Southern California Painting and Drywall Industries Health & Welfare Trust

Reference Guide to Your Health Plan
Effective January 1, 2023

Plan Highlights

- Your medical plan options are Anthem Blue Cross of California (Indemnity /PPO plan) Kaiser Permanente (HMO plan) and Blue Shield Health of California, Inc (Blue Shield/ HMO plan).
- New applicants must select a medical plan option. If no medical plan option is selected, participants will be enrolled in the Anthem Blue Cross of California PPO plan.
- The Indemnity/PPO network is managed by Anthem Blue Cross of California's Prudent Buyer Network. For verification of providers, call the Trust Fund Office at 1.800.752.2394 or 626.279.3020.
- Preauthorization required under the Indemnity/PPO network will be made by Anthem Blue Cross of California managed care staff. For assistance, call 1.800.274.7767.
- The primary hourly rate increased to $8.85, effective on the eligibility month of January, 2023. Your maximum bank has also increased to reflect the rate increase. *(See page 8)*
- Benefit Charts are available in the center of this reference guide book. The Address Change Form is located at the end of this reference guide book.
- Your Enrollment/Change form is included.
- Learn how to use the PPO Plan's Managed Care Network. Read how you can make a difference in your out-of-pocket expenses. *(See page 6)*
- Visit our website's Participant Portal for 24/7 access at www.paintinganddrywalltrustfund.com

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What You Should Know

The network for the Indemnity/PPO Plan is the Anthem Blue Cross of California Prudent Buyer Network.

It is your responsibility to make sure that your provider is part of the Anthem Blue Cross of California Prudent Buyer Network at the time you receive services. Providers often drop out of the network and fail to notify their patients.

Protect yourself from unnecessary out-of-pocket expenses by always verifying that your provider is still part of the Anthem Blue Cross of California Prudent Buyer Network.

Important Numbers

Anthem Blue Cross of California Managed Care Department 1.800.274.7767
www.anthem.com

Kaiser Permanente (Multi-Lingual) 1.800.464.4000
www.kp.org (Spanish) 1.800.788.0616

Blue Shield (Multi-Lingual) 1.855.256.9404
www.blueshieldca.com

Optum RX (Mail Order Customer Service/Option 1) 1.800.562.6223
www.optumrx.com

Trust Fund Office Toll-Free Number 1.800.752.2394
www.paintinganddrywalltrustfund.com

Trust Fund Office 626.279.3020

The Trust Fund Office is located at 1055 Park View Drive., Suite 111, Covina, CA 91724.

Customer Service phone hours are from 7 a.m. to 6 p.m., Monday through Friday, except for some holidays.

Introduction and Preamble

The Board of Trustees is pleased to provide you with the detailed reference guide to the various health benefits for you and your eligible dependents (participants). It is designed to help plan participants understand the benefit options available and assist in enrollment or to change their enrollment in the benefit plans offered by the Southern California Painting and Drywall Industries Health and Welfare Trust Fund (the Fund). This reference guide will also be available at the Trust Fund Office.

The information provided will first serve to guide participants of the Fund through the open enrollment process for benefits. Subsequently, new hires or newly eligible employees will receive this booklet to use for their first enrollment in the benefit plans.

We encourage you to review this reference guide carefully so that you are aware of all the benefits to which you are entitled, as well as some important restrictions and responsibilities. We have prepared this booklet to serve as a detailed reference guide to your various health benefits. However, the information contained does not constitute the Rules and Regulations of the Health Plan which is the legal document governing the Health Plan. The Rules and Regulations are located at the Fund's administrative office (Trust Fund Office). A copy of this document is also available to you upon request. The Trust Fund Office may charge a minimal fee for the cost of photocopying this document and for any postage required.

This reference guide is not a contract and the benefits and coverages provided under the Health Plan to participants are not contractual benefits. Therefore, the benefits and coverages may be reduced, modified or discontinued by action of the Trustees at any time. The Trustees do not promise to continue the benefits and coverages in full or in part in the future, and rights to future benefits and coverages are not vested.

