you or your dependents are covered under the Plan or under the major medical extended benefits provision.

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 Residential Painting) of the Usual, Customary and Reasonable (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 Trust participates with several PPOs in different areas. Contact the PPO (see page 1 for contact information) to locate a provider that meets your needs:

- **Careington Dental** all regions covered by the Trust
- **First Choice Healthcare Network** in Washington, Alaska, Idaho and Montana
- **Managed Healthcare NW** in Oregon
- **Sierra Healthcare Options** in Arizona, California, Nevada and Utah
- **Alaska Coalition:**
  - **Alaska Regional Hospital**
  - **Charter North Hospital**

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 Plan benefits may continue to provide significant financial protection well into the future.

CARE MANAGEMENT PROGRAM

The Care Management Program, while voluntary, helps you, your representative, your doctor and/or 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 Innovative Care Management (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 Innovative Care Management to request precertification.

Innovative Care Management 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 Plan coverage for a particular service or supply and fulfillment of all other Plan requirements are also necessary for benefits to be payable.

Innovative Care Management 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.

! 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 Plan 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 Innovative Care Management if you, your doctor or the hospital, have questions regarding the Care Management Program.

If you have questions regarding the Plan, call the Trust Office. When calling, please identify yourself as a participant in the Employee Painters' Health and Welfare 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 this Plan Document for details). You may call Innovative Care Management for additional information regarding the appeal.

Submit the request in writing (see mailing address on page 1) and include any additional information that may have been omitted from the review or that should be considered by Innovative Care Management.

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 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 Plan benefits are paid in accordance with the coordination of benefits provision.
- 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 when
  - Special and unique covered hospital services are required which are not provided by a local hospital
  - Transportation is medically necessary
- 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

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 and continued on page 24.

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
  - 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 we 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 or 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 illness or injury.

Covered services are limited to:

- Inpatient: Up to 10 days per calendar year
- Outpatient: Up to 20 visits per calendar year

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 illness or injury 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.

- 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 emergency ambulance, air ambulance or a regularly scheduled flight on a commercial airline when
  - Special and unique covered hospital services are required which are not provided by a local hospital
  - Transportation is medically necessary

Transportation is to the nearest hospital equipped to furnish the services

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 rentals up to purchase price of the equipment.

PHYSICAL THERAPY/OCCUPATIONAL THERAPY

Limited to 60 visits per calendar year.

SPEECH THERAPY

Limited to 30 visits per calendar year (must be for restoration of lost speech due to illness or injury).

ORTHOTICS

Orthotics are covered as medically necessary up to $500 per cause.

NEURODEVELOPMENTAL DISORDERS

Limited to dependents age 6 and under.

CHEMICAL DEPENDENCY

Medically necessary, with respect to chemical dependency coverage, means the treatment is indicated in the most recent patient placement criteria for the treatment of substance-abuse-related disorders II 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 regulated and/or alcoholic beverages. 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, we 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 a medical emergency under the Plan; and
  - As long as the patient is not yet enrolled in other chemical dependency treatment, this is not included when calculating the chemical dependency payment maximum described below.
- 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 insured person's choice who is employed by a state-approved treatment program. This will enable the Trust 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)

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, up to $350 per each ear in any period of 36 consecutive months.

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 insured 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 an insured 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 six years of age and under 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 neurodevelopmental therapies services when the dependent child is over six years of age
- 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 insured 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 BeneCard

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—the Plan will not pay for:

- Any drug when the FDA has determined its use to be contraindicated
- Experimental drugs not otherwise approved for any indication by the 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, 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 or 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 Office for additional information.

WEIGHT LOSS SURGERY

The Plan covers medically necessary (as determined by the plan) weight loss surgery when preauthorized. Approval is based on specific plan criteria; please contact the Trust Office for those criteria.

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 Office for a copy of the policy.

MASTECTOMY

The Women's Health and Cancer Rights Act of 1998 requires that your health 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 does not provide benefits for prophylactic mastectomies.

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 may be subject to $100 copay

CONTRACEPTIVES

Contraceptive drugs and/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 and/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 and/or device:

- Requires a physician's written prescription
- Must be approved by the Food and Drug Administration 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 Trust complies with the Women's Health Services portion of the Patient Protection and Affordable Care Act law, where required.

