

**ST. LOUIS PAINTERS  
WELFARE PLAN AND  
SUMMARY PLAN DESCRIPTION**

**YOUR  
GROUP HEALTH  
PLAN**

**Effective Date: January 1, 2021**

## **IMPORTANT ADDRESSES AND TELEPHONE NUMBERS**

### **Eligibility, Benefits or Claims Questions:**

St. Louis Painters Welfare Fund  
13801 Riverport Drive, Suite 501  
P.O. Box 1186  
Maryland Heights, MO 63043  
(314) 656-1072  
[www.paintersdc2benefits.org](http://www.paintersdc2benefits.org)

### **In-Network Provider Membership Questions:**

Anthem Blue Cross Blue Shield  
1831 Chestnut Street  
St. Louis, MO 63103  
(800) 810-BLUE (2583)  
[www.Anthem.com](http://www.Anthem.com)

### **Voluntary Predetermination:**

For Hospital admissions or continued Hospital stays:  
Anthem Blue Cross Blue Shield  
(877) 284-0102  
[Healthlinkmedmgmtrequests@healthlink.com](mailto:Healthlinkmedmgmtrequests@healthlink.com)

For other services and information:  
St. Louis Painters Welfare Fund  
(314) 656-1072

### **Prescription Drug Benefits:**

CVS Caremark  
P.O. Box 52136  
Phoenix, Arizona 85072-2136  
Member Services: (866) 818-6911  
Pharmacist Help Desk: (800) 364-6331  
[www.cvs.com](http://www.cvs.com)

### **Dental:**

Delta Dental  
P.O. Box 8690  
St. Louis, Missouri 63126  
(314) 656-3001 or (800) 335-8266  
[www.deltadentalmo.com](http://www.deltadentalmo.com)

### **Vision:**

EyeMed via Fidelity Security Life  
P.O. Box 8504  
Mason, OH 45040-7111  
(866) 800-5457  
[www.eyemed.com](http://www.eyemed.com)

### **Member Assistance Program:**

Mercy Managed Behavioral Health & EAP  
(314) 729-4600 #2 or (800) 413-8008 #2  
[www.mbh-eap.com/members](http://www.mbh-eap.com/members)

**Voluntary Pregnancy Care Program:**

Future Moms Program through Anthem Blue Cross Blue Shield  
(877) 351-8389

**Life and Accidental Death and Dismemberment (AD&D) Insurance:**

For Claims filing and questions please call Anthem at (800) 813-5682  
Anthem Life Insurance  
P.O. Box 105448  
Atlanta, GA 30348-5448

For Eligibility and Benefit questions, please call the Fund Office at (314) 656-1072.  
St. Louis Painters Welfare Fund  
13801 Riverport Drive, Suite 501  
P.O. Box 1186  
Maryland Heights, MO 63043

Dear Participant:

As You are aware, since the last published St. Louis Painters Welfare Plan and Summary Plan Description dated May 1, 2016, many changes have been made in the benefits covered by the Plan, eligibility and participation requirements, and the administration of Welfare benefits. The Trustees have continued to adapt to the changing health services market and improve the benefits and administrative efficiency of the Plan. This updated Plan and Summary Plan Description (“SPD”) incorporates changes and brings the SPD up to date effective as of January 1, 2021; the SPD also replaces and supersedes any prior SPD.

You and Your family members should review this booklet carefully and then keep it in a safe place as a valuable resource regarding Your participation and entitlement to the benefits provided under the Welfare Plan. **It is important that You comply with the Plan’s terms in order to ensure You and Your Dependents obtain all benefits to which You are entitled under the Plan, including but not limited to providing proof of eligibility for You, Your Dependents and any new Dependents You acquire after Your coverage begins within the time limits provided by the Plan. The Plan imposes strict guidelines for submission of enrollment documentation and failure to submit that documentation within the time limits set by the Plan could result in You and/or Your Dependents not receiving benefits You may have otherwise received. If You have any questions about what documentation You need to provide or the time limits for when that documentation needs to be provided, please contact the Welfare Fund Office.** Your dental benefits and dental claim procedures are described in a separate booklet issued by Delta Dental and your vision benefits and vision claim procedures are described in a separate booklet issued by EyeMed via Fidelity Security Life.

For Your convenience, a list of “Important Addresses and Phone Numbers” is located beginning on the inside front cover page of this booklet. Please feel free to contact the sources listed if You have questions pertaining to their areas of service.

As always, if You have any questions about Your benefits or about a claim for benefits, please do not hesitate to contact the Welfare Fund Office.

Sincerely,

The Board of Trustees

### **Notice of Grandfathered Health Plan Status**

The St. Louis Painters Welfare Fund believes its entire plan of benefits, including the retiree, In-Network and Out-of-Network options provided therein, is a “grandfathered health plan” under the Patient Protection and Affordable Care Act (the “Affordable Care Act”). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that the Plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the plan administrator at (314) 656-1072. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at (866) 444-3272 or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform). This website has a table summarizing which protections do and do not apply to grandfathered health plans.

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## I. SCHEDULE OF BENEFITS

**Please Note:** These Schedules of Benefits are simply outlines of benefits. Consult the more detailed descriptions of benefits later in this booklet for additional conditions and limitations that may apply.

### A. LIFE, ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE

<u>Covered Individuals</u>	<u>Life Insurance Benefit Amount</u>	<u>Accidental Death and Dismemberment Insurance "Principal Sum" Benefit Amount</u>
<b>Participants</b>		
Eligible Active and Self-Pay	\$50,000	\$25,000
<b>Eligible Retired Participants</b>		
Under age 65	\$20,000	\$1,500
Age 65 and over	\$10,000	\$1,500
<b>Dependents of Eligible Active Participants and Active Self-Pay Participants</b>		
Spouse (under the age of 70)	\$5,000	-0-
Child over 15 days of age but younger than 19 years of age	\$2,500	-0-
Child 19 years of age but younger than 23 years of age if a full-time student	\$2,500	-0-
Child 23 years of age or older	-0-	-0-
<b>Dependents of Eligible Retired Participants</b>		
Spouse (under the age of 70)	\$1,000	-0-
Child	-0-	-0-

### B. WEEKLY DISABILITY BENEFITS – ELIGIBLE ACTIVE PARTICIPANTS ONLY

Weekly Benefit	<b>\$300</b>
Maximum Benefit Period	<b>13 weeks</b>
Benefits Begin On	<b>1<sup>st</sup> working day of disability due to Injury</b>
	<b>6<sup>th</sup> working day of disability due to Illness</b>

**No Weekly Disability Benefits are provided to Retired Participants or to any Dependents. Such benefits are provided to Active Participants covered through hours worked in Covered Employment if the Active Participant was eligible for coverage through active work in Covered Employment in the month he/she became Totally Disabled. Weekly Disability Benefits are also provided to Active Participants covered through Hour Bank Credits, but only if the Active Participant was eligible for coverage, through active work in Covered Employment, in the Benefit Month immediately preceding the month in which he/she became Totally Disabled.**

### C. MAJOR MEDICAL BENEFITS

#### 1. In-Network/Out-of-Network Providers

The Plan provides benefits through Anthem's Blue Access Choice program for Participants and Dependents in the St. Louis Metropolitan area. The highest benefits are paid when You use providers in Anthem's Blue Access Choice program for services obtained in the St. Louis Metropolitan area. Sometimes referred to as "In-Network Providers." When using Out-of-Network Providers, the level of benefits paid by the Plan is lower and the Out-of-Network Provider can bill you for the difference between the Usual Customary and Reasonable Charge on which the Plan calculates the benefits it pays and provider's billed amount (known as "balance billing"). In addition, certain services such as preventive care benefits are not covered if You use an Out-of-Network Provider. Therefore, it is to Your direct benefit to use In-Network Providers when at all possible. Using In-Network Providers also benefits You because, in many cases, the In-Network Providers have agreed to discount their

total charges so the amount of Your Co-insurance will be less. In addition, by using In-Network Providers, the Plan saves money allowing it to continue providing You with the high level of benefits it currently provides.

If you receive care from an In-Network Provider that orders covered services on your behalf from a sub-provider or uses a sub-provider to perform covered services on your behalf (such as an anesthesiologist, emergency room physician, or lab) and the sub-provider is not an In-Network Provider, your benefits from the sub-provider will be paid at the In-Network Provider level using the Usual Customary and Reasonable Rate for the covered services if you do not have a choice in the sub-provider used or there is no In-Network sub-provider available through your main provider. **Please note:** While the Fund will pay the benefits at the In-Network Provider level, if the sub-provider is an Out-of-Network Provider, the sub-provider can still balance bill you for the difference between what the Fund pays and what the sub-provider's billed charges are. It is in your best interest to check with your main provider about which sub-providers may be used during your treatment, so you can determine what expense you will incur for the sub-provider.

Participants and Dependents who live or attend school outside of the St. Louis Metropolitan area, have access to the Blue Card PPO program. Any providers participating in the Blue Card PPO program will be considered In-Network Providers for those Participants and Dependents who live or attend school outside of the St. Louis Metropolitan area.

For a list of In-Network Providers go to [www.Anthem.com](http://www.Anthem.com) or call Anthem Blue Cross Blue Shield ("Anthem") at (800) 810-BLUE (2583). When using the website, You should select Anthem's "Blue Access Choice" if you live in the St. Louis Metropolitan area or Anthem's "Blue Card PPO" if you live or attend school outside the St. Louis Metropolitan area.

2. Calendar Year Deductibles

	<u>In-Network</u>	<u>Out-of-Network</u>
Individual	\$200	\$750
Family	\$600	\$2,250

The Calendar Year Deductible applies to nearly all covered services, except as noted in the Major Medical Schedule of Benefits (starting on page 3). You must pay the applicable Calendar Year Deductible amount each year before the Plan pays any benefits for services or supplies incurred during that calendar year.

The total Calendar Year Deductible amount a Participant and all his/her Dependents must pay will be limited to the amount shown above as the "Family" Calendar Year Deductible. Once the Participant and/or his/her Dependents have paid this amount, no further Calendar Year Deductibles will be required for charges incurred during that calendar year by other covered family members.

Note: Expenses applied to the Calendar Year Deductible for any provider category will also be applied to the Calendar Year Deductible requirement for the other provider categories. For example: If You incur Expenses of \$100 from an In-Network Provider, Your remaining Calendar Year Deductible for Out-of-Network Providers will be \$650. If You incur \$750 in Expenses from an Out-of-Network Provider Your Calendar Year Deductible will be satisfied for all In-Network Providers.

The In-Network Provider Calendar Year Deductible applies in any instances where Out-of-Network Provider Expenses are incurred but paid at the In-Network Provider benefit level under the terms of this Plan.

The Calendar Year Deductibles are re-imposed on January 1 of each year. However, Covered Expenses incurred during the last 90 days of a calendar year that are applied to the individual Calendar Year Deductible in that calendar year will also be carried over and applied towards that individual's Calendar Year Deductible in the next calendar year. These Expenses will not count toward the next year's Family Calendar Year Deductible limit.

Common Accident Deductible. If two or more covered members of Your family are injured in the same accident, only one Individual Calendar Year Deductible will apply for that accident. This Common Accident Deductible will also apply to any re-applications of the Calendar Year Deductible for that accident.

**Calendar Year Deductibles do not apply to the Annual Out-of-Pocket Maximum described below.**

3. Annual Out-of-Pocket Maximum (Does NOT Include the Calendar Year Deductible)

	<u>In- Network</u>	<u>Out-of- Network</u>
Individual	\$2,000	\$5,000
Family	\$6,000	\$15,000

Once You have paid the Annual Out-of-Pocket Maximum amount shown above during any calendar year in addition to the applicable Calendar Year Deductible, the Plan will pay 100% of eligible Covered Expenses incurred from providers in the applicable network level during the remainder of that calendar year.

The Annual Out-of-Pocket Maximum does NOT include mail order pharmacy Co-payments, expenses incurred due to reduction to the Usual, Customary and Reasonable Charge level or other non-Covered Expenses. Those expenses will never be paid at 100% and the same Co-payments will continue to apply to mail order prescriptions even after the Annual Out-of-Pocket Maximum has been met.

Note: In-Network Provider Expenses will apply toward the In-Network and Out-of-Network Provider Annual Out-of-Pocket Maximum; however, Out-of-Network Provider Expenses will only apply towards the Out-of-Network Provider Annual Out-of-Pocket Maximum, except where the Out-of-Network Provider Expenses are paid at the In-Network Provider benefit level under the terms of this Plan. The In-Network Provider Annual Out-of-Pocket Maximum applies in any instances where Out-of-Network Provider Expenses are incurred but paid at the In-Network Provider benefit level under the terms of this Plan.

4. Benefits Payable

The Plan will pay benefits according to the Schedule of Major Medical Benefits shown on the following pages. All benefit percentages are based upon the amount of Covered Expenses and are determined by the network level of the service provider, except as noted. After You have satisfied the applicable Calendar Year Deductible, the Plan will pay the applicable benefit percentage shown until the Annual Out-of-Pocket Maximum has been met, at which time additional eligible Expenses will be paid at 100% for the remainder of that calendar year. You are responsible for the percentage of charges not payable by the Plan (Co-insurance), as well as any Co-payment ("Co-pay") amount in addition to the applicable Calendar Year Deductible. In addition, you are responsible to pay any amounts charged over the Usual, Customary and Reasonable Charge for Out-of-Network Providers. All services are subject to the Calendar Year Deductible unless otherwise noted.

5. Schedule of Major Medical Benefits

**The following table is only a summary of Your major medical benefits under the Plan. For a complete description of covered major medical Expenses, as well as any exclusions and limitations, please refer to Section VI.**

Covered Services/Limitations	Benefit Percentage Payable By the Plan	
	<u>In-Network</u>	<u>Out-of-Network</u>
<b>Physician's Office Visit</b>	90%	60%
<b>Hospital Inpatient</b> (Room and Board limited to semi-private room rate)	90%	60%
<b>Hospital Outpatient and Surgery Centers</b>	90%	60%
<b>Urgent Care</b>	90% after \$50 Co-Pay	60% after \$50 Co-Pay

Covered Services/Limitations	Benefit Percentage Payable By the Plan	
	<u>In-Network</u>	<u>Out-of-Network</u>
<b>Emergency Room</b>		
Facility Charges (Co-pay is waived if admitted to Hospital as inpatient)	90% after \$75 Co-pay	60% after \$75 Co-pay
Physician Charges	90%	60%*
<b>Ambulance</b>	90%	60%*
<b>Preventive Care/Screening/ Immunization</b> (All benefits covered to the extent determined by the U.S. Preventive Care Task Force. See Article VI(C)(20) for more information)		
<b>Annual Physical Exam</b> (Limited to one exam per calendar year. Retirees and their Dependents are not eligible for this benefit, and this benefit cannot be combined with Well-Child Care visits)	100%	Not Covered
<b>Routine Mammograms</b>	100%	Not Covered
<b>Routine Pap Smears</b>	100%	Not Covered
<b>Well Women Visit</b>	100%	Not Covered
<b>Colon Cancer Screenings</b>	100%	Not Covered
<b>Well Child Care</b>	100%	Not Covered
<b>Childhood Immunizations</b> (Immunizations as recommended by the ACIP for children under age 26)	100%	Not Covered
<b>Genetic Testing (Preventive Service)</b>	100%	Not Covered
<b>All other Preventive Care/Screening/ Immunization Services</b>	100%	Not Covered
<b>Maternity Care</b> (Pre and post-natal)	100%	60%
<b>Diagnostic Tests</b> (X-ray and lab)	90%	60%*
<b>Physical, Occupational or Speech Therapy</b>	90%	60%
<b>Chiropractic Services</b>		
Office visit, modalities, manipulations, electrical stimulation (Limited to 20 visits per person per calendar year. Limit does not apply in cases where Chiropractic Services are being used to treat a mental health disorder)	90%	60%
In office x-ray and lab	90%	60%
<b>Surgery</b> (Physician services)	90%	60%
<b>Anesthesiologist</b>	90%	60%*
<b>Voluntary Second Surgical Opinion</b>	90%	60%
<b>Durable Medical Equipment</b> (Benefit percentage based on rental charges up to purchase price (may be	90%	60%

\* When services are rendered at an In-Network Facility, Covered Expenses for Out-of-Network Provider emergency room Physicians, professional services for lab and x-ray interpretation, anesthesiologists and ambulance service are payable at the In-Network level and will count towards the In-Network Deductible and Annual Out-of- Pocket Maximum.

Covered Services/Limitations	Benefit Percentage Payable By the Plan	
	<u>In-Network</u>	<u>Out-of-Network</u>
purchased if less than rental))		
<b>Mental Health Treatment</b>		
<i>Inpatient</i>	90%	60%
<i>Outpatient including office visits</i> (Treatment must be rendered by a Physician or Behavioral Health Practitioner.)	90%	60%
<b>Chemical Dependency</b>		
<i>Inpatient</i>	90%	60%
<i>Outpatient including office visits</i> (Treatment must be rendered by a Physician or Behavioral Health Practitioner.)	90%	60%
<b>Home Health Care</b>	90%	60%
<b>Skilled Nursing Facility</b> (140-day limit per confinement)	90%	60%
<b>Hospice</b>		
<i>Inpatient</i> (90-day maximum)	90%	60%
<i>Family and Bereavement Counseling</i> (Available while ill person is on hospice and for up to 6 months following the ill person's death.)	90%	60%
<b>Organ Transplants</b>	90%	60%
<b>Foot Orthotics</b> (Limited to \$400 once every 12 months for adults and once in a period of 6 months for children under age 26 when replacement is required due to growth.)	100%	100%
<b>Genetic Testing (Diagnostic)</b>	90%	60%
<b>All Other Covered services</b>	90%	60%

6. Prescription Drug Benefits

<b>Covered Prescription Drugs Purchased from Retail Pharmacy</b>	
Plan Pays	80%-subject to minimum and maximum Co-pays. See page 67 for more information.
You Pay	20% subject to minimum and maximum Co-pays. See page 67 for more information.
<b>Covered Prescription Drugs Purchased by Mail Order</b>	
Plan Pays	100% after applicable Co-pay
You Pay	\$15.00 Co-pay for generic \$30.00 Co-pay for brand name formulary \$60.00 Co-pay for brand name non-formulary
<b>Specialty Drugs</b>	
Plan Pays	80% until You reach a \$10,000 out-of-pocket maximum, then the Plan pays 100%
You Pay	20% until You reach a \$10,000 out-of-pocket maximum

### **Special Notice – Prescription Benefits for Retirees Eligible for Medicare**

Medicare offers Prescription Drug Coverage (Medicare Part D) through private companies that have been approved by Medicare. This voluntary program, which was developed by the Federal Government's Centers for Medicare and Medicaid Services (CMS), is available to individuals with Medicare.

Since January 1, 2006, the St. Louis Painters Welfare Fund has continued to provide medical and prescription drug coverage. If You are in the St. Louis Painters Welfare Fund, You already have prescription drug coverage that is, on average, more generous than Medicare Prescription Drug Coverage. You will receive a notice from the Plan each year confirming this coverage through the Plan.

Because the Plan's coverage is more generous than Medicare Prescription Drug Coverage, You do not need to enroll for Medicare Prescription Drug Coverage. You will continue to be eligible for prescription drug benefits under the St. Louis Painters Welfare Fund if You: (1) do not enroll for Medicare Prescription Drug Coverage, (2) make the required self-payments for this coverage, and (3) otherwise remain eligible for coverage.

If You are eligible for Medicare and enroll for Medicare Prescription Drug Coverage, You will no longer receive prescription drug benefits under the Plan. However, please note that if You enroll for Medicare Prescription Drug Coverage, Your monthly premium for St. Louis Painters Welfare Fund coverage will not be reduced. That means You will be paying the same amount for less coverage. Plus, You will have to pay a premium for Medicare Prescription Drug Coverage. However, if You decide to enroll and later decide to drop Medicare Prescription Drug Coverage, You will have a one-time only opportunity to re-enroll for the Fund's prescription drug benefits.

### ***D. VISION CARE BENEFITS***

Vision care benefits are available to all Participants and their Dependents. The vision benefits are described in the EyeMed St. Louis Painters Welfare Fund Vision Care Benefits booklet, which is incorporated into this document by reference. Vision care benefits are provided on a fully insured basis through EyeMed via Fidelity Security Life (FSL).

### ***E. DENTAL BENEFITS***

Dental benefits are provided to the following Participants and their covered Dependents: Eligible Active Participants, Eligible Active Self-Pay Participants and to those Retired Participants who pay for such benefits. The dental benefits are described in the Delta Dental Summary Plan Description, which is incorporated into this document by reference.

### ***F. MEMBER ASSISTANCE PROGRAM***

The Fund provides a Member Assistance Program ("MAP") through Mercy Managed Behavioral Health and EAP to all Participants and their Dependents. The MAP offers guidance and encouragement for everyday situations and counselors trained to deal with a range of personal issues. The MAP program can help with the following:

- Strained relationships
- Stress at home or at work
- Anger, resentment
- Budgeting and debt management
- Parenting concerns
- Addictions
- Depression and anxiety
- Conflicts/communication problems
- Grief and loss
- Retirement/aging

Services in the MAP are free and confidential for You. Treatment beyond the scope of the MAP is coordinated through Your other benefits in this Plan or through community services, where available. See Article X for more information on the Member Assistance Program provided through Mercy Managed Behavioral Health & EAP.

## II. DEFINITIONS

The definitions set out here are an important part of this booklet. When one of the following terms is used in this booklet, it has the meaning set out below, unless specifically indicated otherwise in the context in which it is used. Other terms are defined in the text of this booklet.

**Acupuncture Treatment** means the piercing of specific peripheral nerves with needles:

1. to relieve the discomfort of painful disorders; or
2. for therapeutic purposes.

**Bargaining Unit Employee** means an employee performing work for a Contributing Employer that falls within the jurisdiction of the Union pursuant to the terms of a CBA. Bargaining Unit Employees do not include Owner Operators, who are considered Non-Bargaining Unit Employees and are subject to the rules for Non-Bargaining Unit Employees.

**Behavioral Health Practitioner** means a psychiatrist, psychologist, mental health or substance abuse counselor or social worker who has a Master's degree or a Master's level nationally and state certified clinical nurse specialist or Nurse Practitioner in independent practice who is qualified to perform behavioral health counseling. Said individual must be legally licensed and/or legally authorized to practice or provide service, care, or treatment of behavioral health disorders under the laws of the state or jurisdiction where the services are rendered and must act within the scope of his license.

A Behavioral Health Practitioner does not include a person who lives with You or is part of Your family (You; Your spouse; or a child, brother, sister or parent of You or Your spouse) and does not include any professional not listed above.

**Bridge Employee** means an individual who is a Bridge Participant under the St. Louis Painters Pension Fund working in Covered Employment as a Bargaining Unit Employee.

**Chemical Dependency** means the physiological and psychological addiction to a controlled drug or substance, or to alcohol. Dependence upon tobacco, nicotine, and caffeine are not included in this definition.

**Co-insurance** means the percentage of Covered Expenses not covered by the Plan for which You are responsible. For example, if the Plan pays 75% of Covered Expenses for a covered service, the Co-insurance that You must pay is the remaining 25% of the Covered Expense.

**Collective Bargaining Agreement or CBA** means a written agreement between the Union and an employer, which requires contributions to the Welfare Fund on behalf of Bargaining Unit Employees.

**Contributing Employer** means an employer that is required by a Collective Bargaining Agreement with the Union or other written agreement to contribute to the Welfare Fund on behalf of employees covered by those agreements. The term "Contributing Employer" also includes the Union itself and the Finishing Trades Institute of Midwest (or their successors).

**Cosmetic or Reconstructive Surgery** means any surgical procedure performed primarily:

1. to improve physical appearance or to change or restore bodily form without materially correcting a bodily malfunction; or
2. to prevent or treat a mental illness through a change in bodily form.

**Covered Employment** means employment of a Bargaining Unit Employee or Non-Bargaining Unit Employee by a Contributing Employer for which contributions are required to be made to the Fund pursuant to the terms of a CBA or other written agreement.

**Covered Expense or Expense** means the expense incurred for a covered service or supply. A Physician has to order or prescribe the service or supply. A Covered Expense is considered incurred on the date the service or supply is received. A Covered Expense **does not include** any charge:

1. for a service or supply which is not Medically Necessary; or
2. that exceeds the lesser of the applicable In-Network contracted fee or the Usual, Customary and Reasonable Charge for a service or supply.

**Custodial or Long-Term Care** means service or treatment that, regardless of where it is provided:

1. could be rendered safely by a person without medical skills; and
2. is designed mainly to help the patient with daily living activities, including (but not limited to):
  - a. personal care such as help in walking and getting in and out of bed; help with bathing; help with eating by spoon, tube or gastrostomy; exercising; dressing; enema and using the toilet;
  - b. homemaking such as preparing meals or special diets;
  - c. moving the patient;
  - d. acting as a companion or sitter;
  - e. supervising medication which can usually be self-administered;
  - f. oral hygiene; and
  - g. ordinary skin and nail care.

When a confinement or visit is found to be mainly for Custodial or Long-Term Care, some services (such as prescription drugs, X-rays and lab tests) may still be covered. All bills should be routinely submitted for consideration.

**Dentist** means a licensed dentist who performs a service which is payable under the Plan and which is authorized by his or her license.

**Dependent(s)** means a Participant's Eligible Dependents as defined in Section III(C)(1) below.

**Durable Medical Equipment** means equipment that qualifies as "durable medical equipment" under Medicare (i.e., it is able to withstand repeated use, is primarily and customarily used to serve a medical purpose, is not generally useful to a person in the absence of Illness or Injury and is appropriate for use in the home).

**Eligible Active Participant or Active Participant** means:

1. a Bargaining Unit Employee who is eligible for benefits by virtue of the hours he worked in Covered Employment for a Contributing Employer in the applicable Contribution Month for which contributions are received by the Fund,
2. a Non-Bargaining Unit Employee who is eligible for benefits by virtue of his work in Covered Employment for a Contributing Employer who submits contributions to the Fund on his behalf as required pursuant to the terms of the applicable written agreement, or
3. a person who is eligible for benefits by virtue of use of an Hour Bank Credit or through a Pay-Stub Payment.

(See Section III of this booklet).

**Eligible Active Self-Pay Participant or Active Self-Pay Participant** means a Bargaining Unit Employee who, by virtue of his prior work in Covered Employment with a Contributing Employer, is eligible to and does pay for all or part of his own coverage when he has not worked sufficient hours in Covered Employment in the applicable Contribution Month and does not have sufficient Hour Bank Credits to maintain coverage. (See Section III of this booklet).

**Eligible Retired Participant or Retired Participant** means a person who qualifies for and has elected and paid for coverage as a retiree. (See Section III of this booklet).

**Experimental or Investigative** means any experimental or investigative drug, device, medical or dental treatment or procedure. A drug, device, medical or dental treatment or procedure is experimental or investigative:

1. in the case of a drug or device, if it cannot be lawfully marketed without the approval of the U.S. Food and Drug Administration and if such approval has not been given at the time the drug or device is provided to the patient; or
2. if the drug, device, medical or dental treatment or procedure, or the patient informed consent document used with any of them, was reviewed and approved by the treating facility's institutional review board or any other body serving a similar function, or if federal law requires such review or approval; or
3. if the drug, device, medical or dental treatment or procedure is the subject of an ongoing Phase I or Phase II clinical trial, is the research, experimental, study or investigational arm of ongoing Phase III clinical trials, or is otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or how any of these factors compares with standard means of treatment or diagnosis; or
4. in the case of a drug or device, if it is prescribed or used "off label," i.e., dispensed for a use for which it is not approved by the U.S. Food and Drug Administration; or
5. if the drug, device, medical or dental treatment or procedure is considered by the U.S. Department of Health and Human Services Health Care Financing Administration to be investigational, not reasonable and necessary, not primarily medical in nature or not verified as effective by scientific controlled studies.

The Trustees may, from time to time, retain a medical consultant, who may, in the exercise of judgment, waive the exclusion of a drug, device, medical treatment or procedure described in subparagraph 2 or 4 above, or in subparagraph 3 above (but may not waive the exclusion of a drug, device, medical treatment or procedure that is the subject of an ongoing Phase I clinical trial).

**Fund or Trust** means the St. Louis Painters Welfare Trust.

**Genetic Testing** means the process of analyzing cells or tissue to look for changes in genes, chromosomes, or proteins that may be a sign of a disease or condition, such as cancer. These changes may also be a sign that a person has an increased risk of developing a specific disease or condition. Genetic Testing for preventive purposes may include newborn screening analysis that uses DNA, RNA, protein, or metabolite analysis to detect or indicate genotypes, mutations, or chromosomal changes, such as a test for PKU performed so that treatment can begin before a disease manifests or the test to determine whether someone has the BRCA1 or BRCA2 variant evidencing predisposition to breast cancer. Genetic testing for diagnostic purposes may be done on tumor tissue to help diagnose cancer, plan treatment, or find out how well treatment is working.

The term "Genetic Testing" does not include:

1. An analysis of proteins or metabolites that does not detect genotypes, mutations or chromosomal changes;
2. A medical examination that tests for the presence of a virus that is not composed of human DNA, RNA, chromosomes, proteins or metabolites;
3. A test for infectious and communicable diseases that may be transmitted through food handling;
4. DNA testing to detect genetic markers that are associated with information about ancestry;
5. Complete blood counts, cholesterol tests and liver-function tests unless otherwise covered under the Plan.

**He or His** and all other masculine pronouns include the feminine unless the context clearly indicates otherwise.

**Hospital** means any legally constituted institution that:

1. Maintains permanent and full-time facilities for bed care of five or more resident patients;
2. Has a Physician in regular attendance;

3. Continually provides a 24-hour-a-day nursing service by registered nurses;
4. Is primarily engaged in providing diagnostic and therapeutic facilities for medical and surgical care of Injured and Sick persons on a basis other than as a rest home, nursing home, convalescent home, long-term care facility, a place for the aged, a place for drug addicts or a place for alcoholics; and
5. Is operating lawfully in the jurisdiction where it is located and is state-licensed and is nationally accredited by the National Committee for Quality Assurance (NCQA) or the Joint Commission or an accreditation approved by CMS.

**Injury** means any damage to a body part resulting from trauma from an external source, which requires treatment by a Physician. It must result in loss independent of Sickness and other causes.

**In-Network Provider or In-Network Facility** means a health care provider or facility that participates in the managed care organization network with which the Plan has an agreement, based on the area where the Participant or Dependent lives or attends school.