The Trustees and the Appeals Committee are authorized and empowered to construe the meaning of any doubtful or ambiguous provisions of the Health Plan. Any construction thereof adopted by the Trustees or the Appeals Committee in good faith shall be binding upon the Fund and all beneficiaries. The Trustees and the Appeals Committee are authorized and empowered to generally do all things, execute all such agreements, adopt and promulgate all such reasonable rules and regulations, take all such proceedings and exercise all such rights and privileges as are necessary in the establishment, maintenance and administration of the Health Plan.

The nature and extent of benefits provided by the Health Plan and rules governing eligibility are determined solely and exclusively by the Trustees of the Plan. Employees of the Trust Fund Office have no authority to alter those benefits and eligibility rules. Any interpretations or opinions given by employees of the Trust Fund Office are not binding upon the Trustees and cannot change the benefits and the eligibility rules.

If you have any questions about the Plan, please call the Trust Fund Office at 1.800.752.2394 or 626.279.3020, or visit our website at www.paintinganddrywalltrustfund.com, or write the Trust Fund Office at P.O. Box 1679; Covina, CA 91722-0679.

Twelve (12) Month Rolling Enrollment

The benefits provided under this Fund are made possible by monies received by the Southern California Painting and Drywall Health and Welfare Trust Fund primarily as a result of the collective bargaining agreements negotiated between Employers and the International Union of Painters and Allied Trades District Council 36. The Board of Trustees is comprised of trustees appointed by the employers and by the Union. The Trustees as a board represent the employee beneficiaries.

Monies received by the Fund and the benefits provided by the Plan are maintained and administered under the direction of the Board of Trustees.

TWELVE (12) MONTH ROLLING ENROLLMENT
The Board of Trustees adopted the twelve (12) month rolling enrollment effective January 1, 2017.

Once you have chosen your medical/dental plan, you may change your medical/dental plan once every rolling twelve (12) month period from the date of your last change, provided the Participant has participated in the same medical or dental plan for at least twelve (12) months. An exception to this twelve (12) month rule will be made if you have moved out of the service area of the medical/dental plan which you have previously chosen. The change will be effective on the first of the month following your election.

If you already enrolled in the Fund and do not want to make any changes to your current coverage, and if the information on your Health Enrollment Form currently on file with the Trust Fund Office is accurate, you do not need to submit an Enrollment/Change Form.

If you want to enroll in the Fund or make any changes and you have enrolled in the current Plan for at least twelve (12) months (such as switching between the Indemnity Plan and the Kaiser Plan or adding/removing dependents), you need to submit an Enrollment/Change Form to the Trust Fund Office. You can contact the Trust Fund Office at 626.279.3020 or 1.800.752.2394 and request that an enrollment form be mailed to you.

YOUR HEALTH PLAN OPTIONS ARE —
Active Members (*Please select one plan)*

Indemnity/PPO plan or Kaiser Permanente (HMO) plan or Blue Shield (HMO) plan

Retirees-HMO Plan only (*Please select one plan*)

Kaiser Permanente plan or Blue Shield plan.

If you wish to remain in the same medical plan you are enrolled under at this time, you do not need to submit a new enrollment form, unless —

►You wish to change your Plan Level and Benefit Credit banking option.

►You have a change in your personal information, such as your name, address, telephone number or marital status

►You would like to add or remove a dependent from the Plan

►You wish to change your beneficiary on your Death Benefit.

DENTAL BENEFITS
If you are eligible for medical benefits under Plan Level A, you are also eligible for dental benefits through Delta Dental. You may enroll in either DeltaCare (USA) or DELTA PREFERRED OPTION (DPO).

If you are eligible for medical benefits under Plan Level B, your dental plan option is DeltaCare (USA) an HHO plan.

DeltaCare (USA) is a large network of dentists with most services at no cost to you and includes orthodontic coverage.

DELTA PREFERRED OPTION (DPO) features the largest network of dentists in California for in-network benefits and allows you to go to any dentist of your choice for out-of-network benefits.

If you have not completed an Enrollment/Change form, you must complete an Enrollment Form and submit to the Trust Fund Office in order to receive dental coverage

CHANGING MEDICAL PLANS

The member will have the opportunity to change Medical Plans and to upgrade Plan Levels if he/she has been enrolled in the current Plan for 12 consecutive months.