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 insured person is entitled to benefits under any workers' compensation or occupational disease law, or receives any settlement from a worker's compensation carrier (but this exclusion does not apply to any accidental death and dismemberment benefits provision)
- Any expense which is in excess of the usual and customary global charges
- Any expense for genetic testing
- 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 exclusion applies only to any Accidental Death and Dismemberment)
- Any loss, expense or charge resulting from the insured 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
- 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 autistic spectrum disorder, milieu therapy, learning disabilities, developmental disability or for hospitalization for environmental change
- 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 or anorexia that meet standard diagnostic criteria as determined by us, and present significant symptomatic medical problems) 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 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 for sex transformations or any treatment related to sexual dysfunction
- Any loss, expense or charge related to mental disorders which are classified as sexual deviations or disorders
- 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;
- 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 the participant's 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 from developmental disability. (When the Plan, medical staff or a qualified party or entity selected by the Plan 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 insured 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
- Any expense or charge for injuries 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 provisions.

PRESCRIPTION DRUG PLAN OVERVIEW

FOR ACTIVE PARTICIPANTS AND THEIR DEPENDENTS

The Prescription Drug Plan covers most medically necessary medications that are prescribed by a qualified health care provider. This 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), 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 Office or BeneCard (see 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 this Plan.

KEY POINT

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

DAYS' SUPPLY LIMITATIONS

- The maximum days' supply allowable at retail pharmacies is 30 days.
- 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.

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 on page 31 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

Prescription Drug Benefits Summary

Overview	Retail 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	$5,000/year/family	
Supply Limit The maximum supply per refill*	30 days	90 days
Generic Prescriptions	$5 or 15% copay up to $50, whichever is greater	$12.50 or 15% copay up to $125, whichever is greater
Brand Prescriptions	$20 or 25% copay up to $150 (when generic is not available), whichever is greater $20 or 50% copay (when generic is available), whichever is greater	$50 or 25% copay up to $375 (when generic is not available), whichever is greater $50 or 50% copay (when generic is available), whichever is greater

*Specialty Prescriptions are limited to a 30-day supply as of February 1, 2012

GETTING STARTED WITH MAIL-ORDER

1. Request a Patient Profile questionnaire and an envelope, from the Trust Office 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 BeneCard. Please note that Specialty medications are limited to a 30-day supply.

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, Prilosec OTC and their 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.

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 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 Food and Drug Administration'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
- Any item that is listed in the General Exclusions and Limitations included in this Plan Document

DENTAL PLAN OVERVIEW

The Trust has contractual arrangements with Preferred Providers. In accordance with 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 this Plan Document 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 Office or on the www.zenith-american.com 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 Trust will pay the scheduled benefit up to 100% of charges for services whichever is less, 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 Office or on the www.zenith-american.com website.

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

KEY POINT

You may choose any licensed dentist. The Plan pays a certain amount for each covered service; as shown in the Dental Schedule of Covered Services, which you can request from the Trust Office.

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

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	$1,500/person
Covered Services	
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)	Plan pays the amount listed in the Schedule of Covered Services (available from the Trust Office)
Restorative Services Extractions, oral surgery, fillings, periodontic and endodontic procedures, crowns	Plan pays the amount listed in the Schedule of Covered Services (available from the Trust Office)
Prosthodontic Services Dentures and bridges	Plan pays the amount listed in the Schedule of Covered Services (available from the Trust Office)
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

- 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
- Sealants on teeth 2, 3, 14, 15, 18, 19, 30 & 31

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 Painters' Trust a plan of treatment indicating a condition of handicapping malocclusion that is correctable
- The Painter's Trust 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 Painters' Trust 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 Painters' 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 Painters' Trust 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 Trust Office may request:

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

EXCLUSIONS

The Plan will not pay for:

- Any treatment, service or supply not included in the list of covered dental services on pages 33 and 34
- 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 this 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 Health and Welfare Plan provided by the Trust
- Sealants (except as provided on above)
- Appliances (night guards) except for bruxism
- Charges incurred for temporomandibular joint disorder (TMJ)
- Anything excluded under the General Exclusions and Limitations section on in the Medical Plan section of this Plan Document

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 Office to confirm your participation.