**Emergency** means a severe condition which:

1. results in symptoms which occur suddenly and unexpectedly; and
2. requires medical care within 48 hours of the onset of symptoms to prevent death or serious impairment of the individual's health.

**Medically Necessary/Medical Necessity** means that health care services, supplies or treatment must be necessary in connection with the diagnosis or therapeutic treatment of an Injury or Illness. In determining whether a service or supply, what portion of a service or supply or what length of Hospital confinement or amount of treatment is included in this definition, a service or supply must be ordered by a Physician and be commonly and customarily recognized by the Physician's profession in the United States as safe, effective, appropriate, and reasonably necessary treatment of the diagnosed Injury or Illness. It must be neither educational, Experimental nor Investigative in nature, nor provided primarily for research. It must be neither for Custodial Care nor maintenance care (Long-Term Care). Such treatment must be performed in the most cost-efficient manner and type of setting that can be safely provided to the patient and must not be performed principally for the convenience of the provider or patient.

**Morbid Obesity** means a condition in which an adult has been 100 pounds over normal weight for at least five years despite documented unsuccessful attempts to reduce his weight under a Physician-monitored diet and exercise program.

**Non-Bargaining Unit Employee** means an employee performing work for a Contributing Employer that does not fall within the jurisdiction of the Union pursuant to the terms of a CBA, or who is an Owner Operator. Non-Bargaining Unit Employees shall include, but not necessarily be limited to Owner Operators, the office staff of a Contributing Employer, employees of the Union, etc.

**Nurse Practitioner** means a person who is recognized by the state in which he practices as an advance practice nurse who meets the following criteria: (a) holds a current license to practice as a registered professional nurse; and (b) is certified in his respective advanced practice nursing clinical specialty area by a nationally recognized certifying body accepted by the state board of nursing, (c) submits documented evidence of satisfactory, active, up-to-date certification/ recertification/ maintenance and/or continuing education/ competency status to the state board of nursing as required and (d) is practicing within the scope and standards of his license and advanced practice clinical specialty area as defined by the state board of nursing. In order to meet this definition, a Nurse Practitioner must clearly identify himself as a Nurse Practitioner and shall not refer to himself as a doctor, a Physician, or a surgeon.

**Out-of-Network Provider or Out-of-Network Facility** means a health care provider or facility who does not participate in the managed care organization network with which the Plan has an agreement, based on the area where the Participant or Dependent lives or attends school.

**Owner Operator** means any employee of a Contributing Employer who is salaried, an officer or who has an ownership interest in the Contributing Employer and who performs bargaining unit work covered by a CBA. An employee shall be deemed to have an ownership interest in the Contributing Employer if either the employee or the employee's spouse owns or controls the Contributing Employer.

**Participant(s)** means any Active Participant, Active Self-Pay Participant or Retired Participant.

**Pay-Stub Payment** means the payment by a Bargaining Unit Employee whose Contributing Employer is delinquent in contributions to the Fund, to maintain coverage when the employee does not have any Hour Bank Credits but worked enough hours to maintain eligibility. See Section III(A)(1)(d) for additional information about Pay-Stub Payments.

**Physician** means any of the following licensed practitioners who perform a service, consistent with his license, which is covered under the Plan:

- doctor of medicine (MD);
- doctor of osteopathy (DO);
- podiatrist;
- chiropractor;
- optometrist;
- psychologist; or
- Dentist.

A Physician does not include a person who lives with You or is part of Your family (You; Your spouse; or a child, brother, sister or parent of You or Your spouse) and does not include any professional not listed above.

**Physician Assistant (PA)** means a person who (a) has graduated from a physician assistant program accredited by the American Medical Association's Committee on Allied Health Education and Accreditation (or by its successor agency), (b) has passed the certifying examination administered by the National Commission on Certification of Physician Assistants, (c) has active certification by the National Commission on Certification of Physician Assistants and (d) provides health care services delegated by a licensed Physician. A person who has been employed as a physician assistant for three years prior to August 28, 1989 and who has passed the National Commission on Certification of Physician Assistants examination and has an active certification of the National Commission on Certification of Physician Assistants is also included in this definition. In order to meet this definition a physician assistant must clearly identify himself as a physician assistant and shall not refer to himself as a doctor, a Physician, or a surgeon.

**Plan** means the plan of benefits provided by the St. Louis Painters Welfare Trust.

**Sickness or Illness** means a disease, disorder or condition, which requires treatment by a Physician. Childbirth and pregnancy are treated as a Sickness.

**Spinal Treatment** means detection or non-surgical correction (by manual or mechanical means) of a condition of the vertebral column including:

1. Distortion,
2. Misalignment, or
3. Subluxation

to relieve the effects of nerve interference which results from or relates to such conditions of the vertebral column.

**Supervision Agreement** means a written agreement with jointly agreed-upon protocols or standing orders between a supervising Physician and a Physician Assistant or Nurse Practitioner, which provides for the delegation of health services from a supervising Physician to the Physician Assistant or Nurse Practitioner and the review of the Physician Assistant's or Nurse Practitioner's services by the supervising Physician. The supervising Physician must accept responsibility for the oversight of the Physician Assistant's or Nurse Practitioner's activities and the health care services rendered by the Physician Assistant or Nurse Practitioner.

**Totally Disabled** means:

1. for life insurance, that because of an Injury or Sickness a Participant is completely and continuously unable to perform the material and substantial duties of his/her regular occupation; and
2. for major medical benefits, that because of an Injury or Sickness:
  - a. A Participant is completely and continuously unable to perform the material and substantial duties of his/her regular occupation; or

b. A Dependent is unable to perform the normal activities of a person of the same age.

**Union** means the Painters District Council No. 58.

**Usual, Customary and Reasonable (UCR) Charge** means a charge for a service or supply which is no higher than the 80<sup>th</sup> percentile of the prevailing health care charges data used by the Plan. This data reflects a current statistical sampling of charges for services and supplies made in the same or comparable area.

In the event of multiple surgeries or multiple surgeons in attendance during one operation, or for services or supplies for which data is unavailable, usual and customary will be determined by the charges generally incurred for cases of comparable nature and severity in the particular geographical area concerned.

**You or Your** means a person who is covered under the Plan as a Participant or as a Dependent.

### III. ELIGIBILITY

#### A. ELIGIBILITY AND PARTICIPATION REQUIREMENTS FOR ACTIVE PARTICIPANTS

##### 1. Bargaining Unit Employees

###### a. In General

The provisions contained in this Section III(A)(1) apply to Bargaining Unit Employees. A Bargaining Unit Employee will become an Active Participant (that is, become eligible for benefits under the St. Louis Painters Welfare Plan) and maintain his eligibility for benefits as set forth in this Section III(A)(1). The provisions applicable to Non-Bargaining Unit Employees are set out in Section III(A)(2) below.

###### b. Eligibility Calculation Method-Bargaining Unit Employees

Participation and eligibility under the Plan for Bargaining Unit Employees are based on Contribution Months. **A "Contribution Month" is a calendar month for which contributions are submitted to the Welfare Fund for hours worked during pay periods ending during that month. EXCEPT IN CASES OF PAY-STUB PAYMENTS AS SET OUT IN SECTION III(A)(1)(d), IN ORDER TO RECEIVE CREDIT FOR ANY HOURS WORKED, A BARGAINING UNIT EMPLOYEE'S EMPLOYER MUST MAKE THE REQUIRED CONTRIBUTIONS TO THE FUND.**

A Bargaining Unit Employee's eligibility depends on the number of hours he works in Covered Employment for which his employer makes contributions to the Fund in each Contribution Month, except in the case of Pay-Stub Payments as set out in Section III(A)(1)(d).

It is important that individuals be aware that various employers have different one-week pay periods. Some have pay periods that end on Friday, while some have pay periods that end on different days of the week. All hours are reportable by the employer under the Contribution Month in which the pay period ends, even though some of those hours may have been worked during the previous month. For example, if an employer's weekly pay period ends on January 26<sup>th</sup>, hours an employee works from January 27<sup>th</sup> through January 31<sup>st</sup> would be reported and credited in February, the next Contribution Month.

While the Fund automatically credits hours based on pay period ending date, Participants who would otherwise fall short on hours in a particular Contribution Month because part of their hours are being credited to the next Contribution Month due to their pay period ending date, may submit proof to the Fund of when their hours during a particular week were actually worked and said hours will be credited to the Contribution Month during which the hours were actually worked. It is within the discretion of the Trustees to determine what documents are sufficient proof and to require additional forms of proof where the circumstances warrant. Proof must be submitted by the last day of the Lag Month as defined in the next paragraph.

For example: an employee has 75 hours credited to the January Contribution Month as of the last pay period ending date ending on January 26<sup>th</sup>. The employee works 24 hours on Monday, January 29<sup>th</sup> through Wednesday, January 31<sup>st</sup> and 16 hours on Thursday, February 1<sup>st</sup> through Friday, February 2<sup>nd</sup>. The Fund would automatically credit the 40 hours accumulated on January 29<sup>th</sup>-February 2<sup>nd</sup> to the Contribution Month of February, which would result in the employee not having enough hours in the Contribution Month of January to maintain coverage in the Benefit Month of March; however, if the employee notifies the Fund by the last day of February that he would like the hours he worked in January credited to his January Contribution Month and submits the proof required by the Fund, the Fund will credit the 24 hours the employee worked on January 29<sup>th</sup> through January 31<sup>st</sup> to the Contribution Month of January instead of February.

Employees are not permitted to split hours worked in one month between two months; thus, the employee in the above example could not request that 12 of the 24 hours worked between January 29<sup>th</sup> and January 31<sup>st</sup> be credited to the Contribution Month of January and 12 of the 24 hours be credited to the Contribution Month of February. Likewise, once an employee has submitted a request to have hours credited to a particular Contribution Month, the employee will not receive credit for those same hours in another Contribution Month. For example, if the employee in the above example had the 24 hours posted to the Contribution Month of January, those hours would not be included in the Contribution Month of February.

Contribution Months are always separated from Benefit Months by an interval Lag Month. A “Lag Month” is a calendar month during which a Bargaining Unit Employee’s Contribution Month’s hours are totaled and eligibility is determined for the corresponding Benefit Month. A “Benefit Month” is a calendar month during which a Bargaining Unit Employee is eligible for benefits under the Plan based on contributions submitted on his behalf during the Contribution Month or based on a Pay-Stub Payment as set out in Section III(A)(1)(d). For example: hours worked in the Contribution Month of September are received and analyzed in the Lag Month of October, to determine eligibility for the Benefit Month of November.

Hours worked during a Contribution Month will qualify a Bargaining Unit Employee for benefits during that month’s corresponding Benefit Month as set forth in the table below:

<u>Contribution Month</u>	<u>Benefit Month</u>
January	March
February	April
March	May
April	June
May	July
June	August
July	September
August	October
September	November
October	December
November	January
December	February

**Note:** Except in cases of Pay-Stub Payments as set out in Section III(A)(1)(d), A Bargaining Unit Employee will not receive credit under the Plan for any hours worked in Covered Employment during a Contribution Month unless and until the employee’s Contributing Employer actually makes the required contributions to the Welfare Fund. The hours a Bargaining Unit Employee works during a Contribution Month are always credited to that Contribution Month in which the hours were worked—regardless of when contributions are received—and always apply to the corresponding Benefit Month according to the table above.

c. Participation and Eligibility Requirements-Bargaining Unit Employees

**EXCEPT IN CASES OF PAY-STUB PAYMENTS AS SET OUT IN SECTION III(A)(1)(d), IN ORDER TO RECEIVE CREDIT FOR ANY HOURS WORKED TOWARDS THE PARTICIPATION OR ELIGIBILITY REQUIREMENTS, AN EMPLOYEE’S CONTRIBUTING EMPLOYER MUST MAKE THE REQUIRED CONTRIBUTIONS TO THE FUND.**

(i) Participation Requirement

New Bargaining Unit Employees must satisfy a participation requirement (waiting period). If an individual is a new Bargaining Unit Employee of a Contributing Employer, he/she must first meet the following requirement for participation in the Plan. To participate, the individual must work at least 800 hours in Covered Employment with one or more Contributing Employers. The individual must complete the 800 hours of work in Covered Employment within a period of 24 consecutive Contribution Months. (In limited circumstances, the Trustees may waive this participation requirement for employees performing covered work for a newly Contributing Employer.) Bridge Employees are not considered new Bargaining Unit Employees and do not need to satisfy this participation requirement.

(ii) Eligibility Requirements for Coverage

(a) Non-Bridge Employees

After a Bargaining Unit Employee who is not a Bridge Employee has met the participation requirement, he will become eligible for coverage under the Plan **after working 800 hours in Covered Employment in a Contribution Month**. The effective date of a Bargaining Unit Employee’s coverage is the first day of the Benefit Month corresponding to that Contribution Month in which the employee has satisfied **both** the 800-hour participation

**and** the 80-hour eligibility requirements.

If a Bargaining Unit Employee works 80 hours in the Contribution Month during which he/she satisfies the 800-hour participation requirement, the employee will be eligible for benefits beginning the 1<sup>st</sup> day of the Benefit Month corresponding to that Contribution Month.

However, if a Bargaining Unit Employee has less than 80 hours in the Contribution Month in which he/she completes the 800-hour participation requirement, he/she will not become eligible until he/she has the required 80 hours in a Contribution Month. The employee will then become eligible on the first day of the Benefit Month corresponding to that Contribution Month in which the 80 hours were remitted.

Examples:

- i) If at the end of the Contribution Month of May a Bargaining Unit Employee has worked a total of 720 hours in Covered Employment, and then works a total of 80 hours in Covered Employment in the Contribution Month of June, the employee will become eligible for coverage under the Plan as of August 1.
- ii) If at the end of the Contribution Month of May a Bargaining Unit Employee has worked a total of 730 hours in Covered Employment and then works a total of 70 hours in Covered Employment in the month of June, the employee will have satisfied the 800-hour Initial Participation or waiting period requirement. However, until the employee works 80 hours in Covered Employment in a Contribution Month, the employee will not become eligible for coverage under the Plan. That is, if the employee's 80-hour initial eligibility requirement is satisfied in the Contribution Month of July, the hours would be analyzed in the Lag Month of August and the employee will become eligible for coverage under the Plan as of September 1.

(b) Bridge Employees

A Bridge Employee will become eligible for coverage under the Plan as an Active Participant **after working 80 hours in Covered Employment as a Bridge Employee.** The effective date of a Bridge Employee's coverage is the first day of the Benefit Month corresponding to the Contribution Month during which he satisfied the 80-hour eligibility requirement. Bridge Employees are only entitled to return to coverage as an Active Participant one time. Should a Bridge Employee who regained eligibility as an Active Participant under these provisions subsequently lose coverage as an Active Participant, the Bridge Employee becomes subject to the Eligibility and Participation Requirements for Retired Participants set out in Article III, Section B, and may only maintain coverage under the Plan to the extent eligible thereunder.

**Once a Bargaining Unit Employee has met the initial participation and eligibility requirements, he/she is an Eligible Active Participant. An Active Participant must complete an enrollment form and file it with the Fund Office. The Active Participant should do this as soon as he/she becomes eligible for benefits under the Plan. An Active Participant and/or his/her Dependents cannot receive benefits until a completed enrollment form is filed with the Fund Office. An Active Participant with Dependents will also be asked to provide proof of Dependent status before benefits can be provided to them.**

d. Continued Eligibility-Bargaining Unit Employees

**EXCEPT IN CASES OF PAY-STUB PAYMENTS AS SET OUT BELOW, IN ORDER TO RECEIVE CREDIT FOR ANY HOURS WORKED TOWARDS CONTINUED ELIGIBILITY, INCLUDING HOUR BANK CREDITS, AN ACTIVE PARTICIPANT'S EMPLOYER MUST MAKE THE REQUIRED CONTRIBUTIONS TO THE FUND.**

Bargaining Unit Employees who have become Active Participants can maintain eligibility for coverage from

month-to-month in five ways — Hours Worked, Hour Bank Credits, Self-Payment, Pay-Stub Payments or COBRA (discussed later under Section III(F) “COBRA Continuation Coverage”).

(i) Hours Worked-Bargaining Unit Employees

If contributions are made on an Active Participant’s behalf for at least 80 hours of Covered Employment during a Contribution Month, coverage is continued in the corresponding Benefit Month. If an Active Participant works insufficient hours or the Active Participant’s employer fails to make the required contributions, the Active Participant can continue coverage using Hour Bank Credits, by making a Pay-Stub Payment where available or under the Self-Pay Rules.

(ii) Hour Bank Credits-Bargaining Unit Employees

The Hour Bank Credit benefit allows Active Participants to earn credit that can be used to extend eligibility for coverage when an Active Participant (and his/her Dependents) would otherwise lose eligibility because the Active Participant worked insufficient hours, or his employer failed to make required contributions to the Fund and Pay-Stub Payment is not available.

(a) How an Active Participant Earns Hour Bank Credits

Eligible Active Participants earn one-half of an Hour Bank Credit for each Contribution Month in which they work at least 120 hours in Covered Employment for which their employer contributes to the Fund. So, if an Eligible Active Participant meets the eligibility and contribution requirements for two months and works at least 120 hours for which his employer makes contributions to the Fund in each of those months, he will have earned one full Hour Bank Credit. If the Active Participant meets the eligibility and contribution requirements for three months and works at least 120 hours for which his employer makes contributions to the Fund in each of those three months, he will have one-and-one-half Hour Bank Credits, and so on.

The maximum number of Hour Bank Credits an Active Participant can have in his bank at any time is 12. Thus, if an Active Participant works 120 hours in each of 24 months, he will have 12 full Hour Bank Credits and cannot earn any more Hour Bank Credits until he has used one or more of the Credits in his Bank.

(b) How Hour Bank Credits Extend Coverage

If an Active Participant’s eligibility for coverage in a Benefit Month is due to terminate due to a shortage of employer contributions in the corresponding Contribution Month, the Fund Office will automatically use any Hour Bank Credits an Active Participant has in his bank to extend eligibility as long as the Active Participant meets any one of the following “Requirements for Use of Hour Bank Credits.” Each full Hour Bank Credit provides an Active Participant with coverage for one month. Coverage cannot be continued under this provision for a partial month. If an Active Participant has only one-half of an Hour Bank Credit, it can be used to “pay” one-half of the cost and the Active Participant could self-pay the other one-half of the cost of continuing eligibility for coverage in the corresponding Benefit Month under the Self-Pay provisions described in the next section.

(c) Requirements for Use of Hour Bank Credits

**In order to use Hour Bank Credits to extend eligibility for coverage, an Active Participant must either be:**

- **Employed in Covered Employment with a Contributing Employer for fewer than 80 hours in a Contribution Month; or**
- **Employed in Covered Employment with a Contributing Employer who has failed to remit contributions due in a Contribution Month on the Active Participant’s behalf in a timely manner-provided that the Active Participant has not been instructed by the Union to cease working for the offending employer; or**
- **Unemployed and actively seeking employment in the Painting or Taping trade with**

**a Contributing Employer; or**

- **Retired and have insufficient hours to maintain coverage as an Active Participant-provided that the Participant is not employed in the Painting and Taping trade with a non-Contributing Employer who is not required to make contributions on the Participant's behalf.**

(d) Cancellation of Hour Bank Credits

**If a Participant does not qualify to use Hour Bank Credits to extend his eligibility at the time his eligibility for coverage is scheduled to end due to insufficient employer contributions, the Participant's Hour Bank Credits will be cancelled and his eligibility for benefits will be terminated (see subsection (e): "Termination of Eligibility for Coverage" on page 20). Further, a Participant who becomes employed in non-Covered Employment in the trade, will not be able to use his Hour Bank Credits, and those Hour Bank Credits will be canceled and eligibility for benefits terminated, except in the following circumstances:**

- He takes a clearance card from the Union and deposits his card with another Local or District Council of the IUPAT and is actively seeking Covered Employment in that jurisdiction. In such event the Participant may use one-half of his remaining Hour Bank Credits to extend his eligibility for benefits under the St. Louis Painters Welfare Plan. The remaining one-half of the Participant's Hour Bank Credits will be held in suspense and may be restored subject to the following provisions on restoration of canceled Hour Bank Credits.
- He has Hour Bank Credits and enters active military service. He may use those credits to extend coverage during his military service. A Participant may also choose not to use his Hour Bank Credits and retain them for use, consistent with the other terms of this section, after his active military service. However, to retain Hour Bank Credits for use upon return to work, he must notify the Fund Office of his choice prior to entering active military service.
- He is retired and receiving Pension benefits from either the St. Louis Painters Pension Fund or the International Union of Painters and Allied trades Pension Fund (hereinafter referred to as the "IUPAT Pension Fund") and does not enter into non-Covered Employment in the trade.

(e) Restoration of Canceled Hour Bank Credits

If a Participant's Hour Bank Credits **were canceled** either because:

- the Participant took a clearance card, or
- the Participant accepted a non-covered position with a Contributing Employer,

the canceled Hour Bank Credits will be restored if, within six months after the date on which the Participant's coverage ended (not counting extensions of coverage under COBRA or other self-pay provisions), the Participant reestablishes eligibility for coverage by working at least 80 hours in a Contribution Month.

(f) Benefits Provided Through the Use of Hour Bank Credits

When Hour Bank Credits are used to continue eligibility for coverage, a Participant and his Dependents will be covered for all of the Plan's benefits, except, in most cases, the Weekly Disability Benefit. However, a Participant may continue to be eligible for the Weekly Disability Benefit when he uses an Hour Bank Credit, if the Participant was eligible for coverage through active work in Covered Employment in the Benefit Month immediately preceding the month in which the Participant became Totally Disabled.

**Note: In addition to the above Hour Bank Credit provisions, the following restrictions also apply:**

- **Non-Bargaining Unit Employees do not accrue Hour Bank Credits to extend coverage.**

- **Retirees receiving pension benefits from the St. Louis Painters Pension Fund or the IUPAT Pension Fund, who continue to work in Covered Employment, do not accrue Hour Bank Credits on hours worked, but may use remaining Hour Bank Credits to extend eligibility prior to electing retiree self-pay coverage.**

(iii) Active Participant Self-Pay-Bargaining Unit Employees

The Welfare Fund offers continued life, major medical, vision and dental coverage, on a self-pay basis for Bargaining Unit Employees who have become Active Participants where their eligibility is scheduled to terminate because of insufficient hours of employer contributions and lack of Hour Bank Credits. When an Active Participant's eligibility terminates due to insufficient contribution hours, he receives a notice to self-pay informing him of the options for continuation of coverage under the Plan. Once one type of continuation coverage is elected, the right to elect any other type of continuation coverage, including COBRA coverage, will be considered waived and terminated until eligibility for active benefits is reestablished under the Plan through employer contributions on hours worked.

(a) Eligibility to Self-Pay

**To be eligible to self-pay, a former Active Participant must be actively seeking employment in the Painting or Taping trade with an employer who is required to contribute to the St. Louis Painters Welfare Fund and all accumulated Hour Bank Credits must have been applied to the former Active Participant's continued eligibility. Further, if at any time during the Participant's active eligibility or thereafter, he becomes employed in non-Covered Employment, takes a clearance card, or enters into the military, he will not qualify to self-pay and his eligibility for benefits will be terminated (see subsection (e): "Termination of Eligibility for Coverage" on page 20). In addition, the former Active Participant must waive COBRA continuation coverage.**

(b) Payments Required

In order to continue eligibility through self-payment, eligible individuals must make payments in the amount determined by the Trustees, which will be re-evaluated from time to time. **The Fund Office must receive self-payments no later than the 10<sup>th</sup> day of the Benefit Month for which coverage is to be provided.**

(c) Duration of Coverage through Self-payments

Self-payments will be allowed for a maximum of 12 consecutive months (3 months for Bridge Employees). **Also, an Active Self-Pay Participant's right to self-pay will end when he becomes employed in non-Covered Employment or when he is no longer actively seeking employment at the painting trade under the jurisdiction of the Fund, takes a clearance card, or enters into the military.**

If an Active Self-Pay Participant fails to make the required self-payment within the specified time or otherwise loses coverage, he must then re-qualify, to the extent eligible to do so, based upon Contributing Employer contributions as described in "Reinstatement of Eligibility for Coverage" discussed later.

(d) Limited Eligibility to Extend Period of Self-Payment for Life Insurance Only

If a Participant is at least 55-years-old and is vested under the St. Louis Painters Pension Plan at the end of the self-pay period described in the preceding paragraphs, he may continue to self-pay the premium for Life only until his annuity starting date under the St. Louis Painters Pension Plan. The same payment due dates apply.

Furthermore, if a Participant is at least 55-years-old and is vested under the IUPAT Pension Fund and has had coverage under the Welfare Fund for 24 out of the 36 months immediately preceding the end of the self-pay period described in the preceding paragraphs, he may continue to self-pay the premium for Life only until his annuity starting date under the IUPAT Pension Fund. The same

payment due dates apply.

Self-payment for Life only covers the Participant only; that is, it does not include Life Insurance coverage for Dependents. It does not include Accidental Death and Dismemberment (AD&D) coverage for Participants or Dependents.

(e) Benefits for Active Self-Pay Participants

When Self-Payments are used to extend active participation, the Active Self-Pay Participant and his Dependents will be covered by all of the Plan's benefits, except the Weekly Disability Benefits.

**Note: In addition to the above Self-Pay Provisions, the following restrictions also apply:**

- **Non-Bargaining Unit Employees are not eligible to make self-payments to extend eligibility.**
- **Retirees receiving St. Louis Painters Pension Fund benefits who continue to work are not eligible to make self-payments to extend eligibility as an Active Self-Pay Participant (but may elect to make self-payment for coverage under one of the retiree self-pay plans of coverage).**
- **Retirees receiving pension benefits from the IUPAT Pension Fund who continue to work are not eligible to make self-payments to extend eligibility as an Active Self-Pay Participant (but may elect to make self-payment for coverage under one of the retiree self-pay plans of coverage if the retiree, at the time he seeks to make self-payment for coverage under one of the retiree self-pay plans, had coverage under the Welfare Fund 24 out of the last 36 months).**

(iv) Pay-Stub Payments-Bargaining Unit Employees

Generally, an employee does not receive credit for any hours worked in Covered Employment towards continued eligibility unless his Contributing Employer makes the required contributions to the Fund. A limited exception is made to this rule for Bargaining Unit Employees only. Any Bargaining Unit Employee who does not have any Hour Bank Credits and whose Contributing Employer is delinquent in the payment of contributions to the Fund, is permitted to pay the missing contributions in order to maintain coverage subject to the restrictions set out below. This provision cannot be used to establish initial eligibility under the Fund or to reinstate coverage that has previously lapsed.

The employee is only eligible to pay the missing contributions for hours actually worked in Covered Employment, but for which contributions have not yet been submitted by his Contributing Employer. The employee must submit paycheck stubs proving that the employee worked sufficient hours in Covered Employment in the Contribution Month to maintain eligibility in the Benefit Month.

In order to maintain coverage, the employee does not have to pay the missing contributions for every hour actually worked in Covered Employment but must pay the missing contributions for at least the minimum number of hours necessary to maintain eligibility. The employee is permitted to continue his eligibility through payment of missing contributions for no more than 3 Benefit Months related to employment with any particular Contributing Employer. The maximum period of 3 Benefit Months is not extended, even if the Contributing Employer subsequently submits payment for the missing contributions.

If the employee's Contributing Employer subsequently submits payment for the missing contributions, the Employee will receive a refund of any amounts he paid related to those missing contributions.

Example 1: Employee A goes to work for ABC Company in March. Employee A has never worked for ABC Company in the past. Employee A has coverage with the Fund when he goes to work for ABC Company in March and had sufficient hours in February to maintain coverage in April. In March, Employee A works 100 hours for ABC Company in Covered Employment, but ABC Company only submits contributions for 70 hours on Employee A's behalf. Employee A is scheduled to lose coverage in May because Employee A has only had 70 hours reported on his behalf in March. If Employee A submits his paycheck stubs

showing he worked 100 hours in Covered Employment in March, Employee A can pay 10 hours-worth of missing contributions to maintain his coverage under the Fund in May. Employee A needs only to submit 10 hours-worth of missing contributions, because ABC Company submitted 70 hours on his behalf and Employee A only needs 80 total hours to maintain his coverage.

Example 2: Employee A has worked for ABC Company on and off for the previous two years. ABC Company fails to submit contributions in a timely manner from time to time. Employee A has on three occasions in the past paid missing contributions in a Contribution Month to maintain coverage in the corresponding Benefit Month due to ABC Company's failure to submit the required contributions in a timely fashion. For every occasion, ABC Company subsequently paid the missing contributions and Employee A was refunded the amounts he paid to maintain coverage. In September, ABC Company once again fails to submit the required contribution on Employee A's behalf and Employee A's coverage is scheduled to lapse in November due to insufficient hours. Employee A cannot pay the missing contributions to maintain coverage, because he has already maintained his coverage for 3 Benefit Months by paying missing contributions when ABC Company failed to submit contributions on his behalf in a timely manner. This is true even if Employee A's employment with ABC Company was not continuous and the three Benefit Months were in different periods of employment.

e. Termination of Eligibility for Coverage-Bargaining Unit Employee

A Participant's eligibility for coverage will terminate at the end of the last day of the Benefit Month for which the Participant last qualified for coverage by means of:

- Contributions for worked hours,
- Hour Bank Credit,
- Self-payment,
- Pay-Stub Payment or
- COBRA Continuation Coverage.

If eligibility for coverage terminates, the former Participant must re-qualify as set out below. An employee who was a Participant may not begin to self-pay or make Pay-Stub Payments once he has had a lapse in eligibility. If a Participant wishes to continue coverage under COBRA, he must elect to do so within the 60-day election period described in section F beginning on page 30.

In no event will coverage under this Plan be rescinded except as otherwise permitted by law.

f. Reinstatement of Eligibility for Coverage-Bargaining Unit Employee

The following reinstatement rules apply to Bargaining Unit Employees who are not Bridge Employees. Bridge Employees are not permitted to reinstate their Active Participant coverage if it lapses for any reason. If a Bridge Employee loses eligibility as an Active Participant, he must either elect to make self-payment for coverage under one of the retiree self-pay plans of coverage where available or lose coverage under the Plan.

(i) Reinstatement After Lapse in Eligibility for Fewer than 12 Months

When a Bargaining Unit Employee who was a Participant temporarily loses eligibility for fewer than 12 months, he may regain eligibility by working at least 80 hours in Covered Employment in a Contribution Month. The employee's eligibility will be reinstated on the first day of the Benefit Month corresponding to the Contribution Month in which the employee meets the 80-hour requirement.

