

Painters & Allied Trades District Council No. 35

summary plan description

Health Benefits Plan



Painters & Allied Trades District Council No. 35 Trust Funds

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DEBORAH COTTER, FUND ADMINISTRATOR

UPDATE TO HEALTH, PENSION AND ANNUITY SUMMARY PLAN DESCRIPTIONS

Updates the names of the Board of Trustees listed on the inside cover of the Health, Pension and Annuity Summary Plan Description Books.

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UPDATES TO THE PLAN ARE AT THE END OF THIS BOOKLET



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Important Contact Information

Contact	For Questions About	Address	Phone/Fax Number	Website
Fund Office	Medical benefits, eligibility, COBRA, claim payments and appeal procedures	Painters & Allied Trades District Council No. 35 Benefit Funds 25 Colgate Road Suite 204 Roslindale, MA 02131-1105	(617) 524-1240 or (800) 799-1240 Fax: (617) 524-3557	
CareLink	Website for providers in-network, Healthy Rewards program, Summary Plan Descriptions			www.tuftshealthplan.com/carelink/dc35
CareAllies	Medical Certification Program		(800) 558-9639	www.careallies.com
Modern Assistance Programs	Employee Assistance Program Inpatient substance abuse and inpatient psychiatric treatment		(800) 878-2004	www.modernassistance.com
Teamsters Rx	Prescription drug benefit		(866) 888-0104	
Delta Dental	Dental care benefit		(800) 872-0500	www.deltamass.com
Davis Vision	Vision care benefit		(800) 999-5431	www.davisvision.com
HearUSA	Audiology benefit		(800) 333-3389	www.hearusa.com

Meet Your Health Benefits Plan

As a member of the Painters & Allied Trades District Council No. 35, you're eligible for a generous package of health and welfare benefits. The Health Benefits Plan includes:

- comprehensive **medical coverage** with a sharp focus on wellness and preventive care;
- top-notch **dental, vision, hearing care** and **prescription drug** coverage;
- access to great resources and help with mental health and/or substance abuse through the **employee assistance program**;
- access to free **legal services**; and
- **life insurance, accidental death and dismemberment insurance** and a **sickness income benefit** that provides a benefit if you are hospitalized for more than a week.

Using Your Benefits

Once you become eligible for coverage (see page 47 for information about eligibility) you and your dependents can begin taking advantage of the Health Benefits Plan. Your benefits programs are designed to provide a broad spectrum of coverage at reasonable prices. We've contracted with quality vendors that have extensive networks to limit your paperwork and provide discounts whenever possible.

When you visit a provider in-network, you do not have to meet an annual deductible. You simply pay your portion of the charges (your "coinsurance") and the Health Benefits Plan will pay the rest. You may visit a provider who does not participate within the network (an "out-of-network" provider) but your out-of-pocket costs will be greater.

About This Summary Plan Description

This Summary Plan Description has been designed to be easy to read and use. Information about your individual benefits and specific coverage amounts is located in Tab 2. "Exclusions and Limitations" can be found on page 31.

We've also included a "Life Events" section to explain how your benefits are affected by different events (like marriage, divorce, adding a dependent) in your life. See page 41 to learn more.

- For information about eligibility, see page 47.
- For information about continuing your coverage if you lose eligibility, see page 49.
- For information about how to appeal a denied claim, see page 59.
- For information about your privacy rights, see page 67.
- For important contact information, see page 2.





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Medical Benefits

An Overview of Your Medical Benefits

The Painters & Allied Trades District Council No. 35 Health Plan covers most medically necessary expenses. For provider discounts, we contract with CareLink, a Preferred Provider Organization (PPO) alliance between Tufts Health Plan and CIGNA HealthCare. Your medical claims are paid directly by the Painters & Allied Trades District Council No. 35 Health Plan at the Fund Office. Claim payments will be considered and paid in accordance with the CareLink generally accepted procedures and practices.

When you visit a PPO provider (an “in-network” provider) you receive services at a discounted rate. All in-network services are paid at a percentage of a discounted network rate. Most covered medical expenses in the PPO are paid at 90%. You are responsible for paying the other 10% and any applicable copayments.

The Plan will pay up to \$1 million per person in medical expenses. This is called the “Lifetime Maximum.” For more information, see page 13.

What’s Covered?

Most medically necessary services are covered by the Plan. However, different levels of coverage and/or limits apply to some services. Check the Summary of Benefits on the following pages for more information or call the Fund Office at (617) 524-1240 to see if a specific service is covered.

Coverage Out-of-Network

Most providers participate within the PPO network; however, you can still choose to visit an out-of-network provider. The Plan will pay less—60% instead of 90%—and you’ll have to meet a deductible first.

The chart below summarizes the differences between in- and out-of-network coverage.

	In-Network	Out-of-Network
Annual Deductible	\$0	\$250 per individual, \$500 per family
Coverage	90% of PPO rate	60% of “reasonable and customary” rate
Out-of-Pocket Maximum (the most you can pay out of your own pocket for covered medical expenses each year)	\$1,500 individual \$3,000 family	\$3,000 individual \$7,000 family
Lifetime Maximum (the most the Plan will pay on each participant’s behalf)	\$1,000,000	

Summary of Medical Benefits

The following schedule shows the amount the Health Benefits Fund pays for medically necessary covered services and treatment when rendered by a **PPO in-network** provider.

Service	Plan Pays	Notes
Acupuncture and/or Chiropractic Benefit	100% up to \$800 (combined) calendar year maximum	Claims for dependents 18 or younger must have prior approval.
Ambulance Air Ambulance	70% 70% of first \$2,000 in charges for air ambulance	Ambulance services for any other transport must be pre-approved. Physician charges or wheel chair transport not covered. Air ambulance for a life-threatening medical emergency only. See page 73 for more information.
Diagnostic Testing	90% network hospital or 100% network non-hospital	<ul style="list-style-type: none"> • Laboratory • Radiology • MRIs or Pet Scans • Stress/EKG/EEG • Allergy • Sleep study (dependents 18 and under must have prior approval).
Home Health Services/Hospice	100%	Pre-approval by CareAllies is required. See page 74 for more information.
Hospital Services	90%	Pre-approval by CareAllies is required. <ul style="list-style-type: none"> • Anesthesia • Room and board (semi-private room rate) • Maternity • Physician • Surgeon • Surgical Day Care • Outpatient • Dental (see page 19 for details).

Summary of Medical Benefits *continued*

Service	Plan Pays	Notes
Hospital Emergency Room	90% after \$100 deductible	
Injections	90%	<ul style="list-style-type: none"> • Allergy, Spinal, Cortisone
Immunizations	100%	<ul style="list-style-type: none"> • Immunizations must be AMA/FDA approved and provided according to age requirements. No coverage for adult meningitis vaccine.
Learning Disability Benefits	100% after \$20 copayment	No coverage available for ADD, ADHD, Hyperkinetic Syndrome, Conduct Disorders or Developmental Delays except as indicated. Covered services are limited to a neurological evaluation by a neurologist to rule out brain pathology and services of a physician to monitor medication in office setting only.
Medical Equipment or Supplies Purchase or Rental	100%	<p>Rental or purchase of medical equipment must be reviewed and approved through the Fund Office prior to purchase or rental for the following covered expenses:</p> <ul style="list-style-type: none"> • Catheter Supplies • Colostomy/Ostomy • Diabetic Supplies • Insulin Pumps (once every five years) • Nebulizer (up to \$250, once per lifetime) • Prosthetic Appliances - Initial purchase of prosthetic appliance including artificial limbs and eyes. Subsequent purchase or replacement of these items is not a covered expense • Hair Prosthesis (85% maximum, \$5,000 per year) • Wigs (for hair loss due to alopecia or chemotherapy) Limit \$600 every five years. See page 74 for more information.
Occupational/ Physical Therapy	100% Maximum of 60 visits per calendar year	Referring physician must recommend a specific number of treatments prior to service being rendered. See page 75 for more information.
Office Visit	100% after \$20 copayment	

Summary of Medical Benefits *continued*

Service	Plan Pays		Notes	
Organ Transplants	90% All-inclusive fixed dollar limit of \$50,000 for all services and drugs		<ul style="list-style-type: none"> Coverage is limited to a member or dependent who has been covered by the Plan for 12 consecutive months prior to the transplant procedure Transplantation must be performed in a federal or state approved center The transplantation cannot be considered experimental by the American Medical Association Pre-approval by CareAllies required. 	
Physical Exam	100% after \$20 copayment		Covered for the whole family	
Psychiatric Benefit	Inpatient Coverage 90%, 60 days lifetime maximum	Outpatient Coverage 100% after \$20 copay, 25 visits per year (combined with Substance Abuse Benefit)	Inpatient Notes Admissions must be approved in advance by MAP through the Employee Assistance Program.	Outpatient Notes Psychiatric treatment for non-substance abuse. Covers only services of a psychiatrist, psychologist or licensed social worker.
Psychiatric Testing Benefit	90% \$500 per year maximum			
Rehabilitation Hospital Benefit Cardiac/Pulmonary Rehabilitation Outpatient Benefit	90%, 25 days per admission 90%, 36 visits per calendar year		Maximum 25 days per admission; facility must be a licensed rehabilitation hospital. No coverage for vocational rehabilitation facility or skilled nursing facility.	

Summary of Medical Benefits *continued*

Service	Plan Pays		Notes	
Substance Abuse Benefit	Inpatient Coverage 90%, annual maximum \$10,000; lifetime maximum \$15,000	Outpatient Coverage 100%, \$20 copayment; Calendar Year maximum: 25 visits combined with Psychiatric Benefit	Inpatient Notes All admissions must be approved in advance by MAP through the Employee Assistance Program. See page 27 for more information	Outpatient Notes Covers only services of a psychiatrist, psychologist or licensed social worker. Must be approved in advance by MAP through the Employee Assistance Program. See page 27 for more information

Are You Being Overcharged?

Overcharges on hospital bills may range from 10% to 13% of billed charges. Carefully review your Explanation of Benefits. Question charges that look unfamiliar!



Medical Certification Program

Our Medical Plan has a certification component to help ensure that you and your family are not receiving unnecessary medical treatment. You'll need to contact the Medical Certification Program vendor—CareAllies—prior to any medical hospital admissions. CareAllies will confirm the necessity of your inpatient hospital stay so that you can receive the highest level of benefits coverage. If you require inpatient psychiatric or substance abuse treatment, you must contact Modern Assistance Programs prior to the hospitalization. See page 27 for more information.

When to Notify CareAllies

You and/or your covered dependents must call CareAllies at 1-800-558-9639 in the following situations:

- If you are going into the hospital, as soon as your admission date has been scheduled;
- If you are admitted to the hospital on an emergency basis, within 24 hours after the admission. (If you are unable to call within 24 hours, call as soon as possible after admission.); and
- If your doctor is planning to admit you to an acute rehabilitation facility or order home health care services.

What Happens When You Call?

A case associate will ask you for some information about your medical care. Please have this information available when you make the call:

- the member's Social Security or UIN number;
- the patient's name and relationship to you;
- the name of your Fund (Painters & Allied Trades District Council No. 35 Health Fund);
- your doctor's name and telephone number; and
- the name and telephone number of the facility or hospital.

The case associate will assign you a reference number for the inpatient admission. The number is your **guarantee** that you have notified CareAllies. Keep the reference number with your personal files in case you need it in the future.

If You Do Not Call

If you do not contact CareAllies in the situations listed at the left, the Fund will assess you the first \$1,000 of hospital expenses incurred during a hospital stay that has not been certified. If CareAllies decides that the hospital or surgical charges were not medically necessary, or were not performed in the appropriate setting, the Fund will not cover any of the services.

Headed for the Hospital?

You or your dependent should contact CareAllies by calling 1-800-558-9639 to certify your hospital stay.

Payment of Benefits

Coordination of Benefits

Members of a family are often covered by more than one group health insurance plan. As a result, sometimes two or more plans end up paying for the same expense. To avoid this costly problem, your Health Plan provides a Coordination of Benefits provision.

Coordination of Benefits (COB) is an administrative method that health plans follow that allows you to receive coverage under more than one group insurance plan without receiving duplicate payments for the same expenses. If you and your spouse both work, and you're both covered by each other's group medical plan, COB provides that the provisions of both plans are taken into account when benefits are paid. If you fail to notify the Fund Office of other insurance coverage, you will be required to reimburse the Fund for any claims paid. In addition, overpayments made by the Painters & Allied Trades District Council No. 35 Health Plan will be deducted from future medical claim payments.

The Coordination of Benefits provision applies to your medical, prescription and dental coverage. It does not apply to Life Insurance, Accidental Death and Dismemberment or Supplemental In-Hospital Accident and Sickness Income Benefit coverage. Note: If your dependents have prescription drug benefits through another health care plan, they are not eligible to participate in this Prescription Drug program. However, copayments you pay under the other plan may be submitted to the Fund Office for reimbursement. This includes office visit copayments.

COB applies when you have health care coverage under more than one plan, as defined below. COB rules are used to determine whether this Plan is a primary plan or secondary plan when compared to another plan covering the person. When this Plan is primary, its benefits are determined before

those of any other plan and without considering any other plan's benefits. When this Plan is secondary, its benefits are determined after those of another plan and may be reduced so that payments from all group plans do not exceed 100 percent of the total allowable expense. In no event will the amount of benefits paid under this Plan exceed the amount that would have been paid if there were no other plan involved.

If you are eligible for Medicare, this Plan will be coordinated with Medicare Parts A and B whether or not you have enrolled in Part B. This means that if you fail to enroll in Part B, you will be required to pay a larger portion of the bill that would otherwise be payable by Medicare.

Order of Benefit Determination Rules

When two or more plans pay benefits, the first of the following rules that applies determines the order in which the plans pay or provide benefits. The plan that is determined to be the primary plan pays or provides its benefits as if the secondary plan or plans did not exist. The secondary plan may consider the benefits paid or provided by another plan in determining its benefits.

Plan Without Model COB:

A plan that does not contain a coordination of benefits provision consistent with the model COB provisions under Massachusetts law is primary.

Nondependent/Dependent:

The plan that covers the person other than as a dependent (for example, as an employee, member, subscriber or retiree) is primary, and the plan that covers the person as a dependent is secondary. However, if the person is a Medicare beneficiary and Medicare is secondary to the plan covering the person as a dependent and primary to the plan covering the person as other than a dependent (for example, a retiree), then the order of benefits between the two plans is reversed so that the plan covering the person as an employee, member, subscriber or retiree is secondary and the other plan is primary.

Child Covered Under More Than One Plan:

The order of benefits when a child is covered by more than one plan is as follows:

1. if the parents are either married or not separated (whether or not they ever have been married) or if a court decree awards joint custody without specifying that one party has the responsibility to provide health care coverage, the primary plan is the plan of the parent whose birthday is earlier in the year or, if both parents have the same birthday, the plan that covered either of the parents longer;
2. if the specific terms of a court decree state that one of the parents is responsible for the child's health care expenses or health care coverage and the plan of that parent has actual knowledge of those terms, that plan is primary. This rule applies to claim determination periods or plan years commencing after the plan is given notice of the court decree; and
3. if the parents are not married, or are separated (whether or not they ever have been married) or are divorced, the order of benefits is as follows: (a) the plan of the custodial parent; (b) the plan of the spouse of the custodial parent; (c) the plan of the noncustodial parent; and (d) the plan of the spouse of the noncustodial parent.

Active/Inactive Employee:

The plan that covers a person as an employee who is neither laid off nor retired is the primary plan. The same rule holds true if a person is a dependent of a person covered as a retiree and an employee. If the other plan does not have this rule and, as a result, the plans do not agree on the order of benefits, this rule is ignored.

Continuation Coverage:

If a person whose coverage is provided under a right of continuation provided pursuant to federal or state law is also covered under another plan, the plan covering the person as an employee, member, subscriber or retiree (or as that person's dependent) is primary, and the continuation coverage is secondary. If the other plan does not have this rule and, as a result, the plans do not agree on the order of benefits, this rule is ignored.

Longer/Shorter Coverage Period:

The plan that has covered the person as an employee, member, subscriber or retiree longer is primary.

Default Rule:

If the preceding rules do not determine the primary plan, the allowable expenses are shared equally between the plans; however, in no event will this Plan pay more than it would have paid had it been primary.

When this Plan is the secondary plan and its payment is reduced to consider the primary plan's benefits, a record is kept of the reduction. This amount will be used to increase this Plan's payments on the covered individual's later claims in the same calendar year, to the extent there are allowable expenses that would not otherwise be fully paid by this Plan and the others.

Subrogation

You or one of your eligible dependents may incur medical expenses in a situation where a third party—for example, Workers' Compensation or an auto insurance carrier—may be held responsible for their payment. In this case, you must sign a form that permits the Fund to recover all its payments from that third party to the extent that a settlement or judgment makes the third party responsible for payment. In the case of an auto accident, this subrogation will begin when your (or your dependent's) \$8,000 PIP* benefits have been exhausted. Until the form is signed, no expenses will be Covered Charges. The Health Plan does not compromise on liens. No medical claims will be considered for payment until the \$8,000 PIP benefits have been exhausted and the Subrogation/Lien form is properly executed by all parties. A police report must be submitted if requested, for any accident.

**MedPay in New Hampshire or any state health allowance.*

Maximum Lifetime Benefit

The amount of your Maximum Lifetime Benefit for all covered medical charges combined is \$1,000,000. This maximum applies separately to each insured family member. Every January 1, the money you've spent out of your own pocket (up to \$1,000 per year) will be added back to your maximum lifetime benefit amount.

Requesting Reinstatement of the Lifetime Maximum

Any time that the Lifetime Maximum of an insured family member is reduced by at least \$1,000 because of benefits received, you may request reinstatement of the maximum as long as your dependent is then in good health as may be defined from time to time by the Trustees. You must submit medical evidence of your dependent's good health to the Fund Office. The new maximum becomes effective on the date the Fund Office confirms in writing that the evidence is satisfactory and that the Lifetime Maximum has been reinstated.



Wellness Benefits

The Health Benefits Plan has been designed to include a variety of health and wellness programs to keep you and your family healthy. We encourage all members and their dependents to take advantage of these benefits.

Annual Routine Physical Examination

You, your spouse and your children are covered for routine physical exams at **100%** after a \$20 copayment. Please make physical exams a part of your annual routine as a way to protect and maintain good health. Early detection and disease prevention are the best courses of treatment.

Healthy Rewards

The CareLink PPO offers a program called “Healthy Rewards.” This program offers generous discounts at fitness centers, weight and nutrition programs and other health and wellness products.

Healthy Rewards discounts are separate from your Plan coverage. You’re required to pay the entire discounted fee. Not all Healthy Rewards programs are available in all states. Visit <http://www.tuftshealthplan.com/carelink/dc35/> and click on “Healthy Rewards” for more information.

Smart Steps (Disease Management)

The CareAllies “Smart Steps” program provides eligible members and dependents suffering with chronic conditions (such as heart disease and diabetes) with a team of health care professionals who offer free and confidential support in managing these conditions.

The “Smart Steps” program includes support through phone calls, educational materials and free phone access to a health care professional 24 hours-a-day, seven-days-a-week. Contact CareAllies at: 1-800-558-9639 to enroll or to get more information.

24-Hour Nurseline

Part of your wellness benefit coverage includes access to a 24-Hour Nurseline. Just call 1-800-558-9639 to speak with a registered nurse any time you need health advice or assistance. The Nurseline can help you to:

- determine when to immediately call 911 or emergency services;
- find nearby doctors and hospitals—anywhere in the country;
- deal with minor health issues yourself;
- determine if you need to see a doctor or go to the hospital; and
- stay comfortable until you receive additional medical help.

Medical Management

The Medical Management program was designed to help get quality care to you to help improve your health. Early intervention can help reduce in-hospital days and prevent readmission.

If you are admitted to the hospital, case managers and physicians will develop a plan for your care. Once you leave the hospital, additional support is available to you and your family members.

Health Library

The online Health Library has thousands of articles on various conditions, medications and more. It's literally a complete A-Z source of detailed health information. Visit the Health Library to:

- Learn more about illnesses, diseases, symptoms, first aid and wellness — almost every health topic;
- View lists of topics grouped by related health categories;
- Get detailed information on virtually every medical test;
- Research both prescription and non-prescription drugs; and
- Find support groups, self-help and other assistance for various health issues.

Visit <http://www.tuftshealthplan.com/carelink/dc35/> and click on “Healthy Rewards” and then “Your Health Library” for more information.

Preventive Care—Dental, Vision and Hearing

The Health Benefits Plan provides excellent benefits to help encourage you to receive your routine, preventive care exams. In addition to your annual physical exam, we offer the following preventive care benefits:

- **Dental:** Dental cleanings are covered every six months at 80% when you visit an in-network provider;
- **Vision:** Eye exams are covered at 100% once every two years for adults, and once per year for children under age 19 when you visit an in-network provider; and
- **Hearing:** Hearing exams are covered at 100% every two years for adults and once per year for children to age 18 when you visit a HearUSA provider.

Preventive Care Tests and Screenings

Talk to your doctor about scheduling cancer screenings. The tests you need depend on your age, gender and family history. The medical plan covers the following tests at 100% when you visit an in-network non-hospital provider, or 90% if the tests are performed in a network hospital.

- breast cancer screening: mammogram;
- prostate cancer screening: blood test/biopsy;
- cervical cancer screening: pap smear; and
- colon cancer screening: sigmoidoscopy/ colonoscopy.