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

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
- 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 worker's 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 Health and Welfare Plan provided by the Trust

Vision Benefits Summary

Covered Expenses	
Complete Eye Exam One exam allowed per calendar year	Plan pays $72
Lenses Two lenses (one pair) allowed each calendar year	Plan pays based on lens type: Single—$74 Bifocal—$94 Trifocal—$104 Lenticular—$109
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 $104

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.

ACCIDENTAL DEATH & DISMEMBERMENT BENEFITS (AD&D)

The Trust 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(ies) in the event of your death, in the amounts shown in the chart.

KEY POINT

Accidental Death & Dismemberment 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 Office 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 Office.

When the Trust Office 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 Office acknowledges your request.

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

EXCEPTIONS

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
- Is excluded under the General Exclusions and Limitations

WEEKLY DISABILITY BENEFITS

The Trust provides Weekly Disability coverage for active members, which can help you meet your financial responsibilities if you become 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.

Some Flat Rate employers do not contribute to this benefit; please contact the Trust Office to confirm your eligibility for this benefit.

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	$150 or $500 per week
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

DISABILITY PERIODS

A new period of disability begins:

- When you become disabled after you have been back to work full-time for at least 10 consecutive working days 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.

EXCEPTIONS

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
- 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 Office and request form W4S.

CLAIMS AND APPEALS

FILING CLAIMS

SUBMITTING A CLAIM

The Plan will only process claims incurred on or after the effective date of your insurance. In order for you to receive prompt payment for 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 benefits**, you, your physician and employer must complete the form. (Contact the Trust Office 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 Medical Plan for payment.

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 you do assign your benefits, the payment will be sent directly to the provider of service (payments for Preferred Providers are automatically paid to the provider).
- Or, you may pay the bill directly, in which case the benefit checks will be made payable to you.

Submit your claim and all bills connected with it to the Trust Office 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 on page 41:

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 on page 41.

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 insured person or the ability of the insured person to regain maximum function
- Or, in the opinion of a physician with knowledge of the insured person's medical condition, would subject the insured 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 insured 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.

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 page 41) 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 Plan 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 specific Plan 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; including the right to request an appeal and the right to external review
- Instructions on how and where to submit a request for an appeal
- Any other information which may be required under state or federal laws and regulations

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
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	30 days	45 days	30 days (or 60 days, if a second extension is period required)
Weekly Disability	30 days	45 days	15 days

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 their determination that the treatment and/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 of 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.

Response to Appeals 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	30 days	60 days	1
Benefits and Claims Requiring Precertification	60 days	60 days	1
Experimental and Investigational Services	14 days	Any extension requires the informed written consent of the insured person	
Accidental Death & Dismemberment	60 days	60 days	1
Disability	45 days	45 days	1

ADVERSE BENEFIT DETERMINATION: AD&D AND WEEKLY DISABILITY BENEFITS

An adverse benefit determination for Accidental Death & Dismemberment (AD&D) and Weekly 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.

APPEAL RIGHTS AND PROCEDURES

In the event a claim for benefits or a precertification request is denied, or any employee 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 of Trustees will conduct a full and fair review of the precertification and/or claim review decisions in keeping with the Plan's procedures for hearing, researching, recoding and resolving any appeal.

The Trustees suggest you begin by contacting the Trust Office 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 Office before submitting a request for an appeal. The Trust Office may be able to resolve the issue or clarify the benefit decision for you.

BOARD OF TRUSTEES HEARING

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

- Is ruled ineligible by the Trustees (or by a committee of Trustees, an administrative agent, insurance carrier or other organization acting for the Trustees)
- 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 Trustees

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

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

The written decision of the Trustees shall include the specific reasons for the decision as well as specific reference to the pertinent Plan 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 Trustee'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 Trustee's review or that should be considered by the Trustees.

The Board of Trustees 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 the timeframe required after receiving notification of the Trustees initial claim review or precertification decision:

Submitting A Request for an Appeal Type of Benefit	Submit Requests for an Appeal (after notification of Plan's decision)
Urgent Care	72 hours
Benefits and Claims *not* Requiring Precertification	30 days
Benefits and Claims Requiring Precertification	60 days
Experimental and Investigational Services	14 days
Accidental Death & Dismemberment	60 days
Weekly Disability	180 days

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
- The names of all individuals, facilities and/or services involved with the appeal

In reviewing the appeal, the Trustees 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 Trustees, or anyone designated by the Trustees, to review all records (including, but not limited to, your medical records) which the Trustees determine may be relevant to your appeal.