(ii) Reinstatement after Lapse in Eligibility for 12 Consecutive Months

If a Bargaining Unit Employee who was a Participant has been ineligible for benefits for 12 consecutive months or more, he must re-qualify by satisfying a reinstatement participation requirement of 400 hours of work in Covered Employment within a 12-month period.

After a Bargaining Unit Employee who was a Participant has met this reinstatement participation requirement, he will again become eligible after working 80 hours in Covered Employment in any single

Contribution Month. If the employee works 80 hours in the Contribution Month during which the participation requirement is satisfied, those hours may be used to complete the 400-hour requirement. However, if the employee fails to meet the 80-hour eligibility requirement during the same Contribution Month he fulfills the 400-hour requirement, he must work 80 hours during any single Contribution Month before he will be eligible.

The effective date of the Bargaining Unit Employee's reinstated eligibility will be the first day of the Benefit Month corresponding to the Contribution Month in which he has fulfilled both the 400-hour participation and 80-hour eligibility requirements.

**IN ORDER TO RECEIVE CREDIT FOR ANY HOURS WORKED TOWARDS REINSTATEMENT OF ELIGIBILITY, A BARGAINING UNIT EMPLOYEE'S CONTRIBUTING EMPLOYER MUST MAKE THE REQUIRED CONTRIBUTIONS TO THE FUND.**

## **2. Non-Bargaining Unit Employees**

### a. In General

The provisions contained in this Section III(A)(2) apply to Non-Bargaining Unit Employees. A Non-Bargaining Unit Employee will become an Active Participant (that is become eligible for benefits under the St. Louis Painters Welfare Plan) and maintain his eligibility for benefits as set forth in this Section III(A)(2). The provisions applicable to Bargaining Unit Employees are set out in Section III(A)(1) above.

### b. Participation and Eligibility-Non-Bargaining Unit Employees

Participation and eligibility under the Plan for Non-Bargaining Unit Employees are based on contributions submitted by the Contributing Employer each month. A new employee working in Covered Employment will gain initial eligibility for coverage under the Plan once his Contributing Employer has submitted 160 hours of contributions to the Fund on his behalf. Coverage will be effective on the first of the month following the month for which the 160<sup>th</sup> hour was paid. Here are some examples:

Example 1: An employee starts working in Covered Employment as a Non-Bargaining Unit Employee for a Contributing Employer on March 1<sup>st</sup>. On April 10<sup>th</sup>, the Contributing Employer submits 160 hours of contributions to the Fund for the month of March on behalf of the employee. The employee becomes eligible for coverage on April 1<sup>st</sup>.

Example 2: An employee starts working in Covered Employment as a Non-Bargaining Unit Employee for a Contributing Employer on March 23<sup>rd</sup>. On April 10<sup>th</sup>, the Contributing Employer submits 40 hours of contributions to the Fund for the month of March on behalf of the employee. On May 10<sup>th</sup>, the Contributing Employer submits 160 hours of contributions for the month of April on behalf of the employee. The employee's coverage under the Plan becomes effective on May 1<sup>st</sup>.

**Once a Non-Bargaining Unit Employee has met the initial eligibility requirement, he is an Eligible Active Participant. An Active Participant must complete an enrollment form and file it with the Fund Office. The Active Participant should do this as soon as he becomes eligible for benefits under the Plan. An Active Participant and/or his Dependents cannot receive benefits until a fully completed enrollment form is filed with the Fund Office. An Active Participant with Dependents will also be asked to provide proof of Dependent status before benefits can be provided to them.**

A Non-Bargaining Unit Employee remains eligible for coverage after meeting the initial eligibility requirement if his Contributing Employer submits contributions on his behalf each month in the amount and within the time required by the terms of the applicable written agreement. The Non-Bargaining Unit Employee's eligibility for coverage will terminate at the end of the last day of the month for which contributions were submitted to the Fund on the employee's behalf.

Non-Bargaining Unit Employees cannot self-pay to maintain coverage and cannot accrue hour bank credits while working in Covered Employment as a Non-Bargaining Unit Employee. However, a Non-Bargaining Unit Employee who previously worked as a Bargaining Unit Employee and accrued Hour Bank Credits while working as a Bargaining Unit Employee is permitted to retain and use said Hour Bank Credits in accordance

with the provisions of Section III(A)(1)(d)(2)(b)-(d) and (f) if they left Covered Employment as a Bargaining Unit Employee to work for the Union or the Finishing Trades Institute of Midwest. Furthermore, employees of the Union and the Finishing Trades Institute of Midwest, who had Hour Bank Credits on January 1, 2015, are permitted to retain and use said Hour Bank Credits in accordance with the provisions of Section III(A)(1)(d)(2)(b)-(d) and (f).

## **B. ELIGIBILITY AND PARTICIPATION REQUIREMENTS FOR RETIRED PARTICIPANTS**

### **1. In General**

The term "Retire" or "Retired" or "Retirement," as used in this Plan, is defined as the date an individual begins receiving Pension Benefits from the St. Louis Painters Pension Fund or the date an individual begins receiving Pension Benefits from the IUPAT Pension Fund if the individual had coverage under this Welfare Fund for 24 out of the 36 months immediately preceding the date the individual begins receiving Pension Benefits from the IUPAT Pension Fund (an individual's "annuity date").

A Bridge Employee who was a Retired Participant at the time he requalified as an Active Participant as provided for in Article III, Section (A)(1)(c)(2), but then subsequently ceases to be a Bridge Employee because he has resumed Pension Benefits from the St. Louis Painters Pension Fund, shall be deemed to Retire on the date his Pension Benefits from the St. Louis Painters Pension Fund resume and the rules of this Article III, Section B shall apply as if the individual has not previously been a Retired Participant or previously Retired under this Plan. **A Bridge Employee who was not a Retired Participant at the time he requalified as an Active Participant cannot maintain his coverage as a Retired Participant by making retiree self-payments under subsection 4 below after losing his Active Participant status.**

When a Participant Retires, he may continue his eligibility for Welfare benefits by:

- Contributions remitted on his behalf;
- Hour Bank Credits;
- Election of coverage under one of the retiree self-pay plans, or
- COBRA.

### **2. Eligibility by Hours Worked**

When a Participant begins receiving Pension Benefits from the St. Louis Painters Pension Fund/IUPAT Pension Fund, he may continue to work in Covered Employment to maintain Welfare coverage with a minimum of 80 work hours reported in a month.

From the date Participant Retires and begins receiving benefits from the St. Louis Painters Pension Fund/IUPAT Pension Fund, he may no longer acquire additional Hour Bank Credits with the St. Louis Painters Welfare Plan. However, Hour Bank Credits will not be reduced in any month the Participant earns 80 or more hours.

A Participant who does not have the required 80 hours of contributions in a month to maintain coverage, must use his accumulated Hour Bank Credits to continue coverage.

- An Hour Bank Credit shall be used each month the Participant does not have the required 80 hours of contributions to maintain coverage.
- Once a Participant's Hour Bank Credits have been exhausted, he must elect coverage under one of the retiree self-pay plans (subject to meeting eligibility requirements to do so) or elect COBRA to maintain coverage. If the Participant rejects the coverage at this time, he will not be allowed into the program at a later date (except in limited circumstances where he meets the requirements for regaining eligibility for active coverage as a Bridge Employee). In order to elect one of the retiree self-pay plans, the retiree must waive COBRA.
- **Once Hour Bank Credits have been exhausted, contributions received on his behalf will not be considered for eligibility purposes, and he may not re-qualify as an**

**Active Participant (except in limited circumstances where he meets the requirements for regaining eligibility for active coverage as a Bridge Employee).**

### **3. Eligibility by Hour Bank Credits**

If a Participant does not have the required 80 hours of contributions for continued eligibility in a particular Contribution Month, he may use an Hour Bank Credit for coverage in the corresponding Benefit Month. **However, in the first Benefit Month that a Participant's eligibility is scheduled to terminate due to insufficient hour contributions or exhaustion of Hour Bank Credits, the Participant must elect continued coverage under one of the retiree self-pay plan options if eligible (or elect COBRA continuation) if he desires to continue to participate in the Plan.**

Once a retiree self-pay plan has been elected, coverage under the Plan may only be continued through that self-payment plan. Retired Participants may continue to work; however, hours contributed on their behalf will not be considered for eligibility purposes or to accrue Hour Bank Credits (except in limited circumstances where the requirements are met for regaining eligibility for active coverage as a Bridge Employee). A Retired Participant that has already elected a retiree self-pay plan may not use Hour Bank Credits to continue coverage, and he may not re-qualify as an Active Participant (except in limited circumstances where he meets the requirements for regaining eligibility for active coverage as a Bridge Employee).

### **4. Eligibility by Retiree Self-Pay Plan Coverage**

Except as otherwise provided below, an individual will be eligible to elect and make self-payments toward a retiree self-pay plan of coverage if he meets all of the following requirements:

- a. He does not have the required 80 hours of contributions remitted on his behalf during a Contribution Month and has no Hour Bank Credits for continuation of coverage; and
- b. He is receiving a Pension benefit from the St. Louis Painters Pension Fund (or has attained retirement age and is eligible to receive a pension benefit but has elected to postpone the date on which benefits begin); or he is receiving a Pension benefit from the IUPAT Pension Fund (or has attained retirement age and is eligible to receive a pension benefit but has elected to postpone the date on which benefits begin) and he has been eligible for benefits from this Welfare Fund for 24 out of the 36 months immediately preceding the date he started receiving pension benefits from the IUPAT Pension Fund (or the date he attained retirement age and is eligible to receive a pension benefit where he has elected to postpone the date on which benefits begin from the IUPAT Pension Fund), and
- c. He was eligible to receive benefits in the Benefit Month immediately prior to the Benefit Month in which he did not meet eligibility requirements by either hours contributed or Hour Bank Credits and therefore must elect continuation of coverage under a retiree self-pay plan of coverage; and
- d. He was eligible for benefits from the St. Louis Painters Welfare Plan in at least 24 of the 36 calendar months immediately preceding the Benefit Month in which he did not meet eligibility requirements by either hours contributed or Hour Bank Credits and therefore must elect continuation of coverage under a retiree self-pay plan of coverage. Bridge Employees who were Retired Participants at the time they returned to Active Participant status are deemed to have satisfied this requirement when they re-retire assuming they elect continuation of coverage under a retiree self-pay plan of coverage the first month they are required to do so.

**If an individual satisfies the above eligibility requirements and makes the necessary self-payment, he will become an Eligible Retired Participant under his elected retiree self-pay plan of coverage on the first day of the Benefit Month following the last Benefit Month in which he was covered as an Active Participant by either hours contributed or Hour Bank Credits. Bridge Employees who had previously rejected retiree coverage or lost retiree coverage for a reason other than regaining eligibility as an Active Participant due to being a Bridge Employee, are not eligible to elect a retiree self-pay plan of coverage.**

Payment for both of the first and second Benefit Months of coverage under an elected retiree self-pay plan of coverage will be due by the 10<sup>th</sup> day of the first Benefit Month of coverage. Thereafter, payment is due by the 10<sup>th</sup> of the month preceding the Benefit Month for which coverage is to be provided. The self-payment amount will be determined by the Trustees, and the amount will vary depending on the Retired Participant's age, his eligibility for Medicare, whether any of the Retired Participant's Dependents are covered and whether dental benefits are elected.

A Bridge Employee who requalifies as a Retired Participant will make a new coverage election at the time he requalifies and will elect from any retiree self-pay plan of coverage available at that time. A Bridge Employee who requalifies as a Retired Participant will pay the self-pay rates in effect on the date he makes his new coverage election.

**If a Retired Participant fails to make payment for his retiree coverage on a timely basis, he will permanently forfeit the right to retiree coverage. Additionally, if a Participant is either employed for a non-Contributing Employer, self-employed and not required to make contributions to the Fund or becomes a non-Contributing Employer of employees engaged in the Painting and/or Taping trade but not required to make contributions to the Fund, he will become permanently ineligible for retiree coverage under this Plan either by self-payment or COBRA continuation.**

**If a Participant does not meet the above eligibility requirements for continuing coverage under a retiree self-pay plan of coverage, or as an alternative to continuing coverage under a retiree self-pay plan of coverage, he may elect COBRA coverage at the time eligibility for active coverage terminates. If COBRA coverage is elected, a Participant cannot later elect coverage under one of retiree self-pay plans or otherwise qualify for coverage under the St. Louis Painters Welfare Fund (except in limited circumstances where he meets the requirements for regaining eligibility for active coverage as a Bridge Employee).**

## **5. Retiree Benefits**

Retiree benefits are the same as the benefits for Active Participants except for:

- a. Life and AD&D:
  - Retiree accidental death and dismemberment benefit amounts are less than those of Active Participants (as shown in the Schedule of Benefits). The amounts differ for retirees and their spouses who have not reached age 65, and for retirees and their spouses who have reached age 65 (as shown in the Schedule of Benefits).
  - The retiree life insurance benefit amount is less than that for Active Participants and is further reduced when the retiree reaches age 65 (as shown in the Schedule of Benefits).
  - There is no Dependent child life insurance benefit for the retiree's children.
- b. Medicare Coverage:
  - Benefits provided under this Plan are reduced by the amounts that are paid under Medicare Parts A and B for Retired Participants and Dependents who are eligible for Medicare, regardless of whether the eligible person is enrolled in Medicare.
  - Because the Plan thus reduces its benefits, it is very important that the Retired Participant and/or his eligible Dependents enroll in both parts A and B of Medicare as soon as eligible.
  - If an individual who is eligible for Medicare enters into a private contract or agreement with a provider that permits that healthcare provider to charge whatever the provider wishes, free of price limits imposed by Medicare, the Plan will provide no benefits for services or supplies rendered by the provider under that private contract.
- c. Limited Coverage for Younger Disability Retirees with Fewer than 30 Pension Credits

If an individual who was a Participant is under age 60 and is: (1) receiving a Disability Pension from the St. Louis Painters Pension Fund but has fewer than 30 pension credits in the St. Louis Painters Pension Fund, or (2) is receiving a Disability Pension from the IUPAT Pension Fund but has fewer than 30 pension credits in the IUPAT Pension Fund and had coverage under this Welfare Fund for 24 out of the 36 months immediately preceding the date the individual began receiving a Disability Pension from the IUPAT Pension Fund, he may only continue eligibility for retiree benefits (after he is no longer eligible by hours worked or

Hour Bank Credits) by making self-payments until the earlier of:

- 30 consecutive months from the date eligibility terminated, or
- the date he becomes eligible for Medicare benefits.

d. Dependents of Retired Participants

Eligible Retired Participants may continue Dependent coverage for an additional monthly payment. If a Participant has a Dependent on the date retiree self-pay coverage begins, he must choose and pay for Dependent coverage from that date if he wants that Dependent to have coverage. That Dependent cannot become covered at any later time (except in limited circumstances where a Participant, who is a Bridge Employee, meets the requirements for regaining eligibility as a Retired Participant and includes that Dependent in his new election).

If a Retired Participant wants coverage for a Dependent acquired after retiree self-pay coverage begins, he must notify the Fund Office within 30 days after acquiring that Dependent. The newly acquired Dependent will become covered on the first day of the month on or following the date the Retired Participant acquires that Dependent, provided the Retired Participant pays the appropriate additional cost, if any. (If a Retired Participant is already paying for Dependent coverage for at least one Dependent, there will be no additional cost for a newly acquired Dependent).

If a Retired Participant drops Dependent coverage after he begins retiree self-pay coverage, he may not elect to resume such Dependent coverage at a later date (except in limited circumstances where a Participant, who is a Bridge Employee, meets the requirements for regaining eligibility as a Retired Participant and includes that Dependent in his new election).

## **C. DEPENDENT ELIGIBILITY**

### **1. Eligible Dependents**

Only the following individuals may be covered as a Participant's Eligible Dependents under this Plan:

- a. a Participant's lawful spouse; or
- b. a Participant's biological child, adopted child (or a child placed with him/her for adoption), stepchild, or foster child for whom the Participant is legally responsible based upon court order of competent jurisdiction to provide physical custody and financial support, until the end of the month in which the Dependent child reaches age 26.

### **2. Dependents Who Are Not Eligible**

The following are not eligible for coverage as Dependents:

- a Participant's divorced spouse or a spouse from whom the Participant is legally separated;
- anyone, other than a spouse, eligible for coverage as a Participant;
- a child who has attained the limiting age. The limiting age is the child's 26<sup>th</sup> birthday; a Dependent child is considered to reach the limiting age at the end of the month in which the Dependent child reaches age 26; or
- except as otherwise provided in Section 1 above, an individual who does not qualify as the Participant's "dependent" under Section 106(a) of the Internal Revenue Code or relevant IRS regulations.

### **3. Special Rules for Handicapped Children**

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

- is dependent on the Participant for a majority of his support; and
- is not capable of self-sustaining employment.

Coverage will continue only if the Participant presents proof of the child's handicap to the Fund Office:

- no later than 31 days after the child attains the limiting age; and
- thereafter as the Trustees may require, but not more often than once every two years.

#### **4. When Dependent Coverage Begins**

A Participant's Dependent will become covered on the same date the Participant becomes eligible for coverage, or if later, on the date the Participant acquires the Dependent or the Dependent otherwise becomes eligible for coverage.

**IMPORTANT, PLEASE NOTE:** Notwithstanding the foregoing, no benefits will be paid for any loss that occurs or service that is rendered prior to the date the Participant provides the Fund Office with necessary proof of the Dependent's eligibility unless the Participant provides such proof within six (6) months after the Dependent first becomes eligible. For example, if the Participant contacts the Fund Office prior to the birth of the Participant's child to inquire about benefits, and then five months after the child's birth provides the required proof regarding the child's eligibility, the child will be eligible for benefits back to the child's date of birth; however, if that Participant fails to provide the required proof regarding the child's eligibility until six (6) months and one (1) day after the child's date of birth, then the child's eligibility for benefits will not date back to the date of birth, but will instead start from the date the proof was provided. Therefore, the Participant should provide the Fund Office with such proof immediately when his Dependent becomes eligible or he acquires a new Dependent.

#### **5. When Dependent Coverage Ends**

Except as provided under COBRA and any other extensions of coverage available under the Plan (e.g., for surviving Dependents of deceased Participants), a Dependent's benefits under this Plan will end on the earliest of the following:

- The date the Participant's coverage ends;
- The end of the month in which a Participant's spouse becomes divorced or legally separated from the Participant. The date on which a divorce or legal separation occurs is the date a court first enters a decree or judgment of divorce or legal separation;
- In other circumstances, at the end of the month in which the Dependent ceases to meet the Plan's definition of Dependent;
- At 12:00 a.m. on the day the Dependent (other than the Participant's spouse) becomes covered as a Participant in this Plan; or
- At 12:00 a.m. on the day the Dependent spouse enters active duty in any military organization.

#### **6. Your Duty to Inform Plan of Termination of Dependents' Eligibility**

If any of the following occur, it is Your responsibility to inform the Fund Office:

- A Participant and his spouse get divorced or legally separated;
- A Dependent child reaches the limiting age; or
- An incapacitated child recovers.

If You fail to inform the Fund Office within 60 days of the date one of these events occurs, a Dependent may lose his right to COBRA continuation coverage (see section F). Further, if because You have failed to inform the Fund Office, the Plan pays out benefits for an ineligible Dependent, the Plan may have the right to recover such benefits from the Participant, the Dependent, and/or any provider to whom such benefits were paid. The Plan may at its option withhold future benefits due to or on behalf of a Participant and the Participant's other covered Dependents in order to recoup amounts it paid on behalf of an ineligible Dependent. If the Trustees bring a legal action to collect such benefits, the Trustees, upon prevailing, will be entitled to receive and You will be required to pay not only the overpayments, but also pre-judgment interest and the reasonable attorney's fees and costs the Trustees incur in such action.

#### **7. Surviving Dependents of Eligible Retired Participants**

The covered surviving spouse and eligible Dependent children of an Eligible Retired Participant who dies may elect to continue their coverage under the Plan on a self-pay basis for a maximum of three months or they may elect COBRA continuation coverage for up to 36 months from the date of the Participant's death (See Section V). **Important Note: If self-payment is elected, the surviving spouse and Dependent children are no longer entitled to continuation of coverage under COBRA and must waive their right to COBRA**

coverage.

## **8. Surviving Dependents of Eligible Active Participants**

### a. Use of Hour Bank Credits

The surviving Dependent spouse and Dependent children of an Active Participant who dies may use that Participant's Hour Bank Credits to continue their medical, prescription drug, dental and vision benefits. After those Hour Bank Credits are exhausted, those Dependents may continue their coverage by making self-payments (where applicable) as described in the next paragraph or through COBRA. If electing to make self-payments (where applicable), the surviving Dependents must waive their right to COBRA coverage.

### b. Self-Payments

The surviving Dependent spouse and Dependent children of a Bargaining Unit Employee who was an Active Participant and dies may continue their coverage for up to one year on a self-pay basis. The same self-payment rules that apply to Participants will apply to the surviving Dependents. **Important Note: If self-payment is elected, the surviving Dependent spouse and Dependent children are no longer entitled to continuation of coverage under COBRA and must waive their right to COBRA coverage.**

### c. COBRA

As an alternative to making self-payments for 12 months, the surviving Dependents of an Active Participant who dies may elect COBRA continuation coverage for up to 36 months from the date of the Participant's death. (See Section F). COBRA continuation coverage is also available for the surviving Dependents of Non-Bargaining Unit Employees who were Active Participants at the time of death.

## **9. Qualified Medical Child Support Orders**

To the extent not inconsistent with the terms of this Plan, the Plan will enroll dependent children as required by a Qualified Medical Child Support Order ("QMCSO"). A QMCSO is an order issued by a state court or agency that requires the Plan to cover a child and, for purposes of notices about benefits, communications about claims and reimbursements, to treat the child as a Participant. For a copy of the Plan's procedure for handling such orders and determining whether an order is "qualified," call or write the Fund Office, and a copy will be sent to You without charge.

## **D. MISCELLANEOUS ELIGIBILITY PROVISIONS**

### **1. Special Enrollment Rights**

If You decline enrollment for Yourself, Your Spouse or Dependents because of other health insurance or group health plan coverage, You may be able to enroll them in the Plan if You or they lose eligibility for that other coverage (or if the employer stops contributing towards Your or Your Spouse or Dependents' other coverage). However, You must submit enrollment documentation to the Fund Office within six (6) months after the other coverage ends (or after the employer stops contributing towards the other coverage).

In addition, if You have a new Spouse as a result of marriage, or a new Dependent child as a result of birth, adoption or placement for adoption, or placement as an eligible foster child, You may be able to enroll Yourself and Your Spouse and Dependent children. However, You must submit enrollment documentation to the Fund Office within six (6) months after the marriage, birth, adoption or placement for adoption, or placement as an eligible foster child.

You and Your Spouse and Dependent children may also enroll in the Plan if You (or they) have coverage through Medicaid or a State Children's Health Insurance Program (SCHIP) and You (or they) lose eligibility for that coverage. However, You must submit enrollment documentation to the Fund Office within six (6) months after the Medicaid or SCHIP coverage ends.

You and Your Spouse and Dependent children may also enroll in this Plan if You (or they) become eligible for a premium assistance program through Medicaid or SCHIP. However, You must submit enrollment documentation to the Fund Office within six (6) months after You (or they) are determined to be eligible for such assistance.

If You miss the prescribed window explained above, You may still enroll Your Spouse or Dependents, but their coverage will be effective on the date that the enrollment request plus any additional documentation required (such as birth or marriage certificates) are received at the Fund Office.

To request special enrollment or obtain more information, contact the Fund Office.

## **2. Extension of Eligibility for Disabilities**

### a) Generally

There are special rules for extension of an Active Participant's coverage under the Plan if the Active Participant is unable to work due to an Injury or Illness. The length of time the Active Participant's coverage is extended varies according to the nature of the Illness or Injury.

In order to be eligible under these rules, the Active Participant must submit medical evidence of his disability to the Fund Office.

### b) Occupational Injuries

If an Active Participant is injured on the job while working in Covered Employment for a Contributing Employer and while eligible for benefits, his coverage (except for the Weekly Disability Benefit) and that of his Eligible Dependents will be continued for up to a maximum of 12 consecutive months from the date the Active Participant is injured. This means that if the Active Participant is injured on the job, coverage for the Active Participant and his eligible Dependents (except for the Weekly Disability Benefit) is continued for up to a maximum of 12 months at no cost and without using any Hour Bank Credits. After that, Hour Bank Credits, if any, will be applied and then the Participant may make self-payments in accordance with the Self-Pay rules (or You can elect COBRA Continuation Coverage (See Section F)).

**Please Note:** To insure that an Active Participant and his Dependents do not suffer an interruption in coverage and to insure an Active Participant's Hour Bank is not charged for continued coverage when an Active Participant is injured on the job, the Active Participant must notify the Fund Office as soon as possible that he is unable to work due to an on-the-job Injury.

### c) Non-Occupational Injury or Sickness

If an Active Participant incurs a non-occupational Sickness or Injury while employed in Covered Employment by a Contributing Employer and while eligible for benefits, the Active Participant's eligibility and that of his Eligible Dependents will be continued until the last day of the month in which the Active Participant recovers from the disability, up to a maximum of three months. Again, the benefits shown in the Schedule are provided, except no Weekly Disability Benefits are available.

**Please Note:** As indicated above, an Active Participant must notify the Fund Office as soon as possible if he believes he is entitled to extended benefits under this provision.

If an Active Participant is unable to work because of a non-occupational disability which lasts longer than a three-month period, the Active Participant may continue his coverage under the Plan on a self-pay basis for a limited period of time. The rules are as follows:

- i. The Active Participant first uses his Hour Bank Credits, if any, to continue coverage, and then,
- ii. The Participant may make self-payments to continue coverage in accordance with the Self-Pay Rules for Active Participants (or he can elect COBRA Continuation Coverage (See Section F)).

Once an Active Self-Pay Participant has made self-payments for the maximum period of time, no additional self-payments for coverage will be accepted, except as follows:

- i. if a Participant meets the Retiree eligibility requirements, he may continue coverage through self-payments for coverage as a Retiree.
- ii. If a Participant does not meet the Retiree eligibility requirements, but he continues to be totally disabled, he will be permitted to self-pay for retiree coverage for up to a maximum of 30 months, or if earlier, until the date he becomes eligible for Medicare benefits. For the purposes of this

provision, a Participant will be considered totally disabled if he is receiving Social Security disability benefits or he is in the process of appealing the denial of such benefits.

### **3. Eligibility During FMLA Leave**

If a Participant takes approved leave under the Family and Medical Leave Act (FMLA), his employer is required to continue making contributions to the Welfare Fund during such leave. Please notify the Fund Office if a Participant takes such leave so that the Trustees can make sure such contributions are made on the Participant's behalf and that he will continue to be covered to the full extent to which such continued contributions would qualify him. Please note, not all employers are required to comply with the FMLA. Generally, an employer must have at least 50 employees before the FMLA requirements apply to that employer and even then, the FMLA applies only to employees who have been employed by that employer for at least 12 months.

### **4. Rescission of Coverage**

A rescission of coverage is a cancellation or discontinuance of coverage that has retroactive effect, meaning that it will be effective back to the time that you should not have been covered by the Plan. The Plan may rescind your coverage for fraud or intentional misrepresentation of a material fact after the Plan provides you with 30 days advance written notice of that rescission of coverage.

However, the following situations will not be considered rescissions of coverage and do not require the Plan to give you 30 days advance written notice:

- When the Plan terminates your coverage retroactive to the date you lose eligibility for coverage, if there is a delay in administrative recordkeeping between the date you lose eligibility and the date the Plan is notified of your loss of eligibility;
- When the Plan retroactively terminates your coverage because you fail to make timely self-payments for your coverage; or
- When any unintentional mistakes or errors result in you or your Dependents being covered by the Plan when you should not have been covered; in this instance, the Plan will cancel your coverage prospectively – for the future – once the mistake is identified.

## **E. ENROLLMENT**

### **1. Initial Enrollment**

Even after You have met the participation and eligibility requirements set out in this Section, You will not receive benefits until You complete an enrollment form. If You have not received an enrollment form, You should contact the Fund Office as soon as You become eligible for benefits. At that time You will be required to provide proof, such as a marriage license or a birth certificate, that You are eligible under the Plan.

### **2. Updated Enrollment Information**

If a Participant acquires a new Dependent or if an existing Dependent becomes eligible under the Plan, the Participant must complete the enrollment process for that new Dependent. Similarly, if a Participant's Dependent loses eligibility, for example, by divorce or by reaching the limiting age, the Participant must notify the Fund Office. Additionally, the Fund Office may from time to time request that You submit an updated enrollment form.

### **3. Consequences of Failure to Enroll or Update Enrollment Information**

If You fail to initially enroll or update Your enrollment forms and documentation when requested, the Plan will not process any claims until it receives the required documents.

**Note:** The Plan, through Anthem, receives discounts from providers of medical services. These discounts, which can be substantial, are granted only if the Plan pays the providers promptly. If the Plan is unable to pay a claim because You fail to file Your enrollment form, the Plan may lose the discount. If that happens, the Plan will pay only the discounted amount and the medical provider will be free to pursue You for the balance.

If You fail to notify the Fund Office of any loss of Dependent eligibility and the Plan pays out benefits on behalf of an ineligible child, a former spouse or former stepchildren, You will be responsible to repay the Plan such

benefits or the Plan can recover those benefits by withholding future benefits or even bringing a legal action to collect such repayment. (See page 72 for details).

## **F. COBRA CONTINUATION COVERAGE**

### **1. Introduction**

**The following paragraphs generally explain COBRA continuation coverage, when it may become available to You, and what You need to do to protect the right to receive it.**

The St. Louis Painters Welfare Plan provides continued health care coverage on a self-pay basis pursuant to the Consolidated Omnibus Budget Reconciliation Act of 1985, commonly known as COBRA. Eligible Participants and their Dependents are offered the opportunity for a temporary extension of health coverage called "continuation coverage" in certain instances called "Qualifying Events," which would otherwise cause coverage to end.

You do not have to show that You are insurable to qualify for continuation coverage. However, You must pay the cost of the continuation coverage. You may have other options available to You when You lose group health coverage. For example, You may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, You may qualify for lower costs on Your monthly premiums and lower out-of-pocket costs. Additionally, You may qualify for a 30-day special enrollment period for another group health plan for which You are eligible (such as a spouse's plan), even if that plan generally does not accept late enrollees. If You elect COBRA continuation coverage under this Plan, You will have that same special right to enroll in another group health plan at the end of Your COBRA coverage if You keep the COBRA coverage for the maximum period it is available to You.