Adult and Child Immunizations

You and your children are covered at 100% for routine immunizations approved by the American Medical Association/Food and Drug Administration, including the HPV Vaccine, when administered by an in-network provider.

Don't Forget to Get Your Flu Shot!

The Plan covers shots to prevent the onset of influenza at 100% when administered by an in-network provider.

Employee Assistance Program

Your health and wellness refers to more than just your body — your mental health contributes to your overall well-being.

Substance Abuse, Mental Health and Counseling Benefit

Employee Assistance Program (EAP) services are available to all participants and dependents who are eligible for health benefits under the Plan. Modern Assistance Programs (MAP) is the Fund's EAP provider. The EAP provides treatment for substance abuse, mental health benefits and professional counseling for personal problems. It's free, confidential, and available 24/7. See page 27 for more information.

Prescription Drug Coverage

The Health Benefits Plan provides prescription drug coverage through Teamsters Rx—an easy-to-use and cost-effective way for you and your family to fill your medically necessary prescriptions. When you become eligible for coverage, you’ll receive a prescription drug card.

Retail Pharmacy Benefits

When you fill a prescription at a retail pharmacy that participates in the Teamsters Rx prescription drug plan, simply present your drug card when you request your medication. You pay just \$10 for a 30-day supply of generic medication.

In-Network Retail Pharmacy Prescription Drug Copayments	
Brand Name—Retail Pharmacy	\$25 copayment for a 30-day supply
Generic—Retail Pharmacy	\$10 copayment for a 30-day supply

Mandatory Generic Drug Policy

To help cut costs, your Prescription Drug Plan has a mandatory generic drug policy in effect. This means that if a generic drug is available, you must receive that drug instead of the brand-name drug to receive full benefits.

If a generic drug is available and your doctor prescribes the brand-name version or you insist on the brand-name drug, you will be responsible for paying the brand-name drug copayment PLUS the difference in cost between the generic and the brand-name drug.

The Mail-Order Program

The mail-order program, “Teamsters Rx,” is a convenient and less expensive way for you to receive your medication—particularly “maintenance prescriptions”—or drugs that you require on an on-going basis. Examples of maintenance drugs include those you take for high blood pressure, heart conditions or diabetes.

If you order your prescription drugs by mail, you pay a \$20 copayment for generic drugs and \$35 copayment for brand-name drugs for up to a 90-day supply.

Mail-Order Prescription Drug Copayments	
Brand Name—Mail Order	\$35 copayment for a 90-day supply
Generic—Mail Order	\$20 copayment for a 90-day supply

A maintenance drug is any prescription drug dispensed through the mail-order program to treat a chronic or long-term condition such as high blood pressure or diabetes.

Using the Mail-Order Program

Because you know in advance that you need your maintenance medication, it's easy to establish a routine of filling these prescriptions by mail. You are eligible to receive medication for up to a 90-day supply through the mail-order program.

To have your medications filled by the Teamsters Rx Mail-Order Program you must:

1. Call the Fund Office for Patient Profile and Credit/Debit Card Authorization forms;
2. Attach the original prescription to the completed Patient Profile form and send along with the Credit/Debit Card Authorization for your co-payments to 51 Goffstown Road, P.O. Box 5242, Manchester, NH 03108; or
3. Have your doctor fax or call in new prescriptions for a 90-day supply, with three refills, to the Teamsters Rx Mail-Order Pharmacy. Faxed prescriptions must originate from the doctor's office. **Your prescription(s) will be sent to you via US Mail or UPS.**

To reorder, you simply call the Teamsters Rx Mail-Order Pharmacy, 24 hours a day, at 1-866-888-0104, and follow the instructions. Your prescription(s) will be refilled, copays charged to your credit/debit card and the order shipped to you. Check or money orders are accepted; however, the payment must be received before your order can be sent, slowing the process.



This is a very simple way in which you can contribute to containing health care costs for you and for the Painters & Allied Trades District Council No. 35 Health Plan.

Eligibility Restriction

Spouses and dependents who have other prescription drug coverage are not eligible for this Plan's coverage. However, copayments may be submitted directly to the Fund Office for reimbursement.

Allergy Medications

Certain non-sedating antihistamines (i.e., Allegra, Allegra D) carry a different copayment than other medications. If purchased at a retail pharmacy, you pay \$35. If purchased by mail, you pay \$70.

Managed Drug Limitation Policy

The amount of pills that may be dispensed for certain drugs will be limited to the drug manufacturer's recommended dosage. So, if the recommended dosage is 10 pills per 30-day prescription, no more than 10 pills will be dispensed. If your doctor prescribes more than 10 pills, you are responsible to pay for the additional pills as well as the applicable copayment.

Dental Coverage

Healthy teeth and gums are important to your well-being. That's why the Plan provides coverage for dental services through the biggest dental network in the United States, Delta Dental.

The Dental Plan provides coverage at 80% of the reasonable and customary charges for most dental care. You are responsible for paying the remaining 20% of charges. For a complete list of covered dental services, refer to the chart on page 21.

Orthodontic Benefits

You are covered under the Plan for a complete orthodontic exam and comprehensive or limited orthodontic treatment, including appliances. You are responsible for any charges in excess of the benefits listed for covered orthodontic services. A \$2,500 lifetime maximum applies to orthodontic treatment.

The Dental Roll-Over Maximum

Each year, the Plan will pay up to \$2,000 in dental expenses per covered person. However, if your dental expenses do not exceed \$800 in a calendar year, up to \$600 of the amount you have left will be "rolled over" to the next calendar year, increasing your annual maximum for that year.

This can be a great way to accumulate funds to help pay for more expensive dental procedures, such as crowns, bridges and root canals in future years.

To qualify, you must have at least one cleaning or oral exam in a calendar year.

Then if your yearly claims are \$800 or less, you may roll over up to \$600 to use in the next year or beyond, up to an overall capped rollover amount of \$1,500.

If Your Treatment is in Progress

If you or a covered dependent started receiving services for a procedure that requires two or more visits before you become eligible for coverage under the Plan, no benefits are available for services related to that procedure. This limitation does not apply to covered orthodontic services.

Pre-Determination of Benefits

If the charges for a proposed dental treatment exceed \$100, your dentist must file a description of procedures and an estimate of the charges with Delta Dental. Your dentist will perform an initial examination (including x-rays where necessary) and list all procedures and fees for each procedure on a claim form.

Unless treatment is an emergency, your dentist must submit the form to Delta Dental before treatment begins. Eligibility will be verified and benefits for the particular procedures will be determined so that you and your dentist will know in advance what payments will be made under this Plan.

If the pre-determination form is not filed with Delta Dental, the Fund reserves the right to make a determination of benefits payable, taking into account alternate procedures, services, or courses of treatment based on accepted standards of dental practice.

Dental Questions?

Delta Dental processes all dental claims. Call 1-800-872-0500 for any dental claim questions.

NOTE: Coordination of Benefits and Subrogation as described on page 11 also apply to Dental Expense Benefits.

Covered Procedures

If the procedure you need is not listed, contact the Delta Dental Customer Service Office at 1-800-872-0500.

Inpatient Dental Treatment

Dental Inpatient admissions are covered at 90% by the medical plan when the dental condition requires hospitalization or treatment in a surgical day care unit of a hospital. Benefits are limited to the following services:

- Extraction of seven or more permanent teeth;
- Excision of impactions in bone or of unerupted teeth;
- Gingivectomies involving two or more gum quadrants (each quadrant must consist of a minimum of four or a maximum of eight teeth); or Excision of radicular cysts involving the roots of three or more teeth.

Charges for a surgeon are covered 90% by Delta Dental.

Out-of-Network Coverage

Although most dentists participate in the Delta Dental network, you will still be eligible for coverage if you visit an out-of-network provider; however, your costs will be greater. If you visit an out-of-network dentist, you will be responsible to pay the 20% co-insurance and any charges above the reasonable and customary allowances.

To find an in-network dentist, call Delta Dental at 1-800-872-0500 or visit their website: www.deltamass.com.

Schedule of Dental Benefits

Type 1 Services Payable at 80%	Type 2 Services Payable at 80%	Type 3 Services Payable at 80%	Type 4 Services Payable at 90%
<p>Diagnostic</p> <ul style="list-style-type: none"> • Comprehensive Evaluation each 60 months per dentist. • Periodic exam each 6 months • Full mouth x-rays each 60 months • Bitewing x-rays each 6 months • Single tooth x-rays as needed • Study models and casts each 60 months <p>Preventive</p> <ul style="list-style-type: none"> • Teeth Cleaning each 6 months • Periodontal Cleaning each 3 months followed by active periodontal treatment. Not to exceed 2 in a calendar year if combined with regular cleanings. • Fluoride treatment (participants under age 19) each 6 months • Sealants – unrestored permanent molars once per tooth for dependents under age 15. Also covered for members aged 16 to 19 for those who have had a recent cavity and are at risk for decay. • Space maintainers (participants under age 14 and not for the replacement of primary or permanent anterior teeth) • Fluoride toothpaste or Chlorhexidine Mouthrinse – only when administered and dispensed in your dentist's office following scaling/root planning or periodontal surgery. 	<p>Restorative</p> <ul style="list-style-type: none"> • Silver Filling – once every 24 months per surface per tooth. • White Fillings – once every 24 months per surface per tooth on front teeth; single surface only on back teeth. • Temporary Fillings – once per tooth • Stainless Steel Crowns once every 24 months per tooth. <p>Oral Surgery</p> <ul style="list-style-type: none"> • Simple extractions • Surgical extractions • Periodontal Surgery • Scaling and Root Planing – once in 24 months, per quadrant. <p>Endodontics</p> <ul style="list-style-type: none"> • Root canal treatment – once per tooth. • Vital Pulpotomy – limited to deciduous teeth. <p>Prosthetic Maintenance</p> <ul style="list-style-type: none"> • Bridge or denture repair – once within 12 months, same repair. • Rebase or reline of dentures each 36 months • Recementing of crowns, inlays and onlays once per tooth. <p>Emergency Dental Care</p> <ul style="list-style-type: none"> • Minor treatment for pain relief – three occurrences in 12 months. • General anesthesia allowed with covered surgical procedures only. 	<p>Prosthodontics</p> <ul style="list-style-type: none"> • Dentures – once within 60 months. • Fixed bridges and crowns when part of a bridge once every 60 months. <p>Major Restorative</p> <ul style="list-style-type: none"> • Crowns, inlays and onlays when teeth cannot be restored with regular fillings – once within 60 months per tooth. • An Endosteal Implant is covered as Type III to replace one missing tooth (in lieu of a three unit bridge, and when the adjacent teeth do not require crowns). Once per 60 months per implant. 	<ul style="list-style-type: none"> • Gingivectomies involving the roots of three or more teeth. • Gingival Flap • Mucogingival Surgery • Osseous Surgery • Osseous graft and soft tissue graft. • Surgical removal of unerupted teeth when imbedded in bone. • Extraction of seven or more permanent teeth • Excision of a benign or cancerous growth other than a radicular cyst. • Radicular cysts involving the roots of three or more teeth. <p>Type 4 Services are not applied to the Calendar Year Maximum.</p>

Note: There is a \$2,000 Calendar Year Maximum per individual for Type 1, 2 and 3 services.

Vision Care Benefits

Eye exams are essential for helping you maintain your vision. But they also provide early indications of glaucoma, diabetes, hypertension, multiple sclerosis and other serious —yet treatable— diseases and conditions.

Your vision care benefits are provided by Davis Vision. To find a provider within the Davis Vision network, call 800-999-5431 or visit www.davisvision.com.

Summary of Vision Care Benefits

You and each of your family members may receive an eye exam and either a pair of eyeglasses (two pair in lieu of bifocals) or contact lenses once every two years when you use an in-network provider for your eye care services. Your children under age 19 are eligible to receive an eye exam every year.

Service	Your In-Network Cost
Eye Exam	No copayment.
Frames	No copayment when you choose frames from the Special "Davis Vision Selection." If you select frames from outside the premiere selection, there will be additional out-of-pocket expense.
Lenses for Eyeglasses	No copayment* (see page 24).
Contact Lenses	\$35 copayment for standard, soft, daily-wear contact lenses, instead of eyeglasses.
Disposable/Planned Replacement Contact Lenses	\$35 copayment for an initial supply (2 multi-packs) in lieu of eyeglasses.

In-Network Providers

You may visit any optometrist who participates in the Davis Vision network. These optometrists are licensed and are extensively reviewed and credentialed to ensure that the highest standards for quality service are maintained.

Scheduling an Appointment

- Call the network doctor of your choice and schedule an appointment;
- Identify yourself as a Painters & Allied Trades District Council No. 35 Health Benefits Fund member or dependent; and
- Provide the office with the member's Social Security number and the year of birth of any covered children needing services.

Receiving Vision Services

You must receive all services at one time from either a provider in the Davis Vision network, or an out-of-network provider. In other words, you cannot use an in-network provider for some services and an out-of-network provider for others in the same two-year period.

***Optional Frames, Lenses or Lens Coating Available**

You may pay the following low, discounted fixed fees and receive these optional items:

- \$35 for Standard Anti-Reflective Coating (ARC), \$48 for Premium ARC and \$60 for Ultra ARC;
- \$40 for premium brands of progressive addition multifocal lenses;
- \$55 for high-index (thinner and lighter) lenses;
- \$65 for multifocal Transitions® (sun sensitive) plastic lenses; and
- \$75 for Polarized lenses.

Repair or Replacement of Lenses or Frames

Davis Vision will repair or replace (if unable to be repaired) lenses or frames within twelve (12) months of receipt provided they were Davis Vision plan-provided frames and lenses.

Out-of-Network Benefits

If you choose to visit an out-of-network provider, you must pay the provider in full at the time of your visit and submit your claim for reimbursement to:

Vision Care Processing Unit
P.O. Box 2270
Schenectady, NY 12301

Claim Forms

If you need a claim form for out-of-network services, call Davis Vision at 1-800-999-5431.

Reimbursement Schedule

If you use an out-of-network provider, you will be reimbursed according to the schedule below:

Service	Amount you will be reimbursed
Eye Examination	\$12.50
Single Vision Lenses	\$15.00
Bifocal Lenses	\$20.00
Trifocal Lenses	\$25.00
Frames	\$10.00
Contact Lenses	\$52.50

You must receive all services at one time from either an in-network doctor or an out-of-network doctor.

Call-Out-Vision Questions?

For more information about the Vision Plan, call Davis Vision at 1-800-999-5431 or visit the website: www.davisvision.com

Hearing Care Benefit

Your hearing care benefits are provided by the Fund through HearUSA. The Fund pays for a hearing examination once every two years for covered adults and once per year for covered children to age 18 through the HearUSA network only.

You must use a provider in the HearUSA network to receive benefits. There is no coverage if you see a provider outside the HearUSA network.

How the Hearing Plan Works

- Call 1-800-333-3389 for a directory of audiologists in your area;
- Choose an audiologist from the list and make an appointment;
- The audiologist will call the Fund to verify your eligibility;
- The provider will complete the claim form and send it to HearUSA for processing;
- The Fund will pay the benefit amount directly to the network provider.

There is no coverage if you use a provider outside the HearUSA network.

Hearing Tests

The Fund pays for a hearing examination once every two years for adults and once per year for children to age 18 when you use an in-network provider. If a hearing loss is detected, your audiologist will advise you about preventive and rehabilitative options.

Hearing Aid Benefit

After you have had a hearing test, the Fund will pay up to \$1,000 per ear for hearing aids, hearing aid repairs and earmolds, once every five years when you use an in-network provider. Batteries for your hearing aid are not covered. You will be billed for the balance of the allowable charges above the hearing aid benefit amount of \$1,000.

The hearing aid benefit includes a 45-day trial period, during which time you may return the hearing aid(s) for any reason and receive a refund (less \$35 per returned hearing aid, plus custom earmold charge, if any). There is no charge for the return of a defective hearing aid.

Filing Claims

Your HearUSA provider will file your claims for you. The Fund will pay the provider the discounted charges, up to the benefit maximum. You will receive an explanation of benefits from the Fund Office showing paid amounts and remaining allowable charges, if any. You will be responsible for paying the provider the balance of allowable charges above the benefit amount for your hearing aid charges. Allowable charges vary according to the hearing aid technology recommended.

Hearing Care Questions?

If you have questions about your hearing care benefit or the filing of your claim, please contact HearUSA at 1-800-333-3389, Monday through Friday, 7:00 am to 5:00 pm.

Employee Assistance Program

Once you become eligible for benefits, you are automatically eligible to take advantage of our Employee Assistance Program (EAP). The EAP provides treatment for substance abuse, mental health benefits and professional counseling for personal problems. Services are available at no cost to you 24-hours a day, seven days a week.

The EAP provider, Modern Assistance Programs (MAP), has representatives available to assist you in receiving counseling for family problems, stress-related disorders, marital difficulties and/or financial problems.

If you feel there is a life-threatening emergency and you cannot reach a MAP representative, you should go to the emergency room of the nearest hospital, as you would in any emergency. Make sure that a MAP representative is contacted by you or on your behalf within 48 hours of the hospital visit.

Contacting MAP

Call Modern Assistance Programs (MAP) directly at 1-800-878-2004 seven days a week for counseling, mental health or substance abuse treatment. If a MAP representative is not available, leave your name and phone number and someone will return your call promptly.

Hospitalization

All members and eligible dependents must be approved under the Employee Assistance Program before they are hospitalized for alcohol dependency, drug abuse or psychiatric illness. See Summary of Benefits for more information.



Group Legal Services Plan

As an active eligible member of the Painters & Allied Trades District Council No. 35 Health Plan, you and your family members are covered for free legal services through the law firm of Regan Associates. There are no charges for attorney fees, no deductibles, copayments or annual maximum benefit limits on legal services. Your dependents are covered unless their interest is in conflict with yours, such as a divorce proceeding.

Using the Group Legal Services Plan

If you need legal help and you're eligible for active (not COBRA) insurance coverage, call our Plan provider, the Law Firm of Regan Associates, Chartered at 617-367-1100. All conversations with your lawyers are completely confidential and fully protected by the attorney-client privilege.

Eligible members will have unlimited access to legal advice and representation, including jury trials, in the following areas of law:

- Administrative Hearings;
- Bankruptcies, Chapter 7;
- Juvenile Court Proceedings;
- Child Support Issues;
- Mortgage Foreclosures;
- Civil Suits;
- Probate Proceedings;
- Consumer Matters;
- Real Estate Closings;
- Custody Proceedings;
- Visitation Proceedings;
- Divorces;
- Wills;
- Drunk Driving;
- Zoning Violations; and
- Immigration Matters.

Refer to your Group Legal Services Plan Summary Plan Description for more details.

Exclusions and Limitations

The following services are not covered under your Plan of benefits:

Medical Plan

- Adoption fees or surrogate's expenses;
- Audiology exams or hearing aids except through audiology network;
- Biofeedback Therapy;
- Birthing Center, home birth or midwife;
- Blood: Whole blood, packed red blood cells, blood donor or blood storage fees;
- Chelation Therapy;
- Cosmetic Services: Services that are meant only to change or improve your appearance. Benefits are available only for surgical services to correct or repair damage following an injury which occurred on or after the first day of your eligibility or for implant or reconstructive surgery which is medically necessary as a result of mastectomy;
- Court Ordered: Any court ordered treatment including but not limited to substance abuse, psychiatric evaluations, inpatient or outpatient treatment, laboratory test;
- Custodial Care: Care that the Fund decides is custodial;
- Dentist's charges;
- Diet: Diet programs; Exercise programs or surgery designed to treat obesity;
- Donor: All fees related to transplant donor charges;
- Electro Shock Therapy;
- Employment: An illness or injury that the Fund determines arose out of and in the course of your employment;
- Exercise: Exercise, aerobic, biofeedback, meditation programs or exercise equipment;
- Experimental: Procedures, treatments, hospital or physician services, supplies, drugs, or appliances which are not generally accepted and/or are considered experimental or investigational by the American Medical Association; and any clinical trials. See page 74 for more information;
- Foot Care: Routine foot care by a podiatrist, such as trimming of corns, calluses;
- Gastric Bypass or weight loss surgery;
- Genetic Testing and/or Prophylactic Surgery: For the purpose of assessing risk of the development of disease in both participants and their family members. No coverage available for any prophylactic surgery including mastectomy and hysterectomy and any DNA pathology testing or treatment;
- Government Programs: An illness or injury for which any benefits are available through a state or federal government program which provides or pays for health services including immunizations, except as mandated by law. This does not include Medicaid;
- Hospital charges for surgical procedures not approved in a hospital setting (e.g., vasectomy, sigmoidoscopy, lesion removals);
- Hospitalization: Hospitalization benefits for an admission that began prior to the effective date of your enrollment in this Plan;
- Hypnosis;
- Impotence Treatment: Including penile implants mechanical aids for male impotence; office visits, testing or surgery and drugs;
- Incarceration: Services or treatment while incarcerated even if services rendered outside of prison;
- Infant Formula and any food supplements;
- Infertility: In-Vitro Fertilization (IVF), Gamete Intra-Fallopian Transfer (GIFT), Zygote Intra-Fallopian Transfer (ZIFT), gestational surrogate pregnancy, artificial insemination, services related to the procurement or storage of donor sperm. The Health Plan will consider payment for charges incurred for the diagnosis of infertility, but will not consider benefit payments for any medical charges or services incurred for the treatment of infertility including but not limited to prescription drugs, ultrasounds, or any other testing;

- Laboratory services (including urine) for drug and/or alcohol testing that is ordered or is voluntary;
- Learning Disability Charges: Includes diagnosis of ADD, ADHD, Hyperkinetic Syndrome, Conduct Disorders or any Developmental Delays as services are available under state agencies;
- Medical Equipment: Medical equipment not considered durable—only custom made and fitted braces will be considered for reimbursement. No coverage for air-conditioners, purifiers, humidifiers, dehumidifiers, pools, orthopedic mattresses/beds. Refer to page 74 for more information;
- Medically Necessary: Services that are not medically necessary to diagnose or treat an illness or injury;
- Nurse, practitioner or private duty;
- Nutritionist: Except for a one-time visit with diagnosis of diabetes or eating disorder. Prior approval required for medical necessity;
- Nursing Home: All charges including physician or any medical provider charges rendered in a nursing home or any facility that does not meet the Plan's hospital definition;
- Observation Charge by Hospital for care in excess of twenty-four hours – only charges equivalent to the hospital's average semi-private room rate will be paid;
- Personal Comfort: Personal comfort items such as telephone, radio, television, or personal care services;
- Physician: Assistant, practitioner of naturopathy, midwife, nutritionist, holistic services;
- Physician Charges:
 - Charges for an office visit on the same day a surgical procedure is performed and billed by the physician;
 - Simultaneous inpatient medical care by two or more physicians;
 - Physician's charges for telephone advice and consults;
 - Services of a resident or intern billed apart from hospital services.
- Podiatry: Orthotics, strapping, EDG testing;
- Private Room in Hospital—Only charges equivalent to the hospital's average semi-private room;
- Psychiatric Treatment: Psychiatric treatment for marital counseling, or for a condition that is not a mental disorder;
- Reasonable and Customary: Any portion of the expenses for medical service and supplies which exceed the reasonable and customary charge or fair and reasonable value of such services and supplies as determined by the Trustees of this Health Plan, by comparing the charges incurred with the charges made to other individuals of similar age and sex for the same type of illness, disease or injury in the locality where furnished;
- Repetitious Procedures: Repetitious procedure such as injections for varicose veins or hemorrhoids;
- Reversal of sterility procedures;
- Sex change surgery or reversal of sex change or treatment of gender identity disorder;
- Smoking Cessation drugs, gum, patches or any products;
- Speech or Vocal Therapy when used to improve skills that have not fully developed; Speech therapy that is not restorative in nature. See page 76 for more information;
- TMJ: Any and all medical or dental charges for treating temporomandibular joint syndrome (TMJ);
- Vision training; radial keratotomy or any other surgery to correct refractive errors; vision exam/glasses except through Davis Vision; and
- War: services for an injury or illness as a result of a war declared or undeclared including armed aggression.

