

**DISTRICT COUNCIL # 3 PAINTERS AND ALLIED TRADES
WELFARE FUND**

**RESTATED PLAN DOCUMENT
AND
SUMMARY PLAN DESCRIPTION**

Published 2008

Contact Information

In order to assist you, we have placed the following “contact” information on this page:

FUND OFFICE

Wilson-McShane Corp.
3100 Broadway, Suite 805
Kansas City, Missouri 64111
(816) 756-3313
(866) 756-3313 (toll-free)
www.iupatdc3funds.com

PPO

For the most up-to-date provider information, please contact the network directly. Check your I.D. card for your current provider network affiliation.

- Freedom Network Select and Health Partners of Kansas (HPK)
Website: www.phpkc.com
Call: Customer Service Phone No.: (913) 685-6300 or toll-free at (800) 544-3014
- HealthLink
Website: www.healthlink.com
Call: Customer Service Phone No.: (913) 685-6300 or toll-free at (800) 544-3014
- BeechStreet (Wichita and Des Moines-area residents only)
Website: www.beechstreet.com
Call: Customer Service Phone No.: toll-free at (800) 432-1776

PRESCRIPTION BENEFIT MANAGER

Call: 24-hour Customer Service Phone No.: (800) 451-6245
Website: www.Express-Scripts.com

Write:

General Information:

Express-Scripts
13900 Riverport Drive
St. Louis, Missouri 63043

Mail Order:

Express Scripts Mail Pharmacy Service
P.O. Box 66773
St. Louis, Missouri 63166-6773

VISION BENEFIT

UnitedHealthcare Specialty Benefits

Call: Customer Service Phone No.: (800) 638-3120

Website: www.spectera.com

Important!

There are several significant events that may occur while you are covered under the Plan. Please contact the Fund Office, in writing, if any of the following occurs:

- **YOUR ADDRESS CHANGES.**
- **YOU MARRY, DIVORCE OR OBTAIN A LEGAL SEPARATION FROM YOUR SPOUSE.** You must also submit the appropriate legal documents (for example: marriage certificate, legal separation order, divorce decree, custody agreement).
- **YOU CHANGE YOUR BENEFICIARY.**
- **THE STATUS OF A DEPENDENT CHANGES.**
- **YOU BECOME A PARENT.** You must also submit the child's state-certified birth certificate, decree of adoption or a Qualified Medical Child Support Order.
- **YOU GO INTO OR RETURN FROM MILITARY SERVICE.**
- **YOU BEGIN RECEIVING WORKER'S COMPENSATION BENEFITS.**
- **YOU BECOME ELIGIBLE FOR MEDICARE.**
- **YOU RETIRE.**

You may contact the Fund Office at:

**District Council #3 Painters and Allied Trades Welfare Fund
3100 Broadway Suite 805
Kansas City, Missouri 64111
(816) 756-3313
(866) 756-3313 (toll free)
www.iupatdc3funds.com**

A Letter From Your Trustees

Dear Participants and Beneficiaries:

We are pleased to distribute this Restated Plan Document and Summary Plan Description (Booklet) describing the Benefits provided under your Plan. If you do not see the information you are seeking in this Booklet, please contact the Fund Office.

This Booklet contains the general Plan provisions, eligibility rules for participation in the Plan, the Benefits provided to those who are eligible and the procedures which must be followed when filing a claim for Benefits.

As you know, there have been a number of changes to the Plan in light of the 2008 merger between the Painters Plan and Glaziers Plan. As a result, you should **READ THIS BOOKLET CAREFULLY** so that you are up to date on the current Plan rules and Benefits.

From time to time, other changes and improvements to the Plan may be made. When this occurs, we will make every attempt to advise you of them. In order to assist us in keeping you up to date, **IT IS YOUR RESPONSIBILITY TO KEEP THE FUND OFFICE INFORMED OF YOUR CURRENT HOME ADDRESS AT ALL TIMES.** This is the only way to be sure that you receive notice of any Plan changes.

This is your copy of the Booklet describing your Plan. Please take the time to read it in its entirety and refer to it when you have any questions about the Plan. You should keep this Booklet in a safe (but handy) place for future reference. If, at any time, you have questions about the Plan, please feel free to call or write the Fund Office at:

District Council #3 Painters and Allied Trades
Welfare Fund
3100 Broadway Suite 805
Kansas City, Missouri 64111
(816) 756-3313, or toll-free at (866) 756-3313
www.iupatdc3funds.com

We look forward to serving you.

The Board of Trustees or designated Committee shall have the full discretion and authority to interpret, construe and apply all terms of the Restated Plan Document and Summary Plan Description, the Amended Trust Agreement and/or any rules and regulations established by the Board of Trustees including, but not limited to, provisions concerning eligibility for, entitlement to and nature, amount and duration of benefits, in reaching a decision on the Claimant's request for review of the denial of the claim.

The decision of the Board is final.

TABLE OF CONTENTS

Contact Information	i
Important!	ii
A Letter From Your Trustees.....	iii
Board of Trustees	1
About Your Plan	2
Filing an Enrollment Card	3
A Word about Confidential Information.....	4
Section One – Schedule of Benefits.....	5
Section Two – Eligibility	16
A. Establishing Eligibility.....	16
B. Continuing Eligibility	17
C. Eligibility for Retirees and Eligible Dependents	17
D. Effective Date of Dependent Coverage	18
E. Buying Additional Eligibility	18
F. Restoring Eligibility while under COBRA Continuation Coverage.....	19
G. Family and Medical Leave Act (FMLA)	22
H. Termination of Eligibility for Eligible Employees	23
I. Reestablishment of Eligibility.....	23
J. Termination of Eligibility for Dependents.....	24
K. COBRA Continuation Coverage.....	25
L. Survivor Benefit.....	30
M. Service in the Armed Forces.....	30
N. Uniformed Services Employment and Reemployment Rights Act (USERRA)...	30
Section Three – Life Events at a Glance.....	34
Section Four – Medical Benefits.....	35
A. Alcoholism Benefit	35
B. Birth Control Benefit (Prescriptions).....	35
C. Birth Control Benefit (Sterilization)	35
D. Drug Abuse Benefit	35
E. Durable Medical Equipment Benefit	36
F. Home Health Care Benefit.....	37

G. Hospice Benefit.....	38
H. Major Medical Benefit.....	39
I. Maternity Benefit.....	41
J. Mental/Nervous Conditions Benefit.....	42
K. Nurse Practitioner Retail Clinic Visit Benefit.....	42
L. Routine Care/Annual Physicals Benefit.....	42
M. Routine Childcare Benefit (From Birth up to their 15 th Birthday).....	43
N. Skilled Nursing Facility Benefit.....	43
O. Surgery – Second Surgical Opinion Benefit.....	44
Section Five – Organ and Tissue Transplant Benefit.....	45
Section Six – Chiropractic Expense Benefit.....	47
Section Seven – Speech Therapy Benefit.....	48
Section Eight – Vision Expense Benefit.....	49
Section Nine – Hearing Aid Benefit.....	51
Section Ten – Prescription Drug Benefit.....	52
Section Eleven – Dental Expense Benefit.....	56
Section Twelve – Disability Income Benefit.....	57
Section Thirteen – Death and Dismemberment Benefits.....	59
Section Fourteen – Benefit Exclusions and Limitations.....	60
Section Fifteen – Claims Appeal Procedures.....	66
Section Sixteen – Use and Disclosure of Protected Health Information.....	75
Section Seventeen – Administrative Information.....	79
A. Coordination of Benefits.....	79
B. Determination of Benefits.....	85
C. Employer Rights to Contributions.....	85
D. Encumbrance of Benefits.....	85
E. Facility of Payment.....	85
F. Reciprocity and Portability.....	85
G. Termination of Plan.....	85
H. Right to Release or Request Information.....	86
I. Subrogation of Benefits.....	86
J. Physical Examination and Autopsy.....	88
K. Right of Recovery.....	88
Section Eighteen – Your Rights Under Federal Law.....	89

Section Nineteen – Other Important Information	93
Section Twenty – Definitions	95
A. Accident	95
B. Association.....	95
C. Beneficiary	95
D. Benefits	96
E. Collective Bargaining Agreement.....	96
F. Covered Employee.....	96
G. Covered Employment	96
H. Covered Expense	96
I. Covered Person	97
J. Eligible Dependent(s)	97
K. Employee	100
L. Employer.....	100
M. Expense Incurred	100
N. Hospice	101
O. Hospital.....	101
P. Medically Necessary or Medical Necessity	102
Q. Nurse Practitioner	104
R. Mental or Nervous Disorder	104
S. Participant	104
T. Physician.....	104
U. Plan	104
V. Pre-Existing Condition.....	104
W. Retiree	105
X. Room and Board Charge.....	105
Y. Sickness.....	105
Z. Trust Agreement	105
AA. Trustees or Board of Trustees	105
BB. Union.....	105
CC. Usual, Customary and Reasonable Charge (UCR Charge)	105

Board of Trustees
2008

Union Trustees

Mr. Michael D. Williams (Secretary)
Painters District Council No. 3
9902 East 62nd Street
Raytown, Missouri 64133

Mr. David McCabe
Painters District Council No. 3
7412 East 127th Place
Grandview, Missouri 64030

Mr. Dennis E. Johnson
Painters District Council No. 3
9902 East 62nd Street
Raytown, Missouri 64133

Mr. Kenneth E. Nickols
Painters District Council No. 3
422 West Commercial
Springfield, Missouri 65802

Mr. John C. Tompson
Painters District Council No. 3
9902 East 62nd Street
Raytown, Missouri 64133

Mr. Larry Grafton
Painters District Council No. 81
5738 NW 2nd Street
Des Moines, Iowa 50313

Management Trustees

Mr. Jeffrey L. Chaikin (Chairman)
The Builders' Association
632 West 39th Street
Kansas City, Missouri 64111

Mr. Steven M. Banks
PCI Dahmer
1203 Main Street
Grandview, Missouri 64030

Ms. Erica D. Jenkins
The Builders' Association
632 West 39th Street
Kansas City, Missouri 64111

Mr. Phillip Moore
2806 East 215th Street
Belton, Missouri 64012

Mr. John E. (Jack) Carter
Carter Glass Company, Inc.
P.O. Box 411708
Kansas City, Missouri 64141

Mr. Louis Malashock
Sol's Glass Company, Inc.
2416 S. 8th Street
Kansas City, Kansas 66103

About Your Plan

Today a working person's life is far more complicated than ever before. In addition to the responsibilities of getting and holding a job, most workers are vitally concerned about planning for some degree of financial security in a fast moving world.

Some of a family's needs such as the purchase of a home, major appliances or a car can be financed over time. Other needs, such as education for the children or security in one's old age, can be provided only through a careful savings plan. In other words, advance planning is required in order to take care of these needs.

However, no amount of personal financial planning can, by itself, provide adequate protection for major financial problems caused by illness or injury.

To help meet these needs, for you and your fellow workers, your Employer and the Union have established a Plan, which provides a specific, dependable Plan of health and welfare Benefits. The Plan is managed in order to provide the best Benefits possible consistent with sound financial management.

The Plan, known as the District Council #3 Painters and Allied Trades Welfare Fund, was established and is maintained as a result of Collective Bargaining Agreements (sometimes referred to as "labor contracts") between The Builders' Association or an individual Employer and the Union.

The Plan receives the majority of its income through Employer contributions as required under the terms of the Collective Bargaining Agreements. In some cases, Employees are permitted to make self-contributions in order to maintain eligibility for Benefits. The Plan also receives income from investments.

A joint Board of Trustees, which is comprised of an equal number of Employer representatives and Union representatives, makes decisions on Plan operations. Working together, the Trustees establish rules of eligibility, levels of Benefits, supervise the investment of the Plan's money and see that the Fund is in compliance with all applicable federal and state laws.

This, then, is a brief description of how your Plan was established, its purpose and how it operates. The following pages describe how you and your family become eligible for Benefits from the Plan and what your responsibilities are under the Plan. Of course, if you have any questions about the Plan, please feel free to contact the Fund Office. The staff will gladly answer your questions.

Filing an Enrollment Card

IF YOU HAVE NOT FILED AN ENROLLMENT CARD, DO SO NOW!

When you first became employed by an Employer covered under the terms of the Collective Bargaining Agreement, you should have received an “**ENROLLMENT CARD**” from either the Union or the Fund Office.

This card requests certain basic information that is needed for your records in the Fund Office. This information is your full legal name and the full legal names of all of your Eligible Dependents; your address; your Social Security number and the Social Security number of all of your Eligible Dependents; your date of birth and the dates of birth of all of your Eligible Dependents; and the name of your Beneficiary(ies) in the event of your death.

All of this information is vital! Without it, the Fund Office will have difficulty knowing what you and your family are entitled to under the Plan and in keeping you informed about Plan changes.

If you are not sure whether you have an enrollment card on file at the Fund Office, contact the office. The staff will tell you whether you have a card on file and verify that it contains current information. If you do not have current information on file, a card will be sent to you for completion and return.

NOTIFY THE FUND OFFICE PROMPTLY WITH ANY CHANGE IN ADDRESS, BENEFICIARY, DEPENDENTS, MARITAL STATUS, MEDICARE OR RETIREMENT ELIGIBILITY.

When there are Plan changes, you will be sent notice of the change. This means that in order to notify you, the Fund Office must have your current address. **IF YOU MOVE**, make sure to notify the Fund Office of your new address. **IF YOUR MARITAL STATUS CHANGES** don't forget to notify the Fund Office. The Fund Office must receive a complete, signed and dated copy of the marriage certificate, divorce decree or Order of Legal Separation. These documents will be made a permanent part of your file and will be kept in the Fund Office. Failure to send copies of these documents will delay the processing of claims for Benefits.

If you wish to **CHANGE THE NAME OF YOUR BENEFICIARY, DON'T FORGET TO SEND THE CHANGE TO THE FUND OFFICE, IN WRITING.** If you fail to notify the Fund Office of your wishes in writing, the Fund Office will be unable to pay any Death Benefits to anyone other than the person(s) in your latest **written** notification to the Fund Office prior to the time of your death.

If you need to **ADD OR DELETE DEPENDENTS**, you must notify the Fund Office, **in writing**. You should be prepared to provide documentation in the form of a birth certificate, decree of adoption, marriage license, etc. Since the Plan provides Benefits to Eligible Dependents, the Fund Office must know who your dependents are at all times.

If the Plan makes any inadvertent, mistaken or excessive payments of Benefits, the Trustees or their representatives shall have the right to recover the payments.

A Word about Confidential Information

The *Health Insurance Portability and Accountability Act of 1996 (HIPAA)* provides stringent requirements for the Fund, its Trustees and its service vendors concerning the use and disclosure of Participants' personally identifiable 'Protected Health Information' (PHI). Broadly speaking, PHI includes demographic information about you and/or your dependents, such as your name, address, telephone number and Social Security Number, in conjunction with information concerning you and/or your dependents, such as: (1) eligibility for Benefits, (2) medical treatment provided or (3) payment for such medical treatment. Specifically, the Plan will use and disclose PHI only for purposes related to health care treatment, payment for health care and health care operations or as otherwise required or allowed by law.

The Plan's use and disclosures of PHI is set out in detail in the Privacy Notice included with your copy of the SPD. If you would like another copy of this Notice, please contact the Fund Office.

The Plan and the Trustees are committed to observing these privacy rules and in ensuring the confidentiality of your PHI. Your cooperation and understanding in working with the Plan to achieve compliance with these federal requirements is appreciated.

Section One – Schedule of Benefits

The Plan offers Benefits to the following groups of Participants:

- A. Covered Employees and Eligible Dependents
- B. Retired Participants and Eligible Dependents

EXCEPT WHERE OTHERWISE INDICATED, THE SCHEDULE OF BENEFITS COVERS ALL OF THE ABOVE GROUPS OF PARTICIPANTS.

The Fund has negotiated special contracts with Preferred Health Professionals, Inc. (PHP) to provide networks of area Physicians and Hospitals known as Preferred Provider Organizations (PPOs). These participating providers will render services for fees that, in most cases, are below prevailing prices. Providers that are in these networks are referred to as In-Network. Providers that are not in these networks are referred to as Out-of-Network. See page 1 for contact information regarding the contact information for participating providers.

In-Patient hospitalizations require a pre-admission notification. Failure to pre-notify before going to the Hospital will result in a \$100 penalty!! Please notify the Fund Office before being admitted to the Hospital.

If the Covered Person uses an In-Network provider, the Plan will pay 90% of all allowed charges and the Covered Person will pay the remaining 10%. If the Covered Person uses an Out-of-Network provider, the Fund will pay 75% of all allowed charges and the Covered Person will pay the remaining 25%.

Plan Benefits are paid AFTER the Annual Deductible is met, unless otherwise noted.

IN-NETWORK SERVICES

**FUND PAYS 90%
YOU PAY 10%**

OUT-OF NETWORK SERVICES

**FUND PAYS 75%
YOU PAY 25%**

The Major Medical Benefit has a \$100,000 per person limit for new Participants and their Eligible Dependents for the first 12 months of coverage. This \$100,000 per person limit also applies to any current Participant (and Eligible Dependents) whose coverage under the Plan has lapsed for a period of 12 consecutive months preceding the eligibility work month.

Once you have been a Participant for 12 months, you (and your Eligible Dependents) are covered under the Plan's Major Medical Benefit under a \$1,250,000 Lifetime Maximum Benefit per person. Any Benefits used during the first 12 months of coverage count toward the \$1,250,000 per person Lifetime Maximum Benefit.

<u>MAJOR MEDICAL BENEFIT COVERAGE LIMITS</u>	
New Participants and Eligible Dependents	\$100,000 per person for first 12 months
Reinstated Participants and Eligible Dependents (with 12 month lapse of coverage under Plan)	\$100,000 per person for first 12 months
All others \$1,250,000 per person	LIFETIME MAXIMUM
Includes all benefits paid, including but not limited to all medical, prescriptions drugs and dental claims	

In addition, the calendar year deductible for IN-NETWORK care is \$400 per person or \$800 per family and for OUT-OF-NETWORK care is \$800 per person or \$1,600 per family. This is referred to in the Schedule of Benefits as the "Major Medical Benefit Calendar Year Deductible".

<u>IN-NETWORK DEDUCTIBLE</u>	
Annual Deductible (Per Person)	\$ 400
Annual Deductible (Per Family)	\$ 800
<u>OUT-OF-NETWORK DEDUCTIBLE</u>	
Annual Deductible (Per Person)	\$ 800
Annual Deductible (Per Family)	\$1,600

There are individual and family annual Out-of-Pocket Maximums for both In-Network and Out-of-Network care. The In-Network annual Out-of-Pocket Maximums are \$5,000 individual and \$10,000 family. The Out-of-Network annual Out-of-Pocket Maximums are \$10,000 individual and \$20,000 family.

<u>ANNUAL OUT-OF-POCKET MAXIMUMS – IN-NETWORK</u>	
Individual	\$ 5,000
Family	\$10,000
<u>ANNUAL OUT-OF-POCKET MAXIMUMS – OUT-OF-NETWORK</u>	
Individual	\$10,000
Family	\$20,000

Some Benefits are only available to certain individuals. Please refer to Section Twenty for clarification between Participant, Covered Person, Covered Employee and Eligible Dependent.

YOU ARE NOT REQUIRED TO USE AN IN-NETWORK PPO PROVIDER. COMPLETE FREEDOM OF CHOICE IS YOURS. HOWEVER, CHOOSING AN IN-NETWORK PPO PROVIDER FOR YOUR HEALTH CARE NEEDS WILL SAVE YOU AND THE FUND MONEY.

Schedule of Benefits

The following charts summarize Benefit information. Please refer to specific Benefit Sections for more detailed explanations. All Benefits determined as a percentage (%) of the provider's charge are calculated as a percentage (%) of the Usual, Customary and Reasonable Charge as defined herein (see page 105).