STEPS TO TAKE WHEN ENROLLING IN THE INDEMNITY PLAN

►**Review the Enrollment/Change Form**

►**Active Members: Indicate on your form which Plan Level** (A, B or C) **you wish to be enrolled under** and can reasonably maintain for 12 months.

►**Place an X mark in the box identified as Indemnity/PPO Plan.**

►**Complete and sign** the Enrollment/ Change Form

►**Include in your envelope**, any required original or certified documents, such as your Certificate of Marriage, Certificate of Birth of each dependent child. **If you have already submitted your Certificate of Marriage and/or Certificate of Birth of each child, you do not need to resubmit them.**

►**Mail your completed Enrollment/Change Form** and any required original or certified document as described above to the Trust Fund Office.
A self-addressed envelope is enclosed for your convenience.

Steps to Take When Enrolling in the Kaiser Permanente Plan

►**Review the Enrollment/Change Form**

►**Active Members: Indicate on your form which Plan Level** (A, B or C) **you wish to be enrolled under** and can reasonably maintain for 12 months.

►**Place an X mark in the box identified as Kaiser Permanente (HMO) Plan.**

►**Complete and sign** the Enrollment/ Change Form

►**Include in your envelope**, any required original or certified documents, such as your Certificate of Marriage, Certificate of Birth of each dependent child. **If you have already submitted your Certificate of Marriage and/or Certificate of Birth of each child, you do not need to resubmit them.**

►**Mail your completed Enrollment/Change Form** and any required original or certified document as described above to the Trust Fund Office.
A self-addressed envelope is enclosed for your convenience. **DO NOT MAIL YOUR FORM TO KAISER.**

Once the Trust Fund Office has received your form and any required documents, *you and your eligible dependents will be enrolled in the Kaiser Permanente Plan. Kaiser will mail your Medical ID card to you shortly thereafter.*

Steps to Take When Enrolling in the Blue Shield Plan

►**Review the Enrollment/Change Form**

►**Indicate which Plan Level** (A, B or C) **you wish to be enrolled under** and can reasonably maintain for 12 months.

►**Place an X mark in the box identified as Blue Shield Plan.**

►**Complete and sign** the Enrollment/ Change Form

►**Include in your envelope**, any required original or certified documents, such as your Certificate of Marriage, Certificate of Birth of each dependent child. **If you have already submitted your Certificate of Marriage and/or Certificate of Birth of each child, you do not need to resubmit them.**

►**Mail your completed Enrollment/Change Form** and any required original or certified document as described above to the Trust Fund Office.
A self-addressed envelope is enclosed for your convenience. **DO NOT MAIL YOUR FORM TO BLUE SHIELD.**

Once the Trust Fund Office has received your form and any required documents, *you and your eligible dependents will be enrolled in the Blue Shield Plan. Blue Shield will mail your Benefit card to you shortly thereafter.*

Benefits are effective when the Trust Fund receives your signed enrollment/change form, along with any necessary documents required.

WHAT IS THE Optum RX PROGRAM?

The Optum RX Program is part of your medical benefits package under the Southern California Painting and Drywall Industries Health and Welfare Plan.

Optum RX is the Plan's prescription service provider for eligible participants enrolled in the Indemnity or Blue Shield Plans and is in charge of the administration of the program.

If you are already enrolled in the plan of your choice, you do not need to submit anything to the Trust Fund Office at this time.

Your current plan will remain in effect.

Optum RX Drug Program

For All Eligible Participants of the Indemnity/PPO and Blue Shield/HMO Plans

HOW DOES THE Optum RX PROGRAM WORK?

If you are eligible for medical benefits under the Indemnity Plan or the Blue Shield Plan through the Southern California Painting and Drywall Industries Health and Welfare Plan, you are also eligible for prescription benefits through the OptumRx Program, regardless of the plan level you are covered under.