Prescription Drugs

- Any drug that has not been approved by the Food and Drug Administration, or which is investigational or experimental;
- Prescribed or non-prescribed vitamins (however, prescribed prenatal vitamins are covered only if you are pregnant);
- Fluoride;

- Drugs prescribed in connection with an injury or illness sustained in the course of one's employment or dispensed by a government agency or under a plan administered on behalf of a government agency (except as mandated by law);
- Nicorette gum or nicotine patches or any smoking cessation products;
- Rogaine;
- Over-the-counter medications;
- Redux, phen fen or any appetite suppressants or weight loss drugs;
- Infertility drugs;
- Injectables (exception: insulin);
- Infant formula and any food supplements;
- Medications for cosmetic use;
- Retin-A (exception: covered for treatment of acne up to age 26);
- Viagra, or any drugs to treat male or female impotence;
- Medical/surgical supplies or equipment (see page 7 for more information);
- Any medication in excess of the FDA or Manufacturers recommended dosage; and
- Aerochamber: will allow if dependent is under age 11 – maximum of \$60 every 24 months.

Dental Plan

To verify that a procedure is covered, call Delta Dental before you begin treatment. Some of the more common exclusions and limitations under this dental plan include:

- Temporomandibular joint syndrome (TMJ);
- Sealants applied to permanent molars that have decay or fillings;
- Replacement of dentures, bridges, crowns, inlays and onlays within 60 months of their installation;
- Duplicate dentures and bridges;
- Temporary, complete dentures and temporary fixed bridges;
- Endodontic services for non-permanent teeth or for installing dentures;

- Replacement of lost or stolen appliances or prosthetic devices;
- Laboratory examinations;
- Services or procedures which Delta Dental determines not to be generally accepted;
- An illness or injury that Delta Dental determines arose out of and in the course of your employment;
- Services required by a third party, such as an employer or school;
- Services or treatment for which a member would be eligible for full or partial payment under any state, municipal or federal law or regulation, except as mandated by law;
- A method of treatment more costly than is customarily provided (benefits will be based on the least costly method of treatment);
- Services that are meant primarily to change or improve appearance;
- Implantology;
- Charges for completing claims forms;
- Charges for missed appointments;
- Payment by the Painters & Allied Trades District Council No. 35 Health Plan for any dental/surgical procedures; and
- Dental services/surgery performed in a hospital without prior approval by the Health Plan.

Vision Plan

- Medical treatment of eye disease or injury;
- Visual therapy and/or vision training;
- Special lenses designs or coatings, other than those previously described;
- Replacement of lost or stolen eyewear;
- Nonprescription (plano) lenses;
- Eyeglasses and contact lenses during the same benefit period;
- Optical expenses benefits payable under Workers' Compensation Law or if such services or benefits are payable by a federal, state, or municipal agency; and
- Keratotomy or surgery to correct refractive errors.

Employee Assistance Program

- Any court ordered treatment or orders by any outside provider, inpatient or outpatient treatment including but not limited to court ordered treatment for driving under the influence of alcohol or drugs;
- Treatment of substance abuse outside the Commonwealth of Massachusetts requires prior approval from the personnel at Modern Assistance Programs;
- Treatment for substance abuse received in mental health hospitals;
- Treatment ordered by your employer, any court, any medical or non-medical provider due to a failed drug/alcohol test;
- Any treatment including laboratory testing ordered by state, federal, or any agency;
- Laboratory services (including urine) for drug and/or alcohol testing that is ordered or is voluntary; and
- Any mandated substance abuse treatment including facility charges and/or laboratory testing.





Life and Accident Insurance

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35 Life Insurance

37 Accidental Death and Dismemberment Insurance

39 Supplemental In-Hospital Accident and
Sickness Income Benefit

Life Insurance

The Life Insurance benefit of \$25,000 is payable to your beneficiary in the event of your death from any cause while you are eligible. This coverage applies to members only.

Naming a Beneficiary

You may name anyone you wish as your beneficiary, and you may change your beneficiary at any time. Call the Fund Office at (617) 524-1240 for the appropriate form. You do not need to get the beneficiary's consent to change your beneficiary.

The change will be effective when the completed form is received at the Fund Office. Your beneficiary designation form must be on file at the Fund Office at the time of your death to be valid. If no beneficiary designation is on file at the Fund Office, the death benefit will be paid to your Estate.

Automatic Extension

Your Life Insurance will automatically be extended for 12 additional months from the date your regular eligibility terminates. At the end of this extension, your Life Insurance will cease. If you die within 31 days after the extension has ended, your beneficiary will be paid the entire \$25,000 benefit.

Total and Permanent Disability

If you become totally and permanently disabled from your occupation or from any gainful employment before you turn 60, your Life Insurance will remain in force. Coverage will continue during your disability if:

- you file proof of your disability to the insurance company after your total disability has lasted at least nine but less than 12 months; and
- you continue to file proof of your disability every year thereafter.

What is Totally and Permanently Disabled?

You are considered totally and permanently disabled if you are completely unable to perform the duties of your occupation or employment as a result of an injury or illness, and your disability is expected to last for your lifetime.

Conversion

You can convert your Group Life Insurance policy to an individual Life Insurance policy by making application and paying the first premium to the ING Life Insurance Company within 31 days before your Group Life Insurance terminates. This individual policy will be issued without medical examination at the insurance company's regular rates.

Accidental Death and Dismemberment Insurance

Accidental Death and Dismemberment (AD&D) coverage provides benefits for loss of life, limbs, or the full and permanent loss of sight, including losses resulting from occupational bodily injuries. Your accidental death and dismemberment coverage applies to members only.

Benefits are payable if the loss is a direct result of an injury caused by an accident, and if the loss is sustained within 90 days after the date of the accident. The injury causing the loss must occur while you are insured for benefits to be payable.

AD&D benefits are limited to \$25,000. So, if a \$12,500 loss of limb dismemberment benefit is paid out, only \$12,500 is available for any future dismemberment or accidental death claim. If you suffer more than one loss in any one accident, payment will be made only for the loss with the greatest amount payable.

The following AD&D benefits are payable under the Plan:

Type of Loss	Amount Payable
Life	\$25,000 to your beneficiary
Both Hands	\$25,000 to you
Both Feet	\$25,000 to you
Sight of Both Eyes	\$25,000 to you
One Hand and One Foot	\$25,000 to you
One Hand and Sight of One Eye	\$25,000 to you
One Foot and Sight of One Eye	\$25,000 to you
One Hand or One Foot	\$12,500 to you
Sight of One Eye	\$12,500 to you

You may change your beneficiary whenever you wish by calling the Fund Office at (617) 524-1240 and requesting a new Health Fund Data Card.

Who Will Receive Benefits?

For the loss of life, benefits will be paid to the beneficiary you name. If no beneficiary designation is on file at the Fund Office, the death benefit will be paid to your Estate. For any other loss, the benefits will be paid to you.

What’s Not Covered

The purpose of Accidental Death and Dismemberment coverage is to provide benefits for losses due to accidents. Therefore, no benefits are paid for a loss caused or contributed to by:

- bodily or mental infirmity; or
- disease, ptomaines or bacterial infections; or
- medical or surgical treatment (unless made necessary by an injury covered under the Plan); or
- suicide or intentionally self-inflicted injury;
- participating in the commission of a felony; or
- war or any act of war.

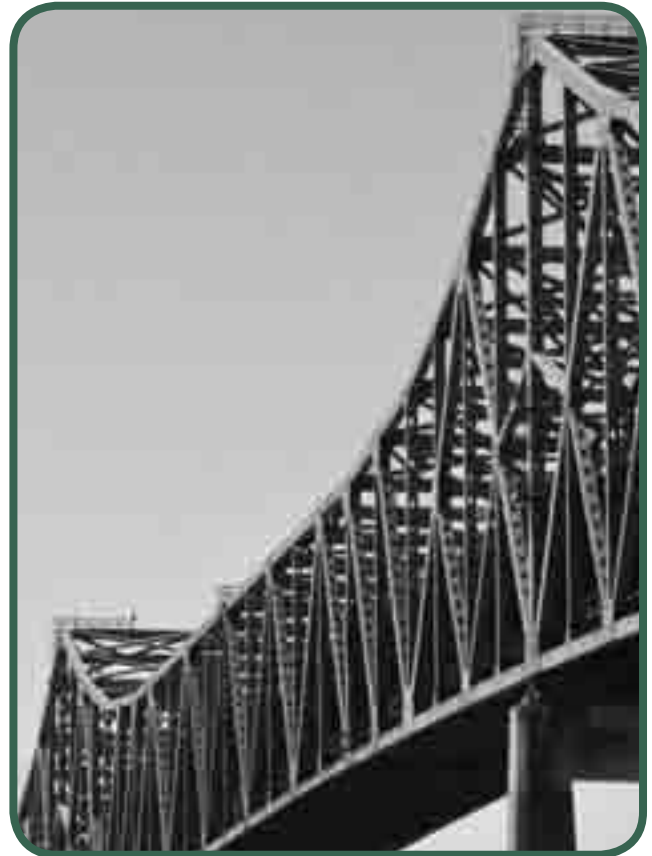
Supplemental In-Hospital Accident and Sickness Income Benefit

If you are hospitalized for more than seven days, you are covered under the Plan to receive a supplemental income benefit. You will be paid up to \$350 per week (\$50.00 per day) beginning on the eighth (8th) day of hospitalization and ending on the day before you are discharged from the hospital. Benefits are available for members only.

Benefits are payable for a maximum period of twenty-six (26) weeks. Successive periods of hospitalization will be counted as one continuous period unless:

- they are separated by at least two continuous weeks of active employment; and
- they are due to different, unrelated causes.

You or a family member must notify the Fund Office at (617) 524-1240 of your continued confinement. After your confinement is verified, your benefits will begin. The Plan provides no benefits for lost wages or income due to either short-term or long-term disability. Benefits are not payable if you are receiving home health care.





Life Events

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- 41 If You Marry
- 41 If You Have a Baby or Adopt a Child
- 41 If Your Child's Eligibility Status Changes
- 41 If You Divorce or Legally Separate
- 42 If You Don't Work Enough Hours to Remain Eligible
- 42 If You Take Family and Medical Leave
- 42 If You or a Dependent Gain Other Health Care Coverage
- 42 If You Enter the Armed Forces
- 42 If Your Spouse or Child Dies
- 42 If You Become Disabled
- 43 If You Stop Working
- 43 If You Retire
- 45 If You Die

Life Events

Your benefits are designed to adapt to the different stages of your life. However, your coverage may be affected when certain “life events” occur. You or one of your dependents should contact the Fund Office by calling (617) 524-1240 if you experience one of the following life events.

If You Marry

If you marry, your spouse is automatically eligible for benefits offered through your Plan. To enroll your spouse for coverage, notify the Fund Office at (617) 524-1240 within 30 days of your marriage. The Fund Office will request completion of a new data/beneficiary card along with **a copy of your marriage certificate**.

Please note: if your spouse has his or her own insurance coverage, you are required to provide this information to the Plan. The Plan will coordinate benefits to ensure maximum coverage. Coordination of Benefits is described on page 11.

If You Have a Baby or Adopt a Child

If you become a parent by birth, adoption, placement for adoption, foster care or marriage, you must notify the Fund Office at (617) 524-1240 within 30 days of the event. The Fund Office will request completion of a new data/beneficiary card along with **a copy of the child's birth certificate** and any other appropriate legal papers.

Coverage for your child will go into effect as of the date of the birth, adoption, placement for adoption or foster care, or marriage. If you do not notify the Fund Office, it may result in retroactive coverage of 30 days only.

For the definition of an **eligible dependent**, see pages 47 and 73.

Have You Experienced a “Life Event?”

Contact the Fund Office at (617) 524-1240 as soon as you can so that you do not experience a lapse in coverage or a delayed claim payment.

If Your Child's Eligibility Status Changes

If your child's eligibility status changes, you must notify the Fund Office as soon as possible. Generally, your child will continue to be eligible until the first of these dates occur:

- The date he or she turns 19;
- The date he or she is no longer a full-time student if over 19 or, the date he or she turns age 23, whichever comes first or if full-time student verification is not received timely;
- The date he or she marries; or
- The date your coverage ends (for example because of your death or termination of employment).

Your dependent children may be eligible to continue coverage through COBRA when they no longer satisfy the Plan's definition of “eligible dependent” because of age, marriage or student status. See page 49 for more information about COBRA.

If You Divorce or Legally Separate

If you become divorced or legally separated, you must notify the Fund Office at (617) 524-1240 as soon as possible. Your spouse's Plan coverage will end on the last day of the month in which the divorce or legal separation becomes final. If you fail to notify the Fund Office and claims are paid on behalf of your ex-spouse, you will be responsible to reimburse the Health Plan for any claims paid.

Your spouse will be eligible to receive coverage under the COBRA Continuation Coverage provision if he or she notifies the Fund Office **within 60 days** of the last day of the month in which the divorce or legal separation becomes final.

The Fund Office will request a copy of the judgment of divorce or separate support in order for your former spouse to qualify for COBRA Continuation Coverage.

Losing COBRA Rights

If your spouse does not apply for COBRA Continuation Coverage within 60 days of the later of the date your divorce or legal separation becomes final OR the date of loss of coverage, your spouse will lose his or her right to COBRA coverage.

Qualified Medical Child Support Orders (QMCSOs)

A **Qualified Medical Child Support Order** (QMCSO) is a court order, judgment or decree that recognizes that an alternative recipient may be entitled to benefits under this Plan in the event of a divorce or other family law action. Orders must be submitted to the Fund Office to determine whether the order is a QMCSO as required under federal law. For more information, see “Qualified Medical Child Support Orders” in the definitions on page 75.

If You Don’t Work Enough Hours to Remain Eligible

If you do not work enough hours during a qualifying period to receive coverage during the next eligibility period (explained on page 47), you may draw upon carryover hours that you have earned from the previous qualifying period. If you have not worked the 600 hours and do not have reserve carryover hours, your coverage under this Plan will end. You may elect to continue coverage through the COBRA Self-Payment Provision (see page 51).

If You Take Family and Medical Leave

Family and Medical Leave Act (FMLA)

Under this federal law, you may have the right to take up to 12 weeks of unpaid leave for your serious illness, after the birth or adoption of a child, or to care for your seriously ill spouse, parent, or child. FMLA leave requires certain employers to maintain health coverage during the leave period. If you think that this law may apply to you, please contact your Employer or the Fund Administrator.

If You or a Dependent Gain Other Health Care Coverage

If you or one of your dependents have coverage through another plan, this Plan will coordinate benefits with the other plan to offer you the highest level of coverage. Refer to “Coordination of Benefits” on page 11 for details.

If You Enter the Armed Forces

Uniformed Services Employment and Reemployment Rights Act (USERRA)

If you are absent from employment because of service in the United States Armed Forces, you may be eligible to continue medical coverage under this Plan for you or your dependents on a self-pay basis for the period of your military service (to a maximum of 24 months). Contact the Fund Administrator for additional information about continuation coverage and your rights upon reemployment following qualified military leave.

If Your Spouse or Child Dies

If your spouse or child dies, notify the Fund Office at (617) 524-1240 as soon as possible. You may wish to review your beneficiary designation and determine whether any changes are necessary.

If You Become Disabled

If you become disabled and cannot work, you should contact the Fund Office and your Employer. If necessary, you may need to contact the Social Security Administration so that a formal determination can be made about your disability. This determination is required if you are going to extend your continuation coverage through COBRA. See page 51 for more information.

If you are hospitalized because of your disability, you may be eligible for the **Supplemental In-Hospital Accident and Sickness Income Benefit**. The Supplemental In-Hospital Accident and Sickness Income Benefit entitles you to a weekly disability benefit of up to \$350 per week (\$50 per day) beginning on your eighth (8th) day of hospitalization and ending on the day before you are discharged from the hospital. See page 39 for more information.

If you have a serious injury that is covered by the **Accidental Death and Dismemberment (AD&D)** Plan benefit, you will be eligible for a cash payment through your AD&D coverage. See page 37 for more information.

If you become totally and permanently disabled before you turn 60, your **Life Insurance** coverage will remain in force. Coverage will continue during your disability if:

- you file a request for the extension;
- you file proof of your disability to the Fund Office after your total disability has lasted at least nine but less than 12 months; and
- you continue to file proof of your disability every year thereafter.

Refer to page 35 for more information.

If You Stop Working

If your coverage ends due to your termination or a reduction in hours, you may elect to purchase COBRA Continuation Coverage for yourself and your family for up to 18 months. You must inform the Fund Office within 60 days after the later of the date your reduction in hours or termination of employment, or the date of loss of coverage or you will lose your right to elect COBRA Continuation Coverage.

If your employment is terminated or your hours are reduced, and at that time, or within the first 60 days of your COBRA Continuation Coverage, you or one of your dependents are totally disabled (as determined by Social Security), coverage may continue for an additional 11 months, for a total of 29 months. To continue coverage for an additional 11 months beyond the initial 18 months, you must notify the Fund Office of the determination of disability by the Social Security Administration. See page 51 for more information.

If You Retire

Special Retiree Plan for Retiree Only – No Dependent Coverage

If you retire and are currently eligible for active (not COBRA) health insurance, you may be eligible for benefits under the Special Retiree Plan for a maximum of 12 months.

To be eligible, you must:

- be at least age 60 (but not yet age 65) when your pension payments start from the Painters & Allied Trades District Council No. 35 Pension Fund or, if a Local 391 retiree, collecting from the IUPAT Pension Fund;
- have worked at least 10,000 hours in Covered Employment during the 10 years prior to the year in which you retire;
- have been eligible for benefits under this Plan for at least 17 of the 20 insurance periods in those 10 years;
- not be eligible for Medicare; and
- have worked a total of at least 300 hours in the two (2) eligibility periods immediately preceding the date your coverage terminates due to reduction in hours.

If you meet all of these requirements, you (but not your dependents) will be eligible for a special 12 additional months of health benefits under the active employee plan. You may only be covered under this Special Retiree Plan for a maximum of twelve (12) months. Your eligible dependents are entitled to elect COBRA Continuation Coverage.

This coverage includes vision and hearing care benefits for the retiree only. These benefits are not available through COBRA.

The Special Retiree Plan is considered an alternative plan under COBRA regulations. Therefore, when you lose coverage, if you qualify for the Special Retiree Plan, you must elect it for 12 months or waive it and purchase COBRA.

If you elect the Special Retiree Plan, you will not be able to elect COBRA at a later date. However, you may qualify for the Premium Reimbursement Plan (described on page 44) when your Special Retiree Plan coverage ends.

Premium Reimbursement Plan– Retiree and Eligible Dependents

If you retire and are losing current eligibility under active (not COBRA*) or the Special Retiree Plan, you and your eligible dependents may qualify for the Premium Reimbursement Plan. Prior to the date your active coverage terminates, eligible retirees/dependents must secure health coverage through an outside group or non-group health plan such as Tufts, Harvard-Pilgrim, BlueCross BlueShield or any other plan available to you.