A. *MEDICAL BENEFITS*

DESCRIPTION OF MEDICAL BENEFITS	IN-NETWORK PROVIDERS	OUT-OF-NETWORK PROVIDERS
Major Medical Benefit	90% after deductible	75% after deductible
Benefit Maximums <ul style="list-style-type: none"> • New Participants and Eligible Dependents • Reinstated Participants and Eligible Dependents • All Others 	\$100,000 per person for first 12 months \$100,000 per person for first 12 months \$1,250,000 Lifetime Maximum per person Maximums include all Benefits paid, including but not limited to all medical, prescriptions drugs and dental claims.	
Calendar Year Deductible, effective 1/1/09* <ul style="list-style-type: none"> • In-Network – Individual • In-Network – Family • Out-of-Network – Individual • Out-of-Network – Family <p>* For deductible levels prior to 1/1/09, please refer to the separate “Transition Rules” notice.</p>	\$ 400 \$ 800 \$ 800 \$ 1,600	
Calendar Year Out-of-Pocket Maximum (excluding deductible) <ul style="list-style-type: none"> • In-Network – Individual • In-Network – Family • Out-of-Network – Individual • Out-of-Network – Family 	\$ 5,000 \$ 10,000 \$ 10,000 \$ 20,000	
Pre-Admission Notification A \$100 penalty deductible will apply for failure to pre-notify for In-Patient Hospital confinements. Penalty does not apply to the Out-of-Pocket Maximum.	Provider's/Employee's Responsibility to notify the Fund Office	Employee's Responsibility to notify the Fund Office

DESCRIPTION OF MEDICAL BENEFITS	IN-NETWORK PROVIDERS	OUT-OF-NETWORK PROVIDERS
<p>Alcoholism Benefit In-Patient Treatment</p> <ul style="list-style-type: none"> Treatment in a Hospital – limited to 31 days per Calendar Year in combination with Drug Abuse and Mental/Nervous Conditions Benefits. Treatment in a residential treatment program or a nonresidential treatment program is limited to \$2,000 per Calendar Year. 	<p>50% after deductible</p> <p>50% after deductible</p>	<p>0%</p> <p>0%</p>
<p>Birth Control Benefit</p> <ul style="list-style-type: none"> Prescription Sterilization Maximum Lifetime Sterilization Benefit – \$3,000 	<p>Covered under Prescription Drug Benefit</p> <p>90% after deductible</p>	<p>0%</p> <p>75% after deductible</p>
<p>Chiropractic Expense Benefit Maximum manipulations is 24 per person each Calendar Year.</p> <p>Maximum Benefit per manipulation is \$20</p>	<p>100% no deductible</p>	<p>100% no deductible</p>
<p>Drug Abuse Benefit In-Patient Treatment</p> <ul style="list-style-type: none"> Treatment in a Hospital – limited to 31 days per Calendar Year in combination with Alcoholism and Mental/Nervous Conditions Benefits. Treatment in a residential treatment program or a non-residential treatment program is limited to \$2,000 per Calendar Year. 	<p>50% after deductible</p> <p>50% after deductible</p>	<p>0%</p> <p>0%</p>

DESCRIPTION OF MEDICAL BENEFITS	IN-NETWORK PROVIDERS	OUT-OF-NETWORK PROVIDERS
<p>Durable Medical Equipment Benefit Maximum Benefit for prosthetic devices is \$10,000 per limb every three years (includes purchase, maintenance and service).</p> <p>Orthotics are covered at 50% after deductible with a maximum of \$350 per person each Calendar Year.</p>	90% after deductible	75% after deductible
<p>Hearing Aid Benefit Maximum Benefit is \$700 per person each Calendar Year.</p> <p><i>No additional Benefits are available under Major Medical Benefits.</i></p>	100% no deductible	75% after deductible
<p>Home Health Care Benefit Maximum Benefit is 60 visits per person each Calendar Year (one visit = four hours).</p> <p><i>No additional Benefits are available under Major Medical Benefits.</i></p>	90% after deductible	75% after deductible
<p>Hospice Benefit Maximum Lifetime Benefit is \$25,000 per person.</p> <p><i>No additional Benefits are available under Major Medical Benefits.</i></p>	90% after deductible	75% after deductible
<p>Maternity Benefit Employee and spouse only</p>	90% after deductible	75% after deductible
<p>Mental/Nervous Conditions Benefit</p> <ul style="list-style-type: none"> • In-Patient Treatment limited to 31 days per Calendar Year in combination with Alcoholism and Drug Abuse Benefits. <ul style="list-style-type: none"> - Partial Hospitalization – two partial days equals one In-Patient day. • Out-Patient expenses do not apply to the Out-of-Pocket Maximum, nor will the Benefits be paid at 100% if the Out-of-Pocket Maximum is met. <ul style="list-style-type: none"> - Out-Patient Physician Treatment limited to 50 visits per Calendar Year. 	90% after deductible	0%

DESCRIPTION OF MEDICAL BENEFITS	IN-NETWORK PROVIDERS	OUT-OF-NETWORK PROVIDERS
<p>Nurse Practitioner Retail Clinic* Visit Benefit In-Network Co-Payment is not subject to deductible and does not count towards Calendar Year Out-of-Pocket Maximum</p> <p><i>* For example: MinuteClinics and Take Care Health Centers</i></p>	<p>100% after \$5 Co-Payment</p>	<p>75% after deductible</p>
<p>Organ and Tissue Transplant Benefit Requires transplant case management approval.</p> <p>Subject to Major Medical Benefit Maximums.</p>	<p>90% after deductible</p>	<p>0%</p>
<p>Routine Care / Annual Physicals Benefit Covered Employees, Retirees and their spouses</p> <p>Routine Mammogram Limits: through age 50 – one every two years after age 50 – one every year</p> <p>Maximum Benefit is \$300 per person each Calendar Year</p> <p><i>No additional Benefits are available under Major Medical Benefits.</i></p>	<p>100% no deductible</p>	<p>75% no deductible</p>
<p>Routine Childcare Benefit Limited to children from birth up to their 15th birthday.</p> <p>Maximum Benefit is \$300 per person each Calendar Year</p> <p><i>No additional Benefits are available under Major Medical Benefits.</i></p>	<p>100% no deductible</p>	<p>75% no deductible</p>
<p>Skilled Nursing Facility Must be admitted within seven days of a three-day Hospital or Skilled Nursing Facility confinement, up to a maximum of 60 days per Calendar Year.</p> <p>Limited to 50% of the Hospital's average semi-private room rate.</p>	<p>90% after deductible</p>	<p>75% after deductible</p>

DESCRIPTION OF MEDICAL BENEFITS	IN-NETWORK PROVIDERS	OUT-OF-NETWORK PROVIDERS
<p>Speech Therapy Benefit Limited to Speech Therapy to restore speech lost due to Accident or illness.</p> <p>Maximum Benefit is \$1,000 per person each Calendar Year.</p> <p><i>No additional Benefits are available under Major Medical Benefits.</i></p>	<p>90% after deductible</p>	<p>75% after deductible</p>
<p>Surgery – Second Surgical Opinion Benefit</p>	<p>100% after deductible</p>	<p>75% after deductible</p>
<p>All Other Covered Expenses</p>	<p>90% after deductible</p>	<p>75% after deductible</p>

B. PRESCRIPTION DRUG BENEFITS

DESCRIPTION OF PRESCRIPTION DRUG BENEFITS	PLAN PAYS								
<p>Prescription Drugs Maximum Out-of-Pocket for Retail & Mail Order Prescription Drugs is \$5,000 per person every Calendar Year.</p>	<p><u>ExpressScripts Drug Program Only</u></p>								
<ul style="list-style-type: none"> • Retail (34 day supply per Employee Co-Payment) <table border="0" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 100%; padding: 2px;">Generic</td> <td style="width: 100%; text-align: center; padding: 2px;">\$10</td> </tr> <tr> <td style="padding: 2px;">Formulary Brand Name (no generic available)</td> <td style="text-align: center; padding: 2px;">Greater of \$25 or 25% of cost of drug</td> </tr> <tr> <td style="padding: 2px;">Preferred Brand Name (when generic available)</td> <td style="text-align: center; padding: 2px;">Fund will only pay what it would have paid for medically equivalent generic</td> </tr> <tr> <td style="padding: 2px;">Non-Formulary Brand Name</td> <td style="text-align: center; padding: 2px;">Greater of \$40 or 40% of cost of drug</td> </tr> </table> 	Generic	\$10	Formulary Brand Name (no generic available)	Greater of \$25 or 25% of cost of drug	Preferred Brand Name (when generic available)	Fund will only pay what it would have paid for medically equivalent generic	Non-Formulary Brand Name	Greater of \$40 or 40% of cost of drug	<p><u>Employee Pays</u></p>
Generic	\$10								
Formulary Brand Name (no generic available)	Greater of \$25 or 25% of cost of drug								
Preferred Brand Name (when generic available)	Fund will only pay what it would have paid for medically equivalent generic								
Non-Formulary Brand Name	Greater of \$40 or 40% of cost of drug								
<ul style="list-style-type: none"> • Mail Order (90 day supply per Employee Co-Payment) <table border="0" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 100%; padding: 2px;">Generic</td> <td style="width: 100%; text-align: center; padding: 2px;">\$25</td> </tr> <tr> <td style="padding: 2px;">Formulary Brand Name (no generic available)</td> <td style="text-align: center; padding: 2px;">Greater of \$60 or 25% of cost of drug</td> </tr> <tr> <td style="padding: 2px;">Preferred Brand Name (when generic available)</td> <td style="text-align: center; padding: 2px;">Fund will only pay what it would have paid for medically equivalent generic</td> </tr> <tr> <td style="padding: 2px;">Non-Formulary Brand Name</td> <td style="text-align: center; padding: 2px;">Greater of \$100 or 35% of cost of drug</td> </tr> </table> 	Generic	\$25	Formulary Brand Name (no generic available)	Greater of \$60 or 25% of cost of drug	Preferred Brand Name (when generic available)	Fund will only pay what it would have paid for medically equivalent generic	Non-Formulary Brand Name	Greater of \$100 or 35% of cost of drug	<p><u>Employee Pays</u></p>
Generic	\$25								
Formulary Brand Name (no generic available)	Greater of \$60 or 25% of cost of drug								
Preferred Brand Name (when generic available)	Fund will only pay what it would have paid for medically equivalent generic								
Non-Formulary Brand Name	Greater of \$100 or 35% of cost of drug								
<ul style="list-style-type: none"> • Specialty Drugs (34 day supply per Employee Co-Payment) <i>Mandatory Pre-authorization</i> <table border="0" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 100%; padding: 2px;">Generic</td> <td style="width: 100%; text-align: center; padding: 2px;">\$10</td> </tr> <tr> <td style="padding: 2px;">Formulary Brand Name (no generic available)</td> <td style="text-align: center; padding: 2px;">Greater of \$25 or 25% of cost of drug</td> </tr> <tr> <td style="padding: 2px;">Preferred Brand Name (when generic available)</td> <td style="text-align: center; padding: 2px;">Fund will only pay what it would have paid for medically equivalent generic</td> </tr> <tr> <td style="padding: 2px;">Non-Formulary Brand Name</td> <td style="text-align: center; padding: 2px;">Greater of \$40 or 40% of cost of drug</td> </tr> </table> 	Generic	\$10	Formulary Brand Name (no generic available)	Greater of \$25 or 25% of cost of drug	Preferred Brand Name (when generic available)	Fund will only pay what it would have paid for medically equivalent generic	Non-Formulary Brand Name	Greater of \$40 or 40% of cost of drug	<p><u>Employee Pays</u></p>
Generic	\$10								
Formulary Brand Name (no generic available)	Greater of \$25 or 25% of cost of drug								
Preferred Brand Name (when generic available)	Fund will only pay what it would have paid for medically equivalent generic								
Non-Formulary Brand Name	Greater of \$40 or 40% of cost of drug								

C. DENTAL BENEFITS

DESCRIPTION OF DENTAL BENEFITS	PLAN PAYS
Maximum Calendar Year Benefit	\$1,000
Calendar Year Deductible • Individual	\$50
Diagnostic and Preventative Services • Exam – two per Calendar Year • Prophylaxis – two per Calendar Year • Bitewing X-rays – four per Calendar Year • Fluoride – up to 15 th birthday – one per Calendar Year • Sealants – up to 15 th birthday – one per Calendar Year per tooth • Full Mouth X-rays – one series per three consecutive Calendar Years • Space Maintainers	100% no deductible
Basic Services	80% after deductible
Major Services	50% after deductible
Orthodontia Separate \$1,000 Lifetime Maximum per person	50% no deductible
No additional Benefits are available under Major Medical Benefits except as provided in Section Four, Subsection H, Number 12 on page 41.	

D. VISION BENEFITS

DESCRIPTION OF VISION BENEFITS	PLAN PAYS
Maximum Calendar Year Benefit per Family	\$500
<i>For more details on this Benefit, including Out-of-Network coverage, see Section Eight on page 49.</i>	
Co-Payment for In-Network Vision Benefits • \$10 per examination • \$ 10 per materials (glasses, frames, contacts, etc)	

E. DEATH AND DISMEMBERMENT BENEFIT

DEATH BENEFIT (COVERED EMPLOYEES ONLY)	PLAN PAYS \$15,000
---	------------------------------

DISMEMBERMENT BENEFIT (COVERED EMPLOYEES ONLY)	PLAN PAYS
Loss of:	
Both Hands or Both Feet	\$5,000
Entire Sight of Both Eyes	\$5,000
One Hand and One Foot	\$5,000
One Hand or One Foot and Entire Sight of One Eye	\$5,000
One Hand or One Foot	\$2,500
Entire Sight of One Eye	\$2,500

F. WEEKLY ACCIDENT AND SICKNESS BENEFITS

DESCRIPTION OF WEEKLY ACCIDENT AND SICKNESS BENEFITS (COVERED EMPLOYEES ONLY) <i>Excludes non-bargained Employees unless otherwise stated in participation agreement.</i>	PLAN PAYS
Weekly Benefit	
• Weeks 1 through 13	\$200.00
• Weeks 14 through 26	\$100.00
Maximum Number of Weeks (within 12 month period)	26 weeks
Elimination Period	
• Accident	7 days
• Illness	
• Hospitalization	

Section Two – Eligibility

THE TRUSTEES OF THE PLAN HAVE THE AUTHORITY AND ALL DISCRETION TO INTERPRET, CONSTRUE AND APPLY THE PROVISIONS OF THE HEALTH AND WELFARE PLAN IN DETERMINING YOUR ELIGIBILITY FOR ENTITLEMENT TO AND NATURE, AMOUNT AND DURATION OF BENEFITS. BENEFITS UNDER THIS PLAN WILL BE PAID ONLY IF THE PLAN ADMINISTRATOR DECIDES IN ITS DISCRETION THAT THE APPLICANT IS ENTITLED TO THEM.

The following topics are discussed under this Section on Eligibility:

-
- | | |
|--|---|
| A. Establishing Eligibility | H. Termination of Eligibility for Eligible Employees |
| B. Continuing Eligibility | I. Reestablishment of Eligibility |
| C. Eligibility for Retirees and Eligible Dependents | J. Termination of Eligibility for Dependents |
| D. Effective Date of Dependent Coverage | K. COBRA Continuation Coverage |
| E. Buying Additional Eligibility | L. Survivor Benefit |
| F. Restoring Eligibility while Under COBRA Continuation Coverage | M. Service in the Armed Forces |
| G. Family and Medical Leave Act (FMLA) | N. Uniformed Services Employment and Reemployment Rights Act (USERRA) |
-

A. Establishing Eligibility

You will become eligible on the first day of the second month following the month in which you are credited with your 480th hour of Employer contributions, provided such hours are accumulated in a 12 consecutive month period and the contributions have been paid by the Employer. For example, if you started to work on April 1, 2008 and if you had at least 480 hours of Employer contributions received on your behalf as of June 30, 2008, your coverage would begin effective August 1, 2008. When you initially become eligible, you will receive an identification card. You may continue to use this card for Benefits, so long as you remain eligible.

If you work for an Employer who contributes to the Welfare Fund for your hours worked on a job covered by a written agreement approved by the Trustees and in the jurisdiction of District Council No. 3 Painters and Allied Trades, you are considered working in “Covered Employment”.

During the first 12 months of coverage, the Major Medical Benefit has a \$100,000 per person limit for new Participants and their Eligible Dependents. This \$100,000 per person limit also applies to any current Participant (and Eligible Dependents) whose coverage under the Plan has lapsed for a period of 12 consecutive months preceding the eligibility work month.

Once you have been a Participant for 12 months, you (and your Eligible Dependents) are covered under the Plan's Major Medical Benefit under a \$1,250,000 Lifetime Maximum Benefit per person. Any Benefits used during the first 12 months of coverage counts toward the \$1,250,000 per person Lifetime Maximum Benefit.

B. Continuing Eligibility

Once you establish initial eligibility, you maintain your eligibility in the Plan when you accumulate and your Employer contributes at least 120 hours of Covered Employment in each subsequent month (you earn one hour of credit for each hour in Covered Employment when the hours are reported and contributions are paid to the Fund).

All of your hours will be put into an "Hour Bank" in your name. After establishing initial eligibility, at the end of each work month, 120 hours will be deducted from your account.

If you are credited with more than 120 hours of Covered Employment in a work month, the additional hours will remain in your Hour Bank account. However, your Hour Bank account can never exceed 720 hours. These banked hours will be valuable to you, as we will explain next.

C. Eligibility for Retirees and Eligible Dependents

An eligible Employee who:

- (a) is receiving a pension benefit based solely on his or her work history within the jurisdiction the of District Council No. 3., and
- (b) is eligible for coverage under the District Council No. 3 Painters and Allied Trades Welfare Fund as of his or her date of retirement; and
- (c) first loses eligibility as a Covered Employee under the District Council #3 Painters and Allied Trades Welfare Fund;

will become eligible for continuing Benefits provided under this Plan by making the required self-payments.

An eligible Employee also includes those individuals already retired under the District Council No. 3 Painters and Allied Trades Welfare Fund who turn 65 on or after August 1, 2008 and meet the criteria under (a), (b) and (c) above.

D. Effective Date of Dependent Coverage

Coverage of a Dependent will begin when you become eligible and will terminate when that person no longer meets the Plan's definition of an "Eligible Dependent", or when you lose your eligibility, whichever occurs first. In cases involving dependents identified in a Qualified Medical Child Support Order (QMCSO) or National Medical Support Notice (NMSN), coverage of the dependent will be in effect for the period set forth in the QMCSO or NMSN, provided that you are eligible for coverage during such period. Coverage for Eligible Dependents may be extended, however, as described in Subsection K, entitled COBRA Continuation Coverage on page 25.

However, if you have an unmarried child who is incapable of earning a living because of a mental or physical handicap, and who is dependent on you for support, that child's coverage can be continued indefinitely while you are still eligible. In order to indefinitely continue coverage for a child that would otherwise lose coverage, both of the following conditions must be met: (1) the child's incapacity must have begun before he or she reached the limiting age; and, (2) that you must furnish proof of the child's incapacity within 31 days after he or she reaches the limiting age. The Trustees are authorized to request proof of the continuing existence of the incapacity from time to time.

Your newly acquired Eligible Dependent(s) will be covered automatically, or if applicable, will be covered as specified in a Qualified Medical Child Support Order. Your natural child is eligible for coverage on their date of birth and an adopted child or a child placed for adoption will be covered on the effective date of such adoption or placement for adoption. Your stepchild may be covered as of your date of marriage and any child for whom you have been appointed legal guardian may be covered as of the effective date of such appointment. Regardless of the type of Eligible Dependent, however, the Eligible Dependent must meet the Plan's definition on page 97 of this Plan. You must notify the Fund Office within 30 days after acquiring an Eligible Dependent. You may be required to provide documentation concerning your Eligible Dependent before claims are paid on their behalf.

E. Buying Additional Eligibility

If, after you've met the initial eligibility requirements, you fail to accumulate 120 hours of Covered Employment in a subsequent work month, you can still retain your eligibility, subject to the limitations stated below.

If you have accumulated hours in your Hour Bank account, those hours may be used to "buy" additional eligibility. A deduction of up to 120 hours will be made to your Hour Bank account at the end of a work month during which you did not

accumulate 120 hours of Covered Employment. The exact amount of hours deducted from your Hour Bank account will be the difference in the required 120 hours and the actual amount of hours you worked in Covered Employment. See page 17 for more on your Hour Bank.

If your Hour Bank account balance is less than the amount needed to retain your eligibility, you may still “buy” additional eligibility by making “self-payments” for the balance of hours needed. However, you must have at least one hour in your Hour Bank to use this “self-payment” option.

If you do not have any hours in your Hour Bank account to continue your eligibility, you are not eligible to make self-payments. Continued health care coverage would be available if you elect COBRA continuation coverage.

The hourly self-payment premium is equal to the current Employer contribution rate multiplied by 120, less the balance of work hours in your hour Bank. Self-payments by any third party other than the Employee are NOT permitted, except for COBRA Continuation Coverage.

Continuing Eligibility Limitations

You may only extend your eligibility using bank hours or self-payments during a period of low-hours, temporary layoff or unemployment from Covered Employment. Therefore, if you leave Covered Employment for self-employment or employment by an employer that is not signatory to the District Council #3 Collective Bargaining Agreement, you cannot utilize the Hour Bank or self-payment provisions to maintain your eligibility. Therefore, performance of painters and allied trades bargaining unit work for an employer who is not required to make contributions to the Fund PREVENTS you from utilizing the Hour Bank or Self-Payment provisions to buy additional eligibility.

F. Restoring Eligibility while under COBRA Continuation Coverage

While covered by COBRA, you can restore your Plan eligibility by working 480 hours after your initial COBRA coverage date, or by working 120 or more hours in a single month while covered by COBRA. Once you fulfill either of these eligibility requirements, your Hour Bank will be credited with 120 hours and you will be eligible for coverage as of the next corresponding coverage period.

Example #1 – Buying Eligibility with only Bank Hours

The following example is for Joe, who became eligible on October 1, 2008 and worked in Covered Employment over the next several months. In this example, Joe worked enough hours in Covered Employment to buy the maximum allowed eligibility using only his Hour Bank account.

Work Month	Deposit (Hours Worked)	Deduction	Account Balance (At End of Month)	Self-Payment Hours Required for Eligibility	Benefit Month
10/01/08-10/31/08	160	120	40		Eligible
11/01/08-11/31/08	160	120	80		Eligible
12/01/08-12/31/08	160	120	120		Eligible
1/01/09-1/31/09	160	120	160	0	Eligible
2/01/09-2/28/09	160	120	200	0	Eligible
3/01/09-3/31/09	NONE	120	80	0	Eligible
4/1/09-4/30/09	NONE	120	0	40	Eligible
5/01/09-5/31/09	NONE	NA	0	NA	Must choose COBRA to continue coverage

Example #2 – Buying Eligibility with only Self-Payments

The following example is for Bill, who became eligible on October 1, 2008 and worked varying numbers of hours in Covered Employment over the next several months. However, in this example, Bill did not work enough hours in Covered Employment to have a balance in his Hour Bank account so he must buy the maximum allowed eligibility using only Self-Payments if he wishes to continue his coverage as long as possible.