### **2. What is COBRA Continuation Coverage?**

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "Qualifying Event." Specific Qualifying Events are listed in subsection 3 below, entitled "Who is Entitled to Elect COBRA?"

After a Qualifying Event occurs and any required notice of that event is properly provided, COBRA continuation coverage will be offered to each person who is a "Qualified Beneficiary." A Participant, his spouse, and his Dependent children could become Qualified Beneficiaries if coverage under the Plan is lost because of a Qualifying Event. (Certain newborns, newly adopted children, and alternate recipients under QMCSOs may also be Qualified Beneficiaries. This is discussed in more detail below.)

Under the Plan, Qualified Beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

### **3. Who is Entitled to Elect COBRA?**

A Participant will become a Qualified Beneficiary if he loses coverage under the Plan because either one of the following Qualifying Events happens:

- His hours of employment are reduced, or
- His employment ends for any reason other than his gross misconduct.

The Dependent spouse of a Participant will become a Qualified Beneficiary if he loses coverage under the Plan because any of the following Qualifying Events happens:

- The Participant dies;
- The Participant's hours of employment are reduced;
- The Participant's employment ends for any reason other than his gross misconduct;
- The Participant and spouse become divorced or legally separated.

A Participant's Dependent children will become Qualified Beneficiaries if they lose coverage under the Plan because any of the following Qualifying Events happens:

- The parent-Participant dies;

- The parent-Participant's hours of employment are reduced;
- The parent-Participant's employment ends for any reason other than his gross misconduct;
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a "Dependent child."

**Under the above circumstances, because the Plan does not pro-rate COBRA for partial month coverage, coverage for Bargaining Unit Employees will terminate as of the last day of the Benefit Month in which the Qualifying Event occurs and the effective date of COBRA continuation coverage will be the 1<sup>st</sup> day of the following month. For Non-Bargaining Unit Employees, coverage will terminate as of the last day of the month in which the Qualifying Event occurs and the effective date of COBRA continuation coverage will be the 1<sup>st</sup> day of the following month.**

**Note: Unless otherwise listed above as a Qualifying Event, loss of coverage as the result of not meeting or violating participation requirements established by the Plan does not represent a Qualifying Event entitling continuation of coverage under COBRA.**

#### **4. Notices Required**

Under the law, a Participant's employer is required to notify the Fund Office of the Participant's death, termination or reduction of hours of employment. However, because employers contributing to multi-employer funds may not be aware of these events, the Fund Office will generally rely on its own records to determine when coverage is lost under these circumstances. In order to ensure that You receive the appropriate notices and election forms, it is a good idea for You to also notify the Fund Office.

**IMPORTANT: You must inform the Fund Office in writing of a divorce, legal separation, or a child losing Dependent status under the Plan within 60 days after coverage would terminate due to that event. If You fail to notify the Fund Office within that 60-day period, COBRA continuation coverage will NOT be offered. You must also notify the Fund Office of a second Qualifying Event within 60 days of the date coverage would terminate in order to have the right to extend the maximum COBRA period.**

To help You ensure that You do not suffer a gap in coverage, You should notify the Fund Office of any and all Qualifying Events as soon as the Qualifying Event occurs. Notices must be written and sent or hand-delivered to:

Administrator  
St. Louis Painters Welfare Fund  
13801 Riverport Drive, Suite 501  
P.O. Box 1186  
Maryland Heights, MO 63043

Oral notice, including notice by telephone is not acceptable. Electronic (including e-mailed or faxed) notices are not acceptable. If mailed, the notice must be postmarked no later than the deadline described above. If hand-delivered, the notice must be received by the individual at the address specified above no later than the deadline described above.

The notice must include the following information:

- The name and address of the Participant/former Participant who is/was covered under the Plan;
- The name(s) and address(es) of all Qualified Beneficiary(ies) who lost coverage due to the Qualifying Event;
- The Qualifying Event (divorce, legal separation, or child's loss of Dependent status);
- The date the divorce, legal separation or child's loss of Dependent status happened; and
- The signature, name and contact information of the individual sending the notice.

A notice of a divorce or legal separation must include a copy of the decree of divorce or legal separation.

When the Fund Office receives timely notice that You have had a Qualifying Event, You will be notified within 14 days of Your rights to continuation coverage and will be sent an election form.

#### **5. Election of COBRA Continuation Coverage**

Upon termination of eligibility due to insufficient contribution hours, Active Participants who were Bargaining Unit Employees will be given the option to continue coverage under COBRA or self-payment. Non-Bargaining Unit

Employees may only elect COBRA. The election of either option for Bargaining Unit Employees terminates the right to elect the other type of continuation coverage until eligibility is reestablished through employer contributions on hours worked. Retired Participants who were Bargaining Unit Employees will also be offered a choice between self-payment and COBRA continuation coverage. Once an election is made, the Retired Participant will no longer have the right to elect any other type of continuation coverage at any time in the future, and the other types of continuation coverage will be considered waived.

Any Qualified Beneficiary who wishes to continue coverage under COBRA must complete the Plan's COBRA Election Form (sent as part of the Plan's COBRA Election Notice). The Election Form must be submitted to the Fund Office within 60-days of the later of: (a) the date the notice of the right to elect continuation coverage is provided, or (b) the date coverage would otherwise terminate as a result of the Qualifying Event.

Each Qualified Beneficiary who would lose coverage under this Plan as a result of a Qualifying Event is entitled to independently elect continuation coverage under this Plan. For example, if a Participant's family is covered under the Plan and coverage would terminate due to the Participant's reduced work hours, the Participant may choose to continue coverage for his entire family or only for himself, his spouse and/or any Dependent children. Participants and their Dependent spouses may elect coverage on behalf of all Qualified Beneficiaries and parents may elect COBRA on behalf of their eligible children.

If a Qualified Beneficiary acquires a new Dependent while on COBRA continuation coverage, that new Dependent can be covered for the balance of the maximum coverage period, provided that the Qualified Beneficiary notifies the Fund Office of the new Dependent within 31 days after the date the new Dependent was acquired and pays any additional COBRA premium that may be required. (Note: if a Participant on COBRA has a new child through birth, adoption or placement for adoption; that new child has an independent right to continue coverage for the balance of the applicable maximum coverage period, even if the Participant's coverage does not continue for the entire maximum coverage period. No other Dependent acquired after the commencement of COBRA continuation coverage has this right.)

**If You reject COBRA before the expiration of the 60-day election period, You may change Your mind as long as You submit a completed Election Form to the Fund Office within that 60-day period. If You do not elect COBRA continuation coverage within the 60-day limit, Your health benefits under the Plan will end unless You are eligible for and elect other continuation coverage provided by the Plan.**

## **6. Coverage Provided**

If You elect COBRA continuation coverage, the Plan is required to provide You with the health (medical, prescription drug, dental and vision) coverage You were receiving on the day before the Qualifying Event and which is identical to the coverage provided under the Plan to similarly situated Participants and their Dependents, excluding Life Insurance, Accidental Death and Dismemberment and Weekly Disability Benefits. Plan changes that apply to Active Participants/Dependents will also apply to any Qualified Beneficiaries who are continuing coverage under COBRA.

You may elect to continue Your medical benefits only or Your medical benefits together with dental and vision benefits.

## **7. Payment**

You are responsible for the payment of contributions for such continued coverage, however such payments may be made by a third party on Your behalf. The premium amount may be up to 102% of the cost of coverage (or 150% of the cost of coverage for the additional 11 months of COBRA continuation coverage available to Totally Disabled Qualified Beneficiaries). The amount of the payment for COBRA continuation coverage is established by the Trustees on an annual basis and will vary depending on which benefits You decide to continue.

The initial payment is due in the Fund Office within 45 days after the date on which the election of COBRA continuation coverage is made. The initial payment must include payment for all months up to the date of the election. Payments for subsequent months are due on the first day of each month and must be made no later than 30 days after the first day of the month to which they apply. Payment by check without sufficient funds in the bank ("bounced" checks) will not be considered as payment and You will lose Your right to COBRA continuation coverage unless You make full payment by money order or cashier's check within the applicable grace period.

Failure to make timely payments will result in termination of coverage, except that if a payment is short by an insignificant amount (the lesser of \$50 or 10% of the total amount due), the Qualified Beneficiary will be notified in writing and will be given 30 days from the date of such notice to pay the deficient amount.

## **8. Period of COBRA Coverage**

Qualified Beneficiaries are entitled to continue coverage for up to the following maximum coverage periods:

- a. 18 months from the Qualifying Event, if that event is the termination or reduction of hours of employment.

Note, however that if any person who is a Qualified Beneficiary as a result of this Qualifying Event is determined by the Social Security Administration to have been disabled anytime during the first 60 days of continuation coverage (measured from the later of the date of the Qualifying Event or date coverage would have terminated in the absence of a COBRA election), then any or all of the Qualified Beneficiaries who have coverage as a result of that Qualifying Event, are entitled to 11 additional months of continuation coverage, for a maximum of 29 months. In order to qualify for the additional 11 months, the Qualified Beneficiary seeking the extension must provide the Fund Office with a copy of the Social Security determination before the end of the original 18-month maximum coverage period and within 60 days of the later of:

- the date of the disability determination;
- the date of the Qualifying Event; or
- the date the Qualified Beneficiary would lose coverage under the Plan.

If the disabled Qualified Beneficiary elects this 11-month extension, the Plan may charge up to 150% of the regular premium during the 11-month extension. If the Qualified Beneficiary is determined by the Social Security Administration to no longer be disabled, the Qualified Beneficiary must notify the Plan within 30 days of that determination.

Note also, if the Participant was entitled to Medicare prior to this Qualifying Event, his Dependents' maximum coverage period will end on the later of 36 months from the date he became eligible for Medicare or 18 months from the date of the Qualifying Event.

- b. 36 months after the original Qualifying Event for covered Dependents, if coverage is being continued due to a Participant's termination of employment or reduced work hours and that Participant's covered Dependents experience a second Qualifying Event (Participant's death, divorce or legal separation or loss of Dependent status) during the initial 18 (or 29) months of continuation coverage. This extension of the maximum COBRA period will only apply if the second Qualifying Event would have caused a loss of coverage under the Plan had the first Qualifying Event not occurred;
- c. 36 months after the Qualifying Event, for covered Dependents who are continuing coverage due to a Participant's death, divorce or legal separation from a Participant or loss of Dependent status under the Plan.

## **9. Termination of COBRA Coverage**

COBRA continuation coverage will end for You when any of the following occurs:

- (a) any premium due for COBRA continuation coverage is not paid in full and on time;
- (b) after the COBRA election, You become covered under another group health plan;
- (c) after the COBRA election, You become entitled to Medicare benefits (under Part A, Part B, or both);
- (d) For coverage that is extended due to disability, the first day of the first month that begins more than 30 days after the date a disabled Qualified Beneficiary is finally determined by Social Security Administration to be no longer disabled;
- (e) the Fund no longer maintains any group health plans; or
- (f) the applicable maximum period of COBRA continuation coverage ends.

## 10. Options other than COBRA

Instead of enrolling in COBRA continuation coverage, there may be other coverage options for You through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. In order to choose a continuation option other than COBRA, such as continuation through self-payments, you must waive your rights to COBRA continuation coverage. You can learn more about many of these options at [www.healthcare.gov](http://www.healthcare.gov).

## 11. Medicare

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period to sign up for Medicare Part A or B, beginning on the earlier of

- The month after your employment ends; or
- The month after group health plan coverage based on current employment ends.

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.

For more information visit <https://www.medicare.gov/medicare-and-you>.

## 12. Questions

Questions concerning Your Plan or Your COBRA continuation coverage rights should be addressed to the contact or contacts identified herein. For more information about Your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in Your area or visit [www.dol.gov/ebsa](http://www.dol.gov/ebsa). (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit [www.HealthCare.gov](http://www.HealthCare.gov).

## 13. Address Changes

To protect Your rights, let the Plan Administrator know about any changes in the addresses for You or Your family members. You should also keep a copy, for Your records, of any notices You send to the Plan Administrator.

**In the event more than one continuation provision under the Plan applies and is not waived, the periods of continued coverage will run consecutively.**

## 14. Military Service

If the reduction of hours of a Participant's employment or the termination of a Participant's employment which causes him to lose coverage is due to his service in the uniformed services of the United States, the Participant is entitled to continue his coverage for up to a maximum of 24 months under the Uniformed Services Employment and Reemployment Rights Act (USERRA). If a Participant's service in the uniformed military service is less than 31 days, his coverage will be continued at no cost during that period of service. The Participant must, however, notify the Plan Office in advance of his entering service in the uniformed military service. If the Participant's period of military service is 31 days or longer, the Participant's leave

under USERRA will be administered under the regular COBRA rules outlined previously, except that the maximum period he may continue coverage will be extended to 24 months.

#### **15. Special Extended Continuation for Older Spouses**

##### **a. Generally**

In limited circumstances, the Plan permits older surviving spouses of Participants, divorced spouses, and legally separated spouses to continue their COBRA coverage beyond the time required by law. If

- i. the Qualifying Event which made the Participant's former spouse eligible for COBRA was the Participant's death or the Participant and spouse's divorce or legal separation, and
- ii. on the date the maximum COBRA period expires, the former spouse who maintained COBRA coverage for the maximum period is at least 55,

that former spouse may continue to purchase continuation coverage. The former spouse may continue to purchase such coverage until the earliest of the following dates:

- i. the end of the last month for which payment is timely made;
- ii. the date the Plan terminates;
- iii. the date on which such former spouse remarries;
- iv. the date on which such former spouse becomes covered under another group health plan; or
- v. the date on which the former spouse becomes eligible to enroll in Medicare.

##### **b. Benefits Provided**

The benefits provided under this special extension will be the same as the COBRA continuation coverage the former spouse had and may include coverage for the former spouse's Dependent children who were covered during the original 18, 29 or 36-month COBRA period.

##### **c. Payments**

The former spouse must make payments under the same rules that apply to COBRA continuation coverage; however, the Trustees may require a higher payment for former spouses who choose this special extended continuation coverage.

#### **16. Keep Your Plan Informed of Address Changes**

Since additional information about Your rights under COBRA will be sent to You if there is a Qualifying Event, it is important that the Fund Office have Your current address. So, if a spouse or any Dependent child has an address different from the Participant's or if Your family status changes, please notify the Fund Office.

You should also keep a copy, for Your records, of any notices You send to the Fund Office.

#### **17. If You Have Questions**

Questions concerning Your Plan or Your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about Your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in Your area or visit the EBSA website at [www.dol.gov/ebsa](http://www.dol.gov/ebsa). (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

**18. Contact for COBRA Questions**

If You have any questions regarding this Plan's COBRA continuation coverage, You should call or write the Fund Office:

St. Louis Painters Welfare Fund  
13801 Riverport Drive, Suite 501  
P.O. Box 1186  
Maryland Heights, MO 63043  
phone (314) 656-1072  
fax (314) 739-1105

## **IV. LIFE INSURANCE AND ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS**

### **A. GENERALLY**

The life insurance benefits for a Participant and his Dependents and the accidental death and dismemberment benefits for an Active Participant are provided under a policy of insurance issued by Anthem Insurance Company. The applicable amounts of the life insurance and accidental death and dismemberment benefits are set forth in the Schedule of Benefits. The Plan pays Anthem a premium for these benefits, and Anthem fully insures these benefits. The detailed terms of the insurance policy ultimately control these benefits. We have set forth a summary of the terms of the insurance policy, and to the extent there is any conflict between this summary and the policy, the policy controls. If You would like to receive a copy or review a copy of the complete policy, You may contact the Fund Office.

### **B. ELIGIBILITY**

The rules for eligibility for life insurance are, for the most part, the same as those that apply to the other benefits provided under the Plan. However, as indicated in the Eligibility and COBRA Continuation sections of this booklet, there are some circumstances in which life insurance benefits can be continued when other benefits are not continued and some circumstances in which life insurance benefits are not continued while the other benefits are continued. You should review those sections of this booklet. You should also note that:

1. no life insurance is provided for Dependent children under 15 days old or over 22 years old (however, the attainment of age 23 will not terminate insurance for your Dependent who is incapable of self-support by reason of a mental or physical disability); and
2. Dependent children who have reached age 19, but who are younger than age 23, must be full-time students enrolled in a state-accredited college, university, trade, or secondary school in order to be covered by the Dependent life insurance benefit; and
3. a person who is eligible as a Participant cannot also be eligible for life insurance as a Dependent; and
4. there is no coverage for Dependent children of retirees.

### **C. LIFE INSURANCE BENEFITS**

1. Payment of Benefits.

If a Participant dies while insured, Anthem will generally pay the amount specified in the Schedule of Benefits to the Participant's designated beneficiary. If a Participant's Dependent dies, Anthem will generally pay the amount specified in the Schedule of Benefits to the Participant. (See Section E for more detailed information about who receives the benefits.)

2. Exclusions.

No life insurance benefits are payable for a death that occurs while the insured person is in the Armed Forces on active duty.

3. Method of Payment.

Benefits are paid in a lump sum unless You direct the insurance company, and the insurance company agrees, in writing, to pay them in some other manner. If You want to provide for a different method of payment of Your life insurance benefits, contact the Fund Office at (314) 656-1072.

4. Accelerated Life Insurance Benefit for Participants.

The Anthem Insurance policy provides that a Participant can receive up to three-fourths of the amount of his own life insurance benefits while the Participant is alive if he has a life expectancy of six months or less. The Participant's own doctor and an Anthem-appointed doctor must confirm that the Participant's life

expectancy is six months or less, and any irrevocable beneficiary or assignee of the Participant's life insurance benefits must consent to the accelerated payment of the benefit. The amount of the life insurance benefit payable on the Participant's death will be reduced by the amount paid to the Participant while he was alive. The receipt of the accelerated life insurance benefit may be taxable.

No accelerated benefits are payable if the terminal condition is directly or indirectly due to or associated with: a self-inflicted injury or suicide attempt; the commission of a felony, engaging in an unlawful act or illegal occupation or commission or provocation of an unlawful act; or alcohol or drug abuse. In addition, accelerated benefits are not payable if the insurer has been notified that all or a portion of your benefits are to be paid to your former spouse as part of a divorce agreement.

5. Change of Beneficiary or Method of Payment.

A Participant may change his named beneficiary or the method of payment, unless he has given up that right. Contact the Welfare Fund Office at (314) 656-1072 to request forms for making such changes. When the Fund Office receives the signed change request, such change will be effective on the date the Participant signed the change request. However, no such change will apply to actions taken or payments made by the insurance company prior to receipt of the change request.

6. Termination of Life Insurance.

Life insurance coverage will end for an individual at the same time that individual's eligibility for other benefits under the Plan ends. In addition, life insurance benefits will end:

- (a) at the beginning of any period for which the premium is not paid;
- (b) the date a covered Dependent commences active duty in any military, naval, or air force organization (except for temporary active duty of two weeks or less);
- (c) the date the insurance policy terminates; or
- (d) the date insurance ends for the class of individuals of which the person is a member.

7. Extension of Life Insurance for Disabled Participants.

If a Participant is disabled at the time his life insurance benefits would otherwise end, the Participant's life insurance benefits may be continued without payment of premium. If the Participant believes he is entitled to such an extension of benefits it is very important that the Participant comply with the rules described in this section. The Fund Office (314-656-1072) will help, but it is ultimately the Participant's responsibility.

For the purposes of this provision, a Participant is disabled if he is continuously unable to perform the material and substantial duties of his regular occupation due to Sickness or Injury. A Participant's disability must begin:

- (a) before age 60;
- (b) before retirement; and
- (c) while the Participant is covered by the life benefit.

The Participant's premium will be waived for the period during which coverage is continued for disability as shown below. The Participant's coverage will remain in force as if premiums were being paid.

If the Participant becomes disabled, his life coverage will continue for up to one year. If the Participant dies during that year, Anthem will pay the life benefit upon receipt of due proof of such disability and death.

If the Participant incurs a disability which is expected to continue for longer than one year, the Participant's life coverage will continue, provided proof of permanent disability is furnished to Anthem no later than 12 months after the date disability begins. Upon acceptance of such proof by Anthem, coverage will be extended for another year. Additional one-year extensions of coverage will be made if the Participant furnishes Anthem, annually, proof of continuance of disability. Such proof must be furnished within 3 months before the end of each one-year extension. The waiver of premium will end if any proof is not furnished

within such time durations. If the Participant dies during continuation due to disability, Anthem will pay the life benefit upon receipt of due proof of death.

Written proof of death during disability extension must be given within one year after death. Otherwise, Anthem will not be liable for the benefit.

The amount which will be payable as a life insurance benefit during disability is the lesser of:

- (a) the amount in force for the Participant on his last day of active work; or
- (b) the amount that would be in force for the Participant on the date of death were he not disabled; or
- (c) when the Participant reaches the age for normal retirement, the amount available on retirement, if any.

The Participant's waiver of premium ends at the earliest of the following:

- (a) The Participant's disability ends;
- (b) The Participant does not take a medical examination required by Anthem;
- (c) The Participant fails to furnish proof of continuing disability; or
- (d) The Participant retires, if no benefits are provided for retirees, or any other date the Participant's coverage would end if he were not disabled.

Anthem has the right, at its own expense, to require the Participant to be examined by a physician of Anthem's choice while the premium is being waived. This may be required at reasonable intervals. After coverage has been extended for two years, Anthem will not require examinations more than once a year.

If a Participant's disability ends and he does not return to Covered Employment, the Participant is entitled to his rights under the life conversion privilege.

If a Participant's life insurance is continued without payment of premium due to his disability, the life insurance for the Participant's Dependents may also be continued. This Dependent extension applies:

- (a) only to Dependents who were eligible at the time the Participant's disability began;
- (b) only as long as such Dependents meet the definition of Eligible Dependent for life insurance; and
- (c) only as long as the Plan maintains this policy with Anthem.

#### 8. Conversion to Individual Policy.

If Your life insurance will terminate under the terms of the Plan, You may be able to convert all or part of Your benefit to an individual policy of insurance without being required to provide evidence of insurability, depending on the circumstances that cause the termination of Your coverage under the Plan. If You are interested in converting to an individual life insurance policy, contact the Fund Office (314) 656-1072 as soon as You know Your insurance is going to terminate. You must submit a written application for conversion and payment for the converted policy within 31 days after Your life insurance benefits would otherwise terminate.

Additional terms and conditions may apply to this life insurance benefit. You should check the policy of Life Insurance or call the Fund Office or Anthem for additional information.

### **D. ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS (AD&D BENEFITS) – FOR PARTICIPANTS ONLY**

Benefits are payable for a Participant's death, dismemberment and loss of sight due to Injury. The principal sum is set forth on the schedule of benefits.

1. Benefit.

Anthem will pay benefits for any losses set forth in the table of losses which:

- (a) result solely from Injury that occurs while the Participant's coverage under this benefit is in force; and
- (b) occur within 90 days after the Injury causing the loss.

With regard to loss of hands and feet, loss means complete severance through or above the wrist or ankle joint. With regard to eyes, loss means entire and irrecoverable loss of sight.

**TABLE OF LOSSES**

Loss of Life .....	The Principal Sum
Loss of Both Hands .....	The Principal Sum
Loss of Both Feet.....	The Principal Sum
Loss of One Hand and One Foot.....	The Principal Sum
Loss of One Eye and One Foot .....	The Principal Sum
Loss of One Eye and One Hand .....	The Principal Sum
Loss of Sight of Both Eyes.....	The Principal Sum
Loss of Speech and Hearing in Both Ears .....	The Principal Sum
Quadriplegia .....	The Principal Sum
Paraplegia.....	The Principal Sum
Hemiplegia.....	The Principal Sum
Loss of One Hand.....	One-half the Principal Sum
Loss of One Foot .....	One-half the Principal Sum
Loss of Sight of One Eye .....	One-half the Principal Sum
Loss of Speech or Hearing in Both Ears .....	One-Half the Principal Sum
Loss of Thumb and Index Finger of One Hand.....	One-Quarter of the Principal Sum
Loss of Both Thumbs of Both Hands .....	One-Quarter of the Principal Sum
Loss of All Four Fingers of One Hand.....	One-Quarter of the Principal Sum
Uniplegia.....	One-Quarter of the Principal Sum
Loss of All Toes of One Foot .....	One-Eighth of the Principal Sum

The Table of Losses sets forth each loss for which all or a part of the Principal Sum is payable. The total amount payable for all Injuries from any one accident shall not exceed the Principal Sum.

2. Exclusions.

No Accidental Death and Dismemberment benefits are paid for:

- (a) Bodily or mental infirmity or illness or disease of any kind, or any medical or surgical treatment, diagnostic or preventative care (unless the treatment or care is provided in connection with a Loss). This exclusion does not prevent coverage for pyogenic infections that result from Accidental bodily Injury, and bacterial infections that result from the Accidental ingestion of contaminated substances.
- (b) Suicide or attempted suicide or self-inflicted injury.
- (c) Committing or attempting to commit a felony, or engaging in any unlawful act or illegal occupation, or committing or provoking an unlawful act.
- (d) An act or accident of war, declared or undeclared, whether civil or international, or any substantial armed conflict between organized forces of a military nature.
- (e) Participation in any riot or violent disorder.
- (f) An infection. This exclusion does not prevent coverage for pyogenic infections that result from Accidental bodily Injury, and bacterial infections that result from the Accidental ingestion of contaminated substances.

- (g) Poisoning in any form, including, but not limited to, ingestion or inhalation of gas, fumes, chemicals, drugs, alcohol, or any combination thereof.
- (h) Being under the influence of any drug, narcotic, intoxicant or chemical, unless administered by or taken according to the advice of a Physician.
- (i) Being intoxicated. "Intoxication" under this exclusion means being legally intoxicated as determined by the laws of the jurisdiction where the Accident occurred. Conviction is not necessary for determination of being intoxicated.
- (j) Travel or flight in any aircraft except solely as a passenger in a powered civil aircraft having a valid and current airworthiness certificate and operated by a duly licensed or certified pilot while such aircraft is being used for the sole purpose of transportation only. Parachuting or descent from any aircraft in flight will be deemed to be part of such flight.
- (k) Taking part in the sports of parachute jumping, sky diving or hang gliding.
- (l) Riding, driving, or testing a motorized vehicle used in a race or speed contest.
- (m) Any period while an Insured is confined to a penal or correctional institution.
- (n) Any Loss or Injury as a result of autoerotic asphyxiation.
- (o) Any Loss or Injury that occurs while in the course of operating any Motorized Vehicle:
  - (1) under the influence of any intoxicant or drug, unless prescribed by a physician. This exclusion will apply if You are legally intoxicated according to the jurisdiction where the accident occurred; or
  - (2) if Your blood alcohol concentration is in excess of the legal limit in the jurisdiction in which the Accident occurred.

## **E. CLAIM PAYMENT PROVISIONS**

### 1. Life Benefits.

You may contact the Fund Office for a claim form. Benefits will be paid when Anthem receives the claim form and due proof of death. Benefits will be paid to the beneficiary.

A Participant may designate the beneficiary for his own life insurance, on a form approved by Anthem. If there are two or more beneficiaries, the Participant may specify their respective shares. Otherwise, they will share equally. If a beneficiary dies before the Participant, his beneficiary interest ends unless the Participant has made written request to the contrary. If there is no designated beneficiary, or if no beneficiary survives, benefits will be paid to the first of the following beneficiary classes in which there is a surviving person:

- (a) The Participant's legal spouse;
- (b) The Participant's biological and legally adopted children;
- (c) The Participant's parents;
- (d) The Participant's brothers and sisters;
- (e) The Participant's estate.

The Participant will be the beneficiary for any Dependent benefits. If the Participant is not living when his spouse dies, the spouse's benefit will be paid to the spouse's estate. If the Participant is not living when his Dependent child dies, the child's benefit will be paid to the Participant's spouse, if living, and if not to the child's siblings in equal shares, or if there are no surviving siblings, to the child's estate.

2. Accidental Death and Dismemberment Benefits.

Benefits will be paid to the Participant, if living, otherwise to the Participant's beneficiary. Benefits will be paid when Anthem receives due proof of loss. If there is no designated beneficiary, or no beneficiary survives, benefits will be paid either to the Participant's estate or, at Anthem's option, as shown in the facility of payment provision.

3. Payment Error.

Any benefit paid in error may be recovered from the person receiving the incorrect payment or from the Participant. At Anthem's option, it may offset the overpayment against future benefit payments.

4. Fraudulent Claim Submission.

If any covered person knowingly submits or participates in the submission of a claim for benefits that contains false or misleading information that would have the effect of increasing the benefit payable, Anthem shall have the right to revoke that person's coverage to the date the fraud was perpetrated. Such rescission is without prejudice to any other right or remedy that might be available to Anthem at law or in equity.

5. Facility of Payment.

Anthem may pay up to \$2,000.00 of a Participant's life insurance benefit to any person who incurred expenses for the Participant's fatal illness or burial. Also, Anthem may, in certain circumstances, make monthly payments of not more than \$50.00 to the person or institution caring for a beneficiary if the beneficiary is a minor or is not competent.

## **F. GENERAL PROVISIONS**

1. Incontestability/Time Limit on Certain Defenses.

All statements made by the Plan or by a covered person are representations and not warranties. No such statement shall be used to contest the validity of coverage or reduce benefits unless it is in writing, signed by Plan or by the covered person. A copy of such statement, if contested, will be furnished to the Plan, or the covered person or his beneficiary, whichever applies.

2. Records, Physical Examinations, and Autopsy.

With written authorization, Anthem may obtain a covered person's medical records. While a claim is pending, Anthem has the right to have a covered person examined. The exam will be at Anthem's expense and as often as reasonably necessary. Anthem may also have an autopsy made at its expense where allowed by law.

Anthem has the right to require the covered person to provide information in addition to the proof of loss to determine benefits payable. Any cost associated with providing this information is the responsibility of the covered person.

3. Legal Action.

For life insurance claims, no legal action may be brought under the Anthem policy after the expiration of 10 years from the date of death.

For other claims, no legal action may be brought to recover benefits under the Anthem policy within 60 days after written proof of loss has been given as required herein. No such action may be brought after 2 years from the time written proof is required to be given.

## **V. WEEKLY DISABILITY BENEFITS – ACTIVE PARTICIPANTS ONLY**

### **A. ELIGIBILITY**

Only Active Participants are eligible for the Weekly Disability Benefits. An Active Participant covered through hours worked in Covered Employment is eligible for the Weekly Disability Benefit if he was eligible for coverage through active work in Covered Employment in the month he became Totally Disabled. Further, Active Participants who are covered through the use of Hour Bank Credits, are eligible for the Weekly Disability Benefit only if the Active Participant was eligible for coverage, through active work in Covered Employment, in the Benefit Month immediately preceding the month in which he became Totally Disabled.