Under the Premium Reimbursement Plan, the Health Fund will reimburse you for up to one-half (to the maximums listed below) of the premium you pay on a quarterly basis for up to either 36 or 60 months. Life Insurance and/or COBRA Continuation Coverage does not qualify for premium reimbursement.

To qualify for premium reimbursement of a non-group (or group) health plan, you must have been eligible for active (not COBRA*) health insurance during the most recent eligibility period (or the immediately preceding period and subsequent eligibility periods), and be collecting a pension from the Painters & Allied Trades District Council No. 35 Pension Fund, or if a Local 391 member, from the IUPAT Pension Fund. There is no premium reimbursement if you are eligible for Medicare, (whether you apply or not), you become eligible for Medicare during the 36- or 60-month period or for your spouse if you are divorced or become divorced during the premium reimbursement period.

If you are able to join your spouse's health plan, we will also reimburse one-half of your premium to the limits indicated below.

A set monthly maximum for reimbursement applies. The monthly reimbursement limit is:

One Person	\$350
Two People	\$700
Family	\$700

- Retirees age 55 to 59 (and eligible dependents) may elect premium reimbursement of a group or non-group health plan for 36 months or pay the full COBRA premium for 18 months. Local 391 members who retire prior to age 55, from the IUPAT Pension Fund, with at least 60,000 hours will also qualify for up to 36 months;
- Retirees age 60 to 65 (and eligible dependents) may elect premium reimbursement of a group or non-group health plan for 60 months or pay the full COBRA premium for 18 months;
- Individuals (and eligible dependents) who are awarded a "partial" disability pension (disabled from painting only) may elect premium reimbursement of a group or non-group health plan for 36 months or pay the full COBRA premium for 18 months;
- Employees who are totally and permanently disabled from any gainful employment and who are collecting a total disability pension from the Painters & Allied Trades District Council No. 35 Pension Fund may elect premium reimbursement of a group or non-group health plan for their dependents for 60 months or pay the full COBRA premium for 18 months. The retiree should be eligible for Medicare after being disabled for 29 months, assuming he or she was awarded a Social Security disability pension;
- The surviving spouse, not eligible for Medicare, (and eligible dependents) of a retiree may elect premium reimbursement of a group or non-group health plan for 24 months after the date of death;
- The surviving spouse, not eligible for Medicare, (and eligible dependents) of an active vested participant may elect premium reimbursement of a group or non-group health plan for 36 months or pay the full COBRA premium for 36 months;
- Retirees will receive information from the Fund Office regarding their eligibility for the Premium Reimbursement Plan prior to termination of active coverage; and
- If you are retired and on COBRA Continuation Coverage due to a Workers' Compensation illness/injury, you may be eligible for this Premium Reimbursement Plan.

*If on the day a participant retires, he/she is purchasing COBRA Continuation Coverage due to a work related injury, he/she will be eligible for the Premium Reimbursement Plan.

Vision and Hearing Benefits for Retiree and Spouse

If you retire and are currently eligible under active (not COBRA*) or the Special Retiree Plan, you and your spouse may qualify for Vision Care Benefits through Davis Vision and Hearing Benefits through HearUSA.

If You Die

If you die from any cause while you are eligible under active (not COBRA) coverage, your beneficiaries may be eligible to receive certain benefits such as:

- Your Life Insurance benefit of \$25,000; and
- Accidental Death and Dismemberment benefits, depending on your cause of death.

Your designated beneficiary must provide the Fund Office with proof of your death before benefits will be paid.

Your family will continue to be eligible for health coverage until you would have lost coverage due to a reduction in hours. Then they will have the option to purchase COBRA for 36 months. Refer to page 49 for more information on COBRA Continuation Coverage.

* If on the day a participant retires, he/she is purchasing COBRA Continuation Coverage due to a work related injury, he/she will be eligible for the Premium Reimbursement Plan.



Eligibility

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47 Eligibility for Participation

Eligibility for Participation

Your participation in the Health Benefits Plan is based on the hours you work in covered employment during a “**qualifying period**.” A qualifying period is the six-month period that begins on either January 1 or July 1.

To qualify for coverage, you must work at least 600 hours in a qualifying period.

Your coverage (and coverage for your eligible dependents) will begin on the April 1 or October 1 that follows the qualifying period in which you met the 600 hours requirement. April 1 and October 1 mark the beginning of what’s called an “**eligibility period**”—a six-month period during which you and your dependents are covered under the Health Benefits Plan.

If You Work At Least 600 Hours in the Qualifying Period . . .	You’ll Have Coverage for the Corresponding Eligibility Period. . .
January 1 – June 30	October – March 31
July 1 – December 31	April 1 – September 30

For Example: If Tom works 625 hours in the qualifying period January 1, 2007 to June 30, 2007, he will have coverage during the October 1, 2007 to March 31, 2008 eligibility period.

Carryover Hours

If you work more than the 600 hours needed to maintain eligibility, you may carry over up to 200 hours to the next eligibility period.

For Example: Because Tom worked 625 hours in the qualifying period January 1, 2007 to June 30, 2007, he is able to carry over 25 of his hours to be used during the next qualifying period. That way, if Tom works 575 hours in the July 1, 2007 – December 31, 2007 qualifying period, he can still maintain coverage, because he can apply his 25 carryover hours from the prior qualifying period. Therefore, Tom will continue to have coverage during the April 1, 2008 – September 30, 2008 eligibility period.

Any carryover hours you accrue in one qualifying period must be used in the **next eligibility period**. Any unused carryover hours will be cancelled at the end of that second period. Note that if your coverage terminates under the Plan because of insufficient hours, any carryover hours you have will be forfeited.

Carryover Hours

Any carryover hours you accrue in one qualifying period must be used in the next eligibility period or you will lose them.

Coverage for Your Dependents

Once you become eligible for coverage, your eligible dependents are also entitled to health care coverage under this Plan. In general, your dependents are:

- your lawful **spouse** (see page 76 for more information);
- each unmarried **child** (see page 73 for more information) from the date of birth to his or her 19th birthday, or 23rd birthday if attending an accredited school or college on a full-time basis; and
- each unmarried child who is incapable of self-sustaining employment and became disabled before his or her 19th birthday. Proof of continuing disability may be required from time to time. See page 73 for definition of a dependent child.

Continuation of Medical Benefits for Certain Incapacitated Children

Your child may continue his or her medical benefits under this Plan if he or she:

- is incapable of earning his/her own living because of mental or physical disability; and became incapable of doing so before he/she reached age 19;
- is dependent on the member for over half of his/her support on the date he/she attains age 19; and

- has had proof submitted to the satisfaction of the Trustees that the disability existed on his or her 19th birthday while he/she was covered under the Plan.

The Fund Office may, from time to time, require proof that the child continues to be incapacitated.

When Coverage Ends

Your coverage and your eligible dependents' coverage under the Plan will terminate on the last day of an eligibility period if:

- The number of credited carryover hours plus the hours you actually work totals less than 600 hours; or
- You enter active military service, unless you take advantage of the self-pay option provided by USERRA (described on page 42); or
- The Plan terminates.

Your eligible dependents may lose coverage if:

- You divorce;
- Your dependents are no longer eligible dependents (e.g., your child marries and is no longer a dependent under the Plan); or
- You die.

Continuing Coverage

If you and/or your dependents lose coverage under the Plan, you may be eligible to self-pay to continue your coverage for a period time through COBRA.

See page 49 for information.





COBRA

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49 COBRA Continuation Coverage

COBRA Continuation Coverage

If you lose your coverage because of a “Qualifying Event” (see below), you may be eligible to continue Medical, Prescription Drug, Employee Assistance Program, and Dental coverage under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA).

Qualifying Events

To be eligible for COBRA Continuation Coverage, you (as the member) and/or your dependent(s) must lose coverage due to any one of the following Qualifying Events:

Qualifying Event	Who May Purchase Continuation Coverage	Maximum Period of Coverage
Member loses eligibility due to termination or a reduction in hours of employment (including retirement)	Member, spouse and/or dependent children	18 months
Termination or reduction in hours while you or your dependent are disabled	Member, spouse and/or dependent children	29 months (18 months plus an additional 11)
Member becomes entitled to Medicare and voluntarily drops Plan coverage	Spouse and/or dependent children	36 months
Member dies	Spouse and/or dependent children	36 months
Member is divorced or legally separated from spouse	Spouse and/or dependent children	36 months*
Child is no longer considered a dependent child by this Plan’s definition	Dependent child	36 months

*An ex-spouse’s health plan coverage will terminate on the last day of the month in which the divorce or legal separation becomes final.

Qualified Beneficiaries

Under the law, only “qualified beneficiaries” are entitled to COBRA Continuation Coverage. Qualified beneficiaries are the following if they were covered under the Plan on the day before the Qualifying Event:

- you, as the member;
- your spouse; and
- your dependent child.

A child who becomes a dependent child by birth, adoption or placement for adoption with you (but not a spouse who becomes your spouse) during a period of COBRA Continuation Coverage is also a qualified beneficiary.

One or more of your family members may elect COBRA even if you do not. However, in order to elect COBRA Continuation Coverage, the members of the family must have been covered by the Plan on the date of the Qualifying Event. A parent may elect or reject COBRA Continuation Coverage on behalf of dependent children living with him or her.

How to Elect COBRA Continuation Coverage

In order to elect COBRA Continuation Coverage, the Fund Office must be notified when you experience a **Qualifying Event**. Failure to provide the proper notice within the required time frames may prevent you or your dependent from obtaining or extending COBRA coverage.

The notice must be postmarked no later than 60 days after the later of the date:

- of the Qualifying Event; or
- you lost coverage under the Plan because of the Qualifying Event.

If you are providing notice of a Social Security Administration determination of disability, the notice must be postmarked no later than 60 days after the latest of:

- the date of the disability determination by the Social Security Administration;
- the date on which the Qualifying Event occurs; or
- the date on which the individual loses (or would lose) coverage under the Plan as a result of the Qualifying Event; and

- before the end of the first 18 months of continuation coverage.

If you are providing notice of a Social Security Administration determination that the individual is no longer disabled, the notice must be postmarked no later than 30 days after the date of the final determination by the Social Security Administration.

Notice may be provided by you, your dependent, or any representative acting on behalf of you or your dependent. Notice from one individual will satisfy the notice requirement for all individuals affected by the same Qualifying Event.

In order to notify the Plan of these Qualifying Events, you must send a COBRA Notice of Qualifying Event for Covered Employees and Other Qualified Beneficiaries to the Fund Office, or alternatively, you must send a notice to the Fund Office containing the following information: the covered member’s name, the qualified beneficiary’s name, the type of Qualifying Event for which the individual is providing notice, and the date of the event. In the event of divorce, you must also submit a copy of the divorce decree; in the event of a Social Security Administration determination of disability, you must submit a copy of the Social Security determination.

Notify the Fund Office

You or a family member should notify the Fund Office when any Qualifying Event occurs to avoid confusion over the status of your health care.

Within thirty (30) days after receiving timely notice of a Qualifying Event, the Fund Office will mail you an election form, information about COBRA and the date on which your coverage will end.

Under the law, you and/or your covered dependents have 60 days from the later of the date:

- you would have lost coverage because of the Qualifying Event; or
- you and/or your covered dependents received the election form and COBRA information.

If you and/or any of your covered dependents do not elect COBRA within 60 days of the Qualifying Event (or, if later, within 60 days after receiving that notice), you and/or your covered dependents will not have any group health coverage from this Plan after your coverage ends.

Paying for COBRA Continuation Coverage

You are responsible for the entire cost of COBRA Continuation Coverage. When you and/or your dependents become eligible for this coverage, the Fund Office will notify you of the COBRA premium amounts that you must pay.

Your COBRA premiums may be up to 102% of the Plan's cost, except in the case of Social Security disability. (See "COBRA Continuation Coverage for Disabled Participants" at the right.)

You must make payments so that your COBRA coverage is continuous. To prevent a lapse in coverage, you must make your first payment to the Fund Office within 45 days from the date you make your election and submit your form to the Fund Office. Payments for subsequent months are due on the first day of the month for which coverage is provided.

If you choose COBRA within the election period but after the date your eligibility ended, you must pay the required COBRA premiums retroactively to cover the elapsed period.

What You Need to Do:

If you lose coverage due to a Qualifying Event:

- Inform the Fund Office of the Qualifying Event and request a COBRA election form.
- Complete and mail back the election form within 60 days of the date you received it, or 60 days of the date the Qualifying Event occurred, whichever is later.
- Make your first payment to the Fund Office within 45 days from the date you make your election and submit your form to the Fund Office.

COBRA Continuation Coverage for Disabled Participants

If you are covered under COBRA for 18 months, and you or one of your covered dependents are disabled at any time during the first 60 days of coverage, you (and/or your dependent) may be eligible to continue COBRA coverage for an additional 11 months.

To be eligible, the Social Security Administration must make a formal determination that you (or your dependent) are disabled and therefore entitled to Social Security disability income benefits. You (or your dependent) must notify the Fund Office of the Social Security determination of disability within 60 days from the date you received the determination.

Need to Contact the Social Security Administration?

Visit the Social Security Administration website at www.ssa.gov, or call 1-800-772-1213.

If you are eligible for the 11-month extension, your COBRA premiums may be up to 150% of the regular premiums for the additional 11 months of coverage.

This extended period of COBRA coverage will end on the earlier of:

- the last day of the month that occurs 30 days after Social Security has determined that you and/or your dependent(s) are no longer disabled;
- the end of the 29 months of COBRA Continuation Coverage; and
- the date the disabled person becomes entitled to Medicare.

If you recover from your disability before the end of the initial 18 months of COBRA Continuation Coverage, you will not have the right to purchase extended coverage. You must notify the Fund Office within 30 days of:

- the date that you receive a final Social Security determination that you and/or your dependent(s) are no longer disabled; or
- the date that the disabled person becomes entitled to Medicare.

Multiple Qualifying Events While Covered Under COBRA

The maximum period of coverage under COBRA is 36 months, even if you experience another Qualifying Event while you're already covered under COBRA. If you're covered under COBRA for 18 months because of your termination of employment or reduction in hours (29 months if disabled), your affected spouse or dependent may extend coverage for another 18 months (7 months if disabled) if:

- you get divorced or legally separated;
- you become entitled to Medicare;
- your child is no longer a dependent under the Plan's definition; or
- you die.

For Example: Kevin stops working (the first COBRA-Qualifying Event), and enrolls himself and his family in COBRA Continuation Coverage for 18 months. Three months after his COBRA Continuation Coverage begins, Kevin's child turns 19 and no longer qualifies as a dependent child under the Plan's definition. Kevin's child can continue COBRA coverage for an additional 33 months, for a total of 36 months of COBRA Continuation Coverage.

You, as the member, are not entitled to COBRA Continuation Coverage for more than a total of 18 months if your employment is terminated or you have a reduction in hours (unless you are entitled to an additional COBRA Continuation Coverage because of a disability). Therefore, if you experience a reduction in hours followed by a termination of employment, the termination of employment is not treated as a second Qualifying Event and you may not extend your coverage.

Coverage if You're Enrolled in Medicare BEFORE a Qualifying Event

If you are enrolled in Medicare before your hours are reduced or your employment is terminated, you and your eligible dependents would be entitled to COBRA for a period of 18 months (29 months if the 11-month Social Security Disability extension applies) from the date of your termination of employment or reduction in hours.

Coverage if You're Enrolled in Medicare AFTER a Qualifying Event

If you become enrolled in Medicare after you begin COBRA Continuation Coverage, your COBRA Continuation Coverage will end. However, your dependents will continue to receive COBRA Continuation Coverage for 36 months measured from the date of your Qualifying Event.

Special COBRA Enrollment Rights

If you marry, have a newborn child, adopt a child or have a child placed with you for adoption while you are enrolled in COBRA, you may enroll that spouse or child for coverage for the balance of the period of COBRA Continuation Coverage. You must enroll your new dependent within 31 days of the marriage, birth, adoption or placement for adoption.

In addition, if you are enrolled for COBRA Continuation Coverage and your spouse or dependent child lose coverage under another group health plan, you may enroll that spouse or child for coverage for the balance of the period of COBRA within 31 days after the termination of the other coverage.

To be eligible for this special enrollment right, your spouse or dependent child must have been eligible for coverage under the terms of the Plan but declined when enrollment was previously offered because he or she had coverage under another group health plan or had other health insurance coverage.

Adding a spouse or dependent child may cause an increase in the amount you must pay for COBRA Continuation Coverage. To find out about COBRA rates, contact the Fund Office.

Confirmation of Coverage to Health Care Providers

Under certain circumstances, federal rules require the Plan to inform your physician and health care providers as to whether you have elected and/or paid for COBRA Continuation Coverage. This rule only applies in certain situations where the physician or provider is requesting confirmation of coverage and you are eligible for (but you have not yet elected) COBRA coverage, or you have elected COBRA coverage but have not yet paid for it.

Termination of COBRA Continuation Coverage

COBRA Continuation Coverage will terminate on the last day of the maximum period of coverage unless it is cut short for any of the following reasons:

- You do not make all required payments on time;
- The person receiving the coverage becomes covered by another group health plan that does not contain any legally applicable exclusion or limitation with respect to preexisting conditions that the covered person may have;
- The person receiving the coverage becomes entitled to Medicare;
- The Plan terminates its group health plan and no longer provides group health coverage to its members; or
- The employer that you worked for before the Qualifying Event has stopped contributing to the Plan; and
- The employer establishes one or more group health plans covering a significant number of the employer's employees formerly covered under this Plan; or
- The employer starts contributing to another multiemployer plan that is a group health plan.

Name, Address and Telephone Number of the Party Responsible for COBRA Administration

Painters & Allied Trades District Council No. 35
Health Benefits Plan
25 Colgate Road
Roslindale, Massachusetts 02131
(617) 524-1240 or (800) 799-1240

Notice of Unavailability of Coverage

If you provide notice to the Fund Office of a Qualifying Event, but are not entitled to COBRA, the Fund Office will send you a written notice stating the reason why you are not eligible for COBRA. This will be provided within the same time frame that the Fund Office is required to provide an election notice.

Notice of Termination of COBRA

If continuation coverage is terminated before the end of the maximum coverage period, the Fund Office will send you a written notice as soon as practicable

following the Fund Office's determination that continuation coverage will terminate. The notice will set out why continuation coverage will be terminated early, the date of termination, and your rights, if any, to alternative individual or group coverage.

Keep the Fund Informed of Address Changes

In order to protect your family's rights, you should keep the Fund Office informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Fund Office.

If You Have Questions

Questions concerning your Plan or your COBRA Continuation Coverage rights should be addressed to the Fund Office. 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. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

Special Self-Payment Provision for Members on Workers' Compensation

If you are receiving Workers' Compensation, you and your eligible dependents may purchase coverage designed to help you meet medical expenses. This Plan includes coverage for your major medical benefits. However, you will not be covered for dental vision or hearing. Please contact the Fund Office for premium rates.

This Plan does not include coverage for the condition for which the member is receiving Workers' Compensation benefits. You are required to provide the Fund Office with proof that you are receiving Workers' Compensation benefits.

There is no deductible if you use an in-network provider. If you use an out-of-network provider, you must meet an annual deductible of \$500 per individual in each calendar year. The family deductible is \$1,000 per year.



Plan Information

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65 Your ERISA Rights

67 The Plan's Privacy Notice

Plan Facts

Board of Trustees Employer Identification Number	04-2150983
Plan Number	501
Fiscal Year End Date	June 30
Fund Administrator	Sharon P. Saganey
Plan Sponsor	The Board of Trustees
Consultants and Actuaries	The Segal Company
Legal Counsel	Feinberg, Campbell & Zack
Prescription Drug Benefits Administered by	Teamsters Rx
Dental Benefits Underwritten by	Delta Dental of Massachusetts
Vision Benefits Administered by	Davis Vision
Audiology Benefits Administered by	HearUSA
Life and Accidental Death and Dismemberment Benefits Underwritten by	ING

The Fund Office

The Fund Office is open to participants from 8:00 a.m. to 4:00 p.m., Monday through Friday. If you'd like detailed information about payments of any claim, you should call the Fund Office and the appropriate Claims Examiner will assist you. Any person calling the Fund Office must be able to supply the member's name, and Unique Identifying or the Social Security Number.

General Information About the Health Benefits Plan

The Plan is a self-insured, self-administered group health and welfare plan that provides medical benefits, prescription drug benefits, dental benefits, employee assistance program benefits, vision benefits, and hearing benefits, as well as life insurance benefits, accidental death and dismemberment benefits, and supplemental in-hospital accident and sickness income benefits.

The Life Insurance benefits are provided through a group insurance policy issued by ING to the Fund. The name and address of the issuer are:

ING
75 Federal St.
8th floor
Boston, MA 02110

If there is a discrepancy between the provisions of this Summary Plan Description and the ING actual provisions of the Evidence of Coverage, insurance policy or certificates of insurance, the ING documents will prevail.

This Plan is administered by a joint Board of Trustees, consisting of Union representatives and Employer representatives. The address and telephone number that you may use to contact the Board of Trustees is:

Painters & Allied Trades District Council No. 35
Health Benefits Plan
25 Colgate Road
Roslindale, Massachusetts 02131
(617) 524-1240 or (800) 799-1240

The Board of Trustees has been designated as the agent for the service of legal process. Legal process may be made upon a Plan Trustee or the Plan Administrator.