If you need a prescription filled, all you need to do is go to one of the Optum RX participating pharmacies and present your ID card to the pharmacist, along with your prescription. At that time, the pharmacist will verify your eligibility under the program. If you are eligible, the pharmacist will then fill your prescription subject to applicable member copays per prescription. It's that easy!

Optum RX also offers a Mail Service Drug Program, which makes it easier for you to receive maintenance medication (up to a 90-day supply). This program also saves you money by reducing your copayment. For more information on the Mail Service Drug Program, please see the Chart on Optum RX Mail Service Drug Program on Page 5.

How much do I pay for prescriptions through the Optum RX Program?

When you fill your prescription through a participating pharmacy, your copay will be —

►$10 for generic drugs

►$15 for formulary drugs

►$20 for non formulary brand-name drugs

Can I get my prescriptions filled without my Optum RX ID card?

Yes. Pharmacists may tell you that you must present your ID card before your prescription can be filled. However, you should still be able to get your prescriptions filled without an ID card.

If you are eligible under the Plan, tell the pharmacist that you are covered under the Optum RX Program and provide the pharmacist with your name and Social Security Number. The pharmacist should then be able to verify your eligibility on the system or should call Optum RX directly.

If your pharmacist tells you that you must have an ID card, you should inform that pharmacist that it is not a requirement and request that he/she calls **Optum RX** at 1.800.788.7871.

Although it is possible to obtain your prescriptions without your ID card, you should make every effort to have your Optum RX ID card available for the pharmacist to speed up the process of getting your prescriptions filled and to eliminate any hassles.

Do I have to use the Optum RX Program to get my prescriptions filled?

No. The Southern California Painting and Drywall Industries Health and Welfare Plan encourages eligible participants in the Indemnity Plan or the Blue Shield Plan to use the Optum RX Program.

If you do not use one of the program's member pharmacies, you will have to pay for the entire cost of your prescriptions up front then submit a claim form to the Trust for reimbursement under the Indemnity Plan.

How much will I be reimbursed if I go to a non-participating pharmacy under the indemnity plan?

Certain deductibles and copayments apply to claims for prescriptions purchased out of the Prescription Solutions Program Plan. The maximum you can be reimbursed for a prescription is 80 percent of the Usual, Customary and Reasonable Charge (UCR), for such a prescription. The plan level you are qualified under will determine the percentage allowable for payment.

Important Note —

In most cases, your out-of-pocket expense would be greater if you filled your prescriptions under the Indemnity Plan than it would if you filled your prescription under the Prescription Solutions Program.

What Are the Advantages to Using the Optum RX Program?

Filling your prescriptions through the Optum RX Program is to your benefit. The advantages are listed below —

- ►There are no claim forms to fill out
- ►The only cost you will incur per prescription is $10 for generic drugs or $15 for formulary drugs or $20 for brand-name drugs.
- ►If you are able to use the same pharmacy for each prescription, that pharmacist can set you up in his/ her system to make future prescriptions and refills much easier and faster to obtain. This will help your pharmacist monitor any potential adverse reactions between drugs that are prescribed and those you may already be taking.

What Should I Do If Optum RX Does Not Show Me As Being Eligible For Benefits?

If you are told that you are not showing eligible for benefits under the Optum RX Program, **contact the Trust Fund Office at 1.800.752.2394**.

Other Questions?

If you would like more information on the Optum RX Program, such as plan exclusions, participating pharmacies, please contact Optum RX directly at **1.800.RxRxRxl**. For questions regarding your eligibility status under the Plan, contact the Trust Fund Office at **1.800.752.2394.**

Optum RX Mail Service Drug Program

Optum RX offers a Mail Service pharmacy Program to members using maintenance medications (medications that are taken on an ongoing basis). With the Mail Service Program, you get the same high quality prescription dispensed by registered pharmacists, without ever leaving your home and saving you money by reducing your copayment. Our mail service pharmacists are backed by a sophisticated computerized quality control system to prevent possible drug interactions and duplicate therapy.

If your doctor prescribes an ongoing medication for you, tell him or her you would like to use the Mail Service Drug Program. Request two prescriptions. One for a 30-day supply to have filled immediately at a contracted pharmacy and one for a 90-day supply with refills. Mail your 90-day supply prescription and the required copayment to Prescription Solutions; P.O. Box 509075; San Diego, CA 92150-9075.