### **B. BENEFITS**

If, while covered under this provision, an Active Participant becomes Totally Disabled by Injury or Sickness, the Plan will pay Weekly Benefits while the Active Participant remains Totally Disabled:

1. at the rate of the Weekly Benefit shown in the Schedule; and
2. up to the Maximum Benefit Period shown in the Schedule for a period of disability.

Benefits begin the later of:

1. the first day following the end of the Waiting Period, if any, shown in the Schedule; or
2. the first day the Active Participant is under the care of a Physician.

### **C. NEW PERIOD OF DISABILITY**

The Maximum Benefit Period for weekly disability benefits shown in the Schedule will be restored each new period of disability.

A new period of disability begins:

1. when an Active Participant becomes Totally Disabled after having been back to work full time for at least 10 consecutive working days since the previous disability; or
2. when an Active Participant becomes Totally Disabled due to a cause not related to any cause of the previous disability, and the new disability begins after the Active Participant has been back to work full-time for at least one day.

### **D. EXTENDED BENEFITS**

If an Active Participant is Totally Disabled by Injury or Sickness on the date his coverage under the Plan ends, the Plan will continue to pay weekly disability benefits for the Active Participant as if coverage had not ended until the earlier of:

1. the date the disability ends; or
2. the date the Maximum Benefit Period shown in the Schedule has been exhausted.

### **E. EXCLUSIONS**

The Plan will not pay any weekly disability benefits:

1. if the Active Participant is not under the regular care and attendance of a Physician;

2. for any Injury or Sickness that arises out of or in the course of employment or self-employment or for which the Active Participant is entitled to or receives benefits under a workers' compensation or occupational disease law;
3. for any Sickness or Injury suffered while the Active Participant is on active duty or training in any armed or uniformed services, the National Guard or the Reserves of any country;
4. for any Sickness or Injury that arises from an act of declared or undeclared war or armed aggression;
5. for any period of disability that is not caused by an Injury or Sickness; and
6. for any period of disability that arises from or in connection with a condition or medical treatment of a condition that is excluded from coverage under the major medical exclusions starting on page 58 of this booklet.

## VI. MAJOR MEDICAL BENEFITS

### A. BENEFIT PAYMENT PROVISIONS

#### Covered Charges

If You incur "Covered Expenses" for services and supplies shown in Section C, "Services and Supplies Covered Under Major Medical Benefits," the Plan will pay benefits as shown in the Schedule of Benefits. Such Expenses must be Medically Necessary for the treatment of a Sickness or Injury, or for any preventive care covered under this Plan. The amount eligible as a "Covered Expense" will be limited to the lesser of the Usual, Customary and Reasonable Charge or the applicable managed care (In-Network) contracted rate.

#### Preferred Provider Benefits

The Plan from time to time enters into special arrangements with one or more Managed Care networks that provide favorable pricing for the Plan for covered persons. Benefits payable by the Plan for Covered Expenses for services, treatments, or drugs and medicines provided by an In-Network Provider will be determined in accordance with the agreement then in effect with such Managed Care Organization as set forth in Your Schedule of Benefits.

#### Allocation and Apportionment of Benefits

The Plan reserves the right to allocate the Deductible amount to any eligible charges and to apportion the benefits to the covered person and any assignees. Such allocation and apportionment shall be conclusive and shall be binding upon the covered person and all assignees.

### B. VOLUNTARY PREDETERMINATION PROGRAM

This Plan does not require precertification prior to receiving services or supplies. The Plan, however, does provide a voluntary predetermination program as to the Medical Necessity of certain services and supplies. If You participate in this program and the service or supply is determined to be Medically Necessary then, when Your claim is submitted after the services are rendered, the claim will not be denied on that basis, assuming the facts are as represented during the predetermination process. (A request for predetermination will not be considered a claim. To file a claim under this Plan, there must be a written request for payment for services or supplies that have already been provided to You. See the "Claim Procedures" section for details on how to file a claim.)

There is no penalty simply because a predetermination of Medical Necessity is not requested or obtained. However, when a claim is submitted after the services or supplies have been received, the Plan will review the claim in accordance with the Plan requirement that services and supplies be Medically Necessary in connection with the diagnosis or therapeutic treatment of an Injury or Illness (see Services and Supplies Covered Under Major Medical Benefits on page 46). Thus, if You receive services or supplies without a predetermination, You risk discovering after receiving such services or supplies, that they are not considered Medically Necessary and are, therefore, not covered under the Plan. **Unless You use voluntary predetermination, Medical Necessity will be decided when the claim is filed after the service is provided. In such a case, You may be entirely responsible for the cost of any non-covered services or supplies.**

If You wish to participate in the Voluntary Predetermination Program, follow the instructions below.

To determine Your eligibility and whether the service or supply is covered or excluded under the terms of the Plan, contact the claim administrator. Neither Anthem nor any medical consultant has the authority to determine whether the service or supply is covered or to what extent benefits are payable. Even after a determination of Medical Necessity, the claim administrator will review the claim for eligibility and coverage only after it is submitted after services are rendered. Thus, a claim for Medically Necessary services could be denied on other grounds. **A finding that a service or supply is Medically Necessary under the voluntary predetermination program is not a guarantee that benefits will be paid. Your claim could be denied on grounds that do not involve Medical Necessity.**

Neither Anthem, the Plan, nor any independent medical consultant will make any decisions regarding Your medical treatment or the receipt of health care services. You should make all final decisions about Your medical care after consultation with Your Physician.

### **1. Surgery, Outpatient Procedures and Home Health Care**

To predetermine whether any scheduled surgical procedure, other outpatient procedure or home health care service is considered Medically Necessary, call the Fund Office at (314) 656-1072. The Fund Office may then refer Your case to Anthem or contact an independent medical consultant to determine the Medical Necessity of the initial treatment program and continued care. You and Your Physician will be notified of the decision.

### **2. Hospital Admissions**

Before You enter a Hospital for a non-Emergency inpatient admission, Your Physician may contact Anthem at [Healthlinkmedmgmtrequests@healthlink.com](mailto:Healthlinkmedmgmtrequests@healthlink.com) or toll-free at (877) 284-0102 to initiate the review process. Anthem and/or an independent medical consultant will determine the Medical Necessity of the hospitalization and You and Your Physician will be notified of the decision.

### **3. Voluntary Concurrent Review**

If You elected voluntary predetermination of Hospital admission, Anthem's nurses will perform periodic reviews of Your medical progress and will check with Your Physician and Hospital. If Anthem approves the continued stay as Medically Necessary, Your claim will not be denied on that basis.

In the event of an Emergency admission, You or Your Physician may contact Anthem within 48 hours following the admission to participate in the voluntary concurrent review program.

### **4. Review of Voluntary Predetermination**

If You or Your Physician disagree with a predetermination that a hospitalization, length of stay, surgery or outpatient procedure is not Medically Necessary, You or Your Physician may contact Anthem at [Healthlinkmedmgmtrequests@healthlink.com](mailto:Healthlinkmedmgmtrequests@healthlink.com) or toll-free at (877) 284-0102 or the Fund Office at (314) 656-1072 to review the situation. Because the Plan does not recognize a claim until after the services are rendered, there is no appeal procedure. If You disagree with the predetermination decision, You may obtain the services and, when the claim is submitted after the services have been performed, the claim will be reviewed by the Plan without deference to the negative predetermination decision made by Anthem or another consultant.

## ***C. SERVICES AND SUPPLIES COVERED UNDER MAJOR MEDICAL BENEFITS***

In general the Plan requires covered medical services and supplies to be Medically Necessary for the treatment of an Injury or Sickness, although this requirement does not apply to certain "preventive" care described in this section. Covered major medical services and supplies, including any conditions or limitations that may apply, are shown in alphabetical order in this section. For services and supplies that are not covered, please refer to the Major Medical Exclusions on page 58.

If You incur a Covered Expense for one of these covered services or supplies, the Plan will pay the benefit percentage shown in the Schedule of Benefits. The amount allowable as a "Covered Expense" is limited to: (a) the applicable In-Network Provider contract rate for In-Network Providers services, or (b) the Usual Customary and Reasonable Charge for Out-of-Network Provider services.

### **1. Ambulance Services**

- a) Local professional ground ambulance transportation to the Hospital where treatment is given or between medical facilities when Medically Necessary. Medically Necessary air ambulance service will also be covered to the nearest Hospital equipped to treat the condition when ground ambulance transportation would not be safe or practical; and
- b) Transportation within the United States by professional non-air ambulance or on a regularly scheduled flight on a commercial airline when:
  - (a) special and unique covered Hospital services are required which are not provided by a local Hospital;

- (b) transportation is Medically Necessary; and
- (c) transportation is to the nearest Hospital equipped to furnish the services.

**2. Cardiac or Pulmonary Rehabilitation**

Charges for Medically Necessary cardiac or pulmonary rehabilitation.

**3. Chemical Dependency Treatment**

The Plan will pay for the following Chemical Dependency treatment:

Inpatient. If while covered under the Plan, You incur Expenses for the treatment of Chemical Dependency while:

- a) Confined in a Hospital;
- b) Participating in a residential treatment program at a facility that is state-licensed and nationally accredited by the National Committee for Quality Assurance (NCQA) or the Joint Commission or an accreditation approved by CMS; or
- c) Participating in a non-residential treatment program at a facility that is state-licensed and nationally accredited by the National Committee for Quality Assurance (NCQA) or the Joint Commission or an accreditation approved by CMS;

the Plan will pay benefits as shown in the Schedule of Benefits.

Outpatient. Care must be rendered by a Physician or Behavioral Health Practitioner.

The Plan will not pay for any Expense which is payable under any other provision of the Plan.

**4. Chiropractic Treatment**

Charges for Spinal Treatment performed by a chiropractor within the scope of his license, including spinal manipulation, related modalities and electrical stimulation, subject to a 20 visit limit per person per calendar year. The 20 visit limit does not apply when Chiropractic Services are being obtained for treatment of a mental health disorder.

Benefits for x-rays and laboratory tests received in connection with chiropractic Spinal Treatment are payable in the same manner as other covered x-rays and are not subject to the calendar year maximum chiropractic benefit.

**5. Dental Services**

Dental services by a Physician or Dentist for the treatment of a dental Injury to sound natural teeth, (including the initial replacement of the injured teeth and any necessary dental x-rays), provided that the treatment plan begins within 90 days of the Injury and is completed within one year after the Injury. No other dental services are payable under Major Medical Benefits; however, the Plan does provide coverage for dental services through Delta Dental (please refer to Your Delta Dental Summary Plan Description for details).

**6. Diagnostic Testing**

Charges for testing to diagnose Injury or Illness, including but not limited to:

- a) X-rays;
- b) MRIs;
- c) CT scans;
- d) Laboratory services.

**7. Durable Medical Equipment**

Rental (up to purchase price) of Durable Medical Equipment, including but not limited to:

- a) rental (up to the purchase price) of a hospital bed for patient care;
- b) rental (up to the purchase price) of a wheelchair.

**8. Foot Orthotics**

Foot Orthotics (orthopedic shoes or other supportive appliances for the feet) prescribed by Your Physician are payable only once every 12 months for adults and once in a period of 6 months for children under age 19 when replacement is required due to growth. The annual maximum plan benefit for foot orthotics is \$400 per person. This benefit will be paid at 100% not subject to Deductible or Co-payments.

**9. Home Health Care Benefits**

- a) Requirements for Coverage

Home Health Care Benefits will be provided only under the following circumstances:

- (1) Your Physician recommends a home health care program and certifies the individual would be Hospital-confined but for the program;
- (2) You were confined in a Hospital within one week prior to the commencement of the program;
- (3) You continue to be under the care of the Physician who recommended the program; and
- (4) The services are provided by a home health care agency which:
  - (a) is approved by Medicare as a home health care agency; or
  - (b) is established and operated in accordance with applicable laws in the jurisdiction in which it is located and, if required, is licensed and approved by the appropriate regulatory authority; or
  - (c) meets all of the following requirements:
    - (i) holds itself out as a home health care agency;
    - (ii) has a full-time administrator;
    - (iii) maintains written records of the services it provides to patients;
    - (iv) has services of at least one registered professional nurse available; and
    - (v) its employees are bonded and it carries malpractice and malplacement insurance.

- b) Covered Services

Only the home health care services of registered professional nurses, licensed practical nurses, home health aides and occupational, physical and licensed respiratory therapists are covered. Further, only the services that the Physician recommends in the program will be covered. No Custodial Care or Long-Term Care services or transportation services are covered.

**10. Hospice Care Services**

- a) Generally.

If Your Physician determines that:

- (1) You suffer from an illness for which there is no reasonable hope for cure, and

- (2) You have less than six months to live,

the Plan will provide coverage for hospice care services shown below. The services must be provided through a hospice care program that:

- (1) meets the standards of the National Hospice Organization, or
- (2) if required by a state law, is licensed or certified by that state as a hospice care program.

b) **Specific Benefits.**

If the above conditions are met, the Plan will cover, the following services:

- (1) inpatient care for up to a lifetime maximum of 90 days per individual while confined in a hospice. The Covered Expense amount will be limited to the lesser of:
  - (a) the most common daily charge for a semiprivate room made by an affiliated Hospital or nursing home; or
  - (b) the managed care contracted rate for an In-Network Facility or Reasonable and Customary Charge for an Out-of-Network Facility;
- (2) charges for hospice care services performed by hospice care team members for the ill individual while not an inpatient;
- (3) for family and bereavement counseling services by hospice care team members for the ill person's family unit while the ill person is on hospice care and for up to 6 months following the ill person's death. This family and bereavement counseling benefit is available only to Participants and Dependents, but where the ill person receiving hospice services is the Participant, the benefit will be payable for up to 6 months following the Participant's death for Dependents who were covered immediately prior to the Participant's death, even if the family's coverage under the Plan ends upon or following the Participant's death.

**11. Hospital Services**

- a) Hospital room and board in a semi-private, Medically Necessary private or intensive care room. Charges for a private room when not Medically Necessary will be covered up to the Hospital's most prevalent daily rate for semi-private accommodations. If a Hospital has no semi-private accommodation, covered charges will be limited to the greater of (a) 90% of the lowest private room rate of the Hospital in which confined or (b) the average semi-private rate of other Hospitals in the community.
- b) Hospital services and supplies used during a covered inpatient confinement;
- c) Hospital outpatient services and supplies in connection with:
  - (1) a surgical operation; or
  - (2) Emergency treatment within 48 hours after an accident or serious illness;
- d) Pre-admission tests that are Medically Necessary in connection with upcoming surgery.

**12. Maternity Coverage**

With respect to maternity coverage, federal law prohibits the Plan from restricting benefits for a Hospital stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery or less than 96 hours following a cesarean section. The Plan may not require that a provider obtain authorization from the Plan for prescribing a length of stay not in excess of 48 or 96 hours, as the case may be. Of course, the mother and her Physician can decide on a shorter Hospital stay.

The Plan pays for covered medical charges incurred in connection with the pregnancy of any covered individual. However, the Plan pays charges incurred for the newborn only if the mother is a covered

Participant or the Dependent spouse of a covered Participant. In addition to Medically Necessary care for Sickness or Injury, the Plan will cover the following routine charges for an eligible newborn:

- a) Covered Expenses for any bassinet or routine nursery care on any day on which both mother and newborn child are jointly confined in a Hospital, not to exceed a total of:
  - (1) 48 hours for a vaginal delivery; and
  - (2) 96 hours for a cesarean section; and
- b) Covered Expenses made by a Physician for well-baby care, provided:
  - (1) the Physician is other than the one who delivered the newborn child; and
  - (2) the care is during the period of time benefits are payable under (a) above.

#### **Future Moms-Voluntary Program at No Additional Cost to You**

Anthem offers a voluntary program, known as "Future Moms," for pregnant Participants and Dependents, designed to promote prenatal and postnatal care. There is no additional cost to You for this program. For more information on the Future Moms program or to get started with the program, please call Anthem toll-free at (877) 351-8389.

#### **13. Mental Health Treatment**

The Plan will pay for the following mental illness treatment:

Inpatient. If while covered under the Plan, You incur Expenses for the treatment of mental illness while:

- a) Confined in a Hospital;
- b) Participating in a residential treatment program at a facility that is state-licensed and nationally accredited by the National Committee for Quality Assurance (NCQA) or the Joint Commission or an accreditation approved by CMS; or
- c) Participating in a non-residential treatment program at a facility that is state-licensed and nationally accredited by the National Committee for Quality Assurance (NCQA) or the Joint Commission or an accreditation approved by CMS,

the Plan will pay benefits as shown in the Schedule of Benefits.

Outpatient. Care must be rendered by a Physician or Behavioral Health Practitioner.

The Plan will not pay for any Expense which is payable under any other provision of the Plan.

#### **14. Miscellaneous Services and Supplies**

- a) oxygen and the rental of equipment for its administration;
- b) blood or blood plasma and its administration; laboratory services preceding surgery for Your donation of blood that will or may be transfused to You during surgery;
- c) chemotherapy, radium, radioactive isotopes, and x-ray therapy; wig to compensate for temporary hair loss resulting from these procedures;
- d) casts, splints, braces, trusses, and crutches;
- e) dialysis;
- f) artificial limbs and eyes to replace lost natural limbs and eyes. Prosthesis and supporting garment (bra) if You have undergone a mastectomy, up to two per calendar year;

- g) initial placement of contact lenses required because of cataract surgery;
- h) Phenyl-free nutritional supplement for the treatment of phenylketonuria;
- i) PUVA Therapy;
- j) Respiratory Therapy;
- k) charges for services provided by a Case Management organization.

**15. Occupational Therapy Benefits**

Occupational therapy benefits are payable only if such services are Medically Necessary and prescribed by Your Physician. You may contact the Fund Office to voluntarily predetermine Medical Necessity of the treatment plan if occupational therapy is prescribed for You.

**16. Organ Transplants**

Subject to the other conditions and limitations of the Plan, the Plan will pay organ transplant donor and recipient Expenses incurred in conjunction with the transplant of a human organ or tissue transplant as set out as follows.

<u>SITUATION</u>	<u>COVERAGE</u>
a. Recipient is covered under this Plan and receives the organ from a cadaver.	Recipient's Expenses, including the charge for the organ, are covered.
b. Recipient is covered under this Plan and receives the organ from a bank.	Recipient's Expenses, including the charge for the organ, are covered.
c. Recipient and donor are both covered under this Plan.	Expenses of both are covered as two separate claims with separate Deductibles and Coinsurance.
d. Recipient is covered under this Plan and donor's Expenses are not covered under any other plan.	Expenses of both are covered as two separate claims with separate Deductibles and Coinsurance.
e. Recipient is covered under this Plan and donor's Expenses are covered under another plan.	Only recipient's Expenses are covered.
f. Donor is covered under this Plan, but recipient is not.	Expenses of neither are covered.

Organ Transplant Expenses include: pre-transplant testing and consultation; all services and supplies incurred for the transplant procedure; postoperative care in the Hospital (inpatient or outpatient); extended care in a facility or at home; pharmaceuticals and their administration (only while hospitalized), including but not limited to high-dose chemotherapy or anti-rejection drugs; Durable Medical Equipment; and, to the extent provided above, the donor's Expenses.

**Please Note:** To the extent the Plan covers a donor's Expenses at all, it covers only those Expenses incurred for the actual donation of the organ or tissue. The Plan does not cover any Expenses for the treatment of any complications resulting from the donation.

The Trustees of the Plan strongly encourage You to contact the Fund Office before undergoing any inpatient procedure, including an organ transplant procedure. If You do not contact the Fund Office, You run the risk of discovering that the procedure is not covered by the Plan, after Expenses have been incurred.

**17. Physical Therapy**

Physical therapy prescribed by Your Physician.

**18. Physician's Services**

Services rendered by a Physician for covered medical care.

## **19. Physician Assistant/Nurse Practitioner Services**

Charges for the following services performed by a Physician Assistant or Nurse Practitioner, provided (a) the Physician Assistant or Nurse Practitioner is employed by a licensed Physician or clinic, which also employs supervisory Physicians, (b) services are rendered under the supervision of the employing Physician or clinic and (c) the employing Physician or clinic and Physician Assistant or Nurse Practitioner participate in the Plan's In-Network Provider networks. Drugs, medications, devices, therapies, or services rendered, furnished, or prescribed by a Physician Assistant or Nurse Practitioner must be rendered, furnished, or prescribed pursuant to a Supervision Agreement that is specific to the clinical condition diagnosed and treated by the supervising Physician.

### Covered Physician Assistant/Nurse Practitioner Services:

- Taking patient histories.
- Performing physical examinations.
- Performing or assisting in the performance of routine laboratory and patient screening procedures.
- Performing routine therapeutic procedures.
- Recording diagnostic impressions and evaluating situations calling for attention of a Physician to institute treatment procedures.
- Instructing and counseling patients regarding mental and physical health using procedures reviewed and approved by the employing Physician.
- Assisting the supervising Physician in institutional settings, including review of treatment plans, ordering tests and diagnostic laboratory and radiological procedures and ordering of therapies, using procedures reviewed and approved by the employing Physician.
- Assisting at surgery.

### Physician Assistant/Nurse Practitioner Services Not Covered by the Plan:

- Services or tasks prohibited by law.
- Services not rendered under the supervision of a Physician.
- Services that the Physician Assistant/Nurse Practitioner has not adequately been trained or is not proficient to perform.
- Abortion, except that the Plan will cover services rendered due to complications of abortion.
- Drugs, medications, devices, therapies, or services that are not rendered, furnished, or prescribed pursuant to a Supervision Agreement that is specific to the clinical condition diagnosed and treated by the supervising Physician.
- Lenses, prisms and contact lenses for the aid, relief or correction of vision or the measurement of visual power or acuity.
- Administration or monitoring of general or regional block anesthesia during diagnostic tests, surgery, or obstetrical procedures.
- Expenses for surgical assistance to Physicians who participate in the Plan's In-Network Provider networks are covered only when billed by the network Physician. No Expenses for surgical assistance billed by a Hospital or surgical facility or an independent Physician Assistant/Nurse Practitioner or Out-of-Network Provider are covered.

- Charges for services performed by the supervising Physician on the same date as billed Physician Assistant/Nurse Practitioner services.

Benefit Amount:

Covered Expenses for services provided by a Physician Assistant or Nurse Practitioner are limited to 85% of the amount that would have been allowed as a Covered Expense had a Physician rendered the services. Such Covered Expenses are subject to the Plan's Deductible, In-Network Provider reimbursement levels and subject to all of the Plan's limitations and exclusions.

**20. Preventive Care**

The Fund will provide benefits for the following preventive health services and any other evidence-based items or services that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force ("Task Force") with respect to the individual involved. Preventive Care services are covered by the Plan for Participants and Dependents, except where otherwise provided, and are not subject to the requirement that covered care be Medically Necessary for the treatment of a Sickness or Injury:

a) Routine Adult Physical Examination

Benefits are payable as shown in the Schedule of Benefits and are not subject to the Calendar Year Deductible. Retirees and their Dependents are not eligible for this benefit and any services performed during a Routine Adult Physical Examination will not be covered for Retirees and their Dependents, even though said services may be covered if received under another provision of this Plan. Services must be performed by an In-Network Provider. No benefits are payable for services performed by Out-of-Network Providers. Covered Expenses for medical care or treatment received during an annual physical examination include charges for the following professional services when ordered as part of such examination:

- |                             |  |
|-----------------------------|--|
| • Office Visit              | • Electrocardiogram (EKG)  |
| • A Medical History         | • Hemocult, and  |
| • Vital Signs               | • Chest X-rays when Ordered by a Physician as Part of an Annual Exam |
| • Vision and Hearing Tests  |  |
| • Pulmonary Function Test   |  |
| • Blood Analysis            |  |
| • Urinalysis                |  |
| • Clinical Laboratory Tests |  |

b) The Plan provides benefits for the following preventive health care services:

- Evidence-based items or services that have in effect a rating of A or B in the current recommendations of the Task Force with respect to the individual involved;
- Immunizations for routine use in children, adolescents, and adults that have in effect a recommendation from the Advisory Committee on Immunization Practices for the Centers for Disease Control and Prevention (Advisory Committee) with respect to the individual involved;
- With respect to infants, children and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration ("HRSA"); and
- With respect to women, evidence-informed preventive care and screening provided for in comprehensive guidelines supported by HRSA (not otherwise addressed by the recommendations of the Task Force).

c) Screenings

The Plan provides benefits for the following screening services:

1. Abnormal aortic aneurysm;

2. Alcohol misuse;
3. Anemia for pregnant women;
4. Autism;
5. Bacteriuria;
6. Blood pressure;
7. Cervical dysplasia;
8. Chlamydia;
9. Cholesterol;
10. Congenital hypothyroidism;
11. Depression;
12. Development for children;
13. Dyslipidemia;
14. Gonorrhea;
15. Gestational diabetes;
16. Hearing in newborns;
17. Hematocrit or hemoglobin for children;
18. Hemoglobinopathies (sickle cell) for newborns;
19. Hepatitis B;
20. HIV;
21. Lead;
22. Obesity;
23. Oral health;
24. Osteoporosis;
25. PKU;
26. RH incompatibility;
27. STI;
28. Syphilis;
29. Tobacco use; and
30. Tuberculin.

d) Counseling

The Plan provides benefits for the following counseling services:

1. Breast cancer;
2. Breastfeeding;
3. Chemoprevention;
4. Diet;
5. Domestic and interpersonal violence;
6. Obesity;
7. Skin cancer;
8. STI; and
9. Tobacco.

e) Breastfeeding

Breastfeeding supplies will be provided to pregnant and nursing mothers at no cost to the Participant.

f) Physical Therapy/Exercise

Exercise and Physical Therapy for adults age 65 and older to prevent falls in community dwellings at no cost to the Participant.

**21. Private Duty Nursing**

Services of a registered graduate nurse (RN) or licensed practical nurse (LPN) for private duty nursing care, but the Plan will not pay for services provided by a person who lives with You in Your home or is a part of Your family.

**22. Routine Foot Care**

**23. Skilled Nursing Facility Benefits**

a) Benefits.

If You are confined in a Skilled Nursing Care Facility because of an Injury or Illness, the Plan will pay the Expenses incurred for a period of confinement up to the Maximum shown in the Schedule of Benefits.

b) Conditions.

The Plan will pay benefits only if the confinement:

- (1) begins within 14 days from the last day of Hospital confinement for which Hospital room benefits are paid for three days or more;
- (2) is for the purpose of receiving the care for the condition which caused the Hospital confinement; and
- (3) is under the supervision of a Physician.

c) New Period of Confinement.

The Skilled Nursing Care Facility day limit shown in the Schedule of Benefits will be restored each new period of confinement.

A new period of confinement begins with any Skilled Nursing Care Facility confinement which:

- (1) begins at least 60 days after You were last confined in a Skilled Nursing Care Facility; and
- (2) satisfies the above "Conditions" provision.

#### **24. Speech Therapy**

Fees of a licensed speech therapist under the direction of a Physician for restorative speech therapy for speech loss or impairment due to an Injury such as head trauma or Illness such as stroke, following surgery performed to correct a congenital defect or for developmental delays.

#### **25. Surgical Services**

Charges for the following surgical services in connection with a Medically Necessary surgery, which is not otherwise excluded under the Plan:

- a) Physician's services for an operation or the repair of a dislocation or fracture.
- b) Active services of an assisting surgeon.
- c) Administration of anesthesia.
- d) Ambulatory surgical center Expenses that would have been covered if provided in a Hospital.
- e) Reconstructive surgery following mastectomies.

In the case of a Participant or Dependent who is receiving benefits in connection with a mastectomy who elects breast reconstruction in connection with the mastectomy, the Plan will provide coverage for:

- reconstruction of the breast on which the mastectomy has been performed;
- surgery and reconstruction of the other breast to produce symmetrical appearance; and
- coverage for prostheses and physical complications of all stages of mastectomy, including lymphedemas

in a manner determined with the attending Physician and patient.

- f) Second Surgical Opinion Benefits

If You consult a "legally qualified Physician" for a second opinion on the need for a surgical procedure of a non-Emergency nature, charges incurred for such surgery consultation will be payable as shown in the Schedule of Benefits, including charges for any necessary x-ray and laboratory examinations recommended by such a "legally qualified Physician."

In the event this second surgical opinion does not confirm the need for surgery, the Plan will cover a third consultation, including any necessary x-ray and laboratory examinations recommended by such a "legally qualified Physician."

For the purpose of this provision, a "legally qualified Physician" shall mean a Physician who is Board certified in the field of proposed surgery or in the field of medical specialization concerned with the condition involved.

No payment shall be made:

- for surgery consultation made by a Physician who is not Board certified in the field of medical specialization concerned with the proposed surgery;
- for more than three surgery consultations made in connection with the proposed surgery;
- for any x-ray and laboratory charges other than the charges made in connection with the surgical consultation;

- unless the individual is examined in person by the Physician rendering the second or third surgical opinion and a written report is submitted to the Fund;
- if the Physician who renders the second or third surgical opinion also performs the surgery, or has a financial interest in the outcome (for or against surgery) of his recommendation; or
- for any surgery consultation rendered for a surgical procedure for which no benefits are payable under the Plan.

## **26. Temporary Benefits Related to COVID-19 Pandemic**

- a) Testing: Effective February 11, 2020, Medically Necessary testing for COVID-19 (as further explained below) will be paid by the Fund at 100% with no pre-approval necessary. This includes only those items and services furnished to an individual during healthcare provider office visits (which includes in-person visits and telehealth visits), urgent care center visits, and emergency room visits that result in an order for or administration of the test, but only to the extent the items and services relate to the furnishing or administration of the test or to the evaluation of the individual for purposes of determining the need of the individual to have the test that was ordered or administered. This benefit shall not be subject to the Fund's Deductible and/or Co-Insurance. This coverage will stay in effect until the emergency period established by the federal government related to COVID-19 expires and thereafter will only be covered to the extent otherwise provided for under the Plan. If a member is diagnosed with COVID-19, all treatment including, but not limited to, hospital, transportation and pharmacy services will be covered in accordance with the terms and conditions set forth in this document.
- b) Telehealth: Effective February 11, 2020 through the end of the National Emergency Period related to the COVID-19 pandemic, services which would otherwise be covered under the terms of the Plan when provided in an office setting, such as physician office visits and outpatient mental health services, will be covered by the Fund when provided in a telehealth setting such as via telephone or video conferencing. The Fund will cover such services at the applicable Co-Insurance amount set out in the Plan as if those services had been obtained in person. All Deductibles and Plan limitations apply.
- c) Vaccination: The Fund will cover 100% of the administrative cost of any COVID-19 vaccine at the In-Network rate for In-Network Providers or up to the Usual, Customary and Reasonable Charge for Out-of-Network Providers through the end of the COVID-19 public health emergency period.
- d) PPE: Charges related to additional supplies and clinical staff time required to mitigate transmission of respiratory infectious diseases while providing evaluation, treatment or procedural services during the COVID-19 national emergency period will be covered up to a maximum of \$100 per visit.