RESPONSE TO APPEALS

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

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

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

- Information regarding their decision
- Information regarding external review appeal rights

TRUSTEE DISCRETION RETAINED

The Board of Trustees reserves the maximum legal discretionary authority to construe, interpret and apply the terms, rules and provisions of the Benefit Plan covered in this Plan Document.

The Trustees retain 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 of Trustees as to the facts related to any claim for benefits and the meaning and intent of any provision of the Benefit 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.

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 (4) 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 (4) 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 or the rescission of a benefit.

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

The Employee Painters' Trust
c/o Zenith American Solutions
111 W. Cataldo, Suite 220
Spokane, WA 99201
509-534-0265 or 800-566-4455
www.zenith-american.com

PRELIMINARY REVIEW OF EXTERNAL REVIEW REQUEST

Within five (5) business days of receipt of a request for external review, the Plan or the Plan Administrator will complete a preliminary review of the external review request. Within one (1) 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 forty-eight (48) hours or the remaining portion of the four (4) 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 Independent Review Organization.

REVIEW BY INDEPENDENT REVIEW ORGANIZATION

When a properly filed request for external review is referred, the Plan will provide the Independent Review Organization the required documentation in the time required by applicable federal regulations. The Independent Review Organization will provide a decision to the individual within forty-five (45) days after it has received the request to review.

If the Independent Review Organization directs that benefits be paid, the Plan shall provide benefits under its Plan in accordance with the decision. If the decision continues to be adverse, the individual has the right to bring suit pursuant to 29 U.S.C. § 1132(a). Any legal action seeking to overturn a denial or other decision that has adversely impacted an individual must be brought within one hundred eighty (180) days of the latest of the following events: An initial denial by the Plan Administrator for which no appeal has been requested; the Plan's final adverse benefit determination by the Trust's Appeals Committee; or a denial by an Independent Review Organization.

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 seventy-two (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 seventy-two (72) hours of the receipt of an urgent claim appeal.

Similarly, if an urgent appeal is submitted to an Independent Review Organization, a decision will be made within seventy-two (72) hours or the expedited timeframe provided in the final applicable federal regulations.

YOUR RIGHTS UNDER HIPAA

PRIVACY NOTICE

The Employee Painters' 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 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 your 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 this 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 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 Employee Painters' 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 on page 48 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 on page 48 under "Your Health Information Privacy Rights".
  - Public health. As permitted by law, the Trust may disclose your health information as described on page 45:
    - 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
    - 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 Plan sponsor. In addition to the circumstances and examples described on page 46, there are three types of health information about you that the Trust may disclose to Board of Trustees.
  - The Trust may disclose to Board of Trustees whether or not you have enrolled in, are participating in, or have dis-enrolled from this health Plan.
  - The Trust may provide Board of Trustees 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
    - To consider modifying, amending, or terminating the health Plan
  - The Trust may disclose your health information to Board of Trustees 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
    - 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, pharmacy benefits managers, 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 on page 46 and 47).

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:

Privacy Contact Person
Zenith American Solutions
201 Queen Anne Ave North Suite 100
Seattle, WA 98109
866-277-3927

Please contact the Privacy Contact Person if you have questions about any part of this notice or the privacy practices at the Employee Painters' 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 your 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 and may not include dates before April 14, 2003. 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 Employee Painters' 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.

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 Plan participants shall be entitled to:

- Receive information about your Plan and benefits.
- Examine, without charge, at the Trust Office 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 Plan 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 Document. The Plan Administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.
- Continue group health Plan coverage for yourself, spouse, or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this Plan Document 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 PLAN FIDUCIARIES

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit Plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a 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 Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan 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 Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

ASSISTANCE WITH YOUR QUESTIONS

If you have any questions about your Plan, you should contact the Trust Office. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

PLAN ADMINISTRATION

STANDARD PROVISIONS

CHANGE IN PLAN BENEFITS

Plan benefits may be changed (including reducing or termination benefits or increasing contribution) any time. A change in the Plan benefits:

- Does not require the consent of any covered person or beneficiary
- 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 this Plan, you and your dependents authorize:

- Any provider to disclose to the Plan Administrator any medical information it requests
- The Plan Administrator to examine your medical records at the offices of any provider
- The Plan Administrator to release to or obtain from any person or organization any information necessary to administer your benefits or your dependent's benefits
- The Plan 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 Office, without charge, information applicable to the Plan's benefits and procedures. In addition, your booklet includes, as applicable, a description of:

- Qualified Medical Child 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, an/or coverage of existing and new drugs
- Employee and dependent eligibility requirements
- Any participating provider requirements; a current listing of such providers shall be furnished automatically 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).