If you are currently using the Optum RX Mail Service Drug Program, you may also order refills by phone and pay for your refills with your credit card.

Please call the Optum RX Mail Customer Service at 1.800.562.6223, press Option 1.

After your prescription is received by Optum RX, your prescription will be filled and shipped by U.S. mail or by UPS within seven to ten days. Reordering information will be enclosed with your order.

You do not need to complete any Enrollment/Change Form to receive prescription benefits.

Prescription Program for Indemnity/PPO and Blue Shield Participants	
Copay	TYPES OF PRESCRIPTION DRUGS UNDER THE 3-TIER PROGRAM
$10	Generic drugs - retail purchase
$20	Generic drugs - mail order purchase of 90-day supply
$15	Formulary drugs - retail purchase
$30	Formulary drugs - mail order purchase of 90-day supply
$20	Non-formulary brand name drugs - retail purchase of 30-day supply
$40	Non-formulary brand name drugs - mail order purchase of 90-day supply

HOW TO USE THE PLAN'S MANAGED CARE NETWORK

The Health Plan uses managed care providers to help control the costs of your health care coverage. When you use the managed care programs, both you and the Plan will save money because the network providers have agreed to accept a designated fee schedule for their services. Any amount over the contracted amount of your medical, vision, mental health, chemical dependency, prescription drug and vision, chiropractic, physical therapy and acupuncture benefits will not be your responsibility. However, if you use a non-contracted provider, any amount over the plan's allowance will be your responsibility.

For each new calendar year, the remaining charges are paid to the provider or reimbursed to you at a percentage after the annual deductible has been paid. The difference between eligible charges and the percentage you pay is called a copayment. The copayment would be your responsibility. Please read the respective Summary of Benefits Charts that may apply to your coverage. Many of the benefits do limit the number of visits allowed in a calendar year and a few during a lifetime. Even if you do visit a contracted provider, visits over the limited number would be your responsibility.

Locating a Network PPO Provider

You may obtain a list of providers in your area by calling the Trust Fund Office at 1.800.752.2394 or 626.279.3020. If you have access to internet service, you may go online at www.anthem.com to obtain a list of providers.

The Plans offered to eligible members are the Indemnity/PPO plan with a choice of the Preferred Provide Organization Plan (PPO) and the Health Maintenance Organization Plan (HMO).

INDEMNITY/PPO PLAN

The Indemnity Plan allows you to choose any doctor and hospital that you wish when seeking health care services. The hallmark of traditional fee-for-service insurance is choice. There is a deductible, which is the amount you are required to pay before benefits are provided.

Important Things to Remember

- ►You receive the highest monetary benefit when staying with the PPO network.
- ►You may have the option to go outside the PPO network at a higher monetary (out-of-pocket) cost to you.
- ►Your options are seldom limited by geographic restrictions. You are responsible for paying a deductible before covered medical benefits are reimbursable or paid out.
- ►You may be required to pay a copayment for covered medical services.
- ► Certain treatments must be preauthorized before services are provided.

Health Maintenance Organizations (HMOs)

Kaiser Permanente and Blue Shield are the HMO organizations. Membership in a HMO requires plan members to obtain their health care services from doctors and hospitals affiliated with the HMO. It is common practice in HMOs for the plan member to choose primary care physician who treats and directs health care decisions and who coordinates referrals to specialties within the HMO network.

Important Things to Remember

- ►You must obtain health care services from HMO providers, except in certain emergency situations.
- ►Your choice of primary care physician is important because he/she directs your care. Also, your primary care physician often coordinates referrals to specialities within the HMO.
- ►Your options may be limited by the geographic restrictions of the HMO network.

Effective Date of Coverage

For new hires, your effective date of coverage is determined upon when you have met all eligibility requirements. (See Eligibility Requirements.)

Coverage changes involving the addition of dependents are effective retroactive to the date of the event such as marriage, birth or adoption, providing the application is filed within 30 days of the event. Deletion