Work Month	Deposit (Hours Worked)	Deduction	Account Balance (At End of Month)	Self-Payment Hours Required for Eligibility*	Benefit Month
10/01/08-10/31/08	120	120	0	0	Eligible
11/01/08-11/31/08	120	120	0	0	Eligible
12/01/08-12/31/08	90	120	-30	30	Eligible
1/01/09-1/31/09	60	120	-60	60	Eligible
2/1/09-2/28/09	NONE	NA	0	NA	Must choose COBRA to continue coverage

Example #3 – Buying Eligibility using both Bank Hours and Self-Payments

The following example is for Sam, who became eligible on October 1, 2008 and worked varying numbers of hours in Covered Employment over the next several months. In this example, Sam worked enough hours in Covered Employment to have a balance in his Hour Bank account but not a large enough balance to buy the maximum allowed eligibility using only banked hours. In this instance, Sam must buy the remaining eligibility using Self-Payments if he wishes to continue his coverage as long as possible.

Work Month	Deposit (Hours Worked)	Deduction	Account Balance (At End of Month)	Self-Payment Hours Required for Eligibility*	Benefit Month
10/01/08-10/31/08	160	120	40	0	Eligible
11/01/09-11/31/09	100	120	20	0	Eligible
12/01/08-12/31/08	100	120	0	0	Eligible
1/01/09-1/31/09	80	120	0	40	Eligible
2/1/09-2/28/09	NONE	NA	0	NA	Must choose COBRA to continue coverage

You receive annual statements from the Administrator. These statements are very important to you. This is the Plan's way of informing you of which Employer(s) contributed on your behalf and how many hours each Employer contributed. If you disagree with the months, hours, or address, it is your responsibility to advise the Fund Office immediately. You do this by returning the statement with the information you are questioning. If it concerns the hours reported, send in copies of your original pay stubs. With this information, your Fund Office can go back to your Employer and request the hours that have been omitted.

G. Family and Medical Leave Act (FMLA)

Pursuant to the requirements of the Family and Medical Leave Act of 1993 (FMLA), eligibility for Benefits shall be extended to active Covered Employees and their Eligible Dependents if the Covered Employee has been granted leave by his/her Employer pursuant to the FMLA and if the Employer makes the required contributions to the Fund.

If a Covered Employee has been granted FMLA leave, the Employer will notify the Fund Office immediately to prevent a loss of eligibility. The Fund Office shall obtain a certificate of the Covered Employee's eligibility from the Employer. The Employer will advise the Fund Office of the beginning date and ending date of the leave. The Employer shall notify the Fund Office of the date a Covered Employee advises the Employer that he/she does not intend to return to work.

The Employer will be required to pay the cost of coverage in an amount equal to contributions for 30 hours of work per week for each week the Covered Employee is on FMLA leave at the contribution rate in effect at the time of the leave. The Employer will remit the payments monthly, in arrears, upon billing by the Fund Office.

Eligibility will not be extended during the FMLA leave if the Employer does not make the required contributions to the Fund. The usual procedures of the Fund will be followed if the Employer does not make timely contributions and a loss of eligibility will result.

The same Benefits payable to active Covered Employee will be payable to Employees while on FMLA leave. If the Trustees amend, terminate or limit the Plan of Benefits for active Covered Employees, such changes, including termination of some Benefits or the entire Plan will apply to Covered Employees on FMLA leave.

H. Termination of Eligibility for Eligible Employees

1. Eligibility will terminate on
 - a. The first day the Employee works for an Employer whose contractual obligation to contribute to the Fund has terminated (termination does not occur if the Employer is negotiating for a new contract and making contributions to the Fund); or
 - b. The first day the Employee works in employment in the jurisdiction of the Fund for an employer that does not have a contractual obligation to contribute to the Fund.
2. A review of the hours contributed on behalf of an Employee shall be made on the first day of each month. Eligibility will terminate on any of these dates if:
 - a. The Employee fails to satisfy the requirements set forth under Continuing Eligibility as explained in Section Two, Subsection B.,
 - b. The Employee fails to elect to buy additional eligibility as explained in Section Two, Subsection E,
 - c. The Employee fails to elect COBRA Continuation Coverage,
 - d. The Employee fails to make a required self-payment, or
 - e. The Employee dies.

I. Reestablishment of Eligibility

If you should lose your eligibility under the Plan (as the Employees in the prior examples did), you may be able to regain your eligibility at a later date. The following is a list of ways to re-establish eligibility:

Participant on Short-Hour Self-Payment

If you are making self-payments due to not meeting the continuing eligibility requirements (120 hours a month) you can reestablish eligibility once you work 120 hours in a month.

Participant Eligible for Short-Hour Self-Payment but Elects not to Self-Pay

If you do not meet the continuing eligibility requirements (120 hours a month) and elect not to self-pay to continue coverage, you can obtain coverage under the Plan by electing and paying for COBRA coverage (see Section Two, subsection K) or by satisfying the initial eligibility requirements. In this case, any unused hours in your Hour Bank will be combined with the hours you work towards meeting the initial eligibility requirements. The initial eligibility requirement is met once you work 480 hours in any 12 consecutive month period. You will then become eligible again in the second month following the month in which you are credited with your 480th hour of Employer contributions, provided such hours are accumulated in a 12 consecutive month period and the contributions have been paid by the Employer.

Participant on COBRA

If you do not meet the continuing eligibility requirements (120 hours a month) and elect COBRA as a way to continue coverage, you can reestablish eligibility by satisfying either the initial or continuing eligibility requirements, whichever is first fulfilled.

If you lost coverage under the Plan for 12 or more consecutive months preceding the eligibility work month, then during the first 12 months of coverage after you have reestablished eligibility, the Major Medical Benefit has a \$100,000 per person limit.

Once you have been a Participant for 12 months, you (and your Eligible Dependents) are covered under the Plan's Major Medical Benefit under a \$1,250,000 Lifetime Maximum Benefit per person. Any Benefits used during the first 12 months of coverage counts toward the \$1,250,000 per person Lifetime Maximum Benefit.

J. Termination of Eligibility for Dependents

The eligibility for Benefits for Eligible Dependents will terminate upon the occurrence of the first of the following:

1. The individual fails to satisfy the definition of Eligible Dependent as defined in Section Twenty J,
2. The individual fails to elect COBRA Continuation Coverage,
3. The individual fails to make a required self-payment,
4. In the case of an eligible spouse of a deceased Retiree, the spouse remarries.

Upon the death of a Covered Employee, the eligibility of that Employee's Eligible Dependents will be extended to the end of the eligibility period based upon the deceased eligible Employee's accrued hours. Thereafter, the eligibility for Benefits will be governed by COBRA Continuation Coverage provisions. Your Eligible Dependents will not be permitted to Buy Additional Eligibility as described in Section Two, Subsection E on page 18.

Upon the death of an eligible Retiree, the eligible spouse will be allowed to continue coverage by self-paying the prevailing retiree premium. The spouse shall be eligible to continue coverage by self-paying the prevailing retiree premium **until he or she remarries.**

K. COBRA Continuation Coverage

Federal law requires that sponsors of group health plans such as the District Council #3 Painters and Allied Trades Welfare Fund offer Covered Employees and their families a temporary extension of their health care coverage under the Plan, (called “COBRA Continuation Coverage”) in exchange for self-contribution payments to the Plan. The right to an extension of health care coverage was created by federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA Continuation Coverage can become available to you and to other members of your family (the Covered Employee’s spouse and dependents under the terms of the Plan) who are covered by the Plan when you would otherwise lose your group health coverage.

What is COBRA Continuation Coverage?

If a Covered Employee or Eligible Dependent loses health care coverage due to a reduction in hours, termination of employment, or certain other events (called qualifying events), the Covered Employee and the Eligible Dependent(s) have the right to elect to continue health care coverage by making premium payments to the Plan.

1. COBRA Continuation Coverage will be offered to a Covered Employee if coverage under the Plan ends for the following reasons:
 - a. The Covered Employee’s hours of employment are reduced as follows:
 - i. There are zero hours left in an Employee’s Hour Bank; or
 - ii. There are one or more hours left in an Employee’s Hour Bank, the Employee has been offered an opportunity to make a short-hour self-payment to continue eligibility and has failed to make such payment.
 - b. The Covered Employee is terminated from employment for any reason other than the Covered Employee’s gross misconduct.
2. COBRA Continuation Coverage will be offered to the spouse of a Covered Employee if coverage under the Plan ends for the following reasons:
 - a. The Covered Employee’s hours of employment are reduced;
 - b. The Covered Employee is terminated from employment for any reason other than the Covered Employee’s gross misconduct;
 - c. The Covered Employee dies;
 - d. The Covered Employee and spouse become legally separated or divorced.

3. COBRA Continuation Coverage will be offered to an Eligible Dependent Child if coverage under the Plan ends for the following reasons:
 - a. The Covered Employee's hours of employment are reduced;
 - b. The Covered Employee is terminated from employment for any reason other than the Covered Employee's gross misconduct;
 - c. The Covered Employee dies;
 - d. The Covered Employee becomes eligible for Medicare;
 - e. The Covered Employee and spouse become legally separated or divorced; or
 - f. The dependent child ceases to be an Eligible Dependent as defined under the terms of the Plan.

How long will COBRA Continuation Coverage last?

1. 18 months

If the Covered Employee and/or the Eligible Dependent lose coverage due to a reduction in the Covered Employee's hours, or due to the end of the Covered Employee's employment (for reasons other than gross misconduct), COBRA Continuation Coverage is available for a maximum of up to 18 months.
2. 29 months

If the Covered Employee and/or Eligible Dependent is disabled (as determined under Titles II or XVI of the Social Security Act) at the time his or her coverage would otherwise terminate because of a reduction of hours or termination of employment, or becomes disabled during the initial 60 days of COBRA Continuation Coverage, and the Fund Office has been notified in writing of the disability prior to the expiration of the initial 18 month period of COBRA Continuation Coverage, the Covered Employee and/or Eligible Dependent can receive up to an additional 11 months of COBRA Continuation Coverage, for a total maximum of 29 months of COBRA Continuation Coverage.
3. 36 months

COBRA Continuation Coverage lasts up to 36 months if the Covered Employee's spouse or Eligible Dependent child's health care coverage ends due to:

 - a. The Covered Employee and spouse legally divorce;
 - b. The Covered Employee becomes eligible for Medicare;

- c. The Covered Employee dies; or
- d. A dependent child ceases to be an Eligible Dependent as defined under the terms of the Plan.

4. Second Qualifying Event

COBRA Continuation Coverage may also be extended for up to 36 months if your family experiences another event, called a “qualifying event” while receiving COBRA Continuation Coverage. If, while receiving COBRA Continuation Coverage, one of the following events occurs, an Eligible Dependent is eligible for an extension of COBRA Continuation Coverage up to a maximum total coverage period of 36 months:

- a. The Covered Employee and spouse become legally separated or divorced;
- b. The Covered Employee becomes eligible for Medicare;
- c. The Covered Employee dies; or
- d. A dependent child ceases to be an Eligible Dependent as defined under the terms of the Plan.

Keeping the Fund Office Informed of Changes

In order to protect your family’s rights, the Fund Office must be informed of any changes concerning your family. The Covered Employee or authorized representative has the responsibility to notify the Fund Office within 60 days of a divorce, legal separation or a dependent child’s loss of dependent status. **Failure to keep the Fund Office informed of these changes may affect your rights to COBRA Continuation Coverage.** While it is the responsibility of the Employer to notify the Fund Office of a reduction in the Covered Employee’s hours, termination of employment, enrollment in Medicare, or Covered Employee’s death, the Covered Employee or authorized representative should also notify the Fund Office of the event in order to prevent a delay in the start of the COBRA Continuation Coverage.

In the event the Covered Employee or Eligible Dependent becomes disabled during the initial 60 day COBRA Continuation Coverage period, it is the responsibility of the Covered Employee or authorized representative to notify the Fund Office of the determination of disability. **Failure to notify the Fund Office of a disability determination may affect your right to extend the COBRA Continuation Coverage period due to disability.**

Electing to Continue Coverage

When the Fund Office is notified that coverage will end due to a qualifying event, the Covered Employee and Eligible Dependent(s) will be notified of their right to choose the Continuation Coverage. The Fund Office will send you and your family a COBRA Election Notice containing information on how to continue your health

care coverage and the applicable COBRA premiums. The Covered Employee and Eligible Dependent(s) will then have **60** days from the date on which coverage under the Plan would otherwise terminate, or **60** days from receipt of the Election Notice to elect the Continuation Coverage. If the Covered Employee or Eligible Dependent(s) does not elect the Continuation Coverage within the 60-day election period, coverage under the Plan will end as of the date the coverage would have otherwise ended without regard to the 60-day election period.

Each Eligible Dependent has an independent right to elect COBRA Continuation Coverage. Parents may make the election on behalf of their Eligible Dependents.

If a Covered Employee or the spouse of a Covered Employee has a newborn child, or adopts a child, or has a child placed with him or her for adoption during the COBRA Continuation Coverage period, this child will be eligible for COBRA Continuation Coverage. The Fund Office must be notified as soon as possible after the birth or placement in order for the child to be added to the COBRA Continuation Coverage.

The COBRA Continuation Coverage offered by the Fund is the same coverage provided under the Plan at the time of termination except for the Disability Income Benefit and Death and Dismemberment Benefits.

If a Covered Employee or Eligible Dependent elects COBRA continuation coverage and the Plan Administrator determines that the Covered Employee or the Eligible Dependent are not entitled to COBRA, then the Covered Employee or the Eligible Dependent will be sent a notice that COBRA is unavailable.

If the Covered Employee's or Eligible Dependent COBRA continuation coverage is terminated before the end of the maximum period of COBRA coverage applicable to the Qualifying Event, the Employee or Eligible Dependent will be sent a notice informing the Covered Employee or Eligible Dependent of this and other information required by law.

Payments

The Trustees will determine the amount of the COBRA Continuation Coverage premiums. The Plan Administrator may require payment for continued coverage in an amount equal to but not greater than 102% of the cost to the Plan for such coverage based on a reasonable actuarial estimate of said cost and in accordance with the maximum payment permitted by law. If coverage is extended to 29 months due to disability, the COBRA premium may be as much as 150% of the applicable premium for the 19th month through 29th month of continuation coverage.

Payment shall be considered to be made in a timely manner if:

1. payment for the period beginning on the date of the Qualifying Event and ending on the date of the election is made within 45 days of such election; and
2. payment for any succeeding period is made within 30 days from the first day of that period; however, if the Plan Administrator is afforded a longer grace period by any insurance company, HMO, or other entity that provides Plan benefits then such longer grace period will be extended to Qualified Beneficiaries who have elected to continue coverage.

After the Covered Employee or Eligible Dependent elects to receive COBRA Continuation Coverage, the first premium payment must be made within 45 days of the election and must include all premiums due to date. Actual coverage will not become effective until the premiums are received by the Fund Office. Failure to make the required premium payments within the initial 45-day period will result in the loss of the COBRA Continuation Coverage.

Remember, if you are short on the hours needed to maintain eligibility under the Plan and you have at least one hour in your Hour Bank you can continue coverage by making short-hour self-payments. If you fail to make a short-hour self-payment, you may elect COBRA. Generally, the short-hour self-pay rate will be less than the COBRA rate.

However, if you are short on hours and have NO hours left in your Hour Bank your only option to continue coverage would be to elect COBRA coverage.

Termination of COBRA Continuation Coverage

COBRA Continuation Coverage will end if any of the following occur:

1. A required self-payment premium for COBRA Continuation Coverage is not made on a timely basis;
2. The Covered Employee or Eligible Dependent becomes covered under another group health plan;
3. The Covered Employee or Eligible Dependent becomes entitled to Medicare;
4. The Fund no longer provides group health care coverage; or
5. The maximum number of months of COBRA Continuation Coverage has been reached, as explained above.
6. With respect to a disabled Covered Person who continues coverage beyond 18 months, the 1st of the month which begins 30 days after the Covered Person is no longer considered disabled by the Social Security office, subject to the 29 month coverage limit.

L. Survivor Benefit

If you have eligible Dependents and you die with hours in your Hour Bank, your Dependents can use the Hour Bank, as described under “Buying Additional Eligibility,” to continue their eligibility, except that self-payments will not be permitted. Further coverage may be purchased as provided under “COBRA Continuation Coverage”.

M. Service in the Armed Forces

Each Covered Employee, whose eligibility “freezes” because of entrance into active duty with the Armed Forces of the United States and who returns to active work with a contributing Employer within the time periods described in Section Two, Subsection N.4. will become eligible under this Plan on the date of commencement of such active work, subject to Uniformed Services Employment and Reemployment Rights Act (USERRA).

If a Covered Employee’s eligibility is frozen because of entry into active duty with the Armed Forces of the United States, any Benefits hereunder with respect to any Eligible Dependent of such Covered Employee on the date of such termination shall be continued in force while such Dependent continues to be an Eligible Dependent but not beyond the end of the Benefit month, subject to USERRA.

N. Uniformed Services Employment and Reemployment Rights Act (USERRA)

The following rules govern your rights under USERRA:

1. Effective Date

The Uniformed Services Employment and Reemployment Rights Act of 1994 was signed into law on October 13, 1994, to protect the eligibility of an Employee and to offer continuation coverage to the Employee and the Employee’s dependents after the Employee enters into Military Service.

2. Return to Work Coverage Guaranteed

USERRA requires an Employer, or a multi-employer health care plan, to protect any health care Benefits an Employee has already earned up to the time an Employee enters Military Service if the Employee re-applies for work within prescribed time periods after an honorable discharge.

The Employee’s eligibility status must be “frozen” when the Employee enters Military Service and must be fully restored when the Employee re-applies for work with the same Employer or, in the case of a multi-employer plan, with any Employer who is signatory to the Collective Bargaining Agreement.

When an Employee returns from Military Service, no exclusion or waiting period may be imposed in connection with the restoration of health care coverage that would not otherwise apply if the Employee had not entered Military Service.

3. Continuation of Coverage While in the Military

USERRA requires a group health care plan to offer identical health care coverage **up to 24 months** to persons who have coverage in connection with their employment but who are absent from such employment due to Military Service. In effect, Military Service is treated as if it is a “qualifying event” for COBRA purposes.

**THE EMPLOYEE MUST NOTIFY THE FUND OFFICE
IMMEDIATELY WHEN THE EMPLOYEE KNOWS
HE/SHE IS ENTERING MILITARY SERVICE.**

If notification of the Fund Office is delayed for several months, the extension of coverage for a maximum of 24 months still begins with the initial date of entry into Military Service and a retroactive payment to that date may be charged. The Employee has an obligation to notify the Fund Office, as soon as the Employee knows he/she is entering Military Service **if the Employee wishes to take advantage of contribution coverage.**

4. Re-employment Requirements when Returning from Military Service

The application period for re-employment is based on a time schedule keyed to the length of time spent in Military Service.

Military Service Less than 31 Days

For Military Service of less than 31 days, a Service member must apply for re-employment with a signatory Employer at the beginning of the next regular scheduled work period on the first day after release from Service, taking into account safe transportation plus an eight hour rest period.

Military Service More than 31 Days but Less than 181 Days

For Military Service of 31 days or more but less than 181 days, an application for re-employment must be filed within 14 calendar days (not work days) after the Service member’s release from the Service.

Military Service Over 181 Days

For Military Service over 181 days, an application for re-employment must be submitted within 90 calendar days (not work days) after an honorable discharge.

5. Definitions

“**Health Coverage**” means Hospital, surgical, medical, dental or vision coverage provided under the Plan. Health Coverage is subject to change as a result of Plan modification.

“USERRA” means the Uniformed Services Employment and Reemployment Rights Act of 1994 (including any amendments to USERRA and any interpretive regulations or rulings).

“Covered Person” means a Covered Employee or Eligible Dependent as defined in Section Twenty of this Plan.

“Service in the Uniformed Services” or “Military Service” 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.

“Uniformed Services” means the United States Armed Forces, the Army National Guard and the Air National Guard when engaged in active duty, active duty 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.

6. Continuation of Group Health Coverage

If Health Coverage ends because of Service in the Uniformed Services, a Covered Person may elect to continue such Health Coverage, if required by USERRA, until the **earlier** of:

- a. The end of the period during which the Covered Employee is eligible to apply for reemployment in accordance with USERRA, or
- b. 24 consecutive months after coverage ended.

To continue coverage, a Covered Person must pay the required premium, unless Service in the Uniformed Service is for fewer than 31 days. The Fund Office shall inform the Covered Person of the procedures to pay premiums. The USERRA premium shall be equal to the COBRA premium.

A Covered Person’s continued Health Coverage under USERRA will end at midnight on the earliest of:

- a. The day the Plan is terminated,
- b. The day a premium is due and unpaid,
- c. The day the Covered Person again becomes covered under the Plan, or
- d. The day the Health Coverage has been continued for the period of time provided above (or any longer period provided in the Plan).

7. Conflict Resolution

In the event of a conflict between this provision and USERRA, the provisions of USERRA shall apply.