- 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.
- 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 on page 51 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
- The total covered expense exceeds $50

! 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
  - 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
  - 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
    - 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 Health Trust 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

This 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 Health Trust 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
- You are actively employed by an ADEA employer which pays all or part of the plan premium.

This 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 Health Trust 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.

This 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 Health Trust 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.

This 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 this plan is primary and Medicare is secondary. After 30 months, Medicare becomes primary.

IMPORTANT INFORMATION ABOUT MEDICARE

Medicare may affect 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 Office 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 this Plan should have paid are instead paid by another plan, this 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 this 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 this 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 permits the health 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 Subrogation Document
  - Will cooperate in doing what is reasonably necessary to assist the Plan in enforcing its reimbursement rights or subrogation rights
  - 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 amount of the Plan's reimbursement will not be reduced by legal fees or court costs incurred in seeking the recovery, unless the Trust Office 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 this 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 person 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 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 attorneys fee's 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 and your attorney will be deemed to hold the recovery in constructive trust for the Plan.

ANTI-FRAUD POLICY

The Plan has adopted vigorous anti-fraud policies and procedures, which includes:

- 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'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 Office. The Board of Trustees 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 attorneys fees and costs.

DEFINITIONS/GLOSSARY

The terms below have the following definitions when used in the booklet.

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 **Plan Administrator** means Zenith American Solutions

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 insured person's 65th birthday occurs.

Bargaining Unit Employee means a person:

- In good standing in the International Brotherhood of Painters, Decorators and Paperhangers of America, 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 phsical 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/or 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 and/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 Trust 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 Trust 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, air conditioners, purifiers, humidifiers, waterpiks or commodes.

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, a Federal statute that, together with other Federal laws and regulations, governs the administration of the Trust and Benefit 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, efficacy 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 Washington State Department of Social and Health Services
  - 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 either:
  - Certified as such by the Washington 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
  - 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 and/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 and/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.

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 by 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 insured person receives or is eligible for under Medicare.

Mental Disorder/Alcohol and Drug Abuse and/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

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 FDA 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 Health & Welfare Plan.

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)

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 this booklet, as well as any of the following coverages which provide benefits payments or services to an insured 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 the above coverages include group and group-type hospital indemnity coverage, Plan also means that amount of indemnity benefits which exceeds $200 a day.

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 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 this Plan.

Reconstructive Surgery means any surgical procedure which repairs an abnormal body structure.

Reimbursement Rights means the Trust'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.

Sickness 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

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

Subrogation Rights, means the Trust's right to enforce 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 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 Brotherhood of Painters, Decorators and Paperhangers of America and any other local Union affiliated with the International Brotherhood of Painters, Decorators and Paperhangers of America which may be added from time to time by mutual agreement between the Trust and the Union.

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 Trust'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.

HEALTH TRUST INFORMATION

SUMMARY PLAN DOCUMENT

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.

This Plan is known as the Employee Painters' Trust Health & Welfare Plan. The Trust through which this 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.

BOARD OF TRUSTEES—PLAN ADMINISTRATOR

This Plan is sponsored and administered by a joint labor-management Board of Trustees, the name, address and telephone number of which is:

Board of Trustees of the Employee Painters' Trust
c/o Zenith American Solutions
201 Queen Anne Ave. N, Suite 100
Seattle, WA 98109
Phone: 509-534-0265 or 800-566-4455
Fax: 509-328-8623

TYPE OF ADMINISTRATION

The Plan is administered by the Board of Trustees. The name and address of the agent for the service of legal process that the Board of Trustees has designated is:

Zenith American Solutions
201 Queen Anne Ave. N, Suite 100
Seattle, WA 98109

Service of legal process may also be made upon any Plan Trustee.