The Board of Trustees consists of Employer and Union representatives who serve without compensation. The number of Trustees may be increased or reduced to such number as the Trustees determine. However, in the event that there is not an equal number of Employer and Union Trustees, the voting strength of the Employer Trustees and the Union Trustees will always be equal (e.g., If there are five Employer Trustees and four Union Trustees, each Employer Trustee's vote shall be counted as four-fifths (4/5) and each Union Trustee's vote shall be counted as one (1)).

The Painters & Allied Trades District Council No. 35 Health Plan is a self-insured, self-administered Taft-Hartley Fund established pursuant to the National Labor Relations Act and any state laws pertaining to insurance companies are pre-empted by the Employee Retirement Income Security Act of 1974 (ERISA).

All contributions to the Plan are made by employers in accordance with the Collective Bargaining Agreements between the Painters & Finishing Employers Association of New England, Inc., and Glass Employers Association of New England, Inc., and the Painters & Allied Trades District Council No. 35. The Collective Bargaining Agreements require contributions to the Health Benefits Plan at fixed rates for each hour worked for which an employee is covered by an agreement.

You may examine these Collective Bargaining Agreements at the Fund Administrator's office upon ten days' advance written request. In addition, you may obtain copies of any such agreements, for a reasonable charge, upon written request to the Fund Administrator.

The Fund Office, upon written request, will provide you with information as to whether a particular employer is contributing to this Plan on behalf of participants working under a Collective Bargaining Agreement and, if so, with the employer's address.

Benefits are provided from the Fund's assets that are accumulated under the provisions of the Collective Bargaining Agreement and the Trust Agreement and held in a Trust Fund for the purpose of providing benefits to covered participants and defraying reasonable administrative expenses.

The Fund's assets and reserves are held in custody by M&I Bank and Trust Company, and invested by McDonnell Investment Management, ICC Capital Management and SSgA S& P 500 Flagship Fund.

The Plan's requirements with respect to eligibility as well as circumstances that may result in disqualification, ineligibility, or denial or loss of any benefits are fully described on page 57 of this descriptive booklet.

The Board of Trustees reserves the right, in its sole discretion, at any time and from time to time, to:

- Amend or terminate either the amount or condition with respect to the payment of any benefit, regardless of employment or retirement status, or illness, injury, condition or disability suffered prior to the effective date of amendment or termination; or

- Alter or postpone the method of payment of any benefit; or
- Amend or terminate the right to continue coverage on a self-payment basis; or
- Amend or terminate any other provisions of the Plan for any class of members, retirees or dependents.

In no event, however, may any amendment or termination cause any part of the Fund to revert to an Employer.

In the event of a Plan termination, only claims and expenses incurred prior to the termination date will be paid in accordance with the Plan. Payment will be made from the assets remaining in the Fund, including any insurance policies issued to the Fund, for the purpose of providing benefits. If there are not enough assets remaining to pay all outstanding claims, the Trustees will decide the manner in which the remaining assets will be used. In no event will the Board of Trustees or any individual Trustee, Employer, Union or other individual or entity be liable to provide the payment of benefits over and beyond the Plan assets in the Fund available for such purpose.

A listing of in-network (PPO) providers is available online. See page 2 for the web addresses for your benefit program carriers.

The procedures to follow for filing a claim for benefits are explained on page 59 of this booklet. If all or any part of your claim is denied, you may appeal that decision. To make an appeal, write to the Fund Office within 180 days as described on page 59 of this booklet.

As someone who is or may be eligible for benefits from this Plan, you are no doubt aware of the fact that the benefits are paid in accordance with Plan provisions out of a Trust Fund that is used solely for that purpose. If you have had any questions or problems as to benefit payments, you have, as you know, had the right to get answers from the Trustees who administer the Plan.

Fraudulent Use of the Plan

If you or your dependent receive benefits as a result of any sort of misleading representation, false information or other fraudulent representation to the Fund, he or she is liable to repay all amounts paid by the Fund and all costs of collection, including interest and attorney's fees.

In addition, the Trustees reserve the right to deny payment for any subsequent claims you or your dependents incur for a time period or amount determined by the Trustees. If this happens, you will be notified of these periods of denial and amounts.

Anyone who contributed to his or her injury by operating an auto or any type of vehicle while under the influence of alcohol, marijuana or a narcotic drug will be ineligible to receive benefits for treatment of any of these injuries from the Fund. A police report will be required to determine appropriate benefits.

If your injury or illness is the result of a commission of a crime, you will be ineligible to receive benefits for treatment from the Fund.

When you add a dependent to the Plan, you'll be required to provide a marriage certificate or birth certificate, as appropriate before the dependent will be eligible for coverage.

Fraudulent Misuse of Prescription Drug Plan

If a member or his dependent fraudulently misuses the prescription drug program, the Fund will seek reimbursement from the member and deny the member and all dependents drug benefits for one year.

Your Authorization for Audit Required

In order to make certain that it pays the correct amount for services rendered to its beneficiaries, the Health Plan has retained the services of an outside auditing firm to substantiate, by means of an on-site hospital audit, that charges that have been billed by a medical provider are accurate.

Since it is essential for the maintenance of the integrity of the Health Plan to perform these reviews on medical providers, each participant or eligible dependent is required to execute the "Release of

Information" authorization allowing the completion of this audit. Since refusal to execute the release may result in the Health Plan paying for services not rendered to its beneficiaries or not covered by the Health Plan, failure to execute the "Release of Information" or to assist and cooperate with the Health Plan in its other attempts to verify charges will result in non-payment of the claim(s).

All claims for benefits should be made within 90 days of the date of the illness or injury. However, a claim may be accepted later if there are exceptional reasons for failing to file the claim within the 90-day period. No benefits will be paid when a claim is submitted more than 180 days after the date the service was provided.

Life Insurance and Accidental Death and Dismemberment claim forms are also available from the Fund Office.

Certificate of Coverage

When your Health Plan coverage ends, you and your dependents are entitled by law to receive a Certificate of Coverage that indicates the period of time you and they were covered under the Plan. You will be given a certificate soon after the Fund Office knows or has reason to know that coverage for you and your covered dependents has ended. You may also request a certificate within two years after your coverage ended.

No Medical Examination or Age Restriction

No medical examination is required of any employee to secure this insurance, and all new employees will be insured regardless of age.

Nothing in this statement is meant to interpret or extend or change in any way the provisions expressed in the Plan or insurance policies. The Trustees reserve the right to amend, modify, terminate or discontinue all or part of this Plan whenever, in their judgment, conditions so warrant.

If you do not understand English and have questions about the benefits or the rules of the Plan, contact the Fund Office to find out how to obtain such help.

No Local Union, Local Union Officer, Business Agent, Local Union Employee, Employer, Employer Representative, Fund Office personnel, consultant or attorney is authorized to speak for, or on behalf of, or to commit the Trustees of this Fund on any matter relating to that Fund without the express authority of the Trustees.

Only the Trustees of the Fund have the authority to determine eligibility for benefits and the right to participate in the Fund, including the manner in which hours are credited, eligibility for any benefit, discontinuance of benefits, status as a covered or non-covered member, the level of benefits, and the interpretation and application of this Summary Plan Description to a particular claim or applicant.

The Newborns' and Mothers' Health Protection Act of 1996

Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours, as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the Plan or issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Women's Health and Cancer Rights Act of 1998

As required by the Women's Health and Cancer Rights Act of 1998, the Plan provides benefits for mastectomy-related services including reconstruction and surgery to achieve symmetry between the breasts, prostheses, and treatment for complications resulting from a mastectomy (including lymphedemas). Contact the Fund Office for more information regarding this benefit.

Claims and Appeals Procedures

This section describes the procedures for filing claims for benefits from the Painters & Allied Trades District Council No. 35 Health Fund. It also describes the procedure for you to follow if your claim is denied in whole or in part and you wish to appeal the decision.

How to File a Claim

A claim for benefits is a request for Plan benefits made in accordance with the Plan's reasonable claims procedures. In order to file a claim for benefits offered under this Plan, you or your provider must submit a completed claim form. Simple inquiries about the Plan's provisions that are unrelated to any specific benefit claim will not be treated as a claim for benefits. In addition, a request for prior approval of a benefit that does not require prior approval by the Plan is not a claim for benefits.

The following information must be completed in order for your request for benefits to be a claim, and for the Fund Office to be able to decide your claim.

- Participant name and address;
- Patient name and address (if different from participant);
- Patient's relationship to insured;
- Patient date of birth;
- Patient's sex;
- Student status;
- SSN or UIN of participant or retiree;
- Was condition related to patient's employment, or accident;
- Date of service;
- Name of referring physician;
- Hospitalization dates, if applicable;
- CPT-4 (the code for physician services and other health care services found in the Current Procedural Terminology, Fourth Edition, as maintained and distributed by the American Medical Association);
- CD-9 (the diagnosis code found in the International Classification of Diseases, 9th Edition, Clinical Modification as maintained and distributed by the U.S. Department of Health and Human Services);
- Billed charge, amount paid and balance due;
- Federal taxpayer identification number (TIN) of the provider;
- Billing name and address; and
- If treatment is due to accident, accident details.

Note: Claims involving Urgent Care (defined below) or requiring Pre-certification must be submitted telephonically to CareAllies by calling 1-800-558-9639.

When you present a prescription to a pharmacy to be filled out under the terms of this Plan, that request is not a "claim" under these procedures. However, if your request for a prescription is denied, in whole or in part, you may file a claim and appeal regarding the denial by using these procedures.

When Claims Must Be Filed

Claims should be filed within 90 days following the date the charges were incurred. Failure to file claims within the time required shall not invalidate or reduce any claim, if it was not reasonably possible to file the claim within such time. However, in that case, the claim must be submitted as soon as reasonably possible and in no event later than 180 days from the date the charges were incurred.

When a Claim Is Considered Received by the Fund

Post-Service Claims

Post-Service Claims are claims for which services have already been provided. Post-Service Claims are considered received as follows:

- Hospital, medical and hearing claims – when received at the Fund Office by U.S. Mail, or electronic delivery (by a provider);
- Vision Claims – when received by Davis Vision; and
- Dental Claims – when received by Delta Dental.

Pre-Service Claims

Pre-Service Claims are claims for pre-authorization and approval of certain treatment. Pre-Service Claims are considered received as follows:

- Hospitalizations – when received by telephone to CareAllies.
- Mental Health or Alcohol/Substance Abuse Treatment – when received by telephone to Modern Assistance Programs.
- Dental Pre-determination of Benefits – when Delta Dental is contacted by U.S. Mail, or electronically, by your dentist.

Where to File Claims

Claims should be filed with the Fund Office at the following address:

Painters & Allied Trades District Council No. 35
Health Benefits Plan
25 Colgate Road
Roslindale, MA 02131
(617) 524-1240 or (800) 799-1240
FAX (617) 524-3557

Urgent claims and requests for Pre-certification of hospital admissions may not be submitted in writing to the Fund Office, but must be submitted to CareAllies using the following telephone number: 1-800-558-9639.

- Delta Dental processes all dental claims and they can be reached at 1-800-872-0500;
- Vision care claims are handled by Davis Vision and they can be reached at 1-800-999-5431;
- Employee Assistance Pre-certifications are handled by the Modern Assistance Programs and they can be reached at 1-800-878-2004.

Authorized Representatives

An authorized representative, such as your spouse, may complete the claim form for you if you are unable to complete the form yourself and have previously designated the individual to act on your behalf. A form can be obtained from the Fund Office to designate an authorized representative. The Plan may request additional information to verify that this person is authorized to act on your behalf. A health care professional with knowledge of your medical condition may act as an authorized representative in connection with an Urgent Care Claim (defined below) without your having to complete the special authorization form.

Comprehensive Medical Benefits

The claims procedures for comprehensive medical benefits will vary depending on whether your claim is for a Pre-Service Claim, an Urgent Care Claim, a Concurrent Care Claim, or a Post-Service Claim. Read each section carefully to determine which procedure is applicable to your request for benefits.

Pre-Service and Urgent Care Claims

A Pre-Service Claim is a claim for a benefit for which the Plan requires approval from CareAllies of the benefit (in whole or in part) before medical care is obtained. Under this Plan, prior approval of services is required for all hospital admissions. Important: If you fail to pre-certify an inpatient admission, you will be assessed a \$1,000 penalty.

If you improperly file a Pre-Service Claim, CareAllies will notify you, or your doctor's office, as soon as possible but not later than five days after receipt of the claim, of the proper procedures to be followed in filing a claim.

You will only receive notice of an improperly filed Pre-Service Claim if the claim includes:

1. your name;
2. your specific medical condition or symptom; and
3. a specific treatment, service or product for which approval is requested.

Unless the claim is refiled properly, it will not constitute a claim.

For properly filed Pre-Service Claims, you and your doctor will be notified of a decision within 15 days from receipt of the claim unless additional time is needed. If medical circumstances require a faster response, you must notify CareAllies at the time the request for service is made. The time for response may be extended up to 15 days if necessary due to matters beyond the control of the Plan/CareAllies. You will be notified of the circumstances requiring the extension of time and the date by which a decision is expected to be rendered.

If an extension is needed because the Plan/CareAllies needs additional information from you, the extension notice will specify the information needed. In that case you and/or your doctor will have 45 days from receipt of the notification to supply the additional information. If the information is not provided within that time, your claim will be denied. During the period in which you are allowed to supply additional information, the normal period for making a decision on the claim will be suspended. The deadline is suspended from the date of the extension notice until either 45 days or the date you respond to the request (whichever is earlier). The Plan/CareAllies then has 15 days to make a decision on a Pre-Service Claim and notify you of the determination.

Urgent Care Claim

An Urgent Care Claim is any claim for medical care or treatment with respect to which the application of the time periods for making Pre-Service Claim determinations:

1. could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function; or
2. 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.

Whether your claim is an Urgent Care Claim is determined by CareAllies applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine. Alternatively, any claim that a physician with knowledge of your medical condition determines is an Urgent Care Claim within the meaning described above, shall be treated as an Urgent Care Claim.

If you improperly file an Urgent Care Claim, CareAllies will notify you as soon as possible but not later than 24 hours after receipt of the claim, of the proper procedures to be followed in filing a claim. Unless the claim is refiled properly, it will not constitute a claim.

If you are requesting Pre-certification of an Urgent Care Claim, the time deadlines are different. CareAllies will respond to you and your doctor with a determination by telephone as soon as possible taking into account the medical exigencies, but not later than 72 hours after receipt of the claim by the Plan. The determination will also be confirmed in writing.

If an Urgent Care Claim is received without sufficient information to determine whether or to what extent benefits are covered or payable, CareAllies will notify you and your doctor as soon as possible, but not later than 24 hours after receipt of the claim, of the specific information necessary to complete the claim. You and/or your doctor must provide the specified information within 48 hours. If the information is not provided within that time, your claim will be denied.

Notice of the decision will be provided no later than 48 hours after the Plan receives the specified information or the end of the period given for you to provide this information, whichever is earlier.

Concurrent Claims

A Concurrent Claim is a claim that is reconsidered after an initial approval was made and results in a reduction, termination or extension of a benefit, or is a request for additional treatment. (An example of this type of claim would be an inpatient hospital stay originally certified for five days that is reviewed at three days to determine if the full five days is appropriate.) In this situation a decision to reduce, terminate or extend treatment is made concurrently with the provision of treatment.

A reconsideration of a benefit with respect to a Concurrent Claim that involves the termination or reduction of a previously approved benefit (other than by Plan amendment or termination) will be made by CareAllies as soon as possible, but in any event early enough to allow you to have an appeal decided before the benefit is reduced or terminated.

Any request by a claimant to extend approved Urgent Care treatment will be acted upon by CareAllies within 24 hours of receipt of the claim, provided the claim is received at least 24 hours prior to the expiration of the approved treatment. A request to extend approved treatment that does not involve Urgent Care will be decided according to Pre-Service or Post-Service time frames, whichever applies.

Post-Service Claim

The following procedure applies to Post-Service Claims. A Post-Service Claim is a claim that is not a Pre-Service Claim (for example, a claim submitted for payment after health services and treatment have been obtained).

1. Obtain a claim form.
2. Complete the employee's portion of the claim form.
3. Have your physician either complete the Attending Physician's Statement section of the claim form, submit a completed HCFA health insurance claim form, or submit a HIPAA-compliant electronic claims submission.
4. Attach all itemized hospital bills or doctor's statements that describe the services rendered.

Check the claim form to be certain that all applicable portions of the form are completed and that you have submitted all itemized bills. By doing so, you will speed the processing of your claim. If the claim forms have to be returned to you for information, delays in payment will result.

Ordinarily, you will be notified of the decision on your Post-Service Claim within 30 days from the Plan's receipt of the claim. This period may be extended one time by the Plan for up to 15 days if the extension is necessary due to matters beyond the control of the Plan. If an extension is necessary, you will be notified before the end of the initial 30-day period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision.

If an extension is needed because the Plan needs additional information from you, the extension notice will specify the information needed. In that case you will have 45 days from receipt of the notification to supply the additional information. If the information

is not provided within that time, your claim will be denied. During the period in which you are allowed to supply additional information, the normal period for making a decision on the claim will be suspended. The deadline is suspended from the date of the extension notice until either 45 days or until the date you respond to the request (whichever is earlier). The Plan then has 15 days to make a decision on a Post-Service Claim and notify you of the determination.

Notice of Decision

You will be provided with written notice of a denial of a claim (whether denied in whole or in part). This notice will state:

- The specific reason(s) for the determination;
- Reference to the specific Plan provision(s) on which the determination is based;
- A description of any additional material or information necessary to perfect the claim, and an explanation of why the material or information is necessary;
- A description of the appeal procedures and applicable time limits;
- A statement of your right to bring a civil action under ERISA Section 502(a) following an adverse benefit determination on review;
- If an internal rule, guideline or protocol was relied upon in deciding your claim, you will receive either a copy of the rule or a statement that it is available upon request at no charge;
- If the determination was based on the absence of medical necessity, or because the treatment was experimental or investigational, or other similar exclusion, you will receive an explanation of the scientific or clinical judgment for the determination applying the terms of the Plan to your claim, or a statement that it is available upon request at no charge; and
- For Urgent Care Claims, the notice will describe the expedited review process applicable to Urgent Care Claims. For Urgent Care Claims, the required determination may be provided orally and followed with written notification.

For Urgent Care Claims and Pre-Service Claims, you will receive notice of the determination even when the claim is approved.

Request for Review of Denied Claim

If your claim is denied in whole or in part, or if you disagree with the decision made on a claim, you may ask for a review. Your request for review must be made in writing to the Fund Office within 180 days after you receive a notice of denial. Appeals involving Urgent Care Claims may be made orally by calling the Fund Administrator at the number listed in this booklet.

Review Process

The review process works as follows:

You have the right to review documents relevant to your claim. A document, record or other information is relevant if it was relied upon by the Plan in making the decision; it was submitted, considered or generated (regardless of whether it was relied upon); it demonstrates compliance with the Plan's administrative processes for ensuring consistent decision-making; or it constitutes a statement of Plan policy regarding the denied treatment or service.

Upon request, you will be provided with the identification of medical or vocational experts, if any, that gave advice to the Plan on your claim, without regard to whether their advice was relied upon in deciding your claim.

A different person will review your claim than the one who originally denied the claim. The reviewer will not give deference to the initial adverse benefit determination. The decision will be made on the basis of the record, including such additional documents and comments that may be submitted by you.

If your claim was denied on the basis of a medical judgment (such as a determination that the treatment or service was not medically necessary, or was investigational or experimental), a health care professional who has appropriate training and experience in a relevant field of medicine will be consulted.

Timing of Notice of Decision on Appeal

- **Pre-Service Claims:** You will be sent a notice of decision on review within 30 days of receipt of the appeal by the Fund.
- **Urgent Care Claims:** You will be sent a notice of a decision on review within 72 hours of receipt of the appeal by the Fund.
- **Post-Service Claims:** Post-Service Claims will be reviewed and determined by the Fund Administrator within 30 days of the receipt of the claim. If your claim is denied, you have the right to an appeal to the Board of Trustees. Appeals to the Board of Trustees will be made at the next regularly scheduled meeting of the Board of Trustees following receipt of your request for review of the Fund Administrator's determination. However, if your request for review is received within 30 calendar days of the next regularly scheduled meeting, your request for review will be considered at the second regularly scheduled meeting following receipt of your request. In special circumstances, a delay until the third regularly scheduled meeting following receipt of your request for review may be necessary. You will be advised in writing in advance if this extension will be necessary. Once a decision on review of your claim has been reached, you will be notified of the decision as soon as possible, but no later than five days after the decision has been reached.

Notice of Decision on Review

The decision on any review of your claim will be given to you in writing. The notice of a denial of a claim on review will state:

- The specific reason(s) for the determination;
- Reference to the specific Plan provision(s) on which the determination is based;
- A statement that you are entitled to receive reasonable access to and copies of all documents relevant to your claim, upon request and free of charge;
- A statement of your right to bring a civil action under ERISA Section 502(a) following an adverse benefit determination on review;
- If an internal rule, guideline or protocol was relied upon by the Plan, you will receive either a copy of the rule or a statement that it is available upon request at no charge; and
- If the determination was based on medical necessity, or because the treatment was experimental or investigational, or other similar exclusion, you will receive an explanation of the scientific or clinical judgment for the determination applying the terms of the Plan to your claim, or a statement that it is available upon request at no charge.

Limitation on When a Lawsuit May Be Started

You may not start a lawsuit to obtain benefits until after you have requested a review and a final decision has been reached on review, or until the appropriate time frame described previously has elapsed since you filed a request for review and you have not received a final decision or notice that an extension will be necessary to reach a final decision. The law also permits you to pursue your remedies under Section 502(a) of the Employee Retirement Income Security Act without exhausting these appeal procedures if the Plan has failed to follow them. No lawsuit may be started more than three years after the end of the year in which medical or dental services were provided.