Section Three – Life Events at a Glance

There are several significant events that may occur while you are covered under the Plan. Please contact the Fund Office, in writing, if any of the following occurs:

- **YOUR ADDRESS CHANGES.**
- **YOU MARRY, DIVORCE OR OBTAIN A LEGAL SEPARATION FROM YOUR SPOUSE.** You must also submit the appropriate legal documents (for example: marriage certificate, legal separation order, divorce decree, custody agreement).
- **YOU CHANGE YOUR BENEFICIARY.**
- **THE STATUS OF A DEPENDENT CHANGES.**
- **YOU BECOME A PARENT.** You must also submit the child's state-certified birth certificate, decree of adoption or a Qualified Medical Child Support Order.
- **YOU GO INTO OR RETURN FROM MILITARY SERVICE.**
- **YOU BEGIN RECEIVING WORKER'S COMPENSATION BENEFITS.**
- **YOU BECOME ELIGIBLE FOR MEDICARE.**
- **YOU RETIRE.**

Section Four – Medical Benefits

There are separate Sections that describe the Plan's Organ and Tissue Transplant Benefit, Chiropractic Expense Benefit, Speech Therapy Benefit, Vision Expense Benefit, Hearing Aid Benefit, Prescription Drug Benefit, Dental Expense Benefit, Disability Income Benefit and Death and Dismemberment Benefit.

NOT ALL BENEFITS ARE AVAILABLE TO ALL COVERED PERSONS. PLEASE CONSULT THE APPLICABLE SCHEDULE OF BENEFITS TO DETERMINE IF YOU OR YOUR DEPENDENTS ARE ELIGIBLE FOR ANY PARTICULAR BENEFIT.

A. Alcoholism Benefit

When alcoholism causes an Eligible Person to incur expenses for treatment, the Fund will pay Benefits according to the Schedule of Benefits, provided the treatment was provided by either a Hospital, Hospital affiliated facility or state licensed specialized care facility and the patient completes the prescribed treatment program.

The Benefit shall be limited to 31 days per calendar year. This limitation is in combination with the Drug Abuse and Mental/Nervous Conditions Benefits. The Benefit is limited to In-Network providers and treatment costs of \$2,000 per calendar year for treatment in residential or non-residential program.

B. Birth Control Benefit (Prescriptions)

Prescription birth control is covered under the Prescription Drug Benefit.

C. Birth Control Benefit (Sterilization)

If an eligible Employee or dependent spouse incurs expenses for a laparoscopy, vasectomy or tubal ligation, Benefits will be paid in accordance with the Surgical Benefit (Out-Patient). This Benefit has a \$3,000 lifetime maximum.

D. Drug Abuse Benefit

When drug abuse causes an Eligible Person to incur expenses for treatment, the Fund will pay Benefits according to the Schedule of Benefits, provided the treatment was provided by either a Hospital, Hospital affiliated facility or state licensed specialized care facility and the patient completes the prescribed treatment program.

The Benefit shall be limited to 31 In-Patient days per calendar year. This limitation is in combination with the Alcoholism and Mental/Nervous Conditions Benefits. The Benefit is limited to In-Network providers and treatment costs of \$2,000 per calendar year for treatment in residential or non-residential program.

E. Durable Medical Equipment Benefit

The Fund will pay eligible Durable Medical Equipment expenses up to the maximum shown in the Schedule of Benefits as follows:

- Durable Medical Equipment, rental or purchase, if more cost effective, including expenses related to necessary repairs. A statement is required from the prescribing Physician describing how long the equipment is expected to be necessary. This statement will determine whether the equipment will be rented or purchased. Replacement of Durable Medical Equipment, if required due to a change in the patient's physical condition; or, if replacement of Durable Medical Equipment is less expensive than repair of existing equipment. If purchased, payments will be made in monthly installments as determined by the Plan.

Durable Medical Equipment must meet each of the following criteria:

- a. Is certified, in writing, by the prescribing Physician as necessary in the treatment, habilitation or rehabilitation of a patient,
- b. Is clearly related to and necessary for the treatment, habilitation, or training of persons with the specified condition,
- c. Must improve the function of a malformed body member or retard further deterioration of the patient's condition,
- d. Would **NOT** be necessary in the absence of an Sickness or physical or mental disability,
- e. Is primarily and customarily used to serve a medical or rehabilitative purpose rather than primarily for transportation, comfort or convenience. The fact that the equipment or device is also useful for transportation, comfort or convenience will NOT serve as a disqualifying factor,
- f. Is not beyond the appropriate level of performance and quality required under the circumstances (i.e., non-luxury, non-deluxe),
- g. Is appropriate for and intended for use in the home

Examples of Durable Medical Equipment shall include, but shall not be limited to, artificial eyes and limbs to replace lost or natural eyes and/or limbs; oxygen concentrator units and the rental of equipment to administer oxygen, delivery pumps for tube feedings, surgical dressings and bandages, casts, splints, trusses, crutches or braces that stabilize an injured body part, mechanical equipment necessary for the treatment of chronic or acute respiratory failure or conditions and rental, up to the purchase price of a

standard wheelchair, standard Hospital type bed, or an iron lung. Nondurable supplies (i.e. tubing, connectors and masks) are a Covered Expense when used with Covered Durable Medical Equipment. This Plan does not cover maintenance fees (i.e. batteries or warranties) related to Covered Durable Medical Equipment.

Requests for Durable Medical Equipment must be accompanied by a Physician's statement describing the Medical Necessity and length of use. Rental of Durable Medical Equipment is covered up to the purchase price. **Contact the Fund Office before purchasing or renting any of these items to know the cost that will be covered.**

- Prosthetic Devices, including their initial purchase, fitting, necessary adjustments and repairs, which replace all or part of an absent body organ (including contiguous tissue) or replace all or part of the function of a permanently inoperative or malfunctioning body organ or limb. Limit \$10,000 every three years per limb, including purchasing, maintaining and/or servicing such prosthetic device.
- Oxygen and rental of equipment required for its use, not to exceed the purchase price of such equipment.
- Blood and/or plasma, if not replaced, and the equipment for its administration.
- Casts, splints, trusses, crutches, braces or other necessary medical supplies, with the exception of dental braces or corrective shoes.
- Initial placement of contact lenses required because of cataract surgery.
- Orthotics, paid at 50% after deductible with \$350 per person limit per calendar year.

F. Home Health Care Benefit

On occasion, Home Health Care may be needed instead of care from a full-service Hospital. The Plan covers Home Health Care visits according to the Schedule of Benefits. Each Home Health Care visit is comprised of up to four hours of Home Health Care by a member of a Home Health Care team. In order to qualify for Home Health Care, the patient must be under the care of a Physician who submits a "Home Health Care Plan" (a written program for care and Treatment in the patient's home and certification that In-Patient confinement in a Hospital or Skilled Nursing Facility would be required if the home care were not provided).

Covered Expenses include, but are not limited to, charges from a Home Health Care Agency for the following:

- part-time nursing care by or under the supervision of a Nurse;
- part-time home health aide services;
- physical, occupational, respiratory, and speech therapy;
- medical supplies, laboratory charges, etc., Medically Necessary for Treatment.

Eligible Home Health Care services will not include:

- Custodial Care, meals, or nutritional services;
- housekeeping services;
- transportation services;
- care for Alcoholism or Drug Abuse;
- care for the deaf or blind;
- care for senility or mental deficiency or retardation, or Mental/Nervous Disorder.

Benefit Limitations

Maximum visits per Calendar Year60 per person
(one visit = up to four hours)

G. Hospice Benefit

Benefits, on behalf of a Covered Person, for Covered Services for Hospice Care will be paid according to the Schedule of Benefits.

Hospice Benefits will only be paid if the patient's attending Physician certifies, in writing, that the patient is terminally ill and that the patient is expected to die within six months or less.

Allowed charges are:

1. Room and board for confinement in a Hospice,
2. Services and supplies furnished by the Hospice while the patient is confined therein,
3. Part-time nursing care by or under the supervision of a Registered Nurse (RN),

4. Home Health Aide services,
5. Nutrition services,
6. Special meals,
7. Counseling services by a licensed social worker or a licensed pastoral counselor, and
8. Bereavement counseling by a licensed social worker or a licensed pastoral counselor for a patient's immediate family but limited to five visits during a six month period following the patient's death.

Hospice Benefits are NOT payable for:

1. Custodial Care or Services (i.e. room and board or other institutional or nursing services which are provided to or for a Covered Person due to the Covered Person's age, mental or physical condition) mainly to aid the person in daily living, or
2. Medical services to maintain the person's present state of health and which cannot reasonably be expected to improve the Covered Person's medical condition.

Benefit Limitations

Maximum Lifetime Benefit\$25,000 per person

H. Major Medical Benefit

Medical expenses included under the Major Medical Benefit will be payable based on the UCR Charge for Medically Necessary care and services that are ordered and prescribed by a Physician according to the Schedule of Benefits.

Deductible Amount

The In-Network Deductible Amount is \$400 per person or \$800 per family per calendar year. The Out-of-Network Deductible Amount is \$800 per person or \$1,600 per family per calendar year for Expenses Incurred Out-of-Network. The Deductible Amount must be paid by the Employee before any Benefits will be paid and will be applied only once per calendar year.

Benefit Maximums

The Major Medical Benefit has a \$100,000 per person limit for new Participants and their Eligible Dependents for the first 12 months of coverage. This \$100,000 per person limit also applies to any current Participant and Eligible Dependents whose coverage under the Plan has lapsed for a period of 12 consecutive months preceding the eligibility work month.

Once a new Participant has been a Participant for 12 months, the Plan's Major Medical Benefit Lifetime Maximum of \$1,250,000 applies to the Participant and their Eligible Dependents.

Any Benefits used during the first 12 months of coverage (under the \$100,000 per person limit) count toward the Lifetime Maximum Benefit (\$1,250,000 per person).

Out-of-Pocket Maximums

There are individual and family annual Out-of-Pocket Maximums for both In-Network and Out-of-Network care. The In-Network annual Out-of-Pocket Maximums are \$5,000 individual and \$10,000 family. The Out-of-Network annual Out-of-Pocket Maximums are \$10,000 individual and \$20,000 family.

Once a Participant meets an annual Out-of-Pocket Maximum, all Covered Expenses will be paid by the Plan at 100% for the remainder of the calendar year. If an individual maximum is met, all Covered Expenses, either In-Network or Out-of-Network, depending on the maximum met, for the remainder of the calendar year for that individual will be paid by the Plan at 100%. If a family maximum is met, all Covered Expenses, either In-Network or Out-of-Network, depending on the maximum met, for the remainder of the calendar year for the Participant and Eligible Dependents will be paid by the Plan at 100%.

Allowed Charges

Medical expenses included under the Major Medical Benefit will be payable for the following Medically Necessary care and services which are ordered and prescribed by a Physician:

1. Hospital Room and Board Charges for a semi-private room, intensive care unit and for routine nursing services during a confinement. Charges for a private room are Covered Expenses to the extent they exceed the semi-private room only if confinement in a private room is Medically Necessary or the Hospital has only private rooms,
2. Hospital services and supplies during a confinement,
3. The use and administration of anesthesia and oxygen,
4. Physician charges for medical care, treatment and surgical operations,
5. Private duty service of a registered graduate/licensed practical nurse, other than a nurse who ordinarily resides in your household or who is related to the Covered Person,
6. Out-Patient and In-Patient surgery,
7. X-ray (other than dental and vision), microscopic and laboratory tests and other diagnostic services,

8. X-ray radioactive therapy,
9. Prescription drugs and medicine if prescribed by a Physician and dispensed by a licensed pharmacist, while Hospital confined,
10. Administration and cost of blood or blood plasma,
11. Services for cosmetic and reconstructive surgery (a) as a result of an Accident, (b) as a result of a surgical procedure for which Benefits were paid under the Plan, or (c) for reconstruction of the non-diseased breast to produce a symmetrical appearance, or for coverage for prostheses and physical complications of all stages of mastectomy (including lymphedemas) in a manner determined in consultation with the attending Physician and the patient,
12. Treatment of injuries to natural teeth, including replacement of such teeth or for setting of a fractured or dislocated jaw.
13. Speech therapy for rehabilitative purposes for speech lost due to an Accident or illness only.

I. Maternity Benefit

Maternity Benefits include all maternity-related medical services for prenatal care, postnatal care, delivery and any related complications.

MATERNITY BENEFITS ARE PAYABLE UNDER THE MAJOR MEDICAL BENEFIT PROVISION ONLY AND ARE SUBJECT TO THE SAME TERMS, CONDITIONS AND LIMITATIONS GOVERNING THE INDIVIDUAL BENEFITS FOR ANY OTHER SICKNESS OR INJURY UNDER THE PLAN.

Allowed charges are:

1. In-Patient stays of at least 48 hours for the mother and newborn child following a vaginal delivery.
2. In-Patient stays of at least 96 hours for the mother and newborn child following a cesarean section delivery.

If the mother agrees, the attending Physician may discharge the mother and/or the newborn child earlier than these minimum time frames.

Benefit Limitations

Maternity Benefits are **NOT** payable for pregnancy expenses of Eligible Dependent children.

J. Mental/Nervous Conditions Benefit

When a Mental or Nervous Disorder causes an Eligible Person to incur expenses for treatment, the Fund will pay Benefits according to the Schedule of Benefits, provided the treatment was provided by a duly licensed clinical psychiatrist, Board certified psychologist or counselor working under the direct supervision of a psychologist or psychiatrist.

The *In-Patient* Benefit shall be limited to 31 days per calendar year. This limitation is in combination with the Alcoholism and Drug Abuse Benefit. Two days of partial hospitalization equals one In-Patient day. This Benefit is limited to In-Network providers.

The *Out-Patient* Benefit shall be limited to In-Network providers and 50 visits per calendar year. Out-Patient expenses do not apply to Out-of-Pocket Maximum. Benefit will not be paid at 100% once Out-of-Pocket Maximum has been met.

K. Nurse Practitioner Retail Clinic Visit Benefit

Benefits are payable for Covered Expenses at a Nurse Practitioner Retail Clinic according to the Schedule of Benefits. Examples of Nurse Practitioner Retail Clinics include MinuteClinics and Take Care Health Centers.

L. Routine Care/Annual Physicals Benefit

Benefits are payable for preventative services and supplies in a calendar year for the UCR Charges according to the Schedule of Benefits.

Allowed charges are:

1. Lab and x-ray test, including Pap smears and mammograms for females,
2. Immunizations and inoculations, and
3. Other preventative diagnostic tests or procedures ordered by the examining Physician.

Benefit Limitations

Routine Mammogram Limits

Through Age 50 one every two years
 After Age 50 one every year

Maximum Benefit (Calendar Year)\$300 per person

Benefit available for Covered Employee, Retiree and their spouses

Benefits under the Routine Care Benefit are **NOT** payable for:

1. Any examination or service provided for non-routine purposes, or
2. Any treatment of a condition diagnosed as a result of a routine examination.

M. Routine Childcare Benefit (From Birth up to their 15th Birthday)

The Plan will provide coverage for routine childcare, including immunizations and related office visits, for dependents from birth up to their 15th birthday. These charges are not subject to the Plan deductible and coinsurance.

Benefit Limitations

Maximum Benefit (per Calendar Year)\$300 per person

N. Skilled Nursing Facility Benefit

The Fund will pay eligible Skilled Nursing Facility expenses up to the maximum shown in the Schedule of Benefits provided that:

- admission to the Skilled Nursing Facility is within seven days after discharge from the Hospital or Skilled Nursing Facility;
- the In-Patient confinement was for at least three days; and
- the patient's Physician has recommended and certified that 24-hour nursing is required in lieu of hospitalization.

Skilled Nursing Facility stays are considered related unless:

- between stays the patient fully recovered from the Illness or injury that caused the prior stay; or
- the confinements result from completely unrelated causes; or
- if the patient is a Covered Employee under this Plan, he/she returns to work for one full day between stays.

Covered Expenses will include room and board in a semi-private room in an approved Skilled Nursing Facility and miscellaneous services and supplies. In the event of a private room, the Covered Expense will be based upon the facility's average semi-private room charge. The Skilled Nursing Facility treatment is limited to a maximum of 60 days per calendar year and is paid at 50% of a Hospital's average semi-private room rate.

The term "Skilled Nursing Facility" means a facility which is primarily engaged in providing skilled nursing care and other therapeutic services to resident patients incurring room and board charges. The facility must be licensed by the state in which it is located and be an eligible provider of Medicare and Medicaid nursing care services. A Skilled Nursing Facility is not, other than incidentally, a place that provides custodial care, ambulatory care, part-time care, or care or treatment for Mental or Nervous Illness, substance abuse, or pulmonary tuberculosis.

O. Surgery – Second Surgical Opinion Benefit

When a Covered Person wishes to secure a second opinion regarding the Medical Necessity for a surgical procedure of a non-emergency nature, the Plan will pay the Physician's fee at 100% for the second opinion provided:

1. The Covered Person is examined in person by a board certified specialist; and the specialist Physician submits a written report of findings and recommendation, and
2. The specialist Physician who renders the second or third opinion does not also perform or assist in performing the recommended Surgical Procedure, and
3. The specialist Physician has no relationship with the Physician(s) who rendered prior opinions or who performs or assists in the Surgical Procedure.

If surgery is performed after the second opinion, the Fund will pay the surgical fees under the Major Medical Benefit.

Section Five – Organ and Tissue Transplant Benefit

If a Covered Person incurs Allowed Charges through an In-Network Provider related to an Organ or Tissue Transplant, Benefits will be paid according to the Schedule of Benefits.

Benefits available for Human Organ and Tissue Transplants are subject to the following:

- The Employee and Eligible Dependent(s) are eligible for Benefits under the Plan.

Definitions

The following definitions apply to the Organ and Tissue Transplant Benefit:

“Allowed Charges” are:

1. In-Patient and Out-Patient Hospital services,
2. Services of a Physician for diagnosis, treatment and surgery,
3. Diagnostic services,
4. Procurement of an organ or tissue, including services provided to a living donor of an organ or tissue for procurement of an organ or tissue, compatibility testing, procurement expenses, donor’s surgical procedure to remove the organ or tissue, and In-Patient and Out-Patient services,
5. Reasonable and necessary transportation costs for travel (refer to Benefit Limitations below for specific limitations) related to a Covered Transplant Procedure for the transplant recipient and one companion during a Transplant Benefit Period. If the transplant recipient is a minor, transportation costs for two companions will be covered,
6. Rental of Durable Medical Equipment for use outside the Hospital, subject to a limit of the purchase price of such equipment,
7. Prescription drugs, including immunosuppressive drugs,
8. Oxygen,
9. Speech Therapy, Occupational Therapy, Physical Therapy and Chemotherapy,
10. Services and supplies for and related to High Dose Chemotherapy and bone marrow tissue transplantation when provided as part of a treatment plan which includes bone marrow transplantation and High Dose Chemotherapy,
11. Surgical dressing and supplies,
12. Home health care.

“Covered Transplant Procedure” means the following Medically Necessary adult and pediatric human organ and tissue transplants: Bone marrow/peripheral stem cell (including High Dose Chemotherapy, Heart, Heart/Lung, Lung, Liver, Pancreas, Kidney/Pancreas, Small Bowel and Kidney).

Benefit Limitations

Expenses Incurred for nonparticipating transplant facilities are not payable under the Major Medical Benefit.

In addition, reasonable and necessary transportation costs are limited as follows:

In-Network Transplant Provider Subject to Major Medical Deductible and Coinsurance
In-Network Transplant Services Subject to Major Medical Deductible and Coinsurance

Out-of-Network Transplant Provider..... No Coverage
Out-of-Network Transplant Services..... No Coverage

Lodging and Meals per day
per Covered Transplant Procedure..... 90% up to \$200

Maximum Plan Benefit for Transportation, Lodging and Meals
per Covered Transplant Procedure.....\$10,000

Maximum Benefit subject to Major Medical Annual/Lifetime Maximums

Benefits under the Organ and Tissue Transplant Benefit are **NOT** payable for:

1. Services and supplies for treatment of complications related to a Covered Transplant Procedure, unless such complications are determined to be the immediate and direct result of a Covered Transplant Procedure,
2. Animal organ or artificial organ transplants, or
3. Biological and/or Mechanical devices used as a bridge to transplant unless specifically included.

Section Six – Chiropractic Expense Benefit

Benefits for Chiropractic Expense Benefit will be paid according to the Schedule of Benefits if the treatment is performed by a licensed chiropractor.

Chiropractic Expense Benefits are **NOT** payable for:

1. Any treatment by a chiropractor other than manual manipulation to correct subluxation, including (but not limited to) allergy therapy, diet or hair analysis,
2. Any diagnostic x-ray or laboratory procedure other than an x-ray to diagnose subluxation, including (but not limited to) urinalysis or blood chemistry,
3. Nutritional or food supplements and/or vitamins which may be legally obtained without a Physician's prescription,
4. Pillows, supports or similar devices,
5. More than one treatment per day, or
6. Booklets.

Benefit Limitations

Visits are limited to 24 manipulations per Covered Person per Calendar Year. Maximum Benefit is \$20 per manipulation. Benefits for or related to treatment by a chiropractor are subject to the same terms, conditions and limitations governing individual Benefits for any other Sickness or injury.

Section Seven – Speech Therapy Benefit

Benefits for Speech Therapy Benefit will be paid according to the Schedule of Benefits to restore normal speech after an Accident or illness.

Benefit Limitations

Maximum Benefit (Calendar Year)\$1,000 per Person

Section Eight – Vision Expense Benefit

If a Covered Person incurs Allowed Charges for vision care services, the Fund will pay In-Network Benefits according to the Schedule of Benefits.

Allowed Charges

Examination (\$10 Co-Payment, once every 12 months)

Receive a comprehensive eye examination from a licensed optometrist or ophthalmologist covered-in-full after the Co-Payment.

Materials (\$10 Co-Payment)

The materials Co-Payment is a single payment that applies to the entire purchase of eyeglasses (lenses and frames), or contacts in lieu of eyeglasses.