THE TRUSTEES

Bob Puzas Rainbow Painting Co. 4126 S.E. Milwaukie Portland, OR 97202	Bud Bartunek Painters District Council #5 11105 NE Sandy Blvd. Portland, OR 97220
Stacey Grund Grund & Company, Inc. 1115 N 97th Seattle, WA 98103	Todd Koch Painters Local 567 1819 Hymer Avenue Sparks, NV 89431
Neil O'Connor Western Partitions, Inc. 8300 S.W. Hunziker St. Tigard, OR 97223	Denis Sullivan Painters District Council #5 6770 E. Marginal Way So. Bldg E Seattle, WA 98108
Steve Malcolm Eastside Glass 11155 120th Avenue NE PO Box 2429 Kirkland, WA 98083	John Smirk Painters Local 159 1701 Whitney Mesa Drive, #105 Henderson, NV 89014
Thomas Pfundstein PDCA 1701 Whitney Mesa Drive, Suite 104 Henderson, NV 89014	Doug Wagner Painters District Council #5 6770 E. Mariginal Way So. Bldg E Seattle, WA 98108

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 this 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

This Plan can be described as a welfare plan, which provides major medical, disability, accidental death and dismemberment and prescription drug benefits.

DESCRIPTION OF COLLECTIVE BARGAINING AGREEMENT

This 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 Trustees.

Such agreements are also available for examination by participants and beneficiaries at the Trust Office or at local union offices upon 10 days advance written request.

The Trustees 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 Employee Painters' Trust for the purpose of enabling the employees working under such agreements to participate in the Employee Painters' Trust Health & Welfare Plan. In addition, employee self-payments are also permitted for retiree coverage and to continue employee and dependent coverage.

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 of Trustees pending the payment of claims and/or benefits and administrative expenses. The balance is invested by the Board of Trustees and held as Trust reserves.

Presently, the Accidental Death and Dismemberment 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 this Plan if they work under one of the collective bargaining agreements described in the paragraph entitled "Description of Collective Bargaining Agreements" on page 61, 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, is guilty of a gross misdemeanor. Civil penalties, including interest, costs and attorney's fees will also be assessed on all false or fraudulent claims.

Where the employee or beneficiary has other group coverage, benefits under this Plan may be reduced or denied due to the Coordination of Benefits provision.

CHANGE OF DISCONTINUANCE OF PLAN

It is hoped this Plan will be continued indefinitely but, as with any group benefit Plan, the right of change or discontinuance by the Trustees at any time must be reserved.

ACCIDENTAL DEATH & DISMEMBERMENT AND WEEKLY DISABILITY DISCLOSURES

You or your dependent(s) are entitled to request from the Plan Administrator, without charge, information applicable to the Plan's benefits and procedures. In addition, your booklet 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

MATERNITY BENEFITS

Under federal law, maternity benefits for inpatient confinement otherwise payable under the Plan shall not be restricted to less than 48 hours following a normal vaginal delivery, or 96 hours following a cesarean section for the mother and the newborn. A provider is not required to obtain any prior authorization from the Plan for prescribing a length of stay not in excess of the above periods.

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 of Trustees 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 the Trustees Discretion section for additional information about how the Plans can be changed. The Board of Trustees and the Plan Administrator are authorized to apply for and accept the Plan and any changes to the Plans.

THE EMPLOYEE PAINTERS' TRUST HEALTH & WELFARE PLAN

111 W. Cataldo Suite 220 Spokane, WA 99201
Phone: (509) 534-5625 or 1-800-566-4455 Fax: (509) 534-5910
www.zenith-american.com

ENROLLMENT FORM

To ensure the Trust has all of the information needed to correctly process your claims in accordance with benefit payment rules, the Trust will not release any claim payments until you have submitted a completed Enrollment Form. This information will be treated as strictly confidential and will not be released to any unauthorized party. Please complete and return an Enrollment Form when you first become eligible and whenever your family status changes, e.g., marriage, divorce, legal separation, birth and adoption of a child.

☐ **New Enrollment.** If you are enrolling dependents, legible copies of state certified marriage certificates and state certified birth certificates are required.

☐ **Add Family Members.** If the dependent is a child, a legible copy of the state certified birth certificate must be attached. If addition, due to marriage, a legible copy of the state certified marriage certificate must be attached. The copies of certificates will be kept in the Trust files. **If the proper documents are not provided, dependents will NOT be added.**

☐ **Delete Family Members.** If deletion is due to death, divorce, or legal separation, please include a copy of death certificate or divorce decree.