Your ERISA Rights

As a participant in the Painters & Allied Trades District Council No. 35 Health Benefits Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants shall be entitled to:

Receive Information About Your Plan and Benefits

- Examine, without charge, at the Fund Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration;
- Obtain, upon written request to the Fund 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; and
- Receive a summary of the Plan's annual financial report. The Fund Administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

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

Reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group Health Plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group Health Plan or health insurance issuer when you lose coverage under the Plan, when you become entitled to elect COBRA Continuation Coverage, when your COBRA Continuation Coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Fund Administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

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

Painters & Allied Trades District Council No. 35 Health Fund Privacy Notice

Section 1: Purpose of This Notice and Effective Date

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.

Effective date. The effective date of this Notice is April 14, 2003.

This Notice is required by law. The Fund is required by law to take reasonable steps to ensure the privacy of your personally identifiable health information and to inform you about:

1. The Fund's uses and disclosures of Protected Health Information (PHI),
2. Your rights to privacy with respect to your PHI,
3. The Fund's duties with respect to your PHI,
4. Your right to file a complaint with the Fund and with the Secretary of the United States Department of Health and Human Services (HHS), and
5. The person or office you should contact for further information about the Fund's privacy practices.

Section 2: Your Protected Health Information

The term "Protected Health Information" (PHI) includes all individually identifiable health information related to your past, present or future physical or mental health condition or to payment for health care. PHI includes information maintained by the Fund in oral, written, or electronic form.

When the Fund May Disclose Your PHI

Under the law, the Fund may disclose your PHI without your consent or authorization, or the opportunity to agree or object, in the following cases:

- **At your request.** If you request it, the Fund is required to give you access to certain PHI in order to allow you to inspect and/or copy it;
- **As required by HHS.** The Secretary of the United States Department of Health and Human Services may require the disclosure of your PHI to investigate or determine the Fund's compliance with the privacy regulations;
- To your personal representative as more fully set forth below;
- **For treatment, payment or health care operations.** The Fund and its business associates will use PHI in order to carry out:
 - Treatment,
 - Payment, or
 - Health care operations.

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, the Fund 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.

Payment includes but is not limited to actions to make coverage determinations and payment (including billing, claims management, subrogation, Fund reimbursement, reviews for medical necessity and appropriateness of care and utilization review and pre-authorizations). For example, the Fund may tell a doctor whether you are eligible for coverage or what percentage of the bill will be paid by the Fund. If we contract with third parties to help us with payment operations, such as a physician that reviews medical claims, we will also disclose information to them. These third parties are known as "business associates." We will also disclose enrollment information to contributing Employers and Union representatives.

Health care operations includes but is not limited to quality assessment and improvement, reviewing competence or qualifications of health care professionals, underwriting, premium rating and other insurance activities relating to creating or renewing insurance contracts. It also includes disease management, case management, conducting or arranging for medical review, legal services, and auditing functions including fraud and abuse compliance programs, business planning and development, business management and general administrative activities. For example, the Fund may use information about your claims to refer into a disease management program, a well-pregnancy program, project future benefit costs or audit the accuracy of its claims processing functions.

Disclosure to the Fund's Trustees. The Fund will also disclose PHI to the Fund Sponsor, which is the Board of Trustees of the Painters & Allied Trades District Council No. 35 Health Fund, for purposes related to treatment, payment, and health care operations, and has amended the Fund Documents to permit this use and disclosure as required by federal law. For example, we may disclose information to the Board of Trustees to allow them to decide an appeal or review a subrogation claim.

When the Disclosure of Your PHI Requires Your Written Authorization

The Plan may provide health information for the purpose of evaluating and processing a claim for Health Fund accident and sickness benefits; for evaluating an application for death benefits from the Pension Fund and/or Annuity Fund; or for evaluating a member's vested status under the Pension Fund. However, the Plan will obtain your written authorization before it will use or disclose any health information for these purposes.

When You Can Object and Prevent the Fund from Using or Disclosing PHI

Disclosure of your PHI to family members, other relatives, your close personal friends and any other person you choose is allowed under federal law if:

- The information is directly relevant to the family or friend's involvement with your care or payment for that care; and
- You have either agreed to the disclosure or have been given an opportunity to object and have not objected.

Use or Disclosure of PHI Without Consent, Authorization or Opportunity to Object

The Fund is allowed under federal law to use and disclose your PHI without your consent or authorization under the following circumstances:

1. **When required by applicable law.**
2. **Public health purposes.** To an authorized public health authority if required by law or for public health and safety purposes. PHI may also be used or disclosed if you have been exposed to a communicable disease or are at risk of spreading a disease or condition, if authorized by law.
3. **Domestic violence or abuse situations.** When authorized by law to report information about abuse, neglect or domestic violence to public authorities if a reasonable belief exists that you may be a victim of abuse, neglect or domestic violence. In such 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.
4. **Health oversight activities.** To a health oversight agency for oversight activities authorized by law. These activities include civil, administrative or criminal investigations, inspections, licensure or disciplinary actions (for example, to investigate complaints against health care providers) and other activities necessary for appropriate oversight of government benefit programs (for example, to the Department of Labor).
5. **Legal proceedings.** When required for judicial or administrative proceedings. For example, your PHI may be disclosed in response to a subpoena or discovery request.
6. **Law enforcement health purposes.** When required for law enforcement purposes (for example, to report certain types of wounds).

7. **Law enforcement emergency purposes.** For certain law enforcement purposes, including:
 - identifying or locating a suspect, fugitive, material witness or missing person, and
 - disclosing information about an individual who is or is suspected to be a victim of a crime.
 - Determining cause of death and organ donation. When required to be given to a coroner or medical examiner to identify a deceased person, determine a cause of death or other authorized duties. We may also disclose PHI for cadaveric organ, eye or tissue donation purposes.
8. **Determining cause of death and organ donation.** When required to be given to a coroner or medical examiner to identify a deceased person, determine a cause of death or other authorized duties. We may also disclose PHI for cadaveric organ, eye or tissue donation purposes.
9. **Funeral purposes.** When required to be given to funeral directors to carry out their duties with respect to the decedent.
10. **Research.** For research, subject to certain conditions.
11. **Health or safety threats.** When, consistent with applicable law and standards of ethical conduct, the Fund in good faith believes the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public and the disclosure is to a person reasonably able to prevent or lessen the threat, including the target of the threat.
12. **Workers' Compensation programs.** When authorized by and to the extent necessary to comply with Workers' Compensation or other similar programs established by law.

Except as otherwise indicated in this notice, uses and disclosures will be made only with your written authorization subject to your right to revoke your authorization.

The Fund may contact you to provide you information about treatment alternatives or other health-related benefits and services that may be of interest to you.

The Fund may disclose protected health information to the sponsor of the Fund for reviewing your appeal of a benefit claim or for other reasons regarding the administration of this Fund. The "Fund Sponsor" of this Fund is the Painters & Allied Trades District Council No. 35 Health Fund Board of Trustees.

Section 3: Your Individual Privacy Rights

You May Request Restrictions on PHI Uses and Disclosures

You have the right to request that the Plan limit its uses and disclosures of PHI in relation to treatment, payment and health care operations or not use or disclose your PHI for these reasons at all. You also have the right to request the Plan restrict the use of disclosure of your PHI to family members or personal representatives. Any such request must be made in writing to the Privacy Contact at the address listed at the end of this notice and must state the specific restriction requested and to whom that restriction would apply. The Fund, however, is not required to agree to your request.

You May Request Confidential Communications

The Fund will accommodate an individual's reasonable request to receive communications of PHI by alternative means or at alternative locations where the request includes a statement that disclosure could endanger the individual.

You or your personal representative will be required to complete a form to request restrictions on uses and disclosures of your PHI. Make such requests to the Privacy Official at the address listed at the end of this Notice.

You May Inspect and Copy PHI

You have a right to inspect and obtain a copy of your PHI contained in a "designated record set," for as long as the Fund maintains the PHI.

You or your personal representative will be required to complete a form to request access to the PHI. A reasonable fee may be charged. Requests for access to PHI should be made to the Privacy Contact at the address listed at the end of this Notice.

If access is denied, you or your personal representative will be provided with a written denial setting forth the basis for the denial, a description of how you may exercise your review rights and a description of how you may complain to the Fund and HHS.

Your PHI includes your medical records and billing records that are maintained by or for a covered health care provider. Records include enrollment, payment, billing, claims adjudication and case or medical management record systems maintained to make decisions about you.

You Have the Right to Amend Your PHI

You have the right to request that the Fund amend your PHI or a record about you for as long as the PHI is maintained. The Fund may deny your request.

If the Fund denied your request in whole or part, the Fund must provide you with a written denial that explains the basis for the decision. 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 that PHI.

You should make your request to amend PHI to the Privacy Contact at the address listed at the end of this Notice.

You or your personal representative will be required to complete a form to request amendment of the PHI.

You Have the Right to Receive an Accounting of the Fund's PHI Disclosures

At your request, the Fund will also provide you with an accounting of certain disclosures by the Fund of your PHI. We do not have to provide you with an accounting of disclosures related to treatment, payment, or health care operations, or disclosures made to you or authorized by you in writing. Accounting requests may not be made for periods of time going back more than six years.

If you request more than one accounting within a 12-month period, the Fund may charge a reasonable, cost-based fee for each subsequent accounting.

You Have the Right to Receive a Paper Copy of This Notice Upon Request

To obtain a paper copy of this Notice, contact the Privacy Contact at the address listed at the end of this Notice.

Your Personal Representative

You may exercise your rights through a personal representative who will be required to produce evidence of authority to act on your behalf before the personal representative will be given access to your PHI or be allowed to take any action for you. Proof of such authority will be a completed, signed and approved Appointment of Personal Representative form. You may obtain this form by calling the Fund Office.

The Fund retains discretion to deny access to your PHI to a personal representative to provide protection to those vulnerable people who depend on others to exercise their rights under these rules and who may be subject to abuse or neglect.

The Fund will recognize certain individuals as personal representatives without your having to complete an Appointment of Personal Representative form. For example, the Fund will automatically consider a spouse to be the personal representative of an individual covered by the Fund. In addition, the Fund will consider a parent or guardian as the personal representative of an unemancipated minor unless applicable law requires otherwise. A spouse, a parent, or child may act on an individual's behalf, including requesting access to their PHI. Spouses and unemancipated minors may, however, request that the Fund restrict information that goes to family members as described at the beginning of Section 3 of this Notice.

Section 4: The Fund's Duties

Maintaining Your Privacy

HIPAA requires the Fund to maintain the privacy of your PHI and to provide you with notice of its legal duties and privacy practices.

The Fund reserves the right to change its privacy practices and to apply the changes to any PHI received or maintained by the Fund prior to that date. If a privacy practice is changed, a revised version of this Notice will be provided to you and to all past and present participants and beneficiaries for whom the Fund still maintains PHI.

The Privacy Notice will be provided by first class mail to all named participants. Any other person, including dependents of named participants, may receive a copy upon request. Any revised version of this Notice will be distributed within 60 days of the effective date of any material change to this Notice.

Section 5: Your Right to File a Complaint With the Fund or the HHS Secretary

If you believe that your privacy rights have been violated, you may file a complaint with the Fund in care of the Privacy Contact at the address listed below.

You may also file a complaint with the Secretary of the U.S. Department of Health and Human Services ("HHS"). Please contact the nearest office of the Department of Health and Human Services, listed in your telephone directory, visit the HHS website at www.hhs.gov, or call the Privacy Official for more information about how to file a complaint. The Fund will not retaliate against you for filing a complaint.

Section 6: If You Need More Information

If you have any questions regarding this Notice or the subjects addressed in it, you may contact the Privacy Contact at Painters & Allied Trades District Council No. 35 Health Fund, 25 Colgate Road, Suite 204, Roslindale, MA 02131.





Definitions

Definitions

When the following terms are used in this booklet, these definitions apply.

Allowable Charge/Expense – A health care service or expense that is covered at least in part by the Health Plan. When a plan provides benefits in the form of services, the reasonable cash value of each service will be considered an allowable expense.

Ambulance – Benefits are payable for emergency ambulance services to the nearest available facility when medically necessary and required to provide immediate treatment for an injury, illness, or pregnancy. Benefits are not payable when other transportation, such as an automobile, would provide sufficient transportation. Non-emergency transports, physician charges and wheel chair transports are not covered. Air ambulance for a life-threatening medical emergency only.

Ambulatory Surgical Facility – Is licensed by the State with an organized medical staff; permanent facilities that are equipped and operated for the purpose of performing surgery, and a continuous staff of physicians and registered nurses is also considered to be a hospital.

Cardiac Rehabilitation – Benefits are payable for cardiac rehabilitation for heart-related conditions and procedures such as angioplasty, heart attack, and bypass surgery for up to 36 visits per year. To qualify for coverage, a patient must:

- have recently had an acute myocardial infarction or cardiac surgery/catheterization; and
- the program must commence within six (6) months of the patient being discharged from the hospitalization.

The program must be under the guidance and supervision of a physician or a group of physicians who periodically review the standards and quality of treatment in order to be covered.

Child Dependent – For the purposes of this Health Benefits Plan, included are natural child, stepchild, adopted child, child placed for adoption, or foster child as long as the child satisfies the dependent eligibility rules. Appropriate legal documents must be submitted for review prior to approval of coverage.

In order for the Health Benefits Plan to consider a child an eligible dependent, the child must have the same principal place of abode as you, and must be dependent on you for support (51% or more). Proof that the child is dependent upon you for 51% or more of his or her support must be furnished to the Health Benefits Plan upon request.

The requirement that you provide 51% or more of the child's support will not apply if: (i) you and the child's other parent are divorced or legally separated under a decree of divorce or separate maintenance, separated under a written separation agreement, or live apart at all times during the last six (6) months of the calendar year; (ii) you and the child's other parent provide over half of the child's support; and (iii) the child is in the custody of one or both parents for more than half of the calendar year.

You will be required to provide proof of your dependent's right to coverage. Proof of dependent status will include a marriage certificate, divorce decree, birth certificate, school registration documents, tax documents, adoption papers or legal foster child documents. Full-Time students between the ages of 19-23 must submit proof of full-time school attendance every semester, September and January. Retroactive coverage beyond 72 days may not be granted if student verification letters are not received timely.

Chiropractic Services – Chiropractic services are services provided by a licensed chiropractor that are:

- permitted by law to be provided by such provider; essential and appropriate for the diagnosis and treatment of an illness or injury to the neuromusculoskeletal system;
- broadly accepted by the standards of the chiropractic industry;
- diagnostically sensitive and specific;
- therapeutically safe;
- clinically effective; and
- not considered to be investigative or experimental.

Coinsurance – The percentage of the negotiated rate that you are responsible for paying to the provider. For most in-network medical services, your coinsurance is 10%. The Plan pays the remaining 90%.

Copayment – The flat dollar amount that you are responsible for paying for certain medical services (for instance, the copayment is currently \$20 for an office visit and \$100 for an emergency room visit.)

Deductible – The amount that you must pay each year for your out-of-network charges before the Plan will begin to pay benefits. For in-network services, there is no annual deductible to meet.

Durable Medical Equipment – Benefits are payable for the purchase of durable medical equipment. Rental charges for durable medical equipment are covered to a maximum of the purchase price for the item. To be covered by the Plan, the item must be prescribed in writing by a physician, and can only be used by the person for whom it is intended. Examples of covered durable medical equipment are:

- hospital-type medical equipment;
- wheelchairs;
- hospital beds;
- oxygen;
- artificial limbs;
- crutches; and
- most custom-made braces.

Benefits are payable for base model, professionally adequate, least costly durable medical equipment only. All add-ons for comfort and/or convenience are not covered. Examples of non-covered durable medical equipment are:

- air conditioners;
- swimming pools;
- non custom-made braces;
- exercise equipment and chairs;
- wigs, except those for hair loss due to alopecia, chemotherapy or radiation treatment. Coverage would then be allowed up to \$600, once every five years; and
- orthotics.

Eligibility Period – April 1 and October 1 mark the beginning of an eligibility period —a six-month period during which you and your dependents are covered under the Health Benefits Plan.

Experimental/Investigational Treatment

or Service: A clinical trial or experimental procedure, treatment, hospital or physician service, supply, drug, or appliance that is not generally accepted and/or are considered experimental or investigational by the American Medical Association or the Federal Drug Administration.

Home Health Care – A home health care plan is a plan of medically necessary home care prescribed or ordered by a physician following a period of hospitalization and approved by CareAllies.

Hospice – A hospice is an agency that provides counseling and incidental medical services and may provide room and board to a terminally ill person and that meets all of the following requirements:

- Has obtained any required state or governmental Certificate of Need approval;
- Provides 24-hour/7-day service;
- Is under the direct supervision of a duly licensed physician;
- Has a Nurse Coordinator who is a Registered Graduate Nurse (R.N.) with four years of full-time clinical experience, at least two years of which involved caring for terminally ill patients;
- Has a Social Service Coordinator who is licensed in the jurisdiction in which it is located;

- Is an agency that has as its primary purpose the providing of hospice services;
- Has a full-time administrator;
- Maintains written records of services provided to the patient;
- Its employees are bonded and are provided malpractice and malplacement insurance; and
- Is established and operated in accordance with the applicable laws in the jurisdiction in which it is located and, where licensing is required, has been licensed and approved by the regulatory authority having responsibility for licensing under the law.

Hospital – A legally constituted and operated institution for the care and treatment of sick and injured people. The institution must provide beds, have full diagnostic surgical and therapeutic facilities under the supervision of a staff of legally qualified physicians and provide 24-hour nursing service by registered nurses. Licensed institutions used for the care and treatment of alcoholism, and mental illness are also considered “hospitals” for the purposes of this Fund. No benefits are available for a vocational rehabilitation facility, rest facility, skilled nursing facility, convalescent facility, facility for the aged, birthing centers or for home births or for any charges incurred by any medical provider while residing in one of these facilities.

No benefits are payable under the Plan for confinement in a U.S. Government hospital (except as mandated by law) or for any surgical, medical or other treatment, services or supplies received in or from such a hospital. No benefits are payable for a confinement, services or supplies for which no charge is made.

Lifetime Maximum – The lifetime maximum is the amount payable for the benefit, service or supply during your lifetime.

Medically Necessary – Any service, supply, treatment or hospital confinement (or part of a hospital confinement) which is essential to the treatment of the injury or illness for which it is prescribed or performed, meets generally accepted standards of medical practice and is ordered by a physician.

Occupational Therapy – Benefits are payable for the medical care and treatment by a Registered Occupational Therapist when prescribed by a duly qualified physician. Charges for an office visit performed by a Registered Occupational Therapist are not covered. Treatment plans of extensive duration will be reviewed for medical necessity and appropriateness of care.

Physical Therapy – Benefits are payable for the medical care and treatment by a Registered Physical Therapist when prescribed by a duly qualified physician. Charges for an office visit performed by Registered Physical Therapist are not covered. Treatment plans of extensive duration will be reviewed for medical necessity and appropriateness of care.

Physician – A licensed and certified individual to perform particular medical or surgical services. The term “physician” does not apply to a practitioner of naturopathy, a midwife, a physician’s assistant, a speech therapist, a nurse or nurse practitioner or a nutritionist.

Qualifying Period – A qualifying period is the six-month period that begins on either January 1 or July 1. To qualify for coverage, you must work at least 600 hours in a qualifying period. Your coverage (and coverage for your eligible dependents) will begin on the April 1 or October 1 that follows the qualifying period in which you met the 600 hours requirement.

Qualified Medical Child Support Orders

(QMCSOs) – A state court or agency may require the Health Plan to provide health benefits coverage to children by issuing a medical child support order. As required by the Employee Retirement Income Security Act (ERISA), the Plan will recognize a QMCSO that:

- provides for child support of child(ren) under these plans;
- provides for health coverage to child(ren) under state domestic relations law (including a community property law); and
- relates to benefits under this Plan.

To qualify, a QMCSO must include your name and mailing address and the name and address of each alternative recipient covered by the order. It must also provide a reasonable description of the type of coverage to be provided and specify the name of the plan and the period to which the order applies.

A QMCSO may not require the Plan to provide any type or form of benefits or option that it does not otherwise provide, unless it's necessary to meet the requirements of the Social Security Act relating to the enforcement of state child support laws and reimbursement of Medicaid.

Once the Fund Office receives a QMCSO, it will notify you and each alternative recipient named in the order in writing, including a copy of the order and of the Plan's procedures for determining whether the order qualifies as a QMCSO. The Fund Office will also allow the alternative recipients to designate representatives to receive copies of notices sent to them. Finally, the Fund Office will determine within a reasonable time whether the order qualifies, notify the appropriate parties of the determination, and ensure that the alternative recipients are treated as beneficiaries under ERISA reporting and disclosure requirements.

Reasonable and Customary – The amount normally charged for similar services and supplies which does not exceed the amount ordinarily charged for comparable services and supplies in the locality where the services or supplies are received. In determining whether charges are reasonable and customary, due consideration will be given to the nature and severity of the condition being treated and any medical complications or unusual circumstances which require additional time, skill or expertise.

Speech Therapy – Benefits are payable for speech therapy prescribed by a duly qualified physician and performed by a licensed Speech Therapist to restore speech loss or impairment due to one of the following conditions:

- Injury, illness or pregnancy;
- Cerebral Vascular Accident (C.V.A.);
- Congenital anomaly; or
- Surgery, radiation therapy, or other treatment that affects the vocal cords.