Pair of Lenses (once every 12 months)

If prescribed, one pair of standard single vision or standard multi-focal lenses is covered in full.

Lens Options

Standard scratch-resistant coating is covered-in-full. Lens options not covered by the Plan, such as progressive lenses, polycarbonate lenses, high index, tints, UV, and anti-reflective coating may be available at a discount.

Frames (once every 12 months)

Receive a \$50 wholesale frame allowance applied toward the wholesale purchase price of a frame at private retailers, or \$130 retail frame allowance at retail chain providers.

Contact Lenses (once every 12 months)

(in lieu of eyeglasses)

- Covered-in-full elective contact lenses
Fitting/evaluation fees, contact lenses and up to two follow-up visits are covered-in-full (after Co-Payment). If you choose disposable contact lenses, you may receive up to four boxes of disposable contacts (depending upon prescription).
- All other elective contact lenses
A \$125 allowance is applied toward the fitting/evaluation fees and purchase of contact lenses outside the covered selection (materials Co-Payment does not apply). Toric, gas permeable and bifocal lenses are examples of lenses outside of covered contacts.
- Necessary contact lenses
Covered-in-full after applicable Co-Payment.

Benefit Limitations

Maximum Benefit (Calendar Year) \$500 per family

If a Covered Person incurs Allowed Charges for Out-of-Network vision care services, you will be reimbursed up to the amounts listed:

Allowed Charges

Exam \$40

Lenses

Single vision \$40

Bifocal \$60

Trifocal \$80

Lenticular \$80

Frames \$45

Contact Lenses instead of Lenses and Frames

Elective \$125*

Necessary** \$210

* less any network fitting/evaluation fee

** Necessary contact lenses are determined at the provider's discretion for one or more of the following conditions: following cataract surgery without intraocular lens implant; to correct extreme vision problems that cannot be corrected with spectacle lenses, with certain conditions of keratoconus. If your provider considers your contacts necessary, you should ask them to contact the vision provider concerning the level of reimbursement that you will receive before you make the purchase.

If you visit an Out-of-Network provider, you will need to send your itemized receipts, Participant's identifier number and the patient's name and date of birth to:

UnitedHealthcare Specialty Benefits Claims Department
P.O. Box 30978
Salt Lake City, UT 84130

Receipts for services and materials purchased on different dates must be submitted at the same time to receive reimbursement. Receipts must be received by the Claims Department within 12 months of service.

If you have questions regarding the status of your eye care provider, please contact UnitedHealthcare Specialty Benefits at (800) 638-3120 or www.spectera.com.

Section Nine – Hearing Aid Benefit

If a Covered Person incurs Allowed Charges for hearing services, the Fund will pay Benefits according to the Schedule of Benefits.

Definitions

The following definitions apply to the Hearing Aid Benefit:

“**Allowed Charges**” are limited to hearing aids.

Benefit Limitations

Maximum Benefit (Calendar Year)\$700 per person

Section Ten – Prescription Drug Benefit

With this Benefit, eligible Employees and Retirees will receive two prescription drug cards. A card should be presented at a participating pharmacy with each prescription drug purchase. The cards will permit eligible Employees and Retirees and their Eligible Dependents to purchase prescription drugs at a discounted price. You will only pay the required Co-Payment when you make a purchase with the card. The Fund will pay the remaining cost.

A. Retail and Mail Order

This Benefit includes both retail pharmacies and a mail order service. A prescription filled at a retail pharmacy can provide medication for no more than 34 days per Co-Payment. A prescription filled through the mail order service can provide your medication for 90 days per Co-Payment.

B. First Dollar Coverage

You do not have to satisfy the annual individual or family deductibles in order to have a prescription covered by the Fund. As long as you are eligible and you are making your purchase at a participating pharmacy, then your purchase will be covered according to the Formulary and Co-Payment schedules.

C. Co-Payments

There are four levels of Co-Payments. What you pay will depend upon the type of prescription drug you are purchasing and where it is being purchased (retail or mail order). The Co-Payment levels are:

Formulary Level - Drug Type	Retail (up to 34-day supply)	Mail Order (up to 90-day supply)
Level 1 – Generic	\$10	\$25
Level 2 – Formulary Brand Name (no generic available)	<u>Greater</u> of \$25 or 25% of cost of drug	<u>Greater</u> of \$60 or 20% of cost of drug
Level 3 – Preferred Brand Name (when generic is available)	Fund will only pay what it would have paid for the medically-equivalent generic	Fund will only pay what it would have paid for the medically-equivalent generic
Level 4 – Non-Formulary Brand Name	<u>Greater</u> of \$40 or 40% of cost of drug	<u>Greater</u> of \$100 or 35% of cost of drug

Maximum Retail and Mail Order Out-of-Pocket\$5,000 per person
per Calendar Year

D. Formulary Choice Guide

Some brand name drugs are very expensive and are no more effective than other medications that have a lower price. Generic drugs are often available that are chemically equal to a brand name drug. In other situations, two brand name drugs are available that treat the same condition. One may be significantly more expensive than the other. The Prescription Drug Benefit will not tell you which medication you should purchase. That is left to you and your Physician. The Benefit will hopefully encourage you to make the most cost effective purchase that is consistent with your medical needs.

You will receive a listing of the Preferred brand name drugs called a Formulary Choice Guide. You will find that most drugs require the Level 2 Co-Payment. If a brand name drug is prescribed and a medically equivalent generic is available, then the Level 3 Co-Payment will apply. For Level 3 drugs, the Fund will pay only what it would have paid for the generic equivalent and you will be responsible for the difference. If a brand name drug is not part of the formulary it will be considered a non-preferred brand name drug and will require a Level 4 Co-Payment.

If you have any questions regarding the Prescription Drug Benefit or have any problems with a purchase at a participating pharmacy, please contact the Prescription Benefit Manager (PBM) listed on the Contact Information page at the beginning of this Booklet.

E. Specialty Drugs

In addition to mail order and retail prescriptions, the Plan's PBM maintains a specialty pharmacy to handle all specialty drugs.

Specialty Drugs include all injectable prescription drugs, with the exception of insulin and any others found under specific exclusions within this Benefit or within Section Fourteen – Benefit Exclusions and Limitations on page 60.

Your first prescription may be filled at any pharmacy. The pharmacy will notify the Plan's PBM of the prescription and you will be contacted directly. The Plan's PBM will arrange for any subsequent refills to be handled by mail order.

If you have any questions regarding specialty drugs, the specialty drug pharmacy, prescription coverage or the specialty pharmacy process, you may contact the PBM listed on the Contact Information page at the beginning of this Booklet.

Your Co-Payment levels for Specialty Drugs are as follows:

Formulary Level – Drug Type	Up to 34-day supply
Level 1 – Generic	\$10
Level 2 – Formulary Brand Name (no generic available)	<u>Greater</u> of \$25 or 25% of cost of drug
Level 3 – Preferred Brand Name (when generic is available)	Fund will only pay what it would have paid for the medically-equivalent generic
Level 4 – Non-Formulary Brand Name	<u>Greater</u> of \$40 or 40% of cost of drug

F. Prescription Exclusions

Benefits are **not** available under your Plan for the following items:

- Over-the-counter (OTC) medications, including non-prescription vitamins or dietary or nutritional supplements;
- Over-the-counter Equivalent drugs – defined as prescription drugs with equivalent products also available OTC. These products are identical in active chemical ingredient, dosage form, strength and route of administration;
- Any drugs classified by the FDA as experimental or investigative (or which otherwise would not have been approved for use by the FDA), and including prescription medications determined to be “less than effective” by the Drug Efficacy Study Implementation Program (DESI);
- Drugs or other prescription products used for the treatment of fertility/infertility or sexual dysfunction;
- Home medical equipment or devices of any type including, but not limited to, contraceptive devices, diabetic supplies, ostomy supplies, therapeutic devices, or artificial appliances;
- Cosmetic drugs and products, including, but not limited to health or beauty aids, topical Minoxidil (Rogaine), Botox, or Renova;
- Tretinoin products (e.g. Retin A) will be available up to age 21. After age 21, this product will require prior authorization.;
- All smoking cessation products;
- Growth Hormone medications or other similar biopharmaceuticals; and
- Allergens.

G. Contact Information

If you have questions or need help determining if a pharmacy is an in-network provider for the Plan’s PBM or if you have questions regarding drug formulary, you will need to call, write or visit their website. Their contact information can be found on your drug card. If you do not have your card, their contact information can be found on the Contact Information page at the beginning of this Booklet.

H. Prescription Claim Appeals

For Appeals Process refer to Section Fifteen – Claims and Appeal Procedures on page 66. Further questions should be directed to the Fund Office at (816) 756-3313 or toll-free at (866) 756-3313.

I. Medicare Part D Coverage

ATTENTION RETIREES AGE 65 AND OLDER: Any Medicare-eligible Participant or Eligible Dependent covered by this Plan who also enrolls in the Medicare Part D coverage will lose his/her prescription drug coverage under this Plan (but not their medical coverage). The Fund Office will be reporting to Medicare the names of the individuals that are covered by this Plan. The Fund Office, in turn, will be advised by Medicare if duplication of coverage occurs.

If your prescription drug coverage under this Plan is terminated because you enroll in the Medicare Part D coverage, you will only have an opportunity to have your prescription drug coverage reinstated under this Plan one time each year – effective the following January 1. Between November 15 and December 31 of each year, you will have an opportunity to enroll (or re-enroll) in the Medicare Part D coverage for the coming calendar year. For example: If you decide to enroll in the Medicare Part D coverage for 2008, you must keep your Part D prescription coverage for one year. Between November 15 and December 31 of 2008, you will have an opportunity to decide on your coverage for 2009. You can re-enroll in the Medicare Part D coverage or you can return to this Plan for coverage (provided that you have continued your medical coverage under this Plan and that you continue to pay all of your monthly self-pay premiums on a timely basis).

Section Eleven – Dental Expense Benefit

If a Covered Person incurs Dental Expenses for dental services, the Fund will pay Benefits according to the Schedule of Benefits.

Definitions

The following definitions apply to the Dental Expense Benefit:

“Dental Expense” means the part of a charge for dental services which meets **all** of the following:

1. Is covered under the Dental Expense Benefit, and
2. Does not exceed the Prevailing Fee for the service, and
3. Is incurred while the patient is eligible for the Dental Expense Benefit.

“Dental Hygienist” means a duly licensed dental hygienist who works under the supervision of a Dentist.

“Dentist” means a duly licensed dentist or Physician who is operating within the scope of a dentist’s or Physician’s license.

“Prevailing Fee” means a charge for Dental Expense which does not exceed the 90th percentile of the Plan’s prevailing health care data.

Benefit Limitations

The Dental Expense Benefit will be limited to a \$1,000 per person per Calendar Year maximum.

Section Twelve – Disability Income Benefit

Covered Employees Only

If a Covered Employee becomes totally and continuously disabled due to accidental bodily injury or Sickness, the Plan will pay the Weekly Disability Benefit for which the Covered Employee is eligible as shown in the Schedule of Benefits.

Benefits will commence on the first day of disability caused by an injury. For a disability caused by Sickness, Benefits will commence on the earlier of the first day of Hospital confinement or the eighth calendar day of disability. Benefits will be payable at \$200 a week for weeks 1-13 and \$100 a week for weeks 14-26 during continuance of total disability during any 12 month period. However, the Covered Employee will not be eligible for this Benefit during any period that the Covered Employee is receiving unemployment income or disability benefits from the Social Security Administration. You must inform the Trustees if you begin receiving unemployment income or disability benefits at any time that you are receiving this Benefit. Furthermore, you will be responsible to repay to the Fund any monies received under this Benefit while also receiving unemployment income or disability benefits.

The Trustees reserve the right to determine, based on evidence presented to them, whether or not a Covered Employee is totally disabled, and may have the Employee examined by a Physician of their choosing in order to verify a claim of initial disability or to verify a claim of continuing disability.

- A. For a continuous disability, the Physician must complete one claim form per month.
- B. No Weekly Income Benefit will be paid on account of Sickness or injury:
 - 1. For or in connection with an injury arising out of, or in the course of, any employment for wage or profit, except that Weekly Disability Benefits are payable for disability absences during which an Employee is totally disabled as a result of an accidental bodily injury or Sickness or disease for which an Employee is not eligible for any benefits under any Workmen's Compensation law or similar statute; or
 - 2. For that portion of a period of disability during which an Employee is not under the care and treatment of a Physician; or
 - 3. For retired members who are on pension income and/or social security; or
 - 4. For Injuries sustained while participating in or as a consequence of having participated in a riot, or the commission of an assault or felony.

In accordance with federal law, the appropriate amount of Social Security taxes (FICA) will be withheld from each payment and forwarded to the appropriate governmental agency. In addition, you will have the right to request that a certain amount of each payment be withheld and forwarded to the Internal Revenue Service in order to satisfy your potential federal tax liability.

For each full week that you receive Worker's Compensation benefits or Weekly Disability Benefits under the Plan (up to the maximum 12 weeks), your Hour Bank will be credited with 30 hours – if you submit satisfactory written proof of the existence of a qualifying disability to the Fund Office (a Physician's statement will be considered satisfactory proof). There is no cash supplement for Worker's Compensation claims.

No Weekly Disability Benefits shall be paid on behalf of an Eligible Dependent, a retired or disabled individual or a widow or widower.

Section Thirteen – Death and Dismemberment Benefits
Covered Employees Only

Your Beneficiary will receive the full amount of your life insurance if you die from any cause.

Life Insurance\$15,000

When bodily injury to a Covered Employee caused solely by an Accident shall result in any of the following losses, the Plan will pay the Benefit stated in the Schedule of Benefits and in the table below.

<u>Loss</u>	<u>Amount</u>
Both Hands or Both Feet.....	\$ 5,000
Entire Sight of Both Eyes	\$ 5,000
One Hand and One Foot.....	\$ 5,000
One Hand or One Foot and Entire Sight of One Eye.....	\$ 5,000
One Hand or One Foot	\$ 2,500
Entire Sight of One Eye	\$ 2,500

Definition

The following definition applies to the Death and Dismemberment Benefit:

“**Loss**” with reference to the hand or foot means complete severance through or above wrist or ankle joint, and with reference to the eye means the irrevocable loss of the entire sight thereof. In the event of multiple losses, Benefits will be paid for the greatest loss sustained as a result of any one Accident.

Benefit Limitations

Benefits will **NOT** be paid for any loss caused by:

1. Injuries suffered during combat, war or act of war or as a result of terrorism,
2. Injuries which were intentionally self-inflicted,
3. Aircraft, except when the eligible Employee is a passenger in a licensed aircraft (other than chartered aircraft) operated by a licensed pilot on a regularly scheduled passenger flight offered between specified airports by a licensed passenger carrier,
4. Disease, or
5. Any expense resulting from an injury or illness which arises out of, or in the course and scope of employment.

Section Fourteen – Benefit Exclusions and Limitations

The Plan provides Benefits only for those Medically Necessary covered services and charges expressly described in the Plan. **Any omission of service or charge shall be presumed to be an exclusion even though not expressly stated as such.**

IF YOU ARE UNSURE WHETHER A MEDICAL SERVICE OR PROCEDURE IS EXCLUDED, PLEASE CONTACT THE FUND OFFICE FOR CLARIFICATION. FAILURE TO DO SO COULD RESULT IN YOU BEING RESPONSIBLE FOR ANY NON-COVERED OR EXCLUDED CHARGES YOU INCUR.

Benefits **WILL NOT** be paid for or shall be limited as follows:

1. Services and supplies or days of care which are not Medically Necessary for the diagnosis or treatment of an injury, Sickness or symptomatic complaint. The fact that a Physician may prescribe, order, recommend or approve a service or supply does not, of itself, make it Medically Necessary or make the charge a Covered Expense, even though the service or supply is not specifically listed as an exclusion. The final determination of Medical Necessity remains with the Trustees.
2. Loss caused by accidental bodily injury or Sickness which arises out of or occurs in the course of any occupation or employment for wage or profit; or any accidental bodily injury or Sickness for which the Covered Employee is entitled to any benefits under any worker's compensation or occupational disease law. The Fund retains the option to withhold Benefits for any injury which may be questionable or compensable under a worker's compensation or occupational disease law, until such time as the Covered Employee shows that such Employee has made reasonable efforts to exhaust a claim for benefits under a worker's compensation or occupational disease law.
3. Services and supplies for which the individual is not legally required to pay for or which no charge would be made if this coverage did not exist.
4. Hospital, medical or surgical treatment provided or any Expense Incurred because of loss suffered in war, whether declared or undeclared, or while in Military Service or the result of a terrorist act in a foreign country.
5. Hospital, medical or surgical treatment provided in a foreign country unless cash was paid and a claim for services at the time of service was submitted.
6. Visual analysis, eye examination or the correction of vision, eyeglasses, therapy or training for muscular imbalance of the eye, or fitting of glasses or orthotics, except as stipulated under the Vision Expense Benefit in the Plan.

7. Expenses related to treatment or services for Accident or Sickness rendered prior to the Covered Person's becoming eligible for Benefits or after losing eligibility for Benefits.
8. Any Expense Incurred for obesity or morbid obesity such as weight reduction programs, drugs, surgical and nonsurgical treatments and procedures, including bariatric surgery, gastric bypass, gastric banding, open or laporoscopic vertical banded gastroplasty, laporoscopic adjustable gastric banding (Lap-Band system), or any other such procedure, as well as cosmetic or other surgery for removal of excess fat or skin following weight loss, pregnancy or surgery, regardless of Medical Necessity or supervision by a Physician. Complications from any excluded expenses are also excluded.
9. Services or supplies related to complications from a non-covered service or supply.
10. Expenses or charges in connection with dental work, dental surgery, or oral surgery except as covered under the Dental Benefit including:
 - Treatment involving any tooth structure, alveolar process, abscess or disease of the periodontal or gingival tissue; or
 - surgery or splinting to adjust dental occlusion.
11. Alternative Treatments as defined by the Office of Alternative Medicine of the National Institutes of Health. Examples of some treatments not covered are acupuncture, aromatherapy, hypnotism, massage therapy and rolfing.
12. Treatment for Mental or Nervous Disorders or for behavioral, conduct and impulse control disorders, except as provided in the Schedule of Benefits.
13. Services for cosmetic and reconstructive surgery except: (a) to repair damage caused by or as a result of an Accident, (b) as a result of a surgical procedure for which Benefits were paid under the Plan, (c) to repair a Medically Necessary congenital defect, or (d) for reconstruction of the non-diseased breast to produce a symmetrical appearance, or for coverage for prostheses and physical complications of all stages of mastectomy (including lymphedemas) in a manner determined in consultation with the attending Physician and the patient.
14. Expenses Incurred for the diagnosis or treatment of fertility or infertility or the promotion of fertility including, but not limited to, fertility tests and procedures, reversal of surgical sterilization, fertility treatments, artificial insemination, in vitro fertilization, gamete intrafallopian transfer (GIFT) procedures, zygote intrafallopian transfer (ZIFT) procedures, penile prosthesis and any related prescription medication treatment.

15. Services or supplies that are not prescribed by a Physician, or Licensed Nurse Practitioner.
16. Charges for alcohol or drug addiction, treatment or rehabilitation, except as provided in the Schedule of Benefits.
17. Hospital, medical or surgical treatment provided for or by the U.S. Government or any agency thereof. Services available at government expense, except if payment is required by state or federal law, the obligation to provide Benefits will be reduced by the amount of payments a Covered Person is eligible for under such program (except Medicaid); or for persons entitled to Medicare Part A and eligible for Part B benefits, the obligation to provide Benefits will be reduced by the amount of payment or benefits such person receives from Medicare. This provision will not apply if the Employee is still actively at work and has elected this Contract as primary. Services provided for renal dialysis and kidney transplant Services will be provided pursuant to federal law.
18. Maternity or obstetrical services for a dependent child in connection with pregnancy or resulting complications.
19. Except as provided under the Vision Expense Benefit, services for or related to any surgical, laser or non-surgical procedures or alterations of the refractive character of the cornea for correction of myopia and/or astigmatism, including radial keratotomy.
20. Expenses Incurred for treatment of temporomandibular joint disorder (TMJ) unless the procedure is determined to be Medically Necessary, appropriate and effective for the treatment of the patient's conditions:
 - a. Bony or cartilaginous tumor of the mandibular condyle;
 - b. Hypomobility and ankylosis;
 - c. Persistent dislocation; or
 - d. Radiographically demonstrable arthropathic changes in the temporomandibular joint, with intractable pain.
21. Expenses Incurred for Chiropractic care in excess of \$20 per visit for first 24 visits per Calendar Year, and all Chiropractic care expenses incurred for visits in excess of 24 visits per Calendar Year.
22. Expenses for treatment incurred as a result of a self-inflicted injury, Sickness or suicide attempt, unless such injury or Sickness results from a medical condition. A medical condition includes both physical and mental health conditions.