## **27. Travel**

Non-Emergency care when traveling outside the United States. Claims will be processed as Out-of-Network.

## **D. CASE MANAGEMENT/ ALTERNATE TREATMENT PLAN**

In cases where Your condition is or is expected to be of a serious nature, the Plan may arrange for review and case management services from a professional qualified to perform such services.

The case manager reviews potentially serious or complex medical situations. The case manager monitors Your progress and treatment and assists You and Your family in getting the right care at the right facilities.

In some situations the case manager may recommend an Alternate Treatment Plan that would not, in normal circumstances, be covered under the Plan.

Based on the case manager's review and recommendations, the Trustees or their designated representative may waive or alter the normal provisions of this Plan and approve such an Alternate Treatment Plan when it is reasonable to expect a cost-effective result without a sacrifice in the quality of the medical care provided to You.

Benefits provided under such an Alternate Treatment Plan will be subject to all other Plan provisions. Alternate Treatment Plans will be considered and established on a case-by-case basis. The approval of an Alternate Treatment Plan in one situation will not in any way bind the Plan to approve any other Alternate Treatment Plan, whether similar or not, in the future.

## **E. MAJOR MEDICAL EXCLUSIONS**

**This Plan does not consider any of the following to be Covered Expenses under the Major Medical Benefit provisions of the Plan and will not provide benefits for any of the following:**

1. **Work-Related Injury or Sickness**—any charges related to any Injury or Sickness which arises out of or in the course of employment or self-employment or for which You are entitled to benefits under a workers' compensation or occupational disease law\*;
2. **Charges Greater Than Contracted Rate or UCR**—any Expense which exceeds the lesser of: (a) the managed care organization's contracted rate with an In-Network Provider; or (b) the Usual, Customary and Reasonable Charges;
3. **Not Medically Necessary/ Not Physician Recommended**—any Expense or charge for services or supplies not Medically Necessary or not recommended by a Physician;
4. **Before Coverage Effective/ After Coverage Termination**—any Expense incurred before coverage is effective or after coverage terminates (except as specifically provided under any extended benefits provisions);
5. **Not Required to Pay**—any Expense or charge which You would not be required to pay in the absence of health insurance or other medical coverage;
6. **Custodial or Long-Term Care** —any Expense or charge for Custodial or Long-Term Care;
7. **Cosmetic Surgery**—any loss, Expense or charge which results from Cosmetic or Reconstructive Surgery, except as Medically Necessary;
8. **Weight Loss**—any loss, Expense or charge which results from appetite control or any treatment of obesity (except for surgery to treat Morbid Obesity);
9. **Orthopedic Shoes/ Orthotics**—any Expense or charge for orthopedic shoes, orthotics or other supportive devices for the feet, except as specifically provided for in Section I(C)(5) and Section VI(C)(8);
10. **Dental Services**—any Expense or charge in connection with dental work or dental surgery (unless specifically provided) including:
  - (a) treatment involving any tooth structure, alveolar process, abscess or disease of the periodontal or gingival tissue; or
  - (b) surgery or splinting to adjust dental occlusion;

If, due to a Medical Necessity, a dental procedure is performed in a Hospital setting due to other medical conditions, all related services connected with the procedure will be covered;
11. **TMJ**—any Expense or charge for treatment of craniomandibular or temporomandibular joint (TMJ) disorders, except Expenses or charges related to surgery where surgery is Medically Necessary to sustain life (i.e. patient's ability to obtain adequate nourishment or breath). The Fund requires medical evidence that the disorder is interfering with patient's ability to sustain life and that surgical intervention will improve patient's condition. Patient further needs to provide documentation that patient has exhausted all possible non-surgical treatment options to correct the disorder and that said non-surgical treatment options have been unsuccessful in correcting the disorder prior to the Fund covering any surgical intervention;
12. **Sex Dysfunction**—any loss, Expense or charge for any treatment related to sexual dysfunction;
13. **Fertility**—any Expense or charge for the promotion of fertility including (but not limited to):

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\* **Note:** While the Plan does not provide medical benefits for Injuries or Sicknesses arising out of employment or self-employment, You should notify the Fund Office when You are injured on the job so that it can make sure You receive any extended eligibility to which You are entitled.

- (a) fertility tests;
  - (b) reversal of surgical sterilization;
  - (c) any attempts to cause pregnancy by hormone therapy, artificial insemination, in vitro fertilization and embryo transfer or any similar treatment or method; and
  - (d) fertility drugs;
14. **Chelation Therapy**—chelation therapy except for acute arsenic, gold, mercury or lead poisoning;
15. **Not Generally Accepted, Experimental, Investigative, Not Safe**—any Expense or charge for services or supplies that are:
- (a) not provided in accord with generally accepted professional medical standards;
  - (b) for Experimental treatment;
  - (c) Investigative; or
  - (d) not proven safe and effective.
16. **Education**—any Expense or charge for services or supplies which are chiefly for instruction, education or training;
17. **Speech Therapy**—any Expense or charge for speech therapy except as specifically provided under Section C. Services and Supplies Covered Under Major Medical Benefits above;
18. **Acupuncture**—any Expense or charge incurred for Acupuncture Treatment (except when used as an anesthetic agent for covered surgery);
19. **Government Agency Provided**—any Expense or charge for services or supplies which are provided or paid for by local, state, or federal governments or their agencies (unless the individual is legally required to pay in the absence of health care coverage);
20. **War**—any loss, Expense or charge which results from an act of declared or undeclared war or armed aggression; or
21. **Armed Services/ Government Liability**—any loss, Expense or charge:
- (a) which is incurred while You are on active duty or training in the Armed Forces, National Guard or Reserves of any state or country; and
  - (b) for which any governmental body or its agencies are liable, except as required by law;
22. **Vision Surgery**—any Expense or charge in connection with radial keratotomy, LASIK or other vision correction surgeries;
23. **Eye Exams**—eye refractions, vision exams, the fitting of visual aids such as glasses or contact lenses, or the visual aids themselves (except for the initial placement of contact lenses required because of cataract surgery.) Note: Eye exams, glasses and contact lenses are covered under the Plan’s Vision Benefit, described starting on page 69;
24. **Hearing Aids**—the fitting of or purchase of hearing aids;
25. **Contraception**—contraceptive drugs, devices, or management, except as specifically shown under Section C. Services and Supplies Covered Under Major Medical Benefits above;
26. **Non-Covered Provider**—any services rendered or supplies furnished or prescribed by any provider other than those providers which are specifically shown to be covered providers in this booklet;

27. **Services Performed by Family Members**—any services rendered to You by a person who is a member of Your family (spouse, parent, child, grandparent or sibling, by birth or marriage) or by a person who resides in Your home;
28. **Abortion**—abortion, unless Medically Necessary to preserve the life of the mother, except that the Plan will cover complications of abortion; and
29. **Gene Therapy**-Expenses (medical and/or prescription drug) related to gene therapy. The Plan excludes coverage for all gene therapy procedures, which are health care services that introduce or are related to the introduction of genetic material into a person intended to replace or correct faulty or missing genetic material, whether those therapies have received approval from the U.S. Food and Drug Administration (“FDA”). Some examples of gene therapy include, but are not limited to, Chimeric Antigen Receptor T-Cell (“CAR-T”) therapies such as Kymriah and Yescarta, as well as other therapies, such as Luxturna and Zolgensma.
30. **Genetic Testing**- Expenses other than testing that is considered preventive or diagnostic. The Plan excludes:
- (a) An analysis of proteins or metabolites that does not detect genotypes, mutations or chromosomal changes;
  - (b) A medical examination that tests for the presence of a virus that is not composed of human DNA, RNA, chromosomes, proteins or metabolites;
  - (c) A test for infectious and communicable diseases that may be transmitted through food handling;
  - (d) DNA testing to detect genetic markers that are associated with information about ancestry; and
  - (e) Complete blood counts, cholesterol tests and liver-function tests unless otherwise covered under the Plan.
31. **Not Shown as Covered**—any treatment, service or supply not specifically shown as covered in this Major Medical Benefits section.

## **F. COORDINATION OF BENEFITS (COB)**

### **1. Generally**

If an individual is covered under both this Plan and another plan or plans (as defined below) the benefits under this Plan and the other(s) will be coordinated so that the benefits paid by all plans do not exceed 100% of the Covered Expense.

### **2. Definitions For This COB Provision**

- (a) “Plan” means any of the following coverages, including policy coverage, and any coverage which is declared to be “excess” to all other coverages, which provide benefit payments or services to an insured person for hospital, medical, surgical, dental, prescription drug or vision care:
- (i) group, or blanket insurance (except school accident-type insurance);
  - (ii) group Blue Cross and/or Blue Shield and other prepayment coverage on a group basis, including HMOs (Health Maintenance Organizations);
  - (iii) coverage under a labor-management trustee plan, a union welfare plan, an employer organization plan, or an employee benefits plan;
  - (iv) coverage under government programs, other than Medicare or Medicaid, and any other coverage required or provided by law;
  - (v) group or individual automobile “no fault” coverage;
  - (vi) other arrangements of insured or self-insured group coverage;
  - (vii) “medical pay” coverage under automobile and homeowner’s insurance policies;

(viii) uninsured or underinsured motorist coverage.

If any of the above coverages include group and group-type hospital indemnity coverage, Plan also means that amount of indemnity benefits which exceeds \$100 a day.

- (b) "Claimant" means the covered person for whom the claim is made.
- (c) "Claim Period" means part or all of a calendar year during which the Claimant is covered under the Plan.
- (d) "Covered Expense" means any Expense which is covered by at least one Plan during a Claim Period. Where a Plan provides benefits in the form of a service rather than cash payments, the reasonable cash value of the service during a Claim Period will also be considered a Covered Expense.

### **3. How COB Works**

The Primary Plan (which is the Plan that pays benefits first) pays the benefits that would be payable under its terms in the absence of this provision.

The Secondary Plan (which is the Plan that pays benefits after the Primary Plan) will limit the benefits it pays so that the sum of its benefit and all other benefits paid by the Primary Plan will not exceed 100% of total Covered Expense.

The "Order of Benefit Determination" paragraph below explains the order in which Plans must pay.

### **4. Order of Benefit Determination**

When another Plan does not have a COB provision, that Plan must pay its benefits first.

When another Plan does have a COB provision, the first of the following rules which apply governs:

- (a) if a Plan covers the Claimant as an employee, member or other non-dependent, then that Plan will pay its benefits before the Plan that covers the Claimant as a dependent.
- (b) if a Plan covers the Claimant as an active employee or the dependent of an active employee, that Plan will pay its benefits before a Plan that covers the Claimant as a former, laid-off, or retired employee or the dependent of a former, laid-off or retired employee.
- (c) if the Claimant is a dependent child whose parents are not divorced or separated, whether or not they have ever been married, then the Plan of the parent whose birthday is earlier in the calendar year will pay first; except:
  - (i) if both parents' birthdays are on the same day, the Plan of the parent covered longer will pay first.
  - (ii) If another Plan does not include this COB rule based on the parents' birthdays, but instead has a rule which results either in each Plan determining its benefits before the other or in each Plan determining its benefits after the other, the provisions of this paragraph will not apply, and that other Plan's COB rule will determine the order of benefits.
- (d) if the Claimant is a dependent child whose parents are divorced or separated then the following rules apply:
  - (1) a Plan which covers a child as a dependent of a parent who by court decree must provide health coverage will pay first, provided, the Plan of that parent has actual knowledge of the terms of the decree;
  - (2) when there is no court decree which requires one parent to provide health coverage to a dependent child, the following rules will apply:

- i. when the parent who has custody of the child has not remarried, that parent's Plan will pay first.
  - ii. when the parent who has custody of the child has remarried, then benefits will be determined by that parent's Plan first, by the custodial parent's spouse's Plan second, by the Plan of the parent without custody third, and by the Plan of the non-custodial parent's spouse's fourth.
  - iii. if the parents have joint custody, the birthday rule will determine the order of payment;
- (e) the Plan which covers the Claimant as a current employee or the dependent of a current employee pays before the Plan which covers the Claimant under COBRA or similar continuation coverage;
- (f) if none of the above rules apply, the Plan that has covered the Claimant for the longer period of time will pay its benefits first.

#### **5. How COB Affects Policy Benefit Limits**

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

#### **6. Right to Collect and Release Needed Information**

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under this Plan and other Plans. This Plan or its claims administrator may get the facts it needs from or give them to other organizations or persons for the purpose of applying these rules and determining benefits payable under this Plan and other Plans covering the person claiming benefits. This Plan and its claims administrator need not tell, or get the consent of, any person to do this. Each person claiming benefits under this Plan must give this Plan and its claims administrator any facts it needs to apply those rules and determine benefits payable.

#### **7. Facility of Payment**

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

#### **8. Special COB Rules Where Both Spouses Are Covered Under This Plan As Participants**

If both a husband and a wife are Participants in the Plan, this Plan will consider each claim submitted on behalf of the husband and wife and the Dependent children the husband and wife share twice. The Plan will not, however, pay more than 100% of the covered charges.

#### **9. Medicare Coordination of Benefits (COB)**

- (a) Generally.

This Medicare COB provision applies when the individual:

- (1) is covered under the Plan; and
- (2) is eligible for insurance under Medicare (whether or not the person has applied or is enrolled for Medicare Benefits).

It applies before any other COB provision of the Plan.

**Important Note:** If a Participant or Dependent is eligible to enroll in Medicare, these COB rules will apply as if the affected person had, in fact, enrolled in both Parts A and B of Medicare. Therefore, it is very important that You contact Your local Social Security office about Medicare coverage before Your 65<sup>th</sup> birthday, or at such other time as You may become eligible for Medicare.

(b) How Medicare COB Works.

If, in accordance with the following rules, this Plan has primary responsibility for the covered person's claims, then the Plan pays benefits first. If, in accordance with the following rules, the Plan has secondary responsibility for the covered person's claims, first Medicare Benefits are determined or paid, and then Plan benefits are paid. For services payable under both plans, the combined Medicare Benefits and Plan benefits will not exceed 100% of the Expense incurred.

(c) Rules for Determining Order of Benefits.

(i) For Participants.

If a Participant is eligible for Medicare, this Plan pays first if the Participant is covered under this Plan as other than an Eligible Retired Participant. If the Participant is covered under this Plan as an Eligible Retired Participant, this Plan pays after Medicare.

(ii) For Dependent Spouses.

If a Participant is covered by this Plan as other than an Eligible Retired Participant, and his spouse is eligible for Medicare, this Plan will pay its benefits on behalf of the spouse before Medicare. If a Participant is covered under this Plan as an Eligible Retired Participant, this Plan will pay benefits on behalf of his spouse after Medicare pays its benefits.

(iii) For a Covered Person with End-Stage Renal Disease.

If You initially become eligible for Medicare as a result of end-stage renal disease, this Plan pays its benefits on Your behalf before Medicare for the first 30 months during which You are covered by Medicare as a result of end-stage renal disease. Thereafter, Medicare will be primary and will pay its benefits for You before this Plan pays its benefits. If You initially become eligible for Medicare by virtue of age or disability, the normal Medicare COB rules apply regardless of whether You have end stage renal disease.

(d) No Benefits Payable Where Private Contract Permits Provider to Bill in Excess of Medicare Limits.

If You are eligible for Medicare and enter into a private contract with a provider of medical services or supplies which permits that provider to bill You amounts in excess of the limits established by Medicare, the Plan will provide no benefits for services or supplies rendered under that private contract.

**10. Right of Recovery**

If this Plan pays more for a Covered Expense than is required under these COB provisions, the excess payment may be recovered from:

- a) the Claimant;
- b) any person to whom the payment was made;
- c) any insurance company, service plan or any other organization which should have made payment; or
- d) future benefits due to the Claimant or any of his family members.

**xi) Coordination of Benefits When Services and Supplies Not Covered Under Primary Plan**

When this Plan's benefits are secondary to another plan or to Medicare (traditional Medicare, Medicare HMOs and other Medicare + Choice plans) no benefits will be payable under this Plan for services and supplies that are not covered by the Primary Plan.

## **G. PLAN'S RIGHTS TO SUBROGATION AND REIMBURSEMENT\***

### **1. Generally**

If this Plan pays out benefits to or on behalf of a covered person in connection with a Sickness or an Injury for which a third party may be responsible, the Plan has the right to recover those benefits either directly from the third party or from the covered person. While these subrogation and reimbursement provisions are most often relevant in connection with automobile accidents, they also apply in any situation in which a covered person's Injury or Sickness is caused by a third party. For example, these provisions apply if a covered person is injured by a faulty product, by medical malpractice, or by some defective condition of a third party's property.

### **2. Definitions**

- a) For purposes of these reimbursement and subrogation provisions, a "covered person" is a person to or on whose behalf this Plan pays out benefits. The term "covered person" also includes such individual's guardian, estate, heirs, or other representatives.
- b) For purposes of these reimbursement and subrogation provisions, a "third party" is a person who caused the covered person's Injury or Sickness and any other person or entity that has an obligation to pay compensation of any sort to the covered person as a result of that Injury or Sickness. For example, both the insurer of the responsible third party and the insurer of the covered person are included in the meaning of "third party" to the extent such insurers are obliged to compensate the covered person as a result of the Injury or Sickness.

### **3. Plan's Right to Reimbursement**

If this Plan pays out any benefits to or on behalf of a covered person in connection with a Sickness or Injury for which a third-party may be responsible, such benefits are paid on the express condition that the covered person (or his or her spouse, to the extent the spouse recovers damages in connection with the covered person's Injury or Sickness) must reimburse the Plan for the benefits it paid out if the covered person (or his or her spouse) recovers any amounts from any third party or parties.

The description or characterization of any recovery from any third party does not affect the Plan's right to reimbursement. By accepting benefits from the Plan, the covered person and his or her spouse acknowledge the Plan's right to reimbursement and agree to make such reimbursement. The covered person and his or her spouse must reimburse the Plan in full for benefits it paid in connection with the Injury or Sickness before any other amounts are deducted from the recovery paid by the third party or parties. However, the Plan's reimbursement may be reduced by its proportionate share of the attorney's fees and costs incurred by the covered person in connection with the recovery, but in no event will the Plan's reimbursement be reduced by more than one-third for fees and costs.

Until the Fund has been reimbursed for the benefits it paid out in connection with the Injury or Sickness, any monies received by or on behalf of the covered person and his/her spouse from any third party are the property of the Fund and are held in constructive trust by the covered person and his/her spouse, as well as their agents, including legal counsel.

### **4. Plan's Right to Subrogation**

The Plan will be subrogated to all claims, demands, actions and rights of action the covered person and his or her spouse may have against any third party or parties. This means that to the extent the covered person and his or her spouse has a claim against anyone as a result of an Injury or Illness for which the Plan pays out benefits, the Plan has a right to pursue the covered person and his or her spouse's claim. In effect, the Plan "stands in the place" of the covered person and his or her spouse with respect to such claim or claims. The amount of the Plan's subrogation interest is equal to the amount it paid out in connection with the Injury or Sickness, plus the attorney's fees and costs it incurs in pursuing the claim against the third party or parties.

The Plan may assert its claim against any third party even if the covered person and his or her spouse does not, or the Plan may join in any action the covered person and his or her spouse brings against any third

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\* **Please Note:** This section does not apply to work-related injuries. The Plan simply does not cover work-related injuries.

party or parties. The Plan does not waive any of its rights to reimbursement by not independently asserting its claim against any third party or by not joining in any action brought by the covered person against any third party.

By accepting benefits from this Plan in connection with any Injury or Sickness for which a third party may be responsible, the covered person expressly acknowledges the Plan's rights to subrogation and agrees to do nothing to prejudice those rights and to cooperate fully with the Plan in asserting those rights.

#### **5. Covered Person's Responsibilities**

In order to receive benefits from this Plan in connection with an Injury or Sickness for which a third party may be responsible to compensate the covered person (and, if applicable, his or her spouse), that covered person and his or her spouse must do all of the following:

- a) Notify the Plan when the covered person suffers an Injury or Sickness for which a third party may be required to compensate the covered person;
- b) Provide the Plan with any and all documents and information regarding the Injury or Sickness the Plan may request;
- c) Execute the Fund's subrogation agreement setting forth the Plan's rights and the covered person and his or her spouse's obligations under these subrogation and reimbursement provisions;
- d) Provide the Plan with notice if the covered person and/or his or her spouse asserts a claim or claims against any third party and keep the Plan informed as to the status of such claim or claims;
- e) Notify their legal counsel immediately of the Fund's right to subrogation, assignment and reimbursement, and the fact that any monies received by or on their behalf, including monies received by the legal counsel from any third party, are the property of the Fund and are to be held in constructive trust.
- f) Notify any third party (including said third party's legal counsel) of the Fund's right to subrogation, assignment and reimbursement, and the fact that any monies received by or on behalf of the covered person and his or her spouse are the property of the Fund and are to be held in constructive trust.
- g) Request that any monies received from any third party be received in the form of a check made out to the covered person and his or her spouse and the St. Louis Painters Welfare Fund jointly.
- h) Obtain the written consent of the Plan or its designee prior to settling any claim to which this Plan is subrogated;
- i) Notify the Plan of any compensation the covered person and his or her spouse receives from any third party in connection with the Injury or Sickness and immediately reimburse the Plan upon the receipt of such compensation;
- j) Assign to the Fund their right to receive payment from the Third Party(ies), including, without limitation, any rights that the covered person and his/her spouse may have to collect any insurance proceeds, including without limitation medical payments or uninsured motorist payments. This assignment shall apply until the Fund is reimbursed in full for benefits paid in connection with the Injury or Sickness.
- k) Cooperate fully with the Plan in its efforts to protect and exercise its rights to subrogation and reimbursement; and
- l) Take no actions to compromise or impair the Plan's rights to reimbursement or subrogation.

If the covered person or his or her spouse fails to comply with these obligations, the Plan will not pay out benefits in connection with that Injury or Illness. If the covered person or his or her spouse fails to reimburse the Plan as required, the Plan may withhold future benefits due the covered person and his or her covered family members or may take any other such action necessary to enforce the Plan's right to reimbursement.

**6. Rejection of “Make-Whole” Doctrine**

This Plan specifically rejects the “make-whole” doctrine. The Plan’s rights to reimbursement and subrogation do not depend on whether the covered person or his or her spouse recovers from third parties monies sufficient to fully compensate the covered person and his or her spouse for their losses.

**7. Plan’s Enforcement of These Provisions**

In the event the covered person or his or her spouse fails to fulfill his or her obligations under these reimbursement and subrogation provisions, the Plan may take any action the Trustees deem necessary to enforce the Plan’s rights under these provisions. The Plan may refuse to pay benefits in connection with the Injury or Sickness if the covered person or his or her spouse or attorney fails to fulfill his or her obligation to provide information and documents or fails to execute the required reimbursement and subrogation agreement. If the Plan does pay benefits and the covered person or his or her spouse or attorney later fails to fulfill his or her duties under this section, the Plan may recoup the amounts it paid out by withholding future benefits from the covered person and his or her covered family members, by seeking refunds from the providers of care or by bringing a legal action against the covered person and his or her spouse. Should the Trustees bring legal action to enforce its rights under these reimbursement and subrogation provisions, and succeed, in whole or in part, in such action, the covered person and his or her spouse shall pay the legal fees and costs the Trustees incur in that action.

**8. Future Claims Relating to the Same Injury or Illness**

Once the covered person’s claims against the third party or parties are resolved, the Plan will not pay out any additional benefits in connection with the Injury or Sickness caused by the third party until the total claims that would otherwise be covered under the Plan exceed the total amount of compensation paid to or on behalf of the covered person by the third party or parties. In such a situation only the excess portion of the otherwise covered claims will be treated as covered.

## VII. PRESCRIPTION DRUG BENEFITS

### A. PRESCRIPTION CO-PAYMENTS

#### Retail Co-payment

20% of the cost of the prescription (for up to a 30-day supply) with the following minimum and maximum Co-payments:

<i>Type of Medication</i>	<i>Minimum Co-payment</i>	<i>Maximum Co-payment</i>
Generic	\$10.00	\$30.00
Brand Name Formulary	\$20.00	\$60.00
Brand Name Non-Formulary	\$40.00	\$60.00

If the actual cost of a generic medication is less than the Minimum Co-payment, then You will only pay the actual cost of the medication. For example, if the cost of Your generic medication is \$9.00, You will pay \$9.00.

#### Mail Order Co-payment

Generic	\$15.00
Brand Name Formulary	\$30.00
Brand Name Non-Formulary	\$60.00

Please note that the Prescription Drug Benefits under the Plan are not part of the Plan's Major Medical Benefit; thus, Prescription Co-payments for both retail and mail order do not apply towards Your Out-of-Pocket Maximum.

#### Specialty Medications Co-payment

20% of the cost of the prescription (for up to a 30-day supply) with an Out-of-Pocket Maximum of \$10,000 per individual.

### B. HOW THE BENEFIT WORKS

#### Participating Pharmacies

When You have Your prescriptions filled at a participating pharmacy in the Pharmacy Benefit Manager (PBM) network, You will receive Your benefits at discounted prices, and You will not have to file claim forms to be reimbursed for prescription drug Expenses. Instead, simply present Your prescription drug ID card and pay Your required Prescription Co-payment. The pharmacy will bill the PBM and the PBM will bill the Welfare Fund for the balance of the cost.

If You have Your prescriptions filled at a pharmacy that does not participate in the PBM network, You will have to pay the full cost of the prescription at the time You have the prescription filled and then submit a claim to the Plan for reimbursement. The Plan will then reimburse You based on the undiscounted amount minus Your Prescription Co-payment. This means You will be paying more since You pay a percentage of a higher amount.

#### Brand Name Formulary

There are often several types of medications that can be used to treat the same condition. To ensure high quality care and to help manage costs, most prescription drug programs have a list of preferred drugs, known as a formulary. A formulary consists of prescription drugs that are either more effective at treating a particular condition than others in their class or as effective as and less costly than similar medications. The PBM maintains a list of preferred drugs known as its Brand Name Formulary. If You chose not to use a generic medication or a generic medication is not available and You use a medication that is not on the PBM's list of preferred drugs, You will be subject to the higher Brand Name Non-Formulary Prescription Co-payment described above. Your pharmacist can help You in substituting a generic or formulary medication when appropriate.

A copy of the PBM's formulary is available online at [www.caremark.com](http://www.caremark.com). You may also obtain a copy from the Fund Office. You may want to bring a copy of the formulary with You when You go to Your doctor's office. When You need a prescription, You may want to ask Your doctor whether a generic or formulary medication is available.

### **Mandatory Maintenance Choice**

Maintenance or routine drugs prescribed by Your Physician must be obtained through a CVS Pharmacy or CVS Caremark Mail Service Pharmacy. New prescriptions may be filled at a retail pharmacy for the Retail Pharmacy Co-payment for a maximum of two (2) 30-day supplies (the original prescription fill and one refill). After 60 days You will be required to use a CVS Pharmacy or CVS Caremark Mail Service Pharmacy to have Your prescription covered under the Plan. This provision only affects You if You are taking maintenance or routine medications on an ongoing basis, such as for high blood pressure or arthritis. You may set your maintenance or routine drugs to auto-refill by calling CVS at (866) 818-6911 and requesting that your prescriptions be set to auto-refill and putting a credit card on file.

This provision saves You money and benefits You by allowing You to have a larger supply filled at one time, because You can have up to a 90-day supply filled at one time through a CVS Pharmacy or CVS Caremark Mail Services Pharmacy.

### **Specialty Pharmacy**

CVS Specialty Pharmacy is responsible for handling specialty pharmacy medications. Specialty medications are prescription drugs that require special handling and close monitoring. They are often considerably more expensive than traditional prescription drugs, partly due to their specialized use and the manner in which they are administered, manufactured, handled, and distributed.

Before attempting to have your prescription for a specialty medication filled, visit [CVSSpecialty.com](http://CVSSpecialty.com) to get started.

### **Brand Name Penalty**

Many prescription medications have two names – a generic name and a brand name. By law, both generic and brand name medications must meet the same standards for safety, purity, and effectiveness. However, on average, generic medications can cost half of the brand name medication amount; and, for some medications, this savings can be as great as 90%. By having Your prescriptions filled with generic medications whenever possible, You save money because You will be paying Your Prescription Co-payment on the less expensive generic medication, and You will help the Fund control the cost of prescription drug coverage.

It is common pharmacy practice to substitute generic medications for brand name medications whenever appropriate and allowed by Your doctor and applicable law. If You have a prescription filled with a brand name medication when a generic is available and appropriate, You will be required to pay the difference in cost between the generic medication and the brand name medication in addition to Your Prescription Co-payment for the brand name medication.

## **VIII. VISION CARE BENEFITS FOR PARTICIPANTS AND THEIR DEPENDENTS**

Initial eligibility and the continuation of eligibility provisions for the Vision Plan are the same as those of the St. Louis Painters Welfare Plan. These benefits are provided through a policy of insurance issued by EyeMed via Fidelity Security Life.

Please refer to the booklet provided by EyeMed, "St. Louis Painters Welfare Fund Vision Care Benefits," for coverage provisions and claim procedures. This booklet is incorporated by reference into this Plan Document and Summary Plan Description.

## **IX. DENTAL BENEFITS**

Initial eligibility and the continuation of eligibility provisions for the Dental Plan are the same as those of the St. Louis Painters Welfare Plan. These benefits are provided through a policy of insurance issued by Delta Dental.

Please refer to the booklet provided by Delta Dental, "St. Louis Painters Welfare Fund Dental Care Benefits," for coverage provisions and claim procedures. This booklet is incorporated by reference into this Plan Document and Summary Plan Description.