Speech therapy is not covered when used to improve skills that have not been fully developed and that is not restorative in nature.

Spouse Dependent – The Plan considers your spouse a dependent spouse if you are legally married. Your marriage certificate must be submitted in order for your spouse to become eligible for benefits. Common law spouse will be recognized as a lawful spouse if you reside in a state where common law marriages are recognized.

You may cover a spouse who is the same gender as you (and such a spouse's eligible dependent children) if the state where you live allows you to legally marry each other. As part of the enrollment process, you will need to submit a marriage certificate to the Fund, as well as birth certificates or adoption documents for any qualified dependent children. Federal law requires that you pay federal income and FICA taxes on the value of the coverage provided to your same-sex spouse (and his/her eligible dependent children, if applicable). You will need to send a payment for each eligibility period to the Fund — for transmission to the IRS — in advance of your spouse receiving coverage. The Fund Office will notify you of the amount due. If you are a Fund Office employee, payment of those taxes will be withheld from your pay.

Painters & Allied Trades D.C. #35 Health Plan
COVERAGE UPDATES
2008 Summary Plan Description (SPD)

DENTAL BENEFIT IMPROVEMENTS EFFECTIVE OCTOBER 1, 2020

Coverage at 90% added for bone grafts as part of an implant.

BREAST PUMP COVERAGE EFFECTIVE APRIL 1, 2020

Covers the purchase of one breast pump, either manual or electric for pregnant or postpartum eligible members or dependents per pregnancy:

PRESCRIPTION DRUG FIRM CHANGED TO OPTUM RX EFFECTIVE JANUARY 1, 2020

(See language in SPD page 17 & 18)

ORTHODONTICS LIFETIME MAXIMUM – Effective July 1, 2017

Increase the lifetime maximum for orthodontics from \$2500 to \$5000

90 DAY PRESCRIPTION at CVS – Effective April 1, 2017

Maintenance medications are now available at CVS. Same rules apply as mail order.

LASIK – Effective March 1, 2017

Reimbursement up to \$2500 per eye (\$5000 for both). One surgery per eye per lifetime.

VISION PLAN ENHANCEMENT - Effective July 1, 2016

(Addition to language in SPD page 23)

Three Pairs of glasses for adults every 24 months, and two pair for children every 12 months. Safety glasses count as one of the 3 pairs. OR twelve-month supply of Davis Vision Contacts, plus one pair of glasses; Non-Davis contacts the member pays costs in excess of \$150.

Co-payments eliminated: Progressive lenses, Standard and Premium Anti-Reflective Coating, Polarized lenses, Plastic Photosensitive Lenses, and Davis Vision Contact Lenses.

Prior change: 4/1/12 - Added extra pair of glasses (replaced 7/1/16)

FOOT ORTHOPTICS - Effective March 1, 2016 - NEW BENEFIT

Reimbursement up to \$250 per person per calendar year for custom-fit orthotics defined as orthopedic shoes or other supportive appliances for the feet provided by an appropriate, licensed medical professional. Network: 100% up to \$250; Out or Network: 60% up to \$250 after \$250 deductible.

CHIROPRACTIC/ACUPUNCTURE ANNUAL MAXIMUM - EFFECTIVE JULY 1, 2015

(Replaces language in SPD page 6)

The annual dollar limit for the combined Chiropractic and Acupuncture benefit has increased. The new maximum is \$1600.00.

DELTA DENTAL IMPROVEMENTS - EFFECTIVE JANUARY 1, 2016

(Replaces language in SPD page 19 & 21)

The annual calendar year maximum increases to \$3,000.00 per person.

Coverage for Type I & II increases from 80% to 100% coverage.

Coverage for Type III increases from 80% to 95% coverage.

(See attached Delta Dental Summary for more information regarding dental benefits.)

Prior change: 7-1-13 - Elimination of the \$2000 annual dental maximum for Type 1, Type 2 and Type 3 services for dependent children under age 19.

WORKER'S COMPENSATION HEALTH CREDIT - April 1, 2015

The Board of Trustees created a benefit for participants receiving workers' compensation benefits as a result of being injured while working in covered employment. A participant may receive up to 160 hours per injury toward health eligibility over two periods.

DEPENDENT CHILDREN ELIGIBLE FOR COVERAGE TO AGE 26 - EFFECTIVE JANUARY 1, 2015

(Replaces language in SPD page 47 & 73)

Dependent children are covered until the last day of the month they turn age 26.

Prior change: 1/1/14 - Dependents are covered through 26th birthday regardless of access to employer-based health coverage.

Prior change: 1/1/11 - Coverage for Your Dependents: once you become eligible for coverage, your eligible dependents are also entitled to health care coverage under this Plan. In general, your qualified dependent children are covered from the date of birth to his or her 26th birthday provided they do not have access to employer-based health coverage.

DOLLAR MAXIMUM LIMITS ELIMINATED FOR BENEFITS WITH A TIME LIMIT

EFFECTIVE JULY 1, 2014

(Replaces language in SPD pages 31, 25 and 74.)

The dollar maximum limit is eliminated for infertility treatment, for the hearing aid benefit and for the wig benefit.

OFFICE VISIT COPAYMENT REDUCED TO \$10 FROM \$20 - EFFECTIVE MAY 1, 2012

(Replaces language in SPD page 6-9)

AIR AMBULANCE REIMBURSEMENT 90% OF CONTRACTED OR R&C AMOUNT AND DOLLAR MAXIMUM LIMIT ELIMINATED EFFECTIVE AUGUST 1, 2011 (Replaces language in SPD page 6)

INFERTILITY TREATMENT - EFFECTIVE January 1, 2011

(Replaces language in SPD page 31)

Infertility treatment including prescription medications will be paid at 50% to a lifetime maximum of \$10,000.

Diagnostic testing to confirm an infertility diagnosis will not be included in the lifetime maximum.

LIFETIME MAXIMUM OF \$1 MILLION ELIMINATED - EFFECTIVE January 1, 2011

(Replaces language in SPD page 5)

GROUP LEGAL SERVICES PLAN ELIMINATED - EFFECTIVE NOVEMBER 1, 2010

(Eliminates language in SPD page 29)

LIFETIME BENEFIT MAXIMUMS FOR MENTAL HEALTH AND SUBSTANCE ABUSE ELIMINATED

EFFECTIVE July 1, 2010 (Replaces language in SPD pages 8-9)

LIFE AND AD&D INSURANCE INCREASED TO \$50,000 - EFFECTIVE APRIL 1, 2009

(Replaces language in SPD page 37)

Painters & Allied Trades District Council No. 35 Trust Funds

UNION TRUSTEES

JEFFREY P. SULLIVAN, *Sec. Treas.*

PAUL CANNING

CHARLES FOGELL

JOSEPH GUARINO

JOSEPH ITRI

WILLIAM LEGRAND

FUND OFFICE

25 COLGATE ROAD

SUITE 204

Roslindale, MA 02131-1105

Telephone (617) 524-1240

Or (800) 799-1240

Fax No. (617) 524-3557

Fax No. (617) 524-0227

EMPLOYER TRUSTEES

THOMAS STEEVES, *Chairman*

JOHN FERRANTE

MARK E. KENNEDY

LAURENCE MILLER

MATTHEW SOEP

PETER TOWNSEND

DEBORAH COTTER, FUND ADMINISTRATOR

Date: December 15, 2020

To: Eligible Health Plan Participants

From: Board of Trustees

Re: Benefit Improvements

Breast Pump Coverage

The Board of Trustees of the Painters & Allied Trades D.C..#35 Health Plan (the Plan) added coverage for breast pumps retroactive to April 1, 2020.

The Plan will cover the purchase of one breast pump, either manual or electric for pregnant or postpartum eligible members or dependents per pregnancy:

- The pump must be obtained from a contracting Durable Medical Equipment (DME) provider;
- The eligible member or dependent must have a physician's prescription.

The Plan will cover the rental/purchase of one hospital-grade breast pump for postpartum eligible members or dependents, in place of the above, when deemed medically appropriate. In addition to the above requirements, **prior authorization is required for a hospital-grade breast pump.**

Previously denied claims have been reprocessed. If you purchased a breast pump after April 1, 2020, and have not submitted the claim for reimbursement, please send a receipt to the Fund Office at the above address. Include your I.D. number on the request.

Dental Benefit Improvements

The Board of Trustees made two changes to the dental coverage.

The first change is effective October 1, 2020. Coverage at 90% added for bone grafts as part of an implant. Benefit does not count toward annual maximum.

The second change is effective January 1, 2021. To ease scheduling burdens for periodontal cleanings, the frequency language was changed from "once every three months" to "four times per year."

See the enclosed 2021 Coverage Summary from Delta Dental for more information.

Painters & Allied Trades District Council No. 35 Trust Funds

UNION TRUSTEES
JEFFREY P. SULLIVAN, *Sec. Treas.*
PAUL CANNING
CHARLES FOGELL
JOSEPH GUARINO
JOSEPH ITRI
WILLIAM LEGRAND

FUND OFFICE
25 COLGATE ROAD
SUITE 204
Roslindale, MA 02131-1105
Telephone (617) 524-1240
Or (800) 799-1240
Fax No. (617) 524-3557
Fax No. (617) 524-0227

EMPLOYER TRUSTEES
THOMAS STEEVES, *Chairman*
JOHN FERRANTE
MARK E. KENNEDY
LAURENCE MILLER
MATTHEW SOEP
PETER TOWNSEND

WILLIAM McDEVITT, FUND ADMINISTRATOR

Date: November 4, 2019

To: Eligible Health Plan Participants

From: William McDevitt, Fund Administrator

Re: Prescription Provider **Change January 1, 2020**

Effective **January 1, 2020**, OptumRx will become your pharmacy **provider** for your retail, mail order and specialty prescriptions. OptumRx is replacing Express Scripts as your pharmacy provider.

Allegiant Rx (formerly TeamstersRx) will remain your Pharmacy Benefit **Manager**. You should continue to call Allegiant RX for help with your prescriptions. Allegiant Rx - 1-866-888-0103

Your benefits, co-payments, and ID numbers are not changing.

Source	Maximum Supply	Brand Co-pay	Generic Co-Pay
Retail	30-days	\$ 25.00	\$ 10.00
Mail order or 90-days at CVS	90-days	\$ 35.00	\$ 20.00

NOVEMBER: You will receive a postcard in the mail from OptumRx announcing its partnership with Allegiant Rx.

DECEMBER: Watch your mail for a "Welcome Kit" with new OptumRX ID cards.

JANUARY: Present your new OptumRx ID card to your retail pharmacy the first time you fill your prescription in 2020;

JANUARY: Update your physician's office for mail-order prescriptions; use OptumRx Mail Order.

SPECIALTY: If you **currently** have a medication filled by Accredo Specialty Pharmacy, OptumRx Specialty Pharmacy will become your new specialty pharmacy. You will be contacted directly by OptumRx Specialty Pharmacy via mail and/or telephone call.

MAIL ORDER: Prescriptions with refills remaining at Express Scripts Mail Order will transfer to OptumRx Mail Order Pharmacy. Your prescription must be current and must be refillable. Check the refill status of all your mail-order medications to ensure you do not run out.

OTHER CHANGES: Prescription providers use formularies to maximize savings. OptumRx's formulary is different from Express Scripts' formulary. A small number of medications included in the present formulary may not be covered January 1, 2020. If a medication you are currently taking is no longer covered, you will receive a letter mid-November advising you of your options. We encourage you to discuss the medication options with your physician.

Maintenance Medicine: Participants who take maintenance medications and who are not currently receiving 90-day prescriptions either via mail order or at CVS should consider having their prescription refill frequency changed. This will save you money in co-payments. For new prescriptions, ask your physician to write a 90-day prescription with three refills. The 90-day prescription is covered via mail order or at CVS.

The change in pharmacy provider will help contain costs while maintaining or improving the quality of service. Allegiant Rx, OptumRx, and the Fund Office are working to ensure a smooth transition with minimal disruption.

If you have any questions, please call the Fund Office at 617-524-1240.

<p>SAVE THE DATE: Sunday, March 22, 2020 at Lombardo's in Randolph, Massachusetts. The Massachusetts Coalition of Taft-Hartley Trust Funds is hosting a Labor Health and Financial Wellness Fair. Additional information will be sent prior to the event.</p>

Painters & Allied Trades District Council No. 35 Trust Funds

UNION TRUSTEES:

JEFFREY P. SULLIVAN, *Sec. Treas.*
PAUL CANNING
CHARLES FOGELL
JOSEPH GUARINO
JOSEPH ITRI
WILLIAM LEGRAND

FUND OFFICE

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or (800) 799-1240
Fax No. (617) 524-3557
Fax No. (617) 524-0227

EMPLOYER TRUSTEES:

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MARK E. KENNEDY
LAURENCE MILLER
MATTHEW SOEP
PETER TOWNSEND
JOHN FERRANTE

WILLIAM McDEVITT, FUND ADMINISTRATOR

Date: May 31, 2017

To: D.C. #35 Eligible Health Plan Participants

From: Board of Trustees

Re: Orthodontics Lifetime Maximum Increase effective July 1, 2017

The Board of Trustees of the Painters & Allied Trades D.C. #35 Health Plan is pleased to announce an increase in the lifetime maximum for orthodontics from \$2,500 to **\$5,000** for eligible participants **effective 7/1/2017.**

The Health Plan covers orthodontic treatment for all eligible members and dependents once per lifetime.

The reimbursement for covered orthodontia benefits is based on 24 months of active treatment and the dentist's total submitted fee divided by 12 months to determine the monthly payment amount.

This amount is paid over a 12-month period until the benefit lifetime maximum has been reached.

The first payment is based on the date of banding (the date that braces are placed). Additional monthly payments are issued automatically assuming the patient is still eligible for orthodontia benefits.

- If you or your dependent begin orthodontia treatment on or after 7/1/2017, the full amount of the increased benefit of \$5,000 will be available for you.
- If you or your dependent is currently in orthodontia treatment and are within 24 months of active treatment as of 7/1/2017, this enhancement will also apply on a prorated basis. The claim may be submitted by your dentist to Delta Dental to see if there are any available additional benefits.

- If you or your dependent is currently in orthodontia treatment and treatment began before 7/1/2015 (meaning you have exceeded the 24 months of active treatment as of 7/1/2017) there will be no additional benefits available.

See the enclosed summary for more information regarding your dental benefits.

The full benefit is contingent on continued eligibility for health benefits.

The Trustees of the Painters & Allied Trades D.C. #35 Health Benefits Plan strive to ensure Plan participants receive quality benefits.

We are ever mindful of the importance of good health. This includes the importance of a comprehensive oral care program.

We encourage you and your family to take advantage of these benefits as a vital part of your overall strategy to maintain good health.

Participating dentists may be found by visiting www.deltadentalma.com.

If you need additional information, please contact the Fund Office at 617-524-1240 or Delta Dental of Massachusetts at 800-872-0500.

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WILLIAM McDEVITT, FUND ADMINISTRATOR

Date: February 15, 2017

To: Painters & Allied Trades D.C. #35 Health Plan Participants

From: The Board of Trustees

Re: Benefit Improvements for Eligible Participants

90 DAY PRESCRIPTION at CVS Beginning 4/1/2017

Eligible participants currently enjoy savings utilizing 90-day mail order for their maintenance medications. Maintenance medications are prescription medications you take every day to control an illness or symptoms of an illness. Medications to control diabetes, high cholesterol, high blood pressure, acid reflux, or asthma are examples of maintenance medications.

For one generic maintenance medicine at retail, an eligible participant pays \$120 for a twelve month supply. Via mail order, the eligible participant pays \$80 for a twelve month supply of the same medicine. **This is a 33% savings.** For a brand name drug, eligible participants pay \$25 for 30 days versus \$35 for 90 days. In one year, mail order provides a **47% savings on brand-name drugs.**

Mail order also saves your Health Plan money. The discounts offered by Express Scripts through mail order are significant. Lower benefit costs means a healthier Plan.

Beginning April 1, 2017, you will have two ways to save. CVS Pharmacy has agreed to match the Express Scripts mail order discounts. This means you can pick up a 90-day supply of your maintenance medications at CVS Pharmacy retail locations. The co-payments for 90-day prescriptions at CVS Pharmacy will be the same as mail order: \$20 generic/\$35 brand!

There is no change to the retail co-payment for prescriptions under 90 days: \$10 generic/\$25 brand.

Please note: 90 Days at Retail is only available at CVS.

To take advantage of lower prices for you and the Plan, have your physician fax a new 90-day supply prescription to Express Scripts Mail order pharmacy at 800-837-0959 for home delivery from Express Scripts **OR**, beginning 4/1/2017, your physician can call or fax a new 90-day supply prescription to your local CVS Pharmacy. Your physician can write the prescription with up to 3 refills at either mail order or CVS.

Important notes:

- **Specialty Drugs continue to go through Accredo** (example: Humira);
- **Prescription medications with state or Federal quantity limits are excluded from the 90 day program** (example: controlled substances);
- **Prescriptions with Plan limits are excluded from the 90 day program** (example: Suboxone).

If you have any questions regarding this benefit, please contact the Fund Office at 800-799-1240 or Teamsters Rx at 866-888-0103.

LASIK Vision Correction Covered effective 3/1/2017

The Board of Trustees added coverage for LASIK Vision Correction surgery to the Plan of Benefits. Reimbursement for these services is effective March 1, 2017. Eligible participants may receive a benefit of up to

\$2500 per eye (\$5000 for both). The once in a lifetime benefit limit is one surgery per eye, and is available to members and dependents.

If you use a Davis Vision provider, Davis will pay the provider directly; you will not need to file a claim form; and you will receive the Davis Vision discount.

The out-of-network benefit does not include the Davis Vision discount, and you must submit a claim form with receipts for reimbursement. Obtain an out-of-network form at www.DavisVision.com or contact the Fund Office.

If you have any questions about this benefit, please contact the Fund Office at 800-799-1240 or Davis Vision at 800-999-5431.

The Board of Trustees of the Painters & Allied Trades D.C. #35 Health Plan is pleased to offer these enhancements. The Trustees make every effort to maintain a strong Health Plan and to add cost-conscious benefit improvements wherever possible. The above improvements reflect their efforts on your behalf.

Painters & Allied Trades District Council No. 35 Trust Funds

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VISION PLAN IMPROVEMENT

EFFECTIVE JULY 1, 2016

The Board of Trustees of the Painters & Allied Trades D.C. #35 Health Plan is pleased to announce effective July 1, 2016 the following changes have been made to the Plan's Vision Benefits:

➤ **Three pairs of glasses** for adults every 24 months, and two pairs for children every 12 months. This is a change from the current benefit which allows one extra pair of glasses. Members and spouses are allowed three of any type of glasses including single and multi-focal glasses. Children are allowed two pairs of glasses. Members please note: Safety glasses are included as one of the three pairs of glasses.

➤ **All co-payments on the options listed below eliminated:**

- Progressive Lenses – Remove \$40.00 Co-pay
- Standard Anti-Reflective Coating (ARC)-Remove \$35.00 Co-pay
- Premium ARC-Lower - Remove \$48.00 Co-pay
- Polarized Lenses - Remove \$75.00 Co-pay
- Plastic Photosensitive Lenses - Remove \$65.00 Co-pay
- Contact lenses – Remove \$35 Co-pay

➤ **Twelve month supply of Davis Vision Collection contact lenses and one pair of glasses.** There is no cost for fitting and follow up for Davis Vision Collection contact lenses. The pair of glasses can be single vision, multi-focal, or safety. For contacts not in the Davis Vision Collection, members pay costs in excess of \$150.

These improvements apply to eligible members and dependents eligible for and receiving services after July 1, 2016.

To find a Davis Vision provider, contact Davis Vision at 1-800-999-5431.

If you have any questions regarding this improvement, contact the Fund Office at (617) 524-1240 or (800) 799-1240.

Please see reverse side for a detailed benefit breakdown.