23. Charges in excess of Usual, Customary and Reasonable Charges.
24. Any expense or charge for services or supplies which:
 - a. Are for devices, treatments or procedures not authorized for payment under Medicare or for prescription drugs not approved by the FDA.
 - b. Result from or relate to the application or use of such drugs, devices, treatments or procedures.
25. Any service furnished by an institution which is primarily a place of rest, a place for the aged, a nursing home, a convalescent home or any institution of like character or for convalescent or custodial services.
26. Routine foot care procedures such as the trimming of nails, corns or calluses, fallen arches or other symptomatic complaints of the feet, impression casts for prosthetics and appliances, including prescriptions for orthotics, unless deemed Medically Necessary.
27. Services and supplies, including tests and check-up examinations that are not Medically Necessary for the care of a diagnosed Sickness or injury.
28. Sex transformations and sexual dysfunction, except as otherwise specifically provided for under the Prescription Drug Expense Benefit.
29. Services or supplies related to sexual dysfunction, including but not limited to prescription drugs, such as Viagra, Levitra, Cialis, etc., except as provided under the Prescription Drug Benefit.
30. Services provided by an audiologist when not performed in connection with a Sickness, hearing aids and other devices to improve hearing and their related fittings, except as provided in the Schedule of Benefits.
31. Rehabilitation therapy for an injury, unless performed by a licensed physiotherapist, subject to Trustee approval according to a complete plan of treatment provided to the Fund Office by the referring Physician.
32. Loss suffered for which a contributing cause was the Covered Person's commission of or attempt to commit an illegal act (including but not limited to driving under the influence of alcohol or drugs and contests of speed) or the Covered Person's engaging in an illegal occupation.
33. No payments will be made for any treatment or service in connection with an elective abortion. Many doctors refer to miscarriages at less than twelve weeks as "spontaneous abortions".

34. Charges for personal care items that are primarily for personal comfort or convenience, including, but not limited to, diapers, bathtub grabbers, handrails, lift chairs, over-bed tables, incontinence pads, ramps, snug seats, recreational items, home improvements and home appliances, spas, wigs and braces for sports.
35. Charges for motor driven wheelchairs or scooters, implantable spinal column stimulator, ThAIRapy vests or non-standard equipment of any type. Any equipment that does not meet the covered Durable Medical Equipment criteria on page 36 is NOT a covered Benefit. Any nondurable supplies related to equipment that is not covered will also not be a covered Benefit.
36. Genetic or chromosomal testing, counseling or therapy.
37. Treatment of hair loss including wigs, toupees, hairpieces, hair implants or transplants and drugs to treat hair loss.
38. Expenses Incurred for Home Health Care, except as provided under Major Medical Benefit on page 40.
39. Expenses Incurred for non-prescription contraceptives and related supplies.
40. Enteral feedings and other nutritional and electrolyte supplements, including infant formula, donor breast milk, nutritional supplements, dietary supplements, electrolyte supplements, diets for weight control or treatment of obesity (including liquid diets or food), food of any kind (diabetic, low fat, cholesterol), oral vitamins, and oral minerals.
41. Physical conditioning programs such as athletic training, bodybuilding, exercise fitness, flexibility, and diversion or general motivation.
42. Growth hormone medications and similar biopharmaceuticals.
43. For more detailed exclusion information regarding Prescription Drug Coverage refer to Section Ten – Prescription Drug Benefit on page 52 or you may call your Pharmacy Benefit Manager as noted in Section Ten.
44. Expenses unnecessary for diagnosis of an Illness or injury, except as specified.
45. Expenses for preparing medical reports, itemized bills or Benefit request forms.
46. Expenses for missed appointments or telephone calls.
47. Professional services performed by a person who ordinarily resides in the Covered Person's household or is related to the Covered Person, such as a spouse, parent, child, brother, sister, or in-law.

48. Educational, vocational or training services and supplies.
49. Travel expenses of a Physician or a Covered Person.
50. Treatment or services rendered outside the continental United States of America or its territories except for an accidental injury or a Medical Emergency; or covering U.S. citizens on temporary or permanent assignment outside of the United States and who do not qualify for socialized medical coverage in their country of residence.
51. Personal comfort or service items while confined in a Hospital, such as but not limited to radio, television, telephone, and guest meals.
52. Expenses for education, counseling, job training or care for learning disorders or behavioral problems, whether or not services are rendered in a facility that also provides medical and/or Mental/Nervous Treatment.
53. Adoption expenses.
54. Surrogate expenses.
55. Marital, family or sex counseling.
56. Equipment such as air conditioners, air purifiers, dehumidifiers, heating pads, hot water bottles, water beds, swimming pools, hot tubs, and any other clothing or equipment which could be used in the absence of an Illness or injury.
57. Hearing Aid Benefits, except as provided in the Schedule of Benefits.
58. Any Speech Therapy Benefit other than rehabilitative services for speech lost due to an Accident or illness.

Section Fifteen – Claims Appeal Procedures

The following procedures to process claims and appeals will apply to any claim filed with the District Council #3 Painters and Allied Trades Welfare Fund (Fund). These procedures have been adopted to comply with regulations issued by the U.S. Department of Labor, at 29 CFR 2560.503-1.

The Board of Trustees is both the Plan Administrator and the fiduciary responsible for all Benefit determinations on appeal. The Board of Trustees may delegate all fiduciary responsibility for claims determination to an Appeal Committee. Such Appeal Committee shall meet once each calendar quarter at regularly scheduled times.

The Board of Trustees or Committee shall have the authority to interpret, construe and apply all terms of the Summary Plan Description and Plan Document, the Agreement and Declaration of Trust and/or any rules and regulations established by the Trustees including, but not limited to, provisions concerning eligibility for, entitlement to and/or nature, amount and duration of Benefits, in making an initial Benefit determination and a determination on appeal.

A Claim should be filed within 90 days after the loss occurs, or as soon as reasonably possible, but not later than one year after the service has been provided, in order to be eligible for payment. Claims filed later than that date may be declined or reduced unless it is not reasonably possible to submit the Claim in that time.

A. Definitions

1. Medical Claim:

A Medical Claim for Benefits is:

A written or Health Insurance Portability and Accountability Act (HIPAA) compliant electronic post-service request for payment of Benefits from the Fund:

- a. Made by a Claimant;
- b. Received by the Fund Office or applicable PPO within one year of the date of service; and
- c. Includes all of the following:
 - Participant's Name;
 - ID #;
 - Address;
 - Patient Name/Date of Birth/Relationship to Participant;
 - Claimant authorization to Pay/or not;

- ICD-9 diagnosis code;
- Date of Service;
- Place of Service;
- CPT procedure codes; Charges;
- Provider federal ID number/Name and Address;
- Patient account number.

A claim is not:

- A verbal inquiry about whether a specific service is a covered Benefit;
 - A voluntary pre-service determination of whether a treatment, service or product is covered;
 - An inquiry regarding eligibility to receive a treatment, service or product. However, after service is incurred, a determination of eligibility will be made by the Fund.
 - An attempt to purchase or receive a prescription drug at the counter. However, any denial of such purchase or receipt entitles the Claimant to file a claim after the denial.
2. Disability Claim: A Disability Claim is a claim for weekly Disability Income Benefits or Hour Bank credits, described in Section Twelve, Disability Income Benefit, on page 57.
3. Claimant: A Claimant is:
- An eligible Participant in the Plan;
 - An eligible Participant's Eligible Dependent, as described in Section Twenty, Definitions, page 97; or
 - The duly appointed Authorized Representative of an eligible Participant, or eligible Participant's Eligible Dependent, as described below.
4. A Medical Claim shall be filed when a health care provider submits a Medical Claim directly to the appropriate PPO.
5. Authorized Representative: An Authorized Representative, for the purpose of this Section, is a person who is specially designated by the Claimant. In order to designate an Authorized Representative, the Claimant must present to the Fund Office a written statement designating an Authorized Representative. The statement must include:
- The name, telephone number, and mailing address of the Authorized Representative;
 - The name, mailing address, date of birth, and social security number of the Claimant;

- A statement describing the claim(s)/appeal(s) for which the designated person has authority to act on behalf of the Claimant; and
- The signature of the eligible Participant or, in the case of an eligible Participant's Eligible Dependent, the individual or a minor child's parent or legal guardian.

The Board of Trustees has the sole discretion to determine whether a Claimant has properly designated an Authorized Representative.

Assigning a health care provider the right to receive benefits does not make the provider an Authorized Representative or a Claimant. Any individual wishing to designate a health care provider as an Authorized Representative must provide the Fund Office with a separate written statement designating the provider as such. For your convenience, a "Designation of Authorized Representative" form is available at the Fund Office.

If a Claimant has designated an Authorized Representative, the Authorized Representative will receive all information and notifications, and will be authorized to act on behalf of the Claimant, with respect to all aspects of the claim. This includes, but is not limited to, the initial determination, requests for documents, appeals, and any other communication regarding the claim. The authorization will remain in effect unless or until the Claimant provides the Fund Office with written notification that restricts or cancels the authorization.

Post-Service Claims

"Post-Service Claim" is any Claim for Benefit that **does not require** pre-approval prior to obtaining medical services and payment is being requested for medical care already rendered to the Claimant.

The Claims Administrator shall notify the Claimant (in writing or electronically) of the Benefit determination as soon as possible, but not later than 30 days after receipt. The prescribed timeframe may be extended by the Claims Administrator for up to 15 days, provided that the Claims Administrator determines that such an extension is necessary due to matters beyond the control of the Claims Administrator and notifies the Claimant, prior to expiration of the initial 30 day period, of the circumstances requiring the extension of time and the date by which the Claims Administrator expects to render a decision.

If the Claim is incomplete, the Claims Administrator shall notify the Claimant (in writing or electronically) as soon as possible, but not later than 30 days after receipt, of the specific information necessary to complete the Claim. The Claimant shall have 45 days to provide the specified information necessary to complete the Claim submission. If the Claimant fails to submit the missing information to complete the Claim, the Claim will be denied. The Claims Administrator's time limit for making a determination shall be

suspended from the time that it provides notice to the Claimant of the incomplete Claim until the earlier of: the date on which the Claimant submits the missing information, or the end of the time provided by the Claims Administrator to supply the additional information.

All claims must be submitted in writing or electronically, in compliance with HIPAA. Verbal inquiries regarding eligibility or coverage are not claims.

Days, for purposes of computing any time period under this Section, Claims Appeals Procedures shall mean calendar days.

B. Time Periods for Initial Determination

1. Medical Claims

The Fund shall make its initial Benefit determination within 30 days. The Fund may extend this initial Benefit determination period 15 days. The Fund shall notify the Claimant within the first 30 days, if an extension will apply. If additional information is needed to process the claim, the Fund will give the Claimant 45 days to provide this additional information. The initial Benefit determination period will be suspended until the earlier of receipt of the information or the end of the 45-day period. The request for additional information may include notice to the Claimant that the claim is denied, in whole or in part, if the requested information is not provided within the 45-day period. Additional information must also be provided to the Claim Administrator, although providing this information is not a requirement for the Claim to be deemed as filed. **If the Claim Administrator requests additional information, the failure to submit the information within the proper time guidelines will result in denial of the Claim.** This additional information includes, but is not limited to:

- Accident date and details;
- verification of Dependent eligibility;
- full-time student verification;
- coordination of benefit information, i.e., if another plan is the primary payer, a copy of their explanation of benefits (EOB); or
- subrogation agreement.

Any adjustment or subsequent Claim payment (e.g., PPO pricing, Medicare, payment error, etc.) will be considered part of the original Claim.

2. Disability Claims

The Fund shall make its initial Benefit determination within 45 days. The Fund may extend this initial Benefit determination up to two times of 30 days each. The Fund shall notify the Claimant if an extension will apply before the end of each previous determination deadline. If additional information is needed to process the claim, the Fund will give the Claimant 45 days to provide this additional information. The initial Benefit determination period is suspended until the earlier of receipt of the information or the end of the 45-day period. The request for additional information may include notice to the Claimant that the claim is denied, in whole or in part, if the requested information is not provided within the 45-day period.

C. Notice of Initial Determination

The Fund shall issue a written or HIPAA electronic notice of Benefit determination, which may be a denial of Benefits, that is an adverse Benefit determination. This notice is also called an explanation of benefits, or EOB. This notice shall contain:

- The specific reason or reasons for the adverse determination;
- Reference to the specific Benefit provisions on which the determination is based;
- A description of any additional material or information necessary for the Claimant to perfect the claim and an explanation of why such material or information is necessary;
- A description of the Fund's review procedures and the time limits applicable to such procedures, including a statement of the Claimant's right to bring a civil action under Section 502(a) of ERISA following an adverse Benefit determination on review;
- If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion shall be provided to the Claimant; or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to the Claimant upon request; or
- If the adverse Benefit determination is based on a Medical Necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Claimant's medical circumstances shall be provided to the Claimant, or a statement that such explanation will be provided free of charge upon request.

D. Time Periods for Appeals – Medical and Disability Claims

A request for review (an appeal) must be submitted in writing to the Fund Office no later than 180 days after the Claimant's receipt of the Notice of adverse Benefit determination. The Board of Trustees may delegate to an Appeal Committee the authority to make all Benefit determinations on appeal. The Fund shall issue a Benefit determination on appeal no later than the next regularly scheduled quarterly meeting of the Appeal Committee of the Board of Trustees. Except that if the appeal is received by the Fund less than 30 days before the next quarterly Appeal Committee meeting, a Benefit determination on appeal shall be made no later than the second quarterly committee meeting after receipt of the appeal. In addition, if due to circumstances beyond the control of the Fund a decision cannot be made, the Fund may extend the period to make a determination until the next quarterly meeting. If a hearing is requested by the Claimant, a Benefit determination shall be made no later than the third Appeal Committee meeting after receipt of the appeal.

The Fund shall issue its decision no later than five days following the Benefit determination.

E. Notice of Determination on Appeal

The Fund shall issue a determination of an appeal in accordance with the following timeframes:

Post-Service Claims

The Claims Administrator shall review the Claim and notify the Claimant of the Benefit determination as soon as possible, but no later than 30 days after the Claims Administrator receives the request for review of the adverse Benefit determination.

All Claims

If, for any reason, the Claimant does not receive a written response within the time periods mentioned above, the Claimant may assume that the appeal has been denied.

F. Claimant's Rights on Appeal

1. As stated above, the Claimant shall have at least 180 days following receipt of a notification of an adverse Benefit determination within which to appeal the determination.
2. The review on appeal shall not give deference to the initial adverse Benefit determination and shall be conducted by an appropriate named fiduciary of the Fund who is neither the individual who made the adverse Benefit determination that is the subject of the appeal, nor the subordinate of such individual.

3. In deciding an appeal of any adverse Benefit determination that is based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is experimental, investigational, or not Medically Necessary or appropriate, the appropriate named fiduciary shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment.
4. The Fund shall provide to the Claimant the identification of any medical or vocational experts whose advice was obtained on behalf of the Fund in connection with the Claimant's adverse Benefit determination, without regard to whether the advice was relied upon in making the Benefit determination.
5. The appeal review process shall provide that the health care professional engaged for purposes of a consultation under paragraph 3 of this Section shall be an individual who is neither an individual who was consulted in connection with the adverse Benefit determination that is the subject of the appeal, nor the subordinate of any such individual.
6. The written decision of the Appeal Committee shall be final, binding and conclusive upon the Claimant.
7. All review procedures described above must be followed and exhausted before a Claimant may institute any legal action including an action or proceedings before any court, administrative agency or arbitrator (legal body). Generally, such legal bodies require a Claimant to follow and exhaust the Fund's review procedures before allowing a Claimant's legal action to proceed. If a Claimant files a legal action before following and exhausting the Fund's review procedures, this may result in a negative ruling by the relevant legal body and impair or cause the loss of the right to bring any further legal action.

G. Content of Notice of Benefit Determination on Appeal

The Plan Administrator shall provide a Claimant with written or electronic notification of the Fund's Benefit determination on review. Any electronic notification shall comply with the standards imposed by law. In the case of an adverse Benefit determination, the notification shall set forth, in a manner calculated to be understood by the Claimant –

1. The specific reason or reasons for the adverse determination.
2. Reference to the specific Benefit provisions on which the Benefit determination is based.

3. A statement that the Claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claimant's claim for Benefits.
4. If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion shall be provided to the Claimant; or a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge to the Claimant upon request.
5. If the adverse Benefit determination is based on a Medical Necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Fund to the Claimant's medical circumstances shall be provided to the Claimant, or a statement that such explanation will be provided free of charge upon request.
6. A statement of the Claimant's right to bring a civil action under Section 502(a) of ERISA.

H. Hearing Procedure

The Board of Trustees establishes the following procedures for hearings:

1. The Claimant and/or duly Authorized Representative shall be afforded an opportunity to appear before the Appeal Committee and shall have the right and opportunity to examine witnesses, produce documents and other evidence material to the claim.
2. The proceeding of the hearing shall be preserved by means of tape recordings, stenographic or court reporter's records.
3. In conducting the hearing, the Appeal Committee shall not be bound by the usual common law or statutory rules of evidence.
4. The Claimant or Authorized Representative shall have the right to review the tape recording of the hearing, obtain a reproduced copy thereof and obtain a copy of all documents and records introduced or referred to. The cost of copies or documents shall be 25¢ per page. The tape recording will be furnished for the actual cost of the tape cassette.
5. There shall be copies made of all documents and records introduced at the hearing, and the copies shall be attached to the record of the hearing and made a part thereof. Instead of attaching copies of the documents and

records, reference may be made to them on the tape recording, and the tape recording and the copies shall be retained on the Claimant's file.

6. All information upon which the Appeal Committee bases its decision shall be disclosed to the Claimant or Authorized Representative at the hearing or in a written decision.

Section Sixteen – Use and Disclosure of Protected Health Information

- A. This Section of the Plan is effective April 14, 2003, is adopted to effect compliance with the Health Insurance Portability and Accountability Act of 1996 and the Regulations issued hereunder by the Secretary of Health & Human Services concerning the privacy of protected health information (together referred to herein as The Privacy Rule). The Privacy Rule is incorporated herein by reference.
- B. All capitalized terms have the meaning as stated in this combination Plan Document and Summary Plan Description or The Privacy Rule.
- C. This Section establishes the required and permitted uses and disclosures of Protected Health Information (PHI) by the Plan Sponsor, which is the Board of Trustees. The Board of Trustees is the Plan Administrator under the Employee Retirement Income Security Act of 1974 (ERISA).
- D. PHI may be used by and disclosed to the Board of Trustees or individual Trustees for purposes of general administration of the Plan, as follows:
 - 1. Underwriting and budgeting;
 - 2. Claims review and processing;
 - 3. Amending or modifying the Plan of Benefits (plan design);
 - 4. Claims assistance;
 - 5. Eligibility review;
 - 6. Any and all general administration of the Plan.
- E. PHI may be disclosed to the Board of Trustees, or individual Trustees as authorized by an individual.
- F. The District Council #3 Painters and Allied Trades Welfare Fund shall make reasonable efforts to limit disclosure and use of PHI to the Board of Trustees to the minimum necessary to accomplish the intended use or disclosure.
- G. The Board of Trustees:
 - 1. Shall not use or further disclose PHI other than as permitted or required by this Plan Document or as required by law.
 - 2. Shall comply with verification procedures of the group health Plan.

3. Shall ensure adequate separation between the group health Plan and the Plan Sponsor as follows:
 - a. Describe those employees or classes of employees or other persons under the control of the Plan Sponsor to be given access to the PHI to be disclosed, provided that any employee or person who receives PHI relating to treatment, payment under, health care operations of, or other matters pertaining to the group health Plan in the ordinary course of business must be included in such description. The Employees or class of Employees of workforce members under the control of the Plan Sponsor who may be given access to individuals' PHI received from the Plan or from a health insurance issuer, HMO, PPO, etc., as applicable, servicing the Plan are:
 - i. Plan Administrator
 - ii. Third Party Administrator/Claims Administrator
 - iii. Claims Supervisors, Processors and clerical staff
 - iv. Information Technology Personnel.
 - b. Restrict the access to and use by such employees and other persons described in paragraph (G)(3)(a) of this Section to the Plan administration functions that the Plan Sponsor performs for the group health Plan; and
 - c. Provide an effective mechanism for resolving any issues of noncompliance by persons described in paragraph (G)(3)(a) of this Section with the Plan Document provisions required by this paragraph.
4. Shall not use or disclose PHI for employment related decisions.
5. Ensure that any agents, including a subcontractor, to whom the Plan Sponsor provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such information.
6. Not use or disclose the information in connection with any other benefit or employee benefit plan of the Plan Sponsor unless authorized by the individual or pursuant to a Business Associate contract.

7. Report to the Plan any use or disclosure of the information that is inconsistent with the allowed uses or disclosures of which it becomes aware.
 8. Make PHI available to the Plan when the Plan is requested by an individual to gain access to PHI in accordance with the access requirements of HIPAA.
 9. Make PHI available to the Plan when the Plan is requested by an individual for amendment and incorporate any amendments to PHI in accordance with HIPAA.
 10. Make available to the Plan the information required to provide an accounting of disclosures.
 11. Make internal practices, books and records relating to the use and disclosure of PHI received from the group health Plan available to the Secretary of HHS for the purposes of determining compliance by the Plan with HIPAA.
 12. Return or destroy all PHI received from the Plan that the Plan Sponsor maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made. If return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction infeasible.
 13. Each Trustee shall certify compliance with the Privacy Rule and the Privacy Policy of the District Council # 3 Painters and Allied Trades Welfare Fund.
- H. This provision of Section Sixteen of the Plan concerning security of electronic PHI is effective April 20, 2005 and is adopted to further comply with The Security Rule, which is incorporated herein by reference. The Board of Trustees shall:
1. Implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of electronic PHI that it creates, receives, maintains or transmits on behalf of the Plan.
 2. Ensure that the adequate separation discussed above in Paragraph G, subparagraph 3, specific to electronic PHI, is supported by reasonable and appropriate security measures.

3. Ensure that any agent, including a subcontractor, to whom it provides electronic PHI agrees to implement reasonable and appropriate security measures to protect the electronic PHI.
4. Report to the Plan any security incident of which it becomes aware concerning electronic PHI.