## **X. MEMBER ASSISTANCE PROGRAM**

The Fund offers a Member Assistance Program ("MAP") through Mercy Managed Behavioral Health & EAP for Participants and their Dependents. The MAP is available to help when You are dealing with job stress, depression, anxiety, strained relationships, child or elder care, grief, substance abuse or other issues. The MAP includes six (6) counseling sessions free of charge. Treatment beyond the scope of the MAP is coordinated through the other benefits provided to You under this Plan or through community services. All services under the MAP are confidential. For more information visit [www.mbh-eap.com/members](http://www.mbh-eap.com/members) or call (314) 729-4600 #2 or (800) 413-8008 #2.

## **XI. CLAIMS PROCEDURES**

Claims and appeal procedures for life and accidental death and dismemberment, weekly disability income, and major medical benefits are described below. Claims and appeal procedures for dental benefits are described in the booklet titled "St. Louis Painters Welfare Fund Dental Care Benefits," which is provided by Delta Dental and claims and appeal procedures for vision benefits are described in the booklet titled, "St. Louis Painters Welfare Fund Vision Care Benefits," which is provided by EyeMed via Fidelity Security Life (FSL).

### **Plan's Right to Recover Overpayments or Mistaken Payments**

If a payment for a claim filed by or for a Participant or his Dependents is found to be more than the amounts payable under the terms of the Plan or is found to have been made in error, then a refund of the excess or erroneous payment may be requested. If a requested refund is not paid or if none is requested, the Trustees of the Health and Welfare Fund may take whatever action they deem necessary to recover the overpaid or mistakenly paid amounts, including, but not limited to, reducing benefits payable for future claims filed by or for the Participant or his Dependents to offset the overpaid or mistakenly paid amounts or bringing a legal action to collect the overpayment. If it is necessary for the Trustees to institute legal proceedings against You to collect an overpayment and they prevail, You will be responsible for paying pre-judgment interest and the reasonable attorney's fees and costs they incur in connection with such action.

### **A. LIFE AND ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS**

#### **1. Submission of Life Insurance and Accidental Death and Dismemberment Claims.**

In the event of death or dismemberment, You or Your beneficiary should contact the Fund Office. You will be provided with the required forms, if any, and will be directed to submit proof of the death or dismemberment to the Fund Office.

#### **2. Time Limit for Filing Life Insurance and Accidental Death and Dismemberment Claims.**

Claims for life insurance or accidental death and dismemberment benefits should be submitted within 90 days after the death or dismemberment and must be submitted within one year after the death or dismemberment unless the claimant is legally incapable of submitting the claim within that period.

#### **3. Payment of Life Insurance and Accidental Death and Dismemberment Claims.**

The death and accidental death and dismemberment benefits will be paid to You or the designated beneficiary by Anthem Life Insurance Company.

#### **4. Notice of Claim Decision**

All claims for life insurance and accidental death and dismemberment insurance, when submitted as required, will be determined within 90 days after Anthem receives the claim. In some circumstances, additional time, up to an additional 90 days, may be required. You will be notified of the need and the reason for such delay and the anticipated length of the delay.

#### **5. Notice of Denial of Claim for Life Insurance and Accidental Death and Dismemberment Benefits**

If the insurance company or plan denies the claim in whole or in part, the insurance company or plan, as appropriate, will notify the claimant of the denial in writing which sets forth the following information:

- a) specific reason for the adverse benefit determination;
- b) reference to the specific plan or policy provisions on which the determination is based;
- c) a description of any additional material or information necessary to perfect the claim;
- d) a description of the review procedures and time limits, including a statement of the claimant's right to bring a civil action under Section 502(a) of ERISA; and
- e) if the decision involved a disability determination, a statement of any internal rule, guideline, protocol, or other criteria relied on and a statement of the claimant's right to obtain a free copy of it.

**6. Appeals from Denials of Claims for Life Insurance and Accidental Death and Dismemberment Benefits.**

The claimant may appeal from such denial by sending Anthem a request for review within 90 days after receiving notice of the denial. If the denial involved a disability determination, the appeal must be submitted within 180 days. The claimant may submit any additional information and documents he believes are relevant. The claimant may also review any documents on which Anthem relied in making its decision.

Anthem will normally decide the appeal within 60 days (45 days for claims involving disability determinations). However, in some circumstances, additional time, up to an additional 60 days (45 days for claims involving disability determinations) may be required. The claimant will be notified of the need and reason for the delay and of the anticipated length of the delay. Anthem will notify the claimant in writing of its final decision on the appeal.

**B. *WEEKLY DISABILITY BENEFITS***

**1. Submission of Claim**

A claimant should obtain a claim form for weekly disability benefits from the Fund Office (314) 656-1072. Both the claimant and his doctor must complete the form and then return it to:

St. Louis Painters Welfare Fund  
13801 Riverport Drive, Suite 501  
P.O. Box 1186  
Maryland Heights, MO 63043

**2. Time Limit for Filing a Claim**

Claims for weekly disability benefits must be submitted within 12 months after the period for which the claimant is seeking benefits.

**3. Payment of Claim**

The Plan will pay the weekly disability benefits to the disabled Active Participant.

**4. Notice of Claims Decision**

The Fund, through the claim administrator, will act on the claim within 45 days from the date the claim is received. If additional information is needed or if special circumstances beyond control of the Fund require more processing time, the Fund may extend the processing time for up to two additional 30-day periods.

If the Fund requires an extension of time to process a claim, the claimant will be notified in writing. The notice will specifically explain the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision on the claim, additional information (if any) needed to resolve those issues and the date by which the Fund expects to render a final decision. If the Fund requests additional information, the claimant will have at least 45 days to supply that information and this time will toll the time period the Fund has to reach its decision on the claim.

The Fund may seek independent medical advice in ruling on the claim and require such other evidence from the claimant as the Fund may reasonably need to decide the Claim. The Fund, at its own expense, may require physical examinations of claimant by Physicians it selects.

**5. Notice of Claim Denial**

If the Fund determines that a person who submits a claim is not entitled to benefits under this Plan or is entitled to a lesser benefit than the amount claimed, the claimant will be furnished a written statement that includes the following information:

- a) The specific reason for an adverse benefit determination;
- b) The specific Plan provision(s) on which the denial was based;
- c) A description of any additional material or information necessary to perfect the claim and an explanation of why such material is necessary;
- d) A statement regarding the right, upon request and free of charge, to access and to receive copies of documents, records, and other information relevant to the claim for benefits;
- e) An explanation of the Plan's appeal procedures, including applicable time limits, and including a statement of the claimant's right to bring civil action following an adverse benefit determination on review;
- f) Information as to whether an internal rule, guideline, protocol, or other similar criterion was relied upon in making the determination and, if so, a statement that the claimant can receive a free copy of the rule, guideline, protocol, or other criterion upon request; and
- g) If the denial was based in whole or part on a medical judgment, experimental treatment, or similar exclusion or limit, a statement that an explanation of the medical judgment will be provided free of charge upon written request to the Fund Office.

## **6. Appeal to Trustees**

A claimant who receives an adverse determination in accordance with the preceding paragraph, or his duly authorized representative, has the right to appeal the Fund's decision to the Trustees by submitting a written statement setting forth issues or comments along with any supporting documents related to his appeal. The written statement must be signed by the claimant or his representative and filed with the Fund Office within 180 days of the receipt by the claimant of the denial notice. Upon request and free of charge, the claimant or his representative may review or obtain copies of documents pertinent to the appeal which are in possession of the Fund Office or claim administrator, including any internal guideline, protocol, or other criteria on which the original benefit determination was based.

Appeals will be reviewed by the Trustees. All appeals will be decided by individuals who were not involved in the original benefit determination (or subordinates of anyone who was involved in the original benefit determination). The appeal determination will be based on all evidence related to the claim, including evidence and statements submitted by the claimant, even if such information was not considered in the original benefit determination. In considering the appeal, no deference will be given to the initial adverse benefit determination.

If the initial adverse benefit determination was 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 Trustees shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment and 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.

The Trustees will decide the appeal no later than the date of the regular Trustees meeting that immediately follows the Plan's receipt of the appeal, unless the appeal is received within 30 days preceding the date of such meeting. In such case, a decision will be made no later than the date of the second meeting following the Plan's receipt of the appeal. If special circumstances require a further extension of time for processing, a decision will be made not later than the third meeting following the Plan's receipt of the appeal. If such an extension of time for review is required because of special circumstances, the claim administrator will notify the claimant in writing of the extension, describing the special circumstances and the date as of which the appeal will be decided, prior to the commencement of the extension.

The claims administrator or the Fund Office will notify the claimant not later than 5 days after the appeal decision is made. The decision will be written in a manner calculated to be understood by the claimant and will include the specific reason(s) for the decision and specific reference(s) to the pertinent Plan provisions on which the decision is based.

The Trustees have broad discretionary authority to rule on all appeals and their decisions shall be final and binding on all parties, including but not limited to Participants, employees, employers, retirees, Dependents and beneficiaries and their service providers. Benefits under this Plan will be paid only if the Trustees decide in their discretion that the applicant is entitled to them.

If the appeal is denied, the claimant has the right to bring a civil suit under ERISA Section 502(a). However, no legal action may be brought to recover under this Plan prior to the exhaustion of the claim appeal process described above. No such action may be brought after three years from the date the Fund's final appeal decision is issued.

### **C. MAJOR MEDICAL BENEFITS (EXCEPT PRESCRIPTION DRUGS)**

**IMPORTANT NOTE REGARDING "CLAIMS":** In order to file a "claim", a request for the payment of benefits for services or supplies that have already been provided by a Physician, Hospital, pharmacy, or other provider must be submitted in writing on an authorized form to the appropriate address shown below in the subsection entitled, "How to File a Claim." However, claims from Physicians and other providers submitted in electronic format will also be accepted to the extent permitted by the Plan or required by law.

#### **1. Submission of Claims**

##### a) Provider Submissions.

Most providers will submit medical claims to the Plan on Your behalf. A provider may submit a claim electronically in accordance with the Electronic Data Interchange (EDI) rules or via a standard industry billing statement that includes the Participant's name and identification number, patient's name, date of service, type of service and amount of charge. Any other person seeking benefits must submit a written request for benefits to the claim administrator, which includes all of the information required for provider claims.

You should always show Your identification card at the time services are rendered.

In some instances, a provider may wish to obtain patient eligibility details, check on the status of a claim, request a service review or obtain a remittance advice in electronic format. Conducting these electronic transactions should be handled as described on Your identification card or by having the provider contact the Plan's clearinghouse:

Interactive Clearinghouse  
1373 Broad St., Ste. 300  
Clifton, NJ 07013  
1-888-718-2700  
[www.interactiveclearinghouse.com](http://www.interactiveclearinghouse.com)

Claims for medical benefits should be submitted to Anthem:

Electronic Claims: EDI Vendor #90001  
EDI Clearinghouse  
Web MD

Written Claims: St. Louis Painters  
Welfare Plan  
P. O. Box 1186  
Maryland Heights, MO 63043

##### b) Where this Plan is Secondary.

If the individual is covered under another plan that is primary pursuant to the COB rules set out in (starting on page 60) this booklet, You will need to submit the explanation of benefits You received from the primary plan.

##### c) Accidents.

While You do not normally need to submit a new claim form each time You receive medical care, if You suffer an accidental Injury or Illness, You must submit a separate claim form in order to receive benefits for that Injury or Illness.

## **2. Time Limit for Filing Claims**

Claims for major medical benefits should be submitted within 90 days after the service was rendered and must be submitted within 12 months of such date unless You are legally incapable of submitting the claim within that period.

## **3. Payment of Major Medical Benefits**

Payment of major medical benefits is made directly to the provider of medical care, unless You submit proof that You paid the provider. In that circumstance, the Plan will reimburse You or the person who is entitled to receive such reimbursement pursuant to a QMCSO. In any case, You will receive an explanation of benefits showing what the Plan paid.

You do not have the right to assign Your right to receive benefit payments under this Plan. The Fund has the right to reject any such assignment and pay benefits either directly to You, the provider, or any other third party as needed to properly carry out the provisions of the Plan, except where prohibited by applicable law. Payments that are made in good faith are considered benefits paid under this Plan.

## **4. Claims Determination and Appeal Procedures**

### **A. Notice of Claim Determination**

All benefit claim determinations will be made by the claims administrator and will be made in accordance with the terms of the Plan and, where appropriate, the Plan provisions will be applied consistently with respect to similarly situated claimants.

The periods of time within which a claim determination is required to be made as set out below, shall begin at the time a claim is filed in accordance with the reasonable procedures of the Fund, without regard to whether all the information necessary to make a claim determination accompanies the filing. In the event that a period of time is extended due to a claimant's failure to submit information necessary to decide a benefit claim, the period for making the claim determination shall be tolled from the date on which the notification of the extension is sent to the claimant until the date on which the claimant responds to the request for additional information.

#### **1) Post-Service Claims**

For most claims, the Fund will act on the claimant's benefit claim, through the claims administrator, within a reasonable period of time, but not later than 30 days from the date the claim is received in the Fund Office. If additional information is needed or if special circumstances beyond the control of the Fund Office require more processing time, the Fund may extend the processing time for up to 15 additional days.

If the Fund requires an extension of time to process a claim, the claimant will be notified in writing prior to the expiration of the initial 30-day period. The notice will specifically explain the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision on the claim, additional information (if any) needed to resolve those issues and the date by which the claims administrator expects to render a final decision. If the Fund requests additional information, the claimant will have at least 45 days to supply that information to the Fund Office and this time will stop the running of the time period the claims administrator has to reach its decision on the claim until such information is received. Failure to supply requested information within the given time limit will lead to a denial of the claim.

#### **2) Claims Involving Urgent Care**

In the case of a Claim Involving Urgent Care, the claims administrator shall notify the claimant of the Fund's claim determination (whether adverse or not) as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the claim by the Fund Office, unless the claimant fails to provide sufficient information to determine whether, or to what extent, benefits are covered or payable under the Plan. In the case of such a failure, the claims administrator shall notify the claimant as soon as possible, but not later than 24 hours after receipt of the claim by the Fund Office, of the

specific information necessary to complete the claim. The claimant shall be afforded a reasonable amount of time, taking into account the circumstances, but not less than 48 hours, to provide the specified information. The claimant shall be notified of the claim determination by the Fund as soon as possible, but in no case later than 48 hours after the earlier of: (1) the Fund Office's receipt of the specified information, or (2) the end of the period afforded the claimant to provide the specified additional information.

### 3) Disability Claims

In the case of a claim for disability benefits, the claims administrator shall notify the claimant of the Fund's adverse benefit determination within a reasonable period of time, but not later than 45 days after receipt of the claim by the Fund Office. This period may be extended by the Fund for up to 30 days, provided the Fund both determines that such an extension is necessary due to matters beyond the control of the Fund and notifies the claimant, prior to the expiration of the initial 45-day period, of the circumstances requiring the extension of time and the date by which the claims administrator expects to render a decision. If, prior to the end of the first 30-day extension period, the claims administrator determines that, due to matters beyond the control of the Fund, a decision cannot be rendered within that extension period, the period for making the determination may be extended for up to an additional 30 days, provided that the claims administrator notifies the claimant prior to the expiration of the first 30-day extension period, of the circumstances requiring the extension and the date as of which the Fund expects to render a decision. In the case of any extension, the notice of extension shall specifically explain the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision on the claim, and the additional information needed to resolve those issues, and the claimant shall be afforded at least 45-days within which to provide the specified information.

All claims for disability benefits will be adjudicated in a manner designed to ensure the independence and impartiality of the persons involved in making the decision. Accordingly, decisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to any individual (such as a claims administrator, claims adjudicator or medical or vocational expert) must not be made based upon the likelihood that the individual will support the denial of benefits.

## **B. Notice of Claim Denial**

If the claims administrator determines that a person who submits a claim is not entitled to benefits under this Plan or is entitled to a lesser benefit than the amount claimed, then the claimant will be furnished a written or electronic notification of the adverse benefit determination that shall set forth in a manner calculated to be understood by the claimant the following information:

- 1) The specific reason for an adverse benefit determination;
- 2) Reference to the specific Plan provision(s) on which the denial was based;
- 3) A description of any additional material or information necessary to perfect the claim and an explanation of why such material is necessary;
- 4) An explanation of the Plan's appeal procedures, including applicable time limits, and including a statement of the claimant's right to bring civil action following an adverse benefit determination on review;
- 5) If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse benefit determination, a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the adverse benefit determination and that a copy of the rule, guideline, protocol, or other criterion will be provided free of charge to the claimant upon request to the Fund Office;
- 6) If the adverse benefit determination was based on a Medical Necessity or Experimental or Investigational treatment or similar exclusion or limit, a statement

that an explanation of the scientific or clinical judgment for the determination will be provided free of charge upon request to the Fund Office;

- 7) In the case of an adverse benefit determination concerning a Claim Involving Urgent Care, a description of the expedited review process applicable to such claims;
- 8) In the case of an adverse benefit determination with respect to disability benefits,
  - (a) A discussion of the decision, including an explanation of the basis for disagreeing with or not following to the extent applicable: (i) the views presented by the claimant to the Fund of health care professionals treating the claimant and vocational professionals who evaluated the claimant; (ii) the views of medical or vocational experts whose advice was obtained on behalf of the Fund in connection with a claimant's adverse benefit determination, without regard to whether the advice was relied upon in making the adverse benefit determination, and (iii) a disability determination regarding the claimant presented by the claimant to the Fund made by the Social Security Administration;
  - (b) If the adverse benefit determination is based on a Medical Necessity or Experimental or Investigational treatment or similar exclusion or limit, a statement that an explanation of the scientific or clinical judgement for the determination will be provided free of charge upon claimant's request to the Fund Office;
  - (c) The specific internal rules, guidelines, protocols, standards, or other similar criteria of the Plan relied upon in making the adverse benefit determination or, alternatively, a statement that such rules, guidelines, protocols, standards, or other similar criteria of the Plan do not exist; and
  - (d) A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits. A document, record, or other information shall be considered "relevant" to a claimant's claim if such document, record, or other information: (i) was relied upon in making the benefit determination; (ii) was submitted, considered, or generated in the course of making the benefit determination, without regard to whether such document, record, or other information was relied upon in making the benefit determination; (iii) demonstrates compliance with the administrative process and safeguards required by 29 C.F.R. 2560.503-1 in making the benefit determination; or (iv) constitutes a statement of policy or guidance with respect to the plan concerning the denied treatment option or benefit for the claimant's diagnosis, without regard to whether such advice or statement was relied upon in making the benefit determination.

In the case of an adverse benefit determination with respect to disability benefits, the notification shall be provided in a culturally and linguistically appropriate manner; and

- 9) In the case of an adverse benefit determination concerning a Claim Involving Urgent Care, the notification of adverse benefit determination may be provided to the claimant orally within the timelines set out above for responding to Claims Involving Urgent Care, provided that a written or electronic notification of adverse benefit determination is provided to the claimant not later than 3 days after the oral notification.

**C. Appeal Procedures and Rights**

1) Time Limit for Filing an Appeal

An appeal must be signed by the claimant and filed in writing with the Fund Office within 180 days of the receipt by the claimant of the adverse benefit determination to which the appeal concerns.

2) Appeal Procedures

A claimant who receives an adverse benefit determination has the right to appeal the decision to the Trustees by submitting a written statement setting forth issues or comments along with any supporting documents or records related to his claim for benefits and appeal. The written statement must be signed by the claimant and filed with the Fund Office within 180 days of the receipt by the claimant of the adverse benefit determination. Appeal requests should be sent to:

St. Louis Painters Welfare Fund  
13801 Riverport Drive, Suite 501  
P.O. Box 1186  
Maryland Heights, MO 63043

In the case of a Claim Involving Urgent Care, an expedited appeal process is available. A claimant can request an expedited appeal of an adverse benefit determination for a Claim Involving Urgent Care by submitting the request orally or in writing. In the case of an expedited appeal, all necessary information, including the Fund's benefit determination on appeal, shall be transmitted between the Fund and the claimant by telephone, facsimile or other available similarly expeditious method.

For all appeals, the claimant shall be provided upon request and free of charge, reasonable access to, and copies of, all documents, records, or other information relevant to the claimant's claim for benefits. A document, record, or other information shall be considered "relevant" to a claimant's claim if such document, record, or other information: (i) was relied upon in making the claim determination; (ii) was submitted, considered, or generated in the course of making the claim determination, without regard to whether such document, record, or other information was relied upon in making the claim determination; (iii) demonstrates compliance with the administrative processes and safeguards required by 29 C.F.R. 2560.503-1 in making the benefit determination; or (iv) constitutes a statement of policy or guidance with respect to the Fund concerning the denied treatment option or benefit for the claimant's diagnosis, without regard to whether such advice or statement was relied upon in making the claim determination.

All appeals will be decided by the Trustees and no individual who was involved in making the adverse benefit determination, nor the subordinate of any such individual, shall be involved in deciding the appeal. The appeal determination will be based on all the evidence related to the claim, including all comments, documents, records, and other information submitted by the claimant related to the claim, without regard to whether such information was submitted or considered in the initial benefit determination. In considering the appeal, the Trustees will give no deference to the initial adverse benefit determination.

If the initial adverse benefit determination was 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 or Investigative, or not Medically Necessary or appropriate, the Trustees shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment and 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.

In the event any advice was obtained on behalf of the Fund in connection with the claimant's adverse benefit determination from any medical or vocational experts, said medical or vocational experts will be identified without regard to whether the advice was relied upon in making the claim determination.

With regard to claims for disability benefits, no adverse benefit determination on appeal of a disability claim will be provided before the Fund Office provides the claimant, free of charge, with any new or additional evidence considered, relied upon, or generated by the Fund, insurer, or other person making the claim determination (or at the direction of the Fund, insurer or such other person) in connection with the claim; such evidence must be provided as soon as possible and sufficiently in advance of the date on which the notice of adverse benefit determination on appeal is required to be provided to give the claimant a reasonable opportunity to respond prior to that date. In addition, before the Fund can issue an adverse benefit determination on appeal of a disability claim based on a new or additional rationale, the Fund Office shall provide the claimant, free of charge with the rationale. The rationale must be provided as soon as possible and sufficiently in advance of the date on which the notice of adverse benefit determination on appeal is required to be provided to give the claimant a reasonable opportunity to respond prior to that date.

3) Appeal Decision

The Trustees have broad discretionary authority to rule on all appeals and their decisions shall be final and binding on all parties, including but not limited to employers, unions, Participants, retirees, Dependents and beneficiaries and their service providers. Benefits will be paid only if the Trustees decide in their discretion that the claimant is entitled to them.

The Trustees shall have broad discretion to interpret all documents, make determinations of fact and decide all other matters pertaining to the appeal, to determine eligibility for benefits, and to exercise such authority as set forth in this Plan.

The period of time within which a benefit determination on appeal is required to be made under this subsection (C)(3) shall begin at the time an appeal is filed in accordance with the procedures set out herein, without regard to whether all the information necessary to make a benefit determination on review accompanies the filing. In the event that a period of time is extended as permitted herein due to a claimant's failure to submit information necessary to decide a claim, the period for making the benefit determination on review shall be tolled from the date on which the notification of the extension is sent to the claimant until the date on which the claimant responds to the request for additional information.

a) *Post-Service and Disability Claims:*

For post-service and disability claims, the Trustees will decide the appeal no later than the date of the regular Trustees' meeting that immediately follows the receipt of the appeal in the Fund Office, unless the appeal is received within 30 days preceding the date of such meeting. In such case, a decision will be made no later than the date of the second meeting following the receipt of the appeal in the Fund Office. If special circumstances require a further extension of time for processing, a decision will be made not later than the third meeting following the receipt of the appeal in the Fund Office. If such an extension of time for review is required because of special circumstances, the claims administrator will notify the claimant in writing of the extension, describing the special circumstances and the date as of which the appeal will be decided, prior to the commencement of the extension.

The claims administrator will notify the claimant in writing of the appeal decision as soon as possible but not later than five days following the date the decision is made.

All appeals for disability benefits will be adjudicated in a manner designed to ensure the independence and impartiality of the persons involved in making the decision. Accordingly, decisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to any individual (such as the claims administrator, a claims adjudicator or medical or vocational expert) must

not be made based upon the likelihood that the individual will support the denial of benefits.

*b) Urgent Care Claims:*

In the case of a claim involving urgent care, the claims administrator shall notify the claimant of the decision on review as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the claimant's request for review of an adverse benefit determination by the Fund Office.

4) Notice of Benefit Determination on Review Appeal

Within the timelines set out above, the Fund shall provide a claimant with written or electronic notification of the Fund's claim determination on appeal. Any electronic notification will comply with the standards imposed by 29 CFR Section 2520.104b-1(c)(1)(i), (iii) and (iv). The notification shall be set forth in a manner calculated to be understood by the claimant and shall include:

- a) The specific reason or reasons for the adverse determination;
- b) Reference to the specific plan provision(s) on which the benefit determination on appeal is based;
- c) A statement that the claimant is entitled to receive, upon request and free of charge reasonable access to, and copies of all documents, records, and other information relevant to the claimant's claim for benefits. A document, record, or other information shall be considered "relevant" to a claimant's claim if such document, record, or other information: (i) was relied upon in making the claim determination; (ii) was submitted, considered, or generated in the course of making the claim determination, without regard to whether such document, record, or other information was relied upon in making the claim determination; (iii) demonstrates compliance with the administrative process and safeguards required by 29 C.F.R. 2560.503-1 in making the benefit determination; or (iv) constitutes a statement of policy or guidance with respect to the Fund concerning the denied treatment option or benefit for the claimant's diagnosis, without regard to whether such advice or statement was relied upon in making the claim determination;
- d) A statement of the claimant's right to bring an action under Section 502(a) of the Act and a description of any applicable contractual limitations period that applies to the claimant's right to bring such an action, including the calendar date on which the contractual limitations period expires for the claim;
- e) If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse benefit determination on appeal, 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;
- f) If the adverse benefit determination on review is based on a Medical Necessity or Experimental or Investigative treatment or similar exclusion or limit, a statement that an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances will be provided free of charge upon request;
- g) The following statement: "You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to

find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency;" and

- h) In the case of an adverse benefit determination with respect to disability benefits
  - 1) a discussion of the decision including an explanation of the basis for disagreeing with or not following: (1) the views presented by the claimant to the Fund of health care professionals treating the claimant and vocational professionals who evaluated the claimant; (2) the views of medical or vocational experts whose advice was obtained on behalf of the Fund in connection with a claimant's adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination; and (3) a disability determination regarding the claimant presented by the claimant to the Fund made by the Social Security Administration;
  - 2) If the adverse benefit determination is based on Medical Necessity or Experimental or Investigative treatment or similar exclusion or limit, a statement that an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances, will be provided free of charge upon request; and
  - 3) Either the specific internal rules, guidelines, protocols, standards, or other similar criteria of the Plan relied upon in making the adverse benefit determination or, alternatively, a statement that such rules, guidelines, protocols, standards, or other similar criteria of the Plan do not exist.

In the case of an adverse benefit determination on review with respect to a claim for disability benefits, the notification shall be provided in a culturally and linguistically appropriate manner.

#### **D. Appointment of Authorized Representative**

A claimant is permitted to designate an authorized representative to act on his behalf in pursuing a benefit claim or appeal of an adverse benefit determination. The designation must be submitted in writing and delivered to the Fund Office. The authorization must set out at a minimum the following information: (1) the claimant's name, address and plan identification number, and if the claimant is not the Plan Participant, the name of the Plan Participant, (2) the name and address of the individual the claimant is designating as his/her authorized representative, and (3) the specific benefit claim and/or appeal on which the authorized representative is permitted to act, or if not for a specific benefit claim or appeal, the time period to which the designation applies for purposes of representing the claimant for purposes of any benefit claims and appeals arising during that time period.

An assignment of benefits by a claimant to a health care provider, where permitted, does not constitute a designation of an authorized representative for purposes of these Claims Determination and Appeal Procedures. In the case of a Claim Involving Urgent Care, a health care professional with knowledge of the claimant's medical condition shall be permitted to act as the authorized representative of the claimant.

Where the claimant has properly designated an authorized representative to act on his behalf, the authorized representative will stand in the shoes of the claimant; thus, all notices under these Claims Determination and Appeal Procedures will be sent to the claimant's authorized representative only, and the claimant's authorized representative will have the ability, within the scope of the authorization, to pursue benefit claims and appeals on behalf of the claimant.

In order to revoke a designation of an authorized representative, the claimant must submit a written request to revoke said designation to the Fund Office. In addition to setting out the desire to revoke the previously made designation, the written request should include at a minimum: (1) the

claimant's name, address, and plan identification number, and if the claimant is not the Plan Participant, the name of the Plan Participant, and (2) the name and address of the authorized representative whose designation as an authorized representative is being revoked. No such revocation will be effective until received and processed by the Fund Office.

**E. Culturally and Linguistically Appropriate Notices**

To ensure the Plan is providing notifications in a culturally and linguistically appropriate manner when required to do so by law, the Plan will:

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

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

**F. Claims Involving Urgent Care**

For purposes of these Claims Determination and Appeal Procedures, a "Claim Involving Urgent Care" is any claim for medical care or treatment with respect to which the application of the time periods for making non-urgent care determinations: (i) could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function, or, (ii) in the opinion of a physician with knowledge of the claimant's medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim. Except in the instance where a physician with knowledge of the claimant's medical condition determines that a claim is a "Claim Involving Urgent Care," whether a claim is a "Claim Involving Urgent Care" is to be determined by the claims administrator applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine. Where a physician with knowledge of the claimant's medical condition determines that a claim is a "Claim Involving Urgent Care," then the claim shall be treated as a "Claim Involving Urgent Care."

**G. Right to Seek Independent Medical Advice**

The claim administrator and Trustees may seek independent medical advice in ruling on any benefit claim or appeal and may require such other evidence from the claimant as they may reasonably need to decide the benefit claim or appeal. The Fund may, at its own expense, require a physical examination of a claimant by a Physician the Fund selects for purposes of deciding any benefit claim or appeal.

**H. Limitation on Court Actions**

If the appeal is denied, the claimant has the right to bring a civil suit under ERISA Section 502(a). However, no legal action may be brought to recover under this Plan prior to exhaustion of the claims appeals process described above. No such action may be brought after two years from the date the final appeal decision is issued.

## **D. CLAIMS FOR PRESCRIPTION DRUG BENEFITS**

### **1. Submission of Claim**

#### **a. Retail Pharmacies, Non-participating Pharmacies and Secondary Claims**

If You obtain a prescription from a retail pharmacy, a non-participating pharmacy or if this Plan is providing secondary coverage for Your prescription, You should pay the pharmacy for the full cost of the prescription and submit Your receipt, including the Participant's name, address and identification number, patient's name, name of the drug, prescribing Physician, the date the prescription was filled and the cost of the drug to the Fund Office for reimbursement. Send all prescription bills and receipts to:

St. Louis Painters Welfare Fund  
P.O. Box 1186  
Maryland Heights, MO 63043

#### **b. Mail Order Pharmacy**

Maintenance drugs may be obtained through the Plan's mail order pharmacy program through CVS Caremark. Order forms may be obtained from the Fund Office or CVS Caremark.

Submission of a mail order prescription to CVS Caremark does not constitute the filing of a "claim." If You receive a mail order prescription drug from CVS Caremark and believe that the Co-payment amount charged is incorrect or that CVS Caremark inappropriately indicated the person or the drug was not covered, You may then submit a written claim to the Fund Office requesting reimbursement of any amounts You believe were overcharged.

### **2. Time Limit for Filing Claims**

Claims for prescription drug benefits should be submitted within 90 days after the prescription was filled and must be submitted within 12 months of such date unless You are legally incapable of submitting the claim within that period.

### **3. Payment of Claims**

Reimbursement for prescription drugs will be paid directly to the Participant or to the person who is entitled to receive reimbursement pursuant to a QMCSO.

### **4. Notice of Claim Decision**

You will be notified of the decision of Your prescription drug claim according to the rules described above for major medical benefits (see "Notice of Claim Determination" and "Notice of Claim Denial" on pages 76 and 77).

### **5. Appeal Procedures**

Appeals of an adverse benefit determination of a prescription drug claim will be handled as described above under Major Medical Benefits Claim Appeal Procedures and Rights.

## **E. EXTENSIONS DUE TO COVID-19**

On May 4, 2020, the IRS and DOL issued a joint notice ("notice") declaring that for the purpose of accessing certain benefits through the Plan the time period described as the Outbreak Period (March 1, 2020 through sixty (60) days following the end of the National Emergency designated for the novel coronavirus, COVID-19) must be disregarded for calculating a claimant's compliance with applicable deadlines for accessing certain benefits. Benefits covered under the notice are specific to a claimant's eligibility under COBRA, the special enrollment period under HIPAA, filing benefit claims with the Plan, and filing appeals following an adverse benefit determination under the Plan.

Specifically, the Fund will disregard days running during the Outbreak Period in evaluating a claimant's claim for benefits under the following:

- Period for electing COBRA coverage following a qualifying event;
- Period for making the first premium payment for a COBRA claimant;
- Period for notifying the Plan after a qualifying event;
- Period for requesting special enrollment under HIPAA;
- Periods applicable for bringing a benefit claim against the Plan; and
- Periods applicable to requesting an appeal of an adverse benefit determination by the Plan.

In EBSA Disaster Relief Notice 2021-01, the Department of Labor clarified the duration of these deadline extensions, which applies on a case-by-case basis. Specifically, a Participant's deadline is **the earlier of:**

- One year from the date the individual was first eligible for relief (i.e., one year from their original deadline); or
- 60 days after the announced end of the National Emergency.

However, under no circumstances will a deadline extension last longer than one year.

For example, if a Participant's original deadline for electing COBRA coverage was April 1, 2020, he will have until April 1, 2021 to make that election. If a Participant's original deadline for electing COBRA coverage was September 1, 2020, they will have until September 1, 2021 to make that election (or 60 days after the National Emergency ends, if that date occurs before September 1, 2021).

Please contact the Fund Office if you have questions about how the deadline extensions apply to your individual circumstances.

## XII. GENERAL PLAN INFORMATION

### A. NAME, DESCRIPTION, AND PURPOSE OF PLAN

1. Name

This Plan is known as the St. Louis Painters Welfare Plan and is referred to as “the Plan”.

2. Description

This Plan is established and maintained pursuant to Collective Bargaining Agreements between the Union and employers in the painting and associated industries. It is operated and administered by a Board of Trustees, three of whom are appointed by the Union and three of whom are appointed by the employers who contribute to the Plan.

3. Purpose

This Plan is operated for the purpose of providing medical, dental, vision and other benefits to the employees of employers who have Collective Bargaining Agreements with the Union or other agreements requiring contributions to this Plan. Currently, the life insurance and accidental death and dismemberment benefits are provided through Anthem, the member assistance program is provided through Mercy Managed Behavioral Health & EAP, the dental benefits are provided by Delta Dental, the vision benefits are provided through EyeMed via Fidelity Security Life and the rest of the benefits are provided directly by the Plan.

### B. BOARD OF TRUSTEES

The current Trustees of this Plan are as follows:

#### UNION TRUSTEES

Carl Farrell  
Painters District Council No. 58  
2501 59<sup>th</sup> Street  
St. Louis, MO 63110

Joseph Mueller  
Painters District Council No. 58  
2501 59<sup>th</sup> Street  
St. Louis, MO 63110

Shawn Oster  
Painters District Council No. 58  
2501 59<sup>th</sup> Street  
St. Louis, MO 63110

#### EMPLOYER TRUSTEES

Donald Thomas  
Thomas Industrial Coatings, Inc.  
2070 Highway Z  
Pevely, Missouri 63070-2409

Michael Smith  
SmithPro Commercial Painting  
1612 Fairview Ave.  
St. Louis, Missouri 63132

Walter Bazan Jr.  
Bazan Painting Co.  
1273 N. Price Road  
St. Louis, MO 63132

### C. PLAN SPONSOR, PLAN ADMINISTRATOR, AND CLAIMS ADMINISTRATOR

The Board of Trustees is both the Plan Sponsor and Plan Administrator as those terms are defined in the Employee Retirement Income Security Act (ERISA).

BeneSys, Inc has been retained by the Trustees as the claims administrator for major medical claims and weekly disability claims. BeneSys receives, reviews, and adjudicates all claims for medical benefits and weekly disability benefits. However, the Board of Trustees makes the final decision with respect to such claims. BeneSys, Inc may request and receive information regarding any claim for medical or weekly disability benefits.

BeneSys, Inc does not insure or guarantee any claims and it does not pay claims out of its own assets.

#### **D. IDENTIFICATION NUMBER**

The number assigned to this Plan by the Board of Trustees pursuant to instructions of the Internal Revenue Service is 501. The number assigned to the Plan by the Internal Revenue Service is 23-7099221.

#### **E. AGENT FOR SERVICE OF LEGAL PROCESS**

If any legal disputes involving the Plan arise, legal documents should be served upon any of the Trustees at their places of business (as shown in Section B) or at the Fund Office.

#### **F. COLLECTIVE BARGAINING AGREEMENTS**

This Plan is maintained pursuant to Collective Bargaining Agreements between the Union and various employers. The Welfare Office will provide a Participant or beneficiary, upon written request, information as to whether a particular employer or employee organization is contributing to this Plan on behalf of employees working under a Collective Bargaining Agreement and, if so, with such employer's or organization's address. A copy of any Collective Bargaining Agreement pursuant to which the Plan is maintained may be obtained by Participants and beneficiaries upon written request to the Board of Trustees. A fee may be charged for such copy. Copies of such agreements are available for examination by Participants and beneficiaries at the Fund Office.

#### **G. SOURCE OF CONTRIBUTIONS**

The benefits provided by this Plan are funded primarily through employer contributions. The amount of employer contributions and the job classifications of the employees on whose behalf contributions are made are determined by the provisions of the Collective Bargaining Agreements or other agreement requiring contributions. Employee contributions are permitted in limited circumstances.

#### **H. TRUST FUND**

All assets are held in Trust by the Board of Trustees for the purpose of providing benefits to covered Participants and defraying reasonable administrative costs. Mellon Bank provides investment management services for the Board of Trustees with respect to the assets of the Trust.

#### **I. PLAN YEAR**

The records of the Plan are kept separately for each Plan Year. The Plan Year begins on January 1 and ends on December 31 of each year.

#### **J. THE ROLE OF THIRD PARTIES IN PROVIDING BENEFITS**

The life insurance benefits and accidental death and dismemberment benefits are provided under a policy of insurance the Welfare Plan has purchased from:

Anthem Group Insurance

Your claims for life insurance and accidental death and dismemberment benefits are processed and paid by and are insured by Anthem.

Your claims for medical and weekly disability benefits are processed and adjudicated by the claims administrator. See separate section as to where to send claims.

BeneSys, Inc does not insure or guarantee any benefits provided under the Plan.

Your claims for medical benefits are reviewed and repriced by:

Anthem Blue Cross Blue Shield  
1831 Chestnut Street  
St. Louis, MO 63103

In addition, Anthem performs predetermination services. Anthem provides Participants with access to their preferred provider network doctors, Hospitals, and other providers. Anthem does not make decisions about claims for benefits or pay or insure any of Your benefits.

Your dental benefits are provided through a policy of insurance issued by:

Delta Dental  
PO Box 8690  
St. Louis, Missouri 63126-0609

Your claims for dental benefits are processed and paid and Your dental benefits are insured by Delta Dental.

Potentially large medical claims may be reviewed and managed by:

Anthem Blue Cross Blue Shield

Medical Case Management Services does not insure or guarantee any claims.

Your vision benefits are provided through a policy of insurance issued by:

EyeMed via Fidelity Security Life  
P.O. Box 8504  
Mason, OH 45040-7111

Your claims for vision benefits are processed and paid and Your vision benefits are insured by EyeMed via Fidelity Security Life.

## **K. RIGHT TO MAKE PAYMENT**

**The Trustees have the right to pay benefits to any other organization or person, as needed, to properly carry out the provisions of the Plan.**

**The Trustees may pay for or provide services or equipment that they deem to be Medically Necessary but not otherwise covered by the Plan if, in their sole discretion, they conclude that paying for or providing such services or equipment would be financially beneficial to the Plan. No such payment or providing of services or equipment will be deemed to be an amendment to the Plan nor establish precedent, nor will it obligate such payments or providing of services or equipment in the case of any subsequent claim. The Trustees may, but will not be required to, delegate to their administrative manager the authority to authorize such payments on a uniform application.**

**If any person is, in the opinion of the Trustees, legally incapable of giving valid receipt for any payment due and no guardian has been appointed for that person, the Trustees may, at their option, make such payment to the person(s) who, in the opinion of the Trustees, have assumed the care and principal support of such person. If the person should die before all amounts due and payable have been paid, the Trustees, may, at their option, make such payment to the executor, administrator, or personal representative to his estate or to the Person's surviving spouse, parent, child(ren) or to any other person(s) who, in the Trustees' opinion, are entitled thereto.**

## **L. STATEMENT OF RIGHTS UNDER ERISA**

As a Participant in the St. Louis Painters Welfare Plan, You are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan Participants shall be entitled to:

### **1. Receive Information About the Plan and Benefits**

Examine, without charge, at the Plan Administrator's office and at other specified locations, such as 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 Pension & Welfare Benefit 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.

2. Continue Group Health Plan Coverage

Continue health care coverage for the Participant and his Dependents if there is a loss of coverage under the Plan as a result of a qualifying event. A Participant or his Dependents may have to pay for such coverage. Review this Summary Plan Description and the documents governing the Plan for the rules governing COBRA continuation rights.

3. Prudent Actions by Plan Fiduciaries

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

4. Enforce Your Rights

If Your claim for a welfare benefit is denied or ignored, in whole or in part, You have the 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 materials 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 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 frivolous.

5. 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 Pension and Welfare Benefits Administration, U.S. Department of Labor, listed in Your telephone directory, or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits 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 Pension and Welfare Benefits Administration.

## ***M. BOARD OF TRUSTEES TO INTERPRET, CONSTRUE, AND APPLY TERMS OF PLAN DOCUMENTS***

The Trustees of this Plan have broad discretionary authority to determine, pursuant to the terms of this Plan and Summary Plan Description, Trust Agreement, and other relevant documents, questions concerning eligibility for benefits, questions concerning whether the Expense of any given treatment or service is a Covered Expense, and any other questions which may arise in the administration of this Plan. The Trustees also have broad discretionary authority to interpret, construe, apply the terms of the Plan documents, including any ambiguous

terms and make determinations of fact regarding any dispute over Plan benefits. Any interpretation, construction, or application shall be binding on all parties. The Trustees intend that the most deferential standard of judicial review shall apply to their decisions.

#### ***N. BENEFITS ARE NOT GUARANTEED – TRUSTEES MAY ALTER OR TERMINATE***

The benefits described in this Plan and Summary Plan Description are those currently provided by the Plan. The Trustees may alter, modify, reduce, eliminate, or terminate any or all of the benefits, including benefits provided to retirees, when, in their discretion, they determine such action to be necessary. Any such changes shall be made in the form of an amendment or resolution and shall be made by majority vote of the Trustees at a regular or special meeting of the Board of Trustees.

The Welfare Trust that provides Your plan of benefits can be terminated by a majority of the Trustees when there is no longer an agreement between the Union and any employer providing for contributions to the Trust. In such a circumstance, the Trust shall continue for the sole purpose of dissolution, and the monies in the Trust shall be used by the Trustees for the sole purpose of carrying on benefits then in effect to individuals then employed by Contributing Employers until such monies are completely exhausted.

#### ***O. NON-DISCRIMINATION TESTING***

For purposes of non-discrimination testing under the St. Louis Painters Welfare Fund, Bargaining Unit Employees shall be tested separately from Non-Bargaining Unit Employees.

## XIII. COMPLETE NOTICE OF PRIVACY PRACTICES

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY AND CONTACT THE FUND OFFICE IF YOU HAVE ANY QUESTIONS.**

We are required by law, namely the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA), as amended by the Health Information Technology for Economic and Clinical Health Act (HITECH), to make sure that medical information that identifies you is kept private to the extent required by law. We are also required to give you this notice regarding (1) the uses and disclosures of medical information that may be made by the Fund, and (2) your rights and the Fund's legal duties with respect to such information. This notice and its contents are intended to conform to the requirements of HIPAA and its applicable regulations.

Medical information includes all information related to your past or present health condition that individually identifies you or could reasonably be used to identify you and is transferred to another entity or maintained by the Plan in oral, written, electronic or any other form.

### **How We May Use and Disclose Medical Information About You**

The following categories describe different ways that we use and disclose medical information, sometimes referred to in this document as "Protected Health Information" or "PHI." Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

**Treatment.** Treatment is the provision, coordination or management of health care and related services. It also includes but is not limited to consultations and referrals between one or more of your providers. For example, we may disclose to a treating orthodontist the name of your treating dentist so that the orthodontist may ask for your dental x-rays from the treating dentist.

**For Payment.** We may use and disclose medical information about you to determine eligibility for Plan benefits, to facilitate payment for the treatment and services you receive from health care providers, to determine benefit responsibility under the Plan, or to coordinate Plan coverage. For example, we may tell your health care provider about your eligibility for benefits to confirm whether payment will be made for a particular service. We may also share medical information with a utilization review or precertification service provider. Likewise, we may share medical information with another entity to assist with the coordination of benefit payments.

**For Health Care Operations.** We may use and disclose medical information about you for Fund operations. These uses and disclosures are necessary to run the Fund. For example, we may use medical information in connection with conducting quality assessment and improvement activities; underwriting, premium rating, and other activities relating to Plan coverage; reviewing and responding to appeals; conducting or arranging for medical review, legal services, audit services, and fraud and abuse detection programs; and general Fund administrative activities.

**As Required By Law.** We will disclose medical information about you when required to do so by federal, state, or local law. For example, we may disclose medical information when required by a court order in a litigation proceeding such as a malpractice action. When authorized by law to report information about abuse, neglect, or domestic violence to public authorities, we may disclose medical information if there exists a reasonable belief that you may be a victim of abuse, neglect, or domestic violence. In such a case, the Fund will promptly inform you that such a disclosure has been or will be made unless that notice would cause a risk of serious harm. For the purpose of reporting child abuse or neglect, it is not necessary to inform the minor that such a disclosure has been or will be made. Disclosure may generally be made to the minor's parents or other representatives although there may be circumstances under federal or state law when the parents or other representatives may not be given access to the minor's health information.

**To Avert a Serious Threat to Health or Safety.** We may use and disclose medical information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.

**To Inform You About Treatment Alternatives or Other Health Related Benefits.** We may use PHI to identify whether you may benefit from communications from the Fund regarding: (1) available provider networks or available products or services under the Plan, (2) your treatment, (3) case management or care coordination for you, or (4) recommended alternative treatments, therapies, health care providers, or settings of care for you. For instance, we may forward a communication to a participant who is a smoker regarding an effective smoking-cessation program.

Disclosure to Health Plan Sponsor. Medical information may be disclosed to the Plan Sponsors, i.e., the Union and the Associations, or Fund Trustees, solely for purposes of administering benefits under the Fund.

**Organ and Tissue Donation.** If you are an organ donor, we may release medical information to organizations that handle organ procurement or transplantation.

**Military and Veterans.** If you are a member of the armed forces, we may release medical information about you as required by military command authorities.

**Workers' Compensation.** We may release medical information about you for workers' compensation or similar programs.

**Public Health Risks.** We may disclose medical information about you for public health activities to a public authority. These disclosures will be made for the purpose of controlling disease, injury, or disability.

**Health Oversight Activities.** We may disclose medical information to a health oversight agency for activities authorized by law, such as audits, investigations, inspections, and licensure.

**Lawsuits and Disputes.** We may disclose medical information in response to a court order or administrative tribunal. We may also disclose medical information in response to a subpoena, discovery request, or other lawful process, that is not accompanied by an order of a court or administrative tribunal, if we receive satisfactory assurance from the party seeking the information that reasonable efforts have been made to notify you of the request or, if such assurance is not forthcoming, if we have made a reasonable effort to notify you about the request.

**Law Enforcement.** We may release medical information if asked to do so for law enforcement purposes so long as applicable legal requirements have been met.

**Coroners, Medical Examiners and Funeral Directors.** We may release medical information to a coroner or medical examiner.

**Research.** We may disclose medical information for research, subject to conditions.

**National Security and Intelligence Activities.** We may release medical information about you to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

**Inmates.** If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release medical information about you to the correctional institution or law enforcement official.

**Individuals Involved in Your Care or Payment for Your Care.** Unless you object or request additional privacy restrictions or alternative communications that are accepted by the Fund, the Fund may, in the exercise of professional judgment, disclose to your family member, other relative, or close personal friend, PHI directly relevant to such person's involvement in your care or payment for your care.

**Fundraising Activities.** The Fund does not anticipate using or disclosing your medical information for fundraising activities; however, the Fund may use and disclose your PHI, as necessary in order to contact you for fundraising activities. You have the right to opt out of receiving fundraising communications. If you do not want to receive these materials, please submit a written request to the Privacy Officer for the Fund.

#### **Note on Certain Disclosures that Require Your Authorization**

Your written authorization generally will be obtained before the Fund will use or disclose psychotherapy notes about you from your psychotherapist. Psychotherapy notes are separately filed notes about your conversations with your mental health professional during a counseling session. They do not include summary information about your mental health treatment. The Fund may use and disclose such notes when needed by the Fund to defend against litigation filed by you. You may revoke the authorization at any time, provided that the revocation is in writing, except to the extent that the Fund has taken action in reliance thereon.

Your written authorization is also required before the Fund will sell your PHI or use it for marketing purposes. A sale of PHI occurs when remuneration is received, whether directly or indirectly, in exchange for PHI. Marketing of PHI occurs when financial remuneration is received from an entity whose products or services are promoted in communications to you. You may revoke your authorization at any time, provided the revocation is in writing, except to the extent that the Fund has taken action in reliance thereon.

Finally, the Fund may disclose your PHI to disaster relief organizations that seek your PHI to coordinate your care or notify family and friends of your location or condition in a disaster. The Fund will provide you with an opportunity to agree or object to such disclosure whenever it is practical to do so.

## Note on Disclosure of Genetic Information for Underwriting Purposes

If the Fund uses PHI for underwriting purposes, it will not use your "genetic information," as that term is defined under HIPAA, for such purposes.

### Your Rights Regarding Medical Information About You

You have the following rights regarding medical information we maintain about you:

**Right to Inspect and Copy.** You have the right to inspect and copy medical information that may be used to make decisions about your Plan benefits. To inspect and copy such medical information, you must submit your request in writing to the Fund Office. The requested information will be provided within 30 days. A single 30-day extension is allowed if the Fund is unable to comply with the deadline. If you request a copy of this information, we may charge a fee for the costs of copying, mailing or other supplies associated with your request. We may deny your request to inspect and copy your medical information in certain very limited circumstances. If you are denied access to medical information, you may request that the denial be reviewed.

You also have the right to an electronic copy of your electronic PHI ("ePHI") maintained by the Fund in a designated data set in an electronic format. The Fund will make this information available to you in a machine-readable format (however, if you decline to receive any of the formats reasonably offered, then the Fund may provide you with a hard copy). Further, you may request that the Fund provide this information directly to a third party. You must make this request in a signed writing that clearly identifies the individual to whom the Fund should send the ePHI to. You may make this request to the Fund Office.

**Right to Amend.** If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for the Fund. To request an amendment, your request must be made in writing and submitted to the Fund Office. In addition, you must provide a reason that supports your request. The Fund has 60 days after the request is made to act on the request. A single 30-day extension is allowed if the Fund is unable to comply with the deadline. If the request is denied in whole or in part, the Fund must provide you with a written denial that explains the basis for the denial. You or your personal representative may then submit a written statement disagreeing with the denial and have that statement included with any future disclosures of your health information.

We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that: (1) is not part of the medical information kept by or for the Fund, (2) was not created by us, unless the person or entity that created the information is no longer available to make the amendment, (3) is not part of the information which you would be permitted to inspect and copy, or (4) is accurate and complete.

**Right to an Accounting of Disclosures.** You have a right to obtain an accounting of certain disclosures of your medical information. This right to an accounting extends to disclosures, other than disclosures made: (1) to carry out treatment, payment or health care operations, (2) to individuals about their own medical information, (3) incident to an otherwise permitted use or disclosure, (4) pursuant to an authorization, (5) for purposes of creation of a facility directory or to persons involved in the patient's care or other notification purposes, (6) as part of a limited data set, (7) for other national security or to correctional institutions or law enforcement officials, or (8) before April 14, 2003.

To request an accounting of disclosures, you must submit your request in writing to the Fund Office. The requested information will be provided within 30 days if the information is maintained on site or within 60 days if the information is maintained offsite. A single 30-day extension is allowed if the Fund is unable to comply with the deadline. Your request must specify a time period, which may not be longer than six years. Your request should indicate in what form you want the accounting (for example, paper or electronic). The first accounting you request within a 12-month period will be free. For additional accountings, we may charge you for the costs of providing the accounting. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

**Right to Request Restrictions.** You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment, or health care operations. We are not, however, required to agree to your request. To request restrictions, you must make your request in writing to the Fund Office. In your request, you must tell us: (1) what information you want to limit; (2) whether you want to limit our use, disclosure, or both; and (3) to whom you want the limits to apply.

**Right to Request Confidential Communications.** You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail. Such requests shall be honored if, in the sole discretion of the Fund, the requests are reasonable and can be accommodated with minimal disruption to Fund administration. However, the Fund shall accommodate

such a request if the participant clearly provides information that the disclosure of all or part of that information could endanger the participant. To request confidential communications, you must make your request in writing to the Fund Office. Your request must specify how or where you wish to be contacted.

**Right to a Paper Copy of This Notice.** You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice.

**Breach Notification.** The Fund is required by law to maintain the privacy of your PHI. Further, you have a right to receive notice, and the Fund is obligated to notify you, when there has been a breach of your unsecured PHI.

#### **Changes to This Notice**

The effective date of this Notice is May 1, 2016. We reserve the right to: (1) change this notice, and (2) to make the revised or changed notice effective for medical information we already have about you as well as any information we receive in the future. If any changes are made, we will mail the revised Notice to participants. The Fund will comply with the terms of any such Notice currently in effect.

#### **Complaints/Requests for Information**

If you believe your privacy rights have been violated, you may file a complaint with the Fund or with the Secretary of the Department of Health and Human Services. To file a complaint with the Fund, or to receive further information as required by the regulations, contact:

St. Louis Painters Welfare Fund  
ATTN: Privacy Officer  
13801 Riverport Drive  
Suite 501  
P.O. Box 1186  
Maryland Heights, MO 63043  
phone (314) 656-1072  
fax (314) 739-1105

All complaints must be submitted in writing. To file a complaint with the Secretary of the Department of Health and Human Services, contact them by mail at 200 Independence Avenue, S.W., Washington, D.C. 20201, by telephone at (877) 696-6775 or by visiting [www.hhs.gov/ocr/privacy/hipaa/complaints/](http://www.hhs.gov/ocr/privacy/hipaa/complaints/). You will not be penalized for filing a complaint.

#### **Other Uses of Medical Information**

Other uses and disclosures of medical information not covered by this notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose medical information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission.

## XIV. THE PLAN'S USE OF PHI

A complete description of your rights under HIPAA can be found in the Plan's Notice of Privacy Practices as provided above.

The Plan will not use or further disclose information that is protected by HIPAA ("Protected Health Information or PHI") except as necessary for treatment, payment, health care operations and Plan administration, or as permitted or required by law. **In particular, the Plan will not, without your written authorization, use or disclose protected health information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor.**

Except as permitted by HIPAA, the Plan will only use or disclose your PHI for marketing purposes or sell (exchange) your PHI for remuneration (payment), with your written authorization. The Plan may disclose PHI to the Plan Sponsor for the purpose of reviewing a benefit claim, appeal or for other reasons related to the administration of the Plan.

### A. THE PLAN'S USE AND DISCLOSURE OF PHI:

The Plan will use protected health information (PHI), without your authorization or consent, to the extent and in accordance with the uses and disclosures permitted by the privacy regulations under the HIPAA. Specifically, the Plan will use and disclose protected health information for purposes related to health care treatment, payment for health care, and health care operations (sometimes referred to as TPO), as defined below.

#### 1. Treatment

is the provision, coordination or management of health care and related services. It also includes but is not limited to consultations and referrals between one or more of your health care providers. The Plan rarely, if ever, uses or discloses PHI for treatment purposes.

#### 2. Payment

includes activities undertaken by the Plan to obtain premiums or determine or fulfill its responsibility for coverage and provision of Plan benefits with activities that include, but are not limited to, the following:

- a. Determination of eligibility, coverage, cost sharing amounts (e.g. cost of a benefit, Plan maximums, and copayments as determined for an individual's claim), and establishing employee contributions for coverage;
- b. Claims management and related health care data processing, adjudication of health benefit claims (including appeals and other payment disputes), coordination of benefits, subrogation of health benefit claims, billing, collection activities and related health care data processing, and claims auditing; and
- c. Medical necessity reviews, reviews of appropriateness of care or justification of charges, utilization management, including precertification, concurrent review and/or retrospective review.

#### 3. Health Care Operations includes, but is not limited to:

- a. Business planning and development, such as conducting cost-management and planning-related analyses for the management of the Plan, development or improvement of methods of payment or coverage policies, quality assessment, patient safety activities;
- b. Population-based activities relating to improving health or reducing health care costs, protocol development, case management and care coordination, disease management, contacting of health care providers and patients with information about treatment alternatives and related functions;
- c. Underwriting (the Plan does not use or disclose PHI that is genetic information as defined in 45 CFR 160.103 for underwriting purposes as set forth in 45 CFR 164.502(a)(5)(1)), enrollment, premium rating, and other activities relating to the renewal or replacement of a contract of health insurance or health benefits, rating provider and Plan performance, including accreditation, certification, licensing, or credentialing activities;
- d. Conducting or arranging for medical review, legal services and auditing functions, including fraud and abuse detection and compliance programs;
- e. Business management and general administrative activities of the Plan, including, but not limited to management activities relating to implementation of and compliance with the requirements of HIPAA

Administrative Simplification, customer service, resolution of internal grievances, or the provision of data analyses for policyholders, Plan sponsors, or other customers.

- f. Compliance with and preparation of documents required by the Employee Retirement Income Security Act of 1974 (ERISA), including Form 5500's, Summary Annual Reports and other documents.

## **B. WHEN AN AUTHORIZATION FORM IS NEEDED:**

Generally, the Plan will require that you sign a valid authorization form in order for the Plan to use or disclose your PHI **other than** when you request your own PHI, a government agency requires it, or the Plan uses it for treatment, payment or health care operations or other instance in which HIPAA explicitly permits the use or disclosure without authorization. The Plan's Notice of Privacy Practices also discusses times when you will be given the opportunity to agree or disagree before the Plan uses and discloses your PHI.

## **C. DISCLOSURE OF PHI TO THE PLAN SPONSOR:**

The Plan will disclose PHI to the Plan Sponsor only upon receipt of a certification from the Plan Sponsor that the Plan documents have been amended to incorporate the following provisions. With respect to PHI, the Plan Sponsor agrees to:

1. Not use or disclose the information other than as permitted or required by the Plan Document or as required by law;
2. Ensure that any agents, including their subcontractors, 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. This Plan hires professionals and other companies, referred to as Business Associates, to assist in the administration of benefits. The Plan requires these Business Associates to observe HIPAA privacy rules;
3. Not use or disclose the information for employment-related actions and decisions;
4. 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 disclosed in the Plan's Notice of Privacy Practices);
5. Report to the Plan any use or disclosure of the information that is inconsistent with the uses or disclosures provided for of which it becomes aware;
6. Make PHI available to the individual in accordance with the access requirements of HIPAA;
7. Make PHI available for amendment and incorporate any amendments to PHI in accordance with HIPAA;
8. Make available the information required to provide an accounting of PHI disclosures;
9. 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 the Dept. of Health and Human Services (HHS) for the purposes of determining the Plan's compliance with HIPAA;
10. If feasible, 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 of the PHI infeasible; and
11. If a breach of your unsecured Protected Health Information (PHI) occurs, the Plan will notify you.

## **D. SEPARATION BETWEEN THE PLAN AND THE PLAN SPONSOR**

In order to ensure that adequate separation between the Plan and the Plan Sponsor is maintained in accordance with HIPAA, only the following employees or classes of employees may be given access to use and disclose PHI:

1. The Plan Administrator,
2. Fund Office personnel designated to work on Plan administration and operations;
3. Business Associates under contract to the Plan.

## ***E. ACCESS TO AND USE AND DISCLOSE PHI***

The person described in Section D may only have access for plan administration functions that the Plan Sponsor performs for the Plan. If these persons do not comply with this obligation, the Plan Sponsor has designed a mechanism for resolution of noncompliance.

## ***F. THE HIPAA SECURITY REGULATIONS:***

In compliance with the HIPAA Security regulations, the Plan Sponsor will:

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 group health plan,
2. Ensure that the adequate separation discussed in D above, 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, and
4. Report to the Plan any security incident of which it becomes aware concerning electronic PHI.

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