Painters & Allied Trades District Council No. 35 Health Benefits Fund
Vision Care Benefits - Effective March 1, 2017

In-Network – Davis Vision
<p>Adults - <u>Every Two Years</u> Eye Exam, and <u>One of the Following:</u> ➢ <i>three pairs of eyeglasses, regardless of type*</i>; or ➢ <i>12-month supply (4-8 boxes) contact lenses** <u>and</u> one pair of eyeglasses, regardless of type</i></p> <p>Dependent Children Under Age 19 - <u>Every Year</u> Eye Exam, and <u>One of the Following:</u> ➢ <i>two pairs of eyeglasses, regardless of type; or</i> ➢ <i>12-month supply (4-8 boxes) contact lenses** <u>and</u> one pair of eyeglasses, regardless of type</i></p> <p>* <u>Members only</u> may choose to get safety eyeglasses as one of the covered pairs of eyeglasses. Note: Safety eyeglasses are covered for <u>members only</u> even if a member does <u>not</u> need prescription eyeglasses. ** Contact lenses benefit includes evaluation, fitting, and follow up.</p>
<p>Copayments / Member Cost Sharing: <u>Eye Exam</u> – \$0 <u>Frames:</u> • \$0 for frames from the "Davis Vision Frame Collection" • member pays all additional costs over \$14 credit for frames <u>not</u> in the "Davis Vision Frame Collection" <u>Lenses and Lens Coating for Eyeglasses:</u> • \$0 plastic or glass lenses in any prescription range • \$0 glass grey #3 prescription lenses • \$0 oversize lenses • \$0 post-cataract lenses • \$0 tinting of plastic lenses • \$0 polycarbonate lenses • \$0 ultraviolet (UV) coating • \$0 scratch-resistant coating • \$0 glass photochromic lenses • \$0 blended invisible bifocals • <u>progressive addition multifocal lenses:</u> ➢ \$0 standard ➢ \$0 premium ➢ \$90 ultra • \$30 intermediate-vision lenses • <u>anti-reflective coating (ARC)</u> ➢ \$0 standard ➢ \$0 premium ➢ \$60 ultra • \$55 high-index (thinner and lighter) lenses • \$0 plastic photosensitive (transition) lenses • \$0 polarized lenses <u>Contact Lenses:</u> • \$0 for contacts from the "Davis Vision Contacts Collection" fitting and follow up included. • \$150 allowance for contacts outside the "Davis Vision Contacts Collection"; patient pays fitting and follow up and ...costs in excess of \$150</p>
<p>LASIK - Coverage \$2500 per eye (once per eye per lifetime.)</p>
<p>Repair or Replacement of Lenses or Frames: Davis Vision will repair or replace (if unable to repair) Davis Vision plan provided lenses and frames within 12 months of receipt.</p>
Out-of-Network
<p>Reimbursement Schedule***: Eye Exam – \$12.50 Single Vision Lenses – \$15.00 Bifocal Lenses – \$20.00 Trifocal Lenses – \$25.00 Frames – \$10.00 Contact Lenses – \$52.50</p> <p>*** Member pays all costs above the reimbursement schedule.</p>
<p align="center">Contact Davis Vision at 800-999-5431 or www.davisvision.com to find a provider. The Fund Office is available at 1-800-799-1240.</p>

PAINTERS & ALLIED TRADES DISTRICT COUNCIL NO. 35 TRUST FUNDS

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Thomas Steeves
Peter Townsend

William McDevitt, *Fund Administrator*

Date: February 22, 2016
To: Eligible Health Plan Participants
From: D.C #35 Health Plan Board of Trustees
Re: BENEFIT IMPROVEMENT - Foot Orthotics

The Board of Trustees of the Painters & Allied Trades D.C. #35 Health Plan is pleased to provide eligible Plan participants - members and dependents - with a benefit improvement.

Effective March 1, 2016, The Health Plan will provide reimbursement up to \$250 per person per calendar year for custom-fit orthotics defined as orthopedic shoes or other supportive appliances for the feet provided by an appropriate, licensed medical professional (for example, an orthopedic physician, a primary care physician, a podiatrist.) In-network benefits are covered at 100% up to \$250 per year. Out-of-network benefits are subject to an individual annual deductible of \$250 and reimbursed at 60% up to \$250.

Find a network provider at www.tuftshealthplan.com/carelink/dc35

Please contact the Fund Office at 800-799-1240 or 617-524-1240 if you have any questions.

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Visit deltadentalma.com for detailed benefit information

2021 Coverage Summary for
Painters & Allied Trades
D.C. #35 Health Benefits Fund
Group #004207

Calendar Year Maximum: \$3,000 Per Person. (1)

Deductible: N/A

Category / Procedure	Qualifications	Co-insurance	
		In Network	Out of Network(3)
Diagnostic (2) Comprehensive Evaluation Periodic Oral Exam Panoramic or Full Mouth X- rays Bitewing X-rays Single Tooth X-rays	Once every 60 months. Twice per calendar year. Once every 60 months. Twice per calendar year. As needed.	100%	100%
Preventive (2) Teeth Cleaning Fluoride Treatments Space Maintainers Sealants Chlorhexidine Mouth rinse Fluoride Toothpaste	Twice per calendar year. Twice per calendar year for members under age 19. Required due to the premature loss of teeth. For members under age 14 and not for the replacement of primary or permanent anterior teeth. Unrestored permanent molars, every 4 years per tooth for members through age 15. Sealants are also covered for members aged 16 up to age 19 for those who had a recent cavity and are at risk for decay. This is a covered benefit only when administered and dispensed in the dentist's office following scaling and root planing. This is a covered benefit only when administered and dispensed in the dentist's office following periodontal surgery.	100%	100%
Restorative Silver Fillings White Fillings Temporary Fillings Stainless Steel Crowns	Once every 24 months per surface per tooth. Once every 24 months per surface per tooth. Once per tooth. Once per primary tooth per 24 months after a pulpotomy.	100%	100%
Oral Surgery (4) Extractions General Anesthesia	Once per tooth. (See "Additional Benefit Information on back-side for more coverage information) General Anesthesia and IV sedation are allowed with covered surgical impacted teeth only (up to one hour).	100%	100%
Periodontics (4) Periodontal Surgery Scaling and Root Planing Periodontal Cleaning	One surgical procedure per quadrant, in 36 months. (See "Additional Benefit Information on back-side for more coverage information) Once in 24 months, per quadrant. Two quadrants are allowed per date of service. Four per calendar year following active periodontal treatment. Not to be combined with preventive cleanings.	100%	100%
Endodontics Root Canal Treatment Vital Pulpotomy	Once per tooth. Limited to deciduous teeth.	100%	100%
Prosthetic Maintenance Bridge or Denture Repair Rebase or Reline of Dentures Recement of Crowns & Onlays	Once within 12 months, same repair. Once within 36 months. Once per tooth.	100%	100%
Emergency Dental Care	Three occurrences in 12 months.	100%	100%
Prosthodontics Dentures Fixed Bridges and Crowns Implants Bone Grafts (4) Implant Abutments	Once within 60 months. When part of a bridge. Once within 60 months Once per 60 months per Implant. (Pre-estimates recommended). Once per 60 months, covered when placement is in an extraction or implant site. Once per implant only when surgical implant is benefitted.	95%	95%
Major Restorative Crowns	When teeth cannot be restored with regular fillings due to fracture or decay. Once within 60 months per tooth.	95%	95%
Orthodontics: Covered at 100% of Maximum Plan Allowance charges to any age. \$5,000 separate LIFETIME maximum. Orthodontic treatment must be administered/supervised by a licensed dentist. Mail order orthodontic kits are not covered under this plan. (1)			
Dependent Eligibility: Eligible dependents covered until the end of the month the dependent turns age 26.			

Additional Benefit Information

This plan is eligible for Rollover Maximum: Rollover Max dollars do not apply to orthodontic services. To qualify for Rollover Max, you must receive at least one cleaning or oral exam in the calendar year. You must be enrolled for dental coverage before the 4th quarter of the plan year (10/1-12/31) and your paid claims must not exceed the maximum "threshold" amount.

Your calendar year maximum benefit amount.	If your total yearly claims don't exceed this threshold amount.	Then you can roll over this amount to use next year, and beyond.	Your accumulated rollover total is capped at this amount.
\$3,000	\$1,000	\$750	\$1,500

(1) Pediatric Essential Health Benefit as Required by Massachusetts Law

Calendar Year Maximum for members under 19 is unlimited. ROM does not apply. Members under age 19 have an out-of-pocket maximum of \$1,000, once the out-of-pocket maximum has been reached, benefits will be covered at 100%.

The orthodontic lifetime maximum is unlimited for members under age 19 if the treatment is determined to be medically necessary.

(2) Diagnostic and Preventive services DO NOT apply toward the calendar year maximum.

(3) Non-participating dentists may balance bill. Subscribers are responsible for the difference between the non-participating maximum allowance and the full fee charged by the dentist.

(4) Certain qualified surgical procedures are covered at 90% and do not apply to the calendar year maximum. Please call customer service for more information (800-872-0500) or ask your dentist to submit a pre-estimate.

Pre-estimates: Ask your dentist to submit a pre-treatment estimate to Delta Dental for any procedure that exceeds \$300. This will help you estimate in advance any out-of-pocket expenses you may incur and will confirm that the services you're having are covered under your dental coverage.

Delta Dental PPOSM Plus Premier



Easy Access and Great Value – Your Delta Dental Networks

As a Delta Dental PPO Plus Premier subscriber, you have access to two of Delta Dental's extensive national networks- Delta Dental PPO, with more than 283,000 participating dentist locations and Delta Dental Premier, the largest dental network in the country with more than 358,000 dentist locations. Three out of four dentists nationwide participate in one or both of these networks.

You will enjoy great benefits when you receive your dental care from a participating dentist in either the Delta Dental PPO or Delta Dental Premier networks.

- Both networks offer discounted fees and a no balance billing policy.
- You will receive good value from Delta Dental Premier network dentists who generally accept discounted fees.
- You will enjoy the greatest savings when visiting Delta Dental PPO network dentists due to even deeper discounts.
- If you choose to receive services from a non-participating dentist, you will have higher out-of-pocket costs as the Delta Dental contract rates and the no balance billing policy do not apply.

Delta Dental members can also take advantage of expanded discounts on many covered services, even after they have used up their benefit dollars, visit limits and other situations. Get the details at <http://www.deltadentalma.com/members/discounts-on-covered-services/>

Simply visit www.deltadentalma.com to find a participating dentist in your area.

Learn more at deltadentalma.com

Visit the member area of www.deltadentalma.com to find plan information, review eligibility status, check on claim status, or find a dentist. If you have any questions or need additional information, you can call customer service at 1-800-872-0500.

You can also find more information about your plan in the Delta Dental Member Guide, available from your benefits administrator or online at www.deltadentalma.com. In the guide, you can learn how to use your benefits, how to find a dentist or specialist, how to access online resources, and more about keeping a healthy mouth for life.

The information on this coverage summary should be used only as a guideline for your dental benefits plan. For detailed information on your group's plan, riders, terms and conditions, or limitations and exclusions, refer to your plan's Subscriber Certificate, which is available through your benefits administrator.

Your Plan is Administered by:
Delta Dental of Massachusetts
1-800-872-0500
www.deltadentalma.com

465 Medford Street
Boston, MA 02129

Painters & Allied Trades District Council No. 35 Trust Funds

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PETER TOWNSEND

WILLIAM McDEVITT, *Fund Administrator*

Date: February 6, 2015

To: District Council #35 Health Plan Participants

From: Board of Trustees

Re: Health Benefit Improvements

Eligibility: Work Related Injuries-Workers Compensation

Please be advised the Trustees of the Painters and Allied Trades District Council #35 Health Benefits Fund have made a change to the qualifying eligibility rules for members receiving workers compensation.

Participants who are on workers compensation and who will lose coverage, or fail to achieve eligibility, due to the injury can now be credited with up to 160 hours to maintain or achieve coverage during an eligibility period.

- The participant must be receiving or have received worker's compensation for the injury; The participant will suffer a loss of coverage due to a reduction in hours worked in the work period(s) when the injury occurred;
- The participant will fail to achieve eligibility due to a reduction of hours in the work period(s) when the injury occurred (new or reinstated participants);
- The participant is required to provide proof of worker's compensation insurance payments to receive credit;
- The participant will be credited with hours necessary to meet the hours threshold for eligibility to a maximum of 160 hours per injury;
- Credit is only granted if the participant is within 160 hours of the eligibility hours threshold;
- The hours credit may be split over two work/eligibility periods, but cannot exceed 160 hours per injury.

- There is no dollar value associated with this hours credit, and it cannot be used toward carryover hours or toward the COBRA credit.

If this improvement applies to you, please contact the Fund Office.

Hearing Program - New Phone Number

As previously announced, the Board of Trustees eliminated the \$1,000 per hearing aid maximum as of July 1, 2014. Enclosed is an updated brochure describing the enhanced hearing program. Please note the new phone number: HearUSA 1-800-442-8231.

Another change of note is HearUSA will now make the appointments with participating hearing care providers directly. Previously, members received a list of providers with instructions to contact a provider. Eligible participants will now call 1-800-442-8231, and identify themselves as D.C. #35 members to receive services. A HearUSA representative will guide participants through the process.

Both Labor and Management Trustees are pleased to have the ability to make these improvements and are committed to providing the best plan of benefit to our members.

If you have any questions, please contact the Fund Office at 1-800-799-1240.

Your Board of Trustees:

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A network
you can trust.

Meet HearUSA, an experienced team of hearing care professionals. Since 1989, HearUSA has been helping millions of people across the country hear better. Through the use of qualified, licensed providers, you will receive a comprehensive program that includes hearing assessment, evaluation for hearing aids, and a full range of quality products and services. HearUSA is partnered with hundreds of health plans, employer groups and other benefit sponsors to bring you better hearing. We know how important it is to hear well and stay connected with our world of sound.



hearusa.com

Discover how today's NEW technology can provide you with better hearing solutions.

Find out what you may be missing:

The spoken words of a loved one.

*The enjoyment of your favorite
TV show, movie or music.*

The pleasing sounds of nature.

The ring of your telephone or doorbell.

Call today to take
the first step to better hearing:
1-800-442-8231

TTY: 1-888-300-3277

Monday - Friday

8 a.m. - 8 p.m. Eastern Time



hearusa.com



Painters & Allied Trades
D.C. #35 Health Plan



Hearing Care
Program

Provided by:



hearusa.com



Helping People Hear Better

HearUSA is a network that provides hearing care delivered by qualified providers committed to delivering the highest quality services at discounted prices.

HearUSA providers offer a basic annual audiologic assessment, including air conduction testing, bone conduction testing and word recognition measures, at a substantial discount. Members receive a full explanation of the findings of these hearing tests.

Additionally, your HearUSA provider will assist you in recognizing factors which may damage your hearing and will provide helpful solutions.

For additional information and to receive a member handbook, call 1-800-442-8231.

How do you obtain Hearing Care Benefits under this Plan?

Painters & Allied Trades DC #35 Health Plan participants and their dependents are eligible for hearing care benefits through HearUSA.

1. Call 1-800-442-8231 to schedule an appointment and identify yourself as a **Painters and Allied Trades DC #35 member**.
2. HearUSA calls the payer to verify eligibility.
3. HearUSA sends you an appointment confirmation.
4. HearUSA completes the claim and sends it to the payer for processing.
5. The benefit is paid directly to HearUSA. You pay HearUSA the balance of the allowable charges above the benefit amount.
6. During the course of a hearing test, the provider may recommend that you consult a physician for a condition requiring medical attention. This is not a covered service under this Plan. If this situation occurs, you need to file a claim under your medical plan option. If applicable, be sure the physician you choose participates in your medical plan network.

The Fund Office will pay HearUSA directly for all covered services including hearing aids. You must call **1-800-442-8231** to schedule your appointment with an approved provider.



Member Benefits

- **One hearing aid per ear every 5 years**
- **Comprehensive hearing evaluation**
- **Annual cleaning and maintenance of hearing aids**
- **3- year warranty including loss and damage on all hearing aids**
- **3-year supply of hearing aid batteries with purchase**
- **10% discount from HearingShop.com using code **EARPAINT** at checkout**



The benefit information provided is a brief summary, not a complete description of benefits. For more information, please contact the Fund Office at **1-800-799-1240**.

NEW PRESCRIPTION MAIL-IN ORDER FORM

Formulario de Pedido por Correo para Nuevas Recetas

1 Member and physician information — please use black or blue ink. One form per member. Información sobre el miembro y el médico — use tinta negra o azul. Un formulario por miembro.

Member ID Number Número de Identificación del Miembro		
(Additional coverage, if applicable Cobertura adicional, si corresponde) Secondary Member ID Number N.º de Identificación del Miembro Secundario		
Last Name Apellido	First Name Nombre	MI Inicial 2.do Nombre
Delivery Address Dirección de Entrega		Apt. # N.º de Apto.
City Ciudad	State Estado	ZIP Código Postal
Phone Number with Area Code Número de Teléfono con Código de Área		
Date of Birth (mm/dd/yyyy) Fecha de Nacimiento (mm/dd/aaaa)	Gender Sexo <input type="radio"/> M <input type="radio"/> F	Email Correo Electrónico
Physician Name Nombre del Médico		
Physician Phone Number with Area Code Número de Teléfono del Médico con Código de Área		

2 Health history | Historial médico

Medication Allergies Alergias a Medicamentos: <input type="radio"/> None known Ninguna conocida <input type="radio"/> Amoxil/Ampicillin Amoxicilina/Ampicilina <input type="radio"/> Aspirin Aspirina <input type="radio"/> Cephalosporins Cefalosporinas <input type="radio"/> Codeine Codeína <input type="radio"/> Others Otros: _____		<input type="radio"/> Erythromycin Eritromicina <input type="radio"/> NSAIDs NSAID <input type="radio"/> Penicillin Penicilina <input type="radio"/> Quinolones Quinolonas <input type="radio"/> Sulfa Sulfamidas <input type="radio"/> Tetracyclines Tetraciclinas
Health Conditions Condiciones de Salud: <input type="radio"/> None known Ninguna conocida <input type="radio"/> Arthritis Artritis <input type="radio"/> Asthma Asma <input type="radio"/> Cancer Cáncer <input type="radio"/> Diabetes Diabetes <input type="radio"/> Others Otros: _____		<input type="radio"/> Glaucoma Glaucoma <input type="radio"/> Heart condition Condición cardíaca <input type="radio"/> High blood pressure Presión arterial alta <input type="radio"/> High cholesterol Colesterol alto <input type="radio"/> Osteoporosis Osteoporosis <input type="radio"/> Thyroid Disease Enfermedad de la glándula tiroide
Over-the-counter/herbal medications taken regularly Medicamentos a base de hierbas/de venta sin receta que toma regularmente: _____		

T

You may log on to the member website to see if drug pricing information is available before enclosing payment. Once shipped, medications may not be returned for a refund or adjustment. | *Puede iniciar sesión en el sitio de Internet para miembros para ver si hay información sobre el precio de los medicamentos antes de adjuntar el pago. Una vez que los medicamentos se envían, no se aceptan devoluciones para obtener un reembolso o ajuste.*

- New Credit Card Number | Número de Nueva Tarjeta de Crédito

Visa, MasterCard, AMEX and Discover are accepted. | Se aceptan tarjetas Visa, MasterCard, AMEX y Discover.

Signature | *Firma*: _____ Date | *Fecha*: _____

For new prescription orders and maintenance refills, this credit card will be billed for copay/coinsurance and other such expenses related to prescription orders. By supplying my credit card number, **I authorize OptumRx to maintain my credit card on file as payment method for any future charges.** To modify payment selection, contact customer service at any time. | *En el caso de pedidos de nuevas recetas y resurtidos de mantenimiento, se facturará a esta tarjeta de crédito el copago/coaseguro y otros gastos relacionados con los pedidos de recetas. Al proporcionar mi número de tarjeta de crédito, **autorizo a OptumRx a que conserve la información de mi tarjeta de crédito en sus registros como método de pago para cualquier cargo futuro.** Para modificar la selección de pago, comuníquese con el servicio al cliente en cualquier momento.*

OptumRx, P.O. Box 2975, Mission, KS 66201

DO NOT STAPLE OR TAPE PRESCRIPTIONS TO THE ORDER FORM.

NO ENGRAPE NI PEGUE CON CINTA RECETAS EN ESTE FORMULARIO DE PEDIDO.



The Board of Trustees is pleased to announce two Smoking Cessation Programs Effective January 1, 2012

Begin your New Year off right and plan to be Smoke-Free in 2012!! Below please find information about two new Smoking Cessation Programs which go into effect January 1, 2012. Let's make those New Year's Resolutions a reality! Remember we are here to help every step of the way.



Massachusetts State Smoking Cessation Program

The MA State program includes telephone screening, counseling, follow up services, and nicotine replacement patches - all at no cost to you!! To participate in the MA State Smoking Cessation Program, simply call 1-800 – TRYTOSTOP (800-879-8678), identify yourself with promotion code "DC 35". After the Initial Screening Call, you will be provided with 5 telephonic counseling sessions and up to 8 weeks of Nicotine Replacement patches

(NRT). However, you must participate in the telephonic counseling sessions to continue receiving the nicotine patches.

For additional information on quitting, visit www.MAKESMOKINGHISTORY.org. Please note, participation in the State Smoking Cessation Program is limited to two attempts per calendar year. (The state program is closed 1/1 and 1/2.)



Teamsters/Medco Smoking Cessation Prescription Drug Program

Teamsters/Medco will pay for prescription drugs and/or Nicotine Replacement Therapy (ie. gum, lozenges, patch, inhaler) to assist you in your smoking cessation efforts. You must obtain a prescription from your doctor for prescription drugs and for any nicotine replacement therapies. Coverage limited as follows:

- Nicotine Replacement Therapies – ie. gum/patches – 90 day supply in any 365 day period.
- Bupropion (generic Wellbutrin/Zyban) – 90 day supply in any 365 day period.
- Chantix – 180 day supply in any 365 day period.

Applicable prescription co-payments apply.

Programs are available to eligible members, their spouses, and dependent children 18 years of age and older.

If you have any additional questions please feel free to contact the Fund Office at 1-800-799-1240.

NEW MENTAL HEALTH PARITY and ADDICTON EQUITY ACT

(MHPAEA)

Effective July 1, 2010 and in accordance with the Mental Health Parity and Addiction Act, there will no longer be separate limited maximums or co-payments or deductibles for mental health or substance abuse disorder treatments. Beginning July a, 2010 mental health and substance abuse disorder treatments will be subject to the same co-payments and deductibles as currently in effect for the Plan's medical and surgical benefits.

Please remember that all in-patient mental health and substance abuse admissions must be pre-certified by calling Modern Assistance Program at (800) 879-2004.

NOTICE OF GRANDFATHERED STATUS

The Trustees of the Painters and Allied Trades District Council No. 35 Health Benefits Plan (the "Plan") believes the Plan 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 your 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 Fund Office. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.