The terms electronic protected health information, electronic PHI and e-PHI, as used in the Plan, mean protected health information that is transmitted by or that is maintained in an electronic media, including but not limited to: magnetic tape, computer hard drive, computer disks, CDs, CD-ROM, flash memory devices, backup tapes or disks, etc.

Section Seventeen – Administrative Information

The following topics are discussed under this Section on Administrative Information:

-
- | | |
|-------------------------------------|--|
| A. Coordination of Benefits | G. Termination of Plan |
| B. Determination of Benefits | H. Right to Release or Request Information |
| C. Employer Rights to Contributions | I. Subrogation of Benefits |
| D. Encumbrance of Benefits | J. Physical Examination and Autopsy |
| E. Facility of Payment | K. Right of Recovery |
| F. Reciprocity and Portability | |
-

A. Coordination of Benefits

The following rules govern the Coordination of Benefits:

1. Applicability

This Coordination of Benefits (COB) provision applies to This Plan when a Participant or a Participant's Eligible Dependent has health care coverage under more than one plan. "This Plan" and "Another Plan" are defined below.

If this COB provision applies, the Order of Benefit Determination Rules, in Number 3 below should be looked at first. Those rules determine whether the Benefits of This Plan are determined before or after those of Another Plan. The Benefits of This Plan:

- a. Will not be reduced when, under the Order of Benefit Determination Rules, This Plan determines its Benefits before Another Plan; but
- b. May be reduced when, under the Order of Benefits Determination Rules, Another Plan determines its benefits first. The above reduction is described in Subsection 4, "Effect on the Benefits of This Plan".

2. Definitions

- a. **"Allowable Expense"** means a Medically Necessary, reasonable and customary item of expense for health care when the item of expense is covered at least in part by one or more plans covering the person for whom the claim is made.

The difference between the cost of a private Hospital room will not be considered an Allowable Expense under the above definition unless the patient's stay in a private Hospital room is Medically Necessary either in terms of generally accepted medical practice, or as specifically defined in This Plan.

When a plan provides benefits in the form of services, the reasonable cash value of each service rendered will be considered both an Allowable Expense and a benefit paid.

When Benefits are reduced under a Primary Plan because a Covered Person does not comply with the plan provisions, the amount of such reduction will not be considered an Allowable Expense. Examples of such provisions are those related to second surgical opinions, precertification of admissions or services and preferred provider arrangements.

- b. **“Another Plan”** is any of the following which provides benefits or services for, or because of, medical or dental care or treatment that is not District Council # 3 Painters and Allied Trades Welfare Fund:
 - i. Group insurance or group-type coverage, whether insured or uninsured. This includes prepayment, group practice or individual practice coverage. It also includes coverage other than school accident-type coverage.
 - ii. Coverage under a governmental plan, or coverage required or provided by law. This does not include a state plan under Medicaid (Title XIX, Grants to States for Medical Assistance Programs, of the United States Social Security Act, as amended from time to time).

Each contract or other arrangement for coverage under i. or ii. above is a separate plan. Also, if an arrangement has two parts and COB rules apply only to one of the two, each of the parts is a separate plan.

- c. **“Claim Determination Period”** means a calendar year. However it does not include any part of a year during which a person has no coverage under This Plan, or any part of a year before the date this COB provision or a similar provision takes effect.
- d. **“Primary Plan/Secondary Plan”** is determined using The Order of Benefit Determination Rules.

When This Plan is a Primary Plan, its Benefits will be determined before those of Another Plan and without considering Another Plan’s benefits.

When This Plan is a Secondary Plan, its Benefits will be determined after those of Another Plan and may be reduced because of Another Plan's benefits.

When there are more than two plans covering the person, This Plan may be a Primary Plan as to one or more other plans, and may be a Secondary Plan as to a different plan or plans.

- e. **“This Plan”** is the District Council # 3 Painters and Allied Trades Welfare Fund.

3. Order of Benefit Determination Rules

- a. General

When there is a basis for a claim under This Plan and Another Plan, This Plan shall be Secondary Plan which has its Benefit determined after those of Another Plan, unless:

- i. The other Plan has rules coordinating its benefits with those of This Plan; and
- ii. Both those rules and This Plan's rules, in Subsection b. below, require that This Plan's Benefits be determined before those of the other plan.

- b. Rules

This Plan shall determine its order of Benefits using the **first** of the following rules that apply:

- i. Non-Dependent/Dependent

The benefits of the plan which covers the person as an employee, member or subscriber (that is, other than as a dependent) shall be determined before those of the plan which covers the person as a dependent; except that: if the person is also a Medicare beneficiary, and as a result of the rule established by Title XVII of the Social Security Act and implementing regulations, Medicare is Secondary to the plan covering the person as a dependent and Primary to the plan covering the person as other than a dependent (e.g. a retired employee), then the benefits of the plan covering the person as a dependent are determined before those of the plan covering that person as other than a dependent.

- ii. Dependent Child/Parents not Separated or Divorced

Except as stated in Paragraph iii. below, when This Plan and Another Plan cover the same child as a dependent of different

persons, called “parents”, the benefits of the plan of the parent whose birthday (month and day) falls earlier in a year shall be determined before those of the plan of the parent whose birthday (month and day) falls later in that year. But if both parents have the same birthday (month and day), the benefits of the plan which covered one parent longer will be determined before those of the plan which covered the other parent for a shorter period of time.

However, if the other plan does not have the rule described in this Paragraph ii., but instead has a rule based upon the gender of the parent, and if, as a result, the plans do not agree on the order of benefits, the rule in the other plan will determine the order of benefits.

iii. Dependent Child/Separated or Divorced

If two or more plans cover a person as a dependent child of divorced or separated parents, benefits for the child shall be determined in this order:

- (a) First, the plan of the parent with custody of the child;
- (b) Then, the plan of the spouse of the parent with the custody of the child; and
- (c) Finally, the plan of the parent not having custody of the child.

However, if the specific terms of a court decree state that one of the parents is responsible for the health care expense of the child, and the entity obligated to pay or provide the benefits of the plan of that parent has actual knowledge of those terms, the benefits of that plan shall be determined first. The plan of the other parent shall be the Secondary Plan. This Paragraph does not apply with respect to any Claim Determination Period or Plan Year during which any benefits are actually paid or provided before the entity has that actual knowledge.

iv. Joint Custody

If the specific terms of a court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the plans covering the child shall follow the order of benefit determination rules outlined in Paragraph ii. above.

v. Active/Inactive Employee

The benefits of a plan which covers a person as an employee who is neither laid off nor retired shall be determined before those of a plan which covers that person as a laid off or retired employee. The same is true if a person is a dependent of a person covered as a Retiree and an employee. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule will be ignored.

vi. Continuation Coverage

If a person whose coverage is provided under a right of continuation pursuant to federal or state law also is covered under Another Plan, the following will be the order of benefit determination:

(a) First, the benefits of a plan covering the person as an employee, member or subscriber (or as that person's dependent);

(b) Second, the benefits under the continuation coverage.

If the other plan does not have the rule described above, and if, as a result, the plans do not agree on the order of benefits, this rule will be ignored.

vii. Longer/Shorter Length of Coverage

If none of the above rules determines the order of benefits, the benefits of the plan which covered the employee, member or subscriber longer will be determined before those of the Plan which covered that person for the shorter term.

4. Effect on the Benefits of this Plan

The following rules govern the effect on the Benefits of these COB rules:

a. When this Section Applies

This Subsection 4 applies when, in accordance with Subsection 3 "Order of Benefits Determination Rules", This Plan is a Secondary Plan as to one or more other plans. In that event the Benefits of This Plan may be reduced under this Subsection. Such other plan or plans are referred to as "Another Plan" in Subsection b., ii., immediately below.

b. Reduction in This Plan's Benefits

The Benefits of This Plan will be reduced when the sum of:

i. The Benefits that would be payable for the Allowable Expense under This Plan in the absence of this COB provision, and

- ii. The benefits that would be payable for the Allowable Expenses under Another Plan, in the absence of provisions with a purpose like that of this COB provision, whether or not claim is made; exceeds those Allowable Expenses in a Claim Determination Period.

In that case, the Benefits of This Plan will be reduced so that they and the benefits payable under Another Plan do not total more than those Allowable Expenses.

When the Benefits of This Plan are reduced as described above, each Benefit is reduced in proportion. It is then charged against any applicable Benefit limit of This Plan.

c. Right to Receive and Release Needed Information

Certain facts are needed to apply these COB rules. This Plan has the right to decide which facts it needs. To the extent allowed under law, This Plan may get needed facts from or give them to any other organization or person. This Plan need not inform or get the consent of any person to do this, unless required to do so by law. Each person claiming Benefits under This Plan must give any facts This Plan needs to pay the claim.

d. Facility of Payment

A payment made under Another Plan may include an amount which should have been paid under This Plan. If it does, This Plan may pay that amount to the organization which made that payment. That amount will then be treated as though it were a Benefit paid under This Plan. This Plan will not have to pay that amount again. The term “payment made” includes providing Benefits in the form of services, in which case “payment made” means reasonable cash value of the Benefits provided in the form of services.

e. Right of Recovery

If the amount of the payments made by This Plan is more than it should have paid under this COB provision, This Plan may recover the excess from one or more of:

- i. The persons it has paid or for whom it had paid,
- ii. Insurance companies, or
- iii. Other organizations.

The “amount of the payments made” includes the reasonable cash value of any Benefits provided in the form of services.

B. Determination of Benefits

The Trustees have full authority and sole discretion to make determinations of entitlements to and amounts of Benefits. Subject to the right of appeal, the determination shall be final and binding upon all parties claiming Benefits under the Plan.

C. Employer Rights to Contributions

Except in the case of mistaken contributions, the Employers shall have no right, title or interest in the contributions made by them to the Fund and no part of the Fund shall revert to the Employers in the event of a termination of the Fund.

D. Encumbrance of Benefits

No monies, property or equity of any nature whatsoever in the Fund, policies, Benefits or monies payable therefrom, shall be subject in any manner by a Covered Person or person claiming through a Covered Person, to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance, garnishment, mortgage, lien or charge and any attempt to cause any Benefit to be subject thereto shall be null and void; provided however, that Benefits may be assigned by the Covered Person or Beneficiary to the health care provider who furnished the services or supplies for which a Benefit is payable.

E. Facility of Payment

Whenever payments which should have been made under This Plan in accordance herewith have been made under any other plans, the Trustees have the right, exercisable alone and in their sole discretion, to pay to the other organization making such payments any amounts which they determine to be warranted in order to satisfy the intent of this provision. Any amounts paid shall be deemed to be Benefits paid under this Plan and the Trustees shall be fully discharged from any future liability.

F. Reciprocity and Portability

The Trustees may enter into or amend portability or reciprocity agreements with other welfare funds.

G. Termination of Plan

The Benefits provided under this Plan are NOT vested benefits and the Trustees have the authority to terminate any Benefit, including Retiree Benefits, or the entire Plan, at any time.

In the event of termination of the Plan, the Trustees shall apply the Fund to pay or provide the payment of any and all obligations of the Fund and shall distribute and apply any remaining surplus in such manner as will, in their opinion, best effectuate the purposes of the Fund. No part of the corpus or income of the Fund will be used for or diverted to purposes other than for the expenses of the Fund or for other payments in accordance with the provisions of the Fund. Under no circumstances will any portion of the corpus or income of the Fund, directly or indirectly, revert to or accrue to the benefit of the Employers, the Association or the Union.

H. Right to Release or Request Information

For the purpose of determining the applicability and implementing the Coordination of Benefits and/or Subrogation provisions or any similar provisions in other plans, to the extent allowed by law, the Trustees may, without the consent of or notice to any person, release to or obtain from any insurance company or other organization or person, any information with respect to any person which the Trustees deem necessary for such purposes. In so acting the Trustees shall be free from any liability that may arise in relation to such action. Any person claiming Benefits under this Plan must furnish such information as the Trustees may reasonably deem necessary in order to implement this provision.

THE TRUSTEES WILL HAVE NO OBLIGATION TO FURNISH ANY BENEFIT UNDER THE PLAN UNTIL ALL ADDITIONAL INFORMATION REQUESTED HAS BEEN RECEIVED.

I. Subrogation of Benefits

In the event the Fund provides Benefits for injury, illness or other loss (hereinafter the “injury”) to any Covered Person, the Fund is subrogated to all rights of recovery to any funds or monies that person, his or her spouse, dependents, parents, heirs, guardians, conservators, next friend, executors, assigns, personal representative or other representatives (individually and collectively called the “Covered Person”) may have arising out of said injury, illness or other loss. Said recovery will not be limited by characterization of loss and will include recovery for personal injury, lost wages, loss of service, disability and claims for wrongful death, survivor or other claims under any state or federal law. The Fund is not limited or bound by any judgment or settlement that apportions recovery among the various elements of damage. The Fund is entitled to first dollar from any recovery regardless of whether the Covered Person is made whole by said recovery. The Fund is entitled to assert a lien against third parties, insurers, attorneys and other appropriate persons or entities in order to protect its right of subrogation.

The Fund’s subrogation rights include, without limitation, priority to first dollar from any settlement or judgment and all rights of recovery of a Covered Person to any payments made by or on behalf of a responsible person including but not limited to, a recovery:

1. Against any person, insurer or other entity that is in any way responsible for providing compensation, indemnification or benefits for the injury;
2. From any fund, or policy of insurance or accident benefit plan providing No Fault, Personal Injury Protection (PIP) or financial responsibility insurance or coverage;

3. Under uninsured or underinsured motorist insurance;
4. Under motor vehicle medical payment insurance; and
5. Under specific risk accident and health coverage or insurance, including without limitation premises or homeowners medical payments insurance or athletic or sports “school” or “team” coverage or insurance.

The Covered Person, or if a minor, the Covered Person’s parent or legal guardian, conservator or next friend shall execute and deliver such documents and papers (including, but not limited to a Benefits Questionnaire, Subrogation Agreement and Authorization to Release Medical Information) to the Fund as the Fund may require. The Covered Person will do whatever else is necessary to protect the rights of the Fund, including allowing the intervention by the Trustees or Fund or the joinder of the Trustees or Fund in any claim or action against the responsible party or parties.

The Fund Trustees are vested with full discretionary authority to determine eligibility for Benefits, to construe subrogation and other Plan provisions and to reduce or compromise the amount of the Fund’s recoverable interest where, in the sole discretion of the Trustees, circumstances warrant such action. No settlement, however, is binding on the Fund without the Fund’s written approval thereof, and the Fund expressly reserves the right to collect the entire amount of its subrogation interest in all cases. The amount of the Fund’s subrogation interest will be deducted first from any recovery from any entity or source by or on behalf of the Covered Person regardless of any common fund or make-whole doctrines. The amount payable to the Fund, pursuant to the subrogation right, will not be reduced pursuant to the application of any common fund doctrine, any make-whole doctrine and/or any other common law/state law doctrine purporting to reduce the amount of the Fund’s recovery.

The Fund reserves the right to initiate an action in the name of the Covered Person or his or her guardian, conservator or next friend to recover its subrogation interest, and the Covered Person or his or her guardian, conservator or next friend will cooperate fully with the Fund in such instances.

In the event of any failure or refusal by the Covered Person: (1) to execute the Subrogation Agreement or any other document requested by the Fund, or (2) to take any other action requested by the Fund to protect the interest of the Fund, the Fund may withhold payment of the Benefits or deduct the amount of any payments made from future claims of the Covered Person.

The Covered Person will not do any act or engage in any negotiations that would reduce, compromise or prejudice the Fund’s rights to first recovery from any third party. In the event the Covered Person recovers any amount by settlement or judgment from any person, corporation, insurance carrier, governmental agency or

other responsible party: (1) the Fund will be repaid in an amount equal to the full amount of Benefits paid by the Fund; and (2) no further Benefits for treatment or services related to the injury leading to the settlement or recovery will be paid by the Fund. If the Covered Person refuses or fails to repay such amount, or otherwise interferes with the Fund's right to subrogation, the amount of the Fund's claim is deemed to be held in constructive trust, and the Fund will be entitled to seek restitution, impose a constructive trust or seek any other legal or equitable remedies available (including recovery of the Fund's attorneys' fees and costs) by instituting legal action against the Covered Person or other party. In addition, the Fund reserves the right to offset and/or deduct any amounts paid as Benefits against future claims submitted by the Participant and his or her dependents.

The Fund will not pay or be held responsible for any portion of the Covered Person's legal fees or expenses related to any recovery whether by settlement or judgment. The Fund reserves the right to first dollar from any recovery to the full amount of Benefits paid by Fund and hereby claims a first lien against the proceeds of any settlement or judgment and priority over any claim or lien of legal counsel, insurers or any other third party. The Covered Person will provide all of the above referenced individuals with notice of the Fund's first right of subrogation. However, the Trustees may, in their discretion, agree to share legal fees and expenses with the Covered Person or his/her guardian, conservator or next friend, provided any such agreement is established in writing.

If the Covered Person, or his/her guardian, conservator or next friend does not attempt a recovery of the Benefits paid by the Fund or for which the Fund may be obligated, the Fund is entitled to institute legal action against the responsible party or parties in the name of the Fund or Trustees in order that the Fund may recover all amounts paid to or on behalf of the Covered Person.

In an action brought by the Fund, the reasonable cost of recovery, including Fund's attorneys' fees, will first be deducted from any recovery by judgment or settlement against the responsible party or parties. The Fund's subrogation interest, to the full extent of Benefits paid or due as a result of the occurrence causing the injury or illness, will next be deducted with the balance paid to the Covered Person.

J. Physical Examination and Autopsy

The Fund shall have the right and opportunity to examine the person with respect to whom Benefits are claimed when and so often as they may reasonably require during pendency of claim hereunder, and also the right and opportunity to make an autopsy in case of death where it is not forbidden by law.

K. Right of Recovery

If the Plan makes inadvertent, mistaken or excessive payment of Benefits, the Trustees or their representative shall have the right to recover such types of overpayments.

Section Eighteen – Your Rights Under Federal Law

READ THIS SECTION CAREFULLY. This is the only way to ensure that you have the information you need to protect your rights and your best interests under this Plan.

Your ERISA Rights as a Participant

In 1974, Congress passed and the President signed the Employee Retirement Income Security Act, commonly referred to as ERISA. As a Participant of the District Council #3 Painters and Allied Trades Welfare Fund you are entitled to certain rights and protections under ERISA. ERISA provides that all Plan Participants shall be entitled to:

A. **Receive Information About Your Plan and Benefits**

Examine, without charge, at the Plan administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts and Collective Bargaining Agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain, upon written request to the Plan administrator, copies of documents governing the operation of the Plan, including insurance contracts and Collective Bargaining Agreements, and copies of the latest annual report (Form 5500 Series) and updated Summary Plan Description. The administrator may make a reasonable charge for the copies.

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

Be informed that under the Health Insurance Portability and Accountability Act (HIPAA), the Plan must provide you with a "Certificate of Creditable Coverage" if you lose health care coverage under the Plan for any reason. This Certificate reports data on prior periods of health coverage under the Plan compiled in accordance with federal regulations. Participants should retain this "Certificate of Creditable Coverage" and submit it to a new Employer if the new Employer maintains a group health care Plan. The new Employer may be required under federal law to credit such coverage toward any waiting period for coverage of pre-existing conditions under the new employer's plan.

Be informed that the Plan is in compliance with the non-discrimination requirements set forth in Section 2590.701-2 of the DOL's HIPAA regulations. These regulations state that a group health care plan may NOT establish Eligibility Rules based on any of the following factors: (1) health status; (2) medical condition (including both physical and mental illness); (3) prior claims experience; (4) actual receipt of health care; (5) medical history; (6) genetic

information; (7) evidence of insurability (including conditions arising out of domestic violence); or, (8) disability.

Be informed that under the Newborns' and Mothers' Health Protection Act, group health plans and health insurance issuers offering group health insurance coverage generally may NOT restrict Benefits for any Hospital stay in connection with childbirth for the mother or newborn child to less than 48 hours following vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the Plan, or issuer, may pay for a shorter stay if the attending provider (e.g., your Physician, nurse midwife, or Physician assistant), after consultation with the mother, discharges the mother or newborn earlier. Under federal law, plans and issuers may not set the level of Benefits or out-of-pocket costs so that any later portion of the 48 hour or 96 hour stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay. In addition, a plan or issuer may not, under federal law, require that a Physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours or 96 hours, as applicable.

Be informed that under the Women's Health and Cancer Rights Act, group health plans and health insurance issuers offering group health insurance coverage that includes medical and surgical Benefits with respect to mastectomies shall include medical and surgical Benefits for breast reconstructive surgery as part of a mastectomy procedure. Breast reconstructive surgery Benefits in connection with a mastectomy shall at a minimum provide coverage for: (1) reconstruction of the breast on which the mastectomy has been performed; (2) surgery and reconstruction of the other breast to produce a symmetrical appearance; (3) prostheses; and, (4) physical complications for all stages of mastectomy, including lymphedemas. Such surgery shall be in a manner determined in consultation with the attending Physician and the patient. As part of the Plan's Schedule of Benefits, such Benefits are subject to the Plan's appropriate cost control provisions, such as deductibles and coinsurance.

B. Continue Group Health Plan Coverage

Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this Summary Plan Description and the documents governing the Plan on the rules governing your COBRA Continuation Coverage rights.