☐ **Address Change** ☐ **Beneficiary Change** ☐ **Change of Name** (provide legal documentation)

Employee's Name (Please Print) Social Security Number_____/_____/_____ Medicare/ Medicaid ID#_____ ☐ Male ☐ Female

_____ Date of Birth _____/_____/_____
Last First Middle Initial Month Day Year

☐ Single ☐ Married Date Married _____ ☐ Separated ☐ Divorced ☐ Widow(er)

Mailing Address _____
Number Street Apartment #

City_____ State_____ Zip Code_____

Home Phone No (_____)_____-_____ Email Address _____Local Union No. _____

Please list ALL family members eligible for coverage, including spouse.

****For the spouse, please attach a legible copy of your state certified marriage certificate. For children please attach legible copies of state certified birth certificates. The copies of certificates will be kept in the Trust files. If the proper documents are not provided, dependents will NOT be added.***

A new federal law, Section 111 of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA), requires that effective January 1, 2009 all individuals (members and dependents) who are covered by a health plan must report all social security numbers to their health plan. The enclosed enrollment form must be completed for all family members covered by this Plan. The Plan is then required to report all social security numbers to Medicare. You may view this requirement at: www.cms.hhs.gov/MandatoryInsRep. You must complete the enrollment form for your dependents to ensure that the Trust is reporting up to date accurate information.

	Last Name	First	Middle	Birthdate	Relationship	Gender	Social Security No.	Medicare Medicaid ID#
Spouse:								
Child 1:								
Child 2:								
Child 3:								
Child 4:								

FRAUD NOTICE

I understand that the Trust Fund is relying on my answers on this form. I represent, under penalty of perjury, that the answers given to all questions on this form are true and accurate. I understand that if I knowingly and with intent to defraud the Trust Fund, provide any materially false information or conceal, for the purpose of misleading, information concerning any fact material thereto, I may be subject to civil and criminal penalties.

I hereby certify that the foregoing statements, including any accompanying statements and/or documents, are true, correct and complete to the best of my knowledge, and hereby further authorize my Provider of services to release any medical or other information necessary to process claims.

MEMBER SIGNATURE _____ **DATE** _____

THE EMPLOYEE PAINTERS' TRUST HEALTH & WELFARE PLAN
BENEFICIARY DESIGNATION FORM

This is to certify that I hereby revoke all former beneficiary designations, if any, and name the following as beneficiary for any death benefit payable under THE EMPLOYEE PAINTERS' TRUST HEALTH & WELFARE PLAN. You may designate anyone as beneficiary for your life insurance. However, if you are married and the beneficiary you choose is not your spouse, your spouse must consent to the designation by signing below.

Primary Beneficiary:_____
Last Name First Middle Initial

Address:_____
City Apartment # State Zip Code

Date of Birth:_____ Social Security Number:_____ Relationship:_____

Contingent Beneficiary:_____
Last Name First Initial

Address:_____
City Apartment # State Zip Code

Date of Birth:_____ Social Security Number:_____ Relationship:_____

Signature of Spouse (if required): _____

HEALTH & WELFARE PLAN

This is to certify that I hereby revoke all former beneficiary designations, if any, and name the beneficiaries listed above.

_____ _____
Participant Signature Date

OTHER INSURANCE INFORMATION

Coordination of benefits sets forth rules for the order of payment of Expenses when two or more plans – including Medicare – are paying. When an Insured Person is covered by this Plan and another plan, or the Insured Person's spouse is covered by this Plan and by another plan or the couple's covered children are covered under two or more plans the plans will coordinate benefits when a claim is received.

Are you, your spouse, or other family member covered by any other medical, dental or vision Plan? Yes ☐ No ☐

If yes, is the coverage through employment? Yes ☐ No ☐ Name of other health insurance carrier: _____

Type of coverage: Medical ☐ Prescription ☐ Dental ☐ Vision ☐

Name of Insured with other coverage: _____ Relationship to our Insured: _____

Which family members are covered under the other insurance? _____

Please note: If there is a divorce decree or parenting plan that affects these coverages, proper documents will be required for the Trust office to determine which coverage is primary.

Visit us on our website at www.zenith-american.com to view personal information, health eligibility, work history and to obtain claim status, additional forms and links to different health and welfare programs.

04/2013