Exclusionary periods of coverage for Pre-Existing Conditions under the Plan may be reduced or eliminated if you have creditable coverage from another plan. You should be provided a Certificate of Creditable Coverage, free of charge, from this Plan (or any other group health plan), or health insurance issuer when you lose coverage under the Plan, when you become entitled to elect COBRA Continuation Coverage, when your COBRA Continuation Coverage ceases, if you request it before losing coverage, or if you request it up

to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a Pre-Existing Condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

C. Prudent Actions by Plan Fiduciaries

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

D. 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 administrator. If you have a claim for Benefits which is denied or ignored, in whole or in part, you may file suit in a State or Federal court. In addition, if you disagree with the Plan’s decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court. If it should happen that Plan fiduciaries misuse the Plan’s money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

However, all review and appeal procedures described in the Plan usually must be followed and exhausted before a Claimant may institute any legal action including any action or proceedings before any court, administrative agency or arbitrator (“legal bodies”). Generally, such legal bodies require a Claimant to follow and exhaust the Fund’s review procedures before allowing a Claimant’s legal action to proceed. If a Claimant files a legal action before following and exhausting the Fund’s review procedures, this may result in a negative ruling by

the relevant legal body and impair or cause the loss of the right to bring any further legal action.

E. Assistance with Your Questions

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

Section Nineteen – Other Important Information

One of the main goals of the Employee Retirement Income Security Act of 1974 (ERISA) is expanded reporting and disclosure of benefit plan operations and provisions, that is, reporting to the Department of Labor, Internal Revenue Service and to the Plan Participants and Beneficiaries.

It is the intention of the Trustees to comply with all aspects of ERISA. Thus the required information in this Section has been reported to the appropriate federal agencies and is hereby “disclosed” to you.

A. **Administration of Plan**

The Plan is administered by a joint Board of Trustees, one-half of whom are appointed by the Union and one-half of whom are appointed by the Association. The Trustees have hired a contract administrative manager to perform the day-to-day operations of the Plan, such as maintaining records, making Benefit payments and handling general administrative matters. The contract administrative manager is:

Wilson-McShane Corp.
3100 Broadway, Suite 805
Kansas City, Missouri 64111
(816) 756-3313
(866) 756-3313 (toll-free)
www.iupatdc3funds.com

The names and addresses of each Trustee are listed on page 1.

B. **Employer Identification Number**

The Employer Identification Number assigned to the Plan by the Internal Revenue Service is 43-0817513.

C. **Funding Medium for the Accumulation of Plan Assets**

All contributions and investment earnings of the Plan are accumulated in a Trust Fund which is utilized to pay Benefits to eligible individuals and to defray reasonable costs of administration.

D. **Name of Plan**

The full legal name of the Plan is the District Council #3 Painters and Allied Trades Welfare Fund.

E. **Plan Advisors**

Fund Attorney (Person to Receive Service of Legal Process)
Linda N. Winter
Arnold, Newbold, Winter & Jackson, P.C.
1125 Grand Boulevard, Suite 1600
Kansas City, Missouri 64106-2503

Service may also be made on any Plan Trustee or Plan Administrator.

Plan Consultant and Plan Actuary
United Actuarial Services, Inc.
11590 North Meridian Street, Suite 610
Carmel, Indiana 46032-4529

- F. Plan Fiscal Year
October 1 of each year and ends on September 30 of the following year.
- G. Plan Number
The Plan Number is 501.
- H. Plan Year
October 1 of each year and ends on September 30 of the following year.
- I. Sources of Contributions
This Plan is funded through contributions by the Employers on behalf of their Employees, under the terms of a Collective Bargaining Agreement, and by investment income earned on a portion of the Fund's assets. In some cases, a Covered Person will be entitled to make self-payments in order to maintain eligibility for Benefits.
- J. Type of Plan
This Plan provides hospitalization, medical, disability, death, accidental death and dismemberment, maternity, dental, vision and other related health care Benefits. It is maintained pursuant to a Collective Bargaining Agreement between the Union and the Association which is available for examination at the Fund Office. A copy of the agreement may be obtained upon written request to the Fund Office. Upon request, the Fund Office will also inform you if a particular employer or union participates in the Plan and, if so, the address of that employer or union.
- K. Amendment
The Trustees reserve the right to amend, modify or terminate this Plan as circumstances dictate.

Section Twenty – Definitions

THE FOLLOWING WORDS HAVE SPECIFIC MEANINGS WHEN USED IN THE PLAN. IT IS IMPORTANT TO UNDERSTAND THE MEANINGS OF THESE DEFINED TERMS WHILE USING THIS BOOKLET.

A. Accident	P. Medically Necessary or Medical Necessity
B. Association	Q. Nurse Practitioner
C. Beneficiary	R. Mental or Nervous Disorder
D. Benefits	S. Participant
E. Collective Bargaining Agreement	T. Physician
F. Covered Employee	U. Plan
G. Covered Employment	V. Pre-Existing Condition
H. Covered Expense	W. Retiree
I. Covered Person	X. Room and Board Charge
J. Eligible Dependent	Y. Sickness
K. Employee	Z. Trust Agreement
L. Employer	AA. Trustees or Board of Trustees
M. Expense Incurred	BB. Union
N. Hospice	CC. Usual, Customary and Reasonable Charge (UCR Charge)
O. Hospital	

A. Accident
The term *Accident* means a physical injury, such as a cut, break, sprain or bruise, occurring from an unexpected, undesirable and unavoidable act. This does NOT include overuse of muscles resulting in strains or aching arms and legs.

B. Association
The term *Association* means The Builders' Association.

C. Beneficiary
The term *Beneficiary* means a person designated by an Employee or by the terms of the Plan of Benefits established pursuant to the Trust Agreement who is, or who may become, entitled to receive any type of Benefit from the Fund.

When a Benefit is payable to a Beneficiary, it will be paid to the Employee-designated Beneficiary on file at the Fund Office. In the event the Employee fails to designate a Beneficiary or if the designated Beneficiary dies before the Employee, the Benefit shall be payable to the first of the following, if living:

1. To the legal spouse, or
2. If no legal spouse is living, to the living children in equal shares, or
3. If no legal spouse or children are living, to the living parents in equal shares, or
4. If no legal spouse, children or parents are living, to the living brothers and sisters in equal shares, or
5. If none of the above are living, to the Employee's estate.

The Employee may designate a new Beneficiary at any time by filing a **written** request with the Fund Office.

D. Benefits

The term *Benefits* means the Welfare Benefits to be provided pursuant to the Plan together with any amendments, modifications or interpretations adopted by the Board of Trustees.

E. Collective Bargaining Agreement

The term *Collective Bargaining Agreement* means the labor agreement between the Union and the Association and any other Employer, group of Employers or association of Employers.

F. Covered Employee

The term *Covered Employee* means an Employee for whom Payments are made to the Fund as provided by a Collective Bargaining Agreement or other written agreement approved by the Trustees and who is covered according to the provisions set forth under the Eligibility Rules.

G. Covered Employment

The term *Covered Employment* means the work that the Covered Employee performs for an Employer on a job covered by a written agreement approved by the Trustees and in the jurisdiction of District Council No. 3 Painters and Allied Trades.

H. Covered Expense

The term *Covered Expense* means the reasonable cost of a Medically Necessary item or procedure of medical care or service, if prescribed by a Physician and billed by a Physician or a Hospital. The Board of Trustees determines the reasonableness of any charge for which a claim is made under this program.

I. Covered Person

The term *Covered Person* means either the Covered Employee, Retiree or the Eligible Dependent.

J. Eligible Dependent(s)

The term *Eligible Dependent(s)* includes any of the following:

1. The lawful spouse of the Covered Employee or Retiree who lives with the Covered Employee or Retiree.
2. Each unmarried natural or adopted child or stepchild or any other unmarried minor child (as qualified below), for whom the Covered Employee or Retiree has an obligation to support, as defined below, who is:
 - a. Under the age of 19, or under the age of 23 if a full-time student, or totally and permanently disabled; and
 - b. Either has:
 - i. The same principal place of abode as the Covered Employee or Retiree for over one-half of the year and does not provide over one-half of his or her own support for the year; or
 - ii. Received over one-half of his or her support from the Covered Employee or Retiree for the year and is not an Eligible Dependent under this Plan's definition of any other person for that year.
 - c. For purposes of this Section, an obligation to support shall be established if the child is:
 - i. A natural or adopted child of the Covered Employee or Retiree and his or her legal spouse; or
 - ii. A natural or adopted child of the Covered Employee or Retiree whose parents: (A) divorced or legally separated under a decree of divorce or separate maintenance agreement; (B) separated under a written separation agreement; or (C) are married, but live apart at all times during the last six months of the calendar year; AND the child's parents provide over one-half of the child's support, AND the child is in the custody of one or both of his or her parents for more than one-half of the calendar year; or

- iii. The Covered Employee's or Retiree's natural or adopted child if such child is residing with the Covered Employee or Retiree in a normal parent-child relationship on a regular basis and the Covered Employee or Retiree has legal custody of such child; or
 - iv. The Covered Employee's or Retiree's natural child, if the parents of the child have never been legally married to each other, but the Covered Employee or Retiree is required by a court order to acknowledge paternity and has a duty of support for such child; or
 - v. The Covered Employee's or Retiree's stepchild, if living with the Covered Employee or Retiree, and if the Covered Employee's or Retiree's spouse has legal custody of the child or is required by court order to support the child; or
 - vi. Any other unmarried minor child if the child: (A) is related to the Covered Employee or Retiree as described immediately below; or (B) resides with the Covered Employee or Retiree in a normal parent-child relationship and is a member of the Covered Employee's or Retiree's household for the entire calendar year; AND the Covered Employee or Retiree has been appointed by the court as legal guardian of such child as well as been required to provide medical coverage for the child.
 - For purposes of this subparagraph vi. any other unmarried child who is related to the Covered Employee or Retiree must be one of the following: a descendant of a child of the Covered Employee or Retiree, the Covered Employee's or Retiree's brother, sister, stepbrother or stepsister, or a son or daughter of a brother or sister of the Covered Employee or Retiree.
- d. References to an adopted child include a child placed for adoption. The term "placed for adoption" means the assumption and retention by a Covered Employee or Retiree of a legal obligation of a child in anticipation of the adoption of the child prior to that child's 18th birthday. The child's placement with the Covered Employee or Retiree ends upon the termination of such legal obligation.
 - e. A full-time student is an unmarried natural or adopted child, stepchild or any other minor child as described above, who is at least 19 who has not attained age 23, who has not graduated and is

a full-time student in high school or is enrolled as full-time student at an accredited school, college, junior college, university or a vocational or trade school approved by the Department of Labor, and is reported to the Fund Office with proof of full-time student status prior to submitting a claim.

- f. A totally and permanently disabled child qualifies if the physical handicap or mental retardation: (a) occurs before the child reaches age 19; (b) is certified by a Physician; and (c) renders the child incapable of self-sustaining employment so as to make the child dependent upon the parents for financial support and maintenance. Initial proof of such disability and financial dependence must be furnished to the Board of Trustees within 31 days of the child's reaching 19 years of age. The Board of Trustees may require subsequent proof of eligibility after the child reaches age 21, but not more frequently than annually. To be considered totally and permanently disabled, the child must be unable to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months.
3. A child for whom coverage must be provided because of a Qualified Medical Child Support Order ("QMCSO"). A QMCSO is a court order, administrative order pursuant to state law or court decree relating to child support, which provides for a child's coverage under the Plan. The Fund Office will be delegated the authority to determine if a National Medical Support Notice, issued by a state agency pursuant to ERISA § 609; 29 USC § 1169 and the regulations promulgated therefrom, constitutes a QMCSO. QMCSOs other than National Medical Support Notices must contain specific information, must be submitted to the Plan Administrator and must be approved by the Trustees to be qualified. A copy of the Plan's QMCSO qualification procedures is available from the Fund Office upon request at no charge.
 4. For dependents working full-time under the age of 19, living at home and having their own health care coverage, this Plan will coordinate and be the secondary payers.
 5. In the event that two Employees are married to each other, In-Network Benefits will be paid at the rate of 95% as an Employee and an additional 5% as an Eligible Dependent. Out-of-Network Benefits will be paid at the rate of 80% as an Employee and an additional 20% as an Eligible Dependent.

K. Employee

The term *Employee* means:

1. Any person who is employed by an Employer, as that term is defined in the Plan, and for whom the Employer is required to make contributions into the Trust Fund;
2. Any full time employee of the Union or of a participating union;
3. Any full time employee of the Association;
4. Any full time employee of the Board of Trustees; and
5. Any other employee of any Employer who has been accepted as such by the parties to the Trust Agreement.

L. Employer

The term *Employer* means:

1. Any member of the Association who is a party to, or otherwise bound by a Collective Bargaining Agreement with the Union requiring Payments to the Trust Fund with respect to Employees represented by the Union.
2. Any employer who is not a member of the Association who has signed a Stipulation in accordance with Annex "A" of the Trust Agreement or in a form otherwise approved by the Board of Trustees.
3. Any other employer, association of employers or group of employers who have been accepted and approved by the Board of Trustees.
4. The Trustees as to its Employees, the participating unions as to Employees of participating unions, the Association as to Employees of the Association, and related funds as to the Employees of the related funds. Such status of the Union, participating unions, the Trustees and related funds shall be solely for the purpose of making the required contributions to the Trust Fund.

M. Expense Incurred

The term *Expense Incurred* includes only those charges made for Services and supplies which are reasonably priced and are appropriate and consistent with the diagnosis according to accepted standards of community practice, and could not have been omitted without adversely affecting the person's condition or the quality of medical care. All Expenses Incurred will be considered on a Usual, Customary and Reasonable Charge basis in the given geographical area which will be no higher than the 90th percentile of prevailing health care charges data.

N. Hospice

The term *Hospice* means a licensed agency that provides counseling and medical Services to the terminally ill and which meets **all** of the following tests:

1. Has obtained any required state or governmental Certificate of Need approval,
2. Provides Services on a 24-hour, 7 day a week basis,
3. Is under the direct supervision of a Physician,
4. Has a nurse coordinator who is a Registered Nurse (R.N.),
5. Has a social service coordinator who is licensed,
6. Is an agency that has as its primary purpose the provision of Hospice Services,
7. Has a full time administrator,
8. Maintains written records of Services provided to the patients, and
9. Is licensed in the jurisdiction in which it is located, if licensing is required.

O. Hospital

The term *Hospital* means only a facility which meets **all** of the following criteria:

1. Is licensed as a hospital by the state, county or municipality where it is located,
2. Operates primarily for the active care of the sick and injured and not for custodial care or educational service,
3. Provides 24 hour a day, on the premises, nursing services by registered nurses (R.N.),
4. Has a staff of one or more Physicians available at all times,
5. Provides organized facilities for diagnosis and surgery on its premises,
6. Is not primarily a clinic, nursing, rest or convalescent home or extended care facility, and is not a place for substance abuse treatment including but not limited to drug addiction, alcoholism, etc.,

7. Maintains permanent and full time facilities for bed care of 50 or more resident patients.
8. For purposes of Alcohol and Drug Treatment Benefits and Mental Health Benefits, Hospital means: (a) facilities or institutions as defined in Subsection 1, above; or (b) a facility licensed by the appropriate state governmental authority and certified under Medicare as a participating hospital for the treatment of Mental and Nervous Disorders or alcohol or substance abuse disorders. The facility described in (b) shall be located within the States of Kansas or Missouri if a duly accredited facility exists therein, or otherwise shall be approved as a qualified facility by the Trustees prior to treatment.

P. Medically Necessary or Medical Necessity

The term *Medically Necessary or Medical Necessity* means only those services, treatments or supplies provided by a Hospital, a Physician, or other qualified provider of medical services or supplies that are required, in the judgment of the Trustees based upon the opinion of a qualified medical professional, to identify or treat a Covered Person's Accident or Sickness and which:

1. Are consistent with the symptoms or diagnosis and treatment of the eligible individual's condition, disease, ailment, or injury,
2. Are appropriate according to standards of good medical practice,
3. Are not solely for the convenience of the Covered Person, Physician or Hospital,
4. Are the most appropriate which can be safely provided to the Covered Person,
5. Are not deemed to be Experimental or Investigative, and
6. Are not furnished in connection with medical or other research.

For purposes of this Plan, the use of any treatment (which includes use of any treatment, procedure, facility, drug equipment, device, or supply) is considered to be "Experimental" or "Investigative" if the use is not yet generally recognized as accepted medical practice, or if the use of any such item requires federal or other governmental agency approval which has not been granted at the time the service or supply is provided, or if the service, supply or procedure is not supported by Reliable Evidence which shows that, as applied to a particular condition, it:

1. Is generally recognized as a safe and effective treatment of the condition by those practicing the appropriate medical specialty,

2. Has a definite positive effect on health outcome,
3. Over time leads to improvement in health outcomes under standard means of treatment under standard conditions of medical practice outside clinical investigatory settings (i.e. the beneficial effects outweigh the harmful effects), and
4. Is at least as effective as standard means of treatment in improving health outcomes, or is usable in appropriate clinical contexts in which standard treatment is not employable.

Reliable Evidence includes only the following:

1. Published reports and articles in authoritative medical and scientific literature,
2. The written investigational or research protocols and/or written informed consent used by the treating facility or another facility which is studying the same service, supply or procedure, and
3. Compilations, conclusions, and other information which is available and may be drawn or inferred from 1. or 2. above.

Consideration may be given to any or all of the following factors:

1. If the drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished, and
2. If Reliable Evidence shows that the treatment is the subject of ongoing Phase I, II or III clinical trials to determine its maximum tolerated dosage, its toxicity, its safety, its effectiveness, or its effectiveness as compared with standard means of treatment or diagnosis, or
3. If Reliable Evidence shows that consensus among experts regarding the treatment is that further studies or clinical trials are necessary to determine tolerated doses, its toxicity, its safety, its effectiveness, or its effectiveness as compared with standard means of treatment or diagnosis.
4. Final determination of whether the use of a treatment is Experimental or Investigative shall rest solely in the discretion of the Trustees.

- Q. Nurse Practitioner
The term *Nurse Practitioner* means an advanced practice nurse who provides high-quality healthcare services similar to those of a doctor and is licensed as a Nurse Practitioner under the laws of the state of practice, when practicing within the scope of their license.
- R. Mental or Nervous Disorder
The term *Mental or Nervous Disorder* means mental and emotional disorders, mental illnesses, psychiatric illnesses, mental conditions, bipolar disorder, and psychiatric illness (whether organic or non-organic, whether of biological, non-biological, genetic, chemical, or non-chemical origin, and irrespective of cause, basis or inducement). This includes, but is not limited to psychoses, neurotic disorders, affective disorders, personality disorders and psychological or behavioral abnormalities associated with transient or permanent dysfunction of the brain or related neurohormonal systems and disorders, conditions and illnesses listed in Chapter 5 (Mental Disorders) of International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM diagnostic codes 290 through 319).
- S. Participant
The term *Participant* means any Employee or former Employee of an Employer who is, or may become, eligible to receive any type of Benefit from this Plan or whose Benefit from this Fund or whose Beneficiaries may become eligible to receive any such Benefit.
- T. Physician
The term *Physician* means medical doctors, osteopaths, surgeons, dentists, podiatrists, chiropractors, psychologists with a Ph.D. and Nurse Practitioners, when practicing within the scope of their license.
- U. Plan
The term *Plan* means the Schedule of Benefits and the rules and regulations of the District Council #3 Painters and Allied Trades Welfare Plan and the Trust Fund as established heretofore, or as shall be established from time to time by amendments, modifications or interpretations by the Trustees for the administration of the Trust Fund and Plan.
- The Plan was established in 1976, in accordance with the provisions of the Trust Agreement.
- V. Pre-Existing Condition
The term *Pre-Existing Condition* is any illness, injury or other medical condition, whether or not diagnosed, for which the individual received medical treatment, consultation, examination, diagnostic testing or prescribed medication within 6 months prior to the eligibility date (i.e., the beginning of the benefit quarter).

- W. Retiree
The term *Retiree* means a Covered Employee who has retired from active employment and who meets the eligibility requirements for Retirees as explained in Section Two C.
- X. Room and Board Charge
The term *Room and Board Charge* is the fee that a Hospital charges for bed, meals and associated routine care by the Hospital's regular staff. Physician fees and special nursing charges are not considered part of the Room and Board Charges; neither are non-essential items (flowers, rental of television sets, etc.).
- Y. Sickness
The term *Sickness* includes physical illness, pain or a fever not caused by an Accident. Sicknesses resulting from intentional use, such as overdose of drugs, are excluded.
- Z. Trust Agreement
The term *Trust Agreement* means the amended Agreement and Declaration of Trust effective in 1976, including the original Trust Agreement.
- AA. Trustees or Board of Trustees
The term *Trustees or Board of Trustees* means the persons designated in the Trust Agreement, their predecessors or their successors designated and appointed in accordance with the terms of the Trust Agreement. The Trustees shall constitute the "Administrator", the "Plan Sponsor" and the "Named Fiduciaries" of the Trust Fund and of the Plan established and maintained under the authority of the Trust Agreement.
- BB. Union
The term *Union* means District Council No. 3 of the International Union of Painters and Allied Trades, AFL-CIO and local unions affiliated with said District Council.
- CC. Usual, Customary and Reasonable Charge (UCR Charge)
The term *Usual, Customary and Reasonable Charge (UCR Charge)* means that the charge by any provider for a service must be similar to all other like providers of the same service in that geographical area and which is no higher than the 90th percentile of prevailing health care data on such charges. The "geographical area" reference is the zip code for the general level of charges being made by a Physician of similar training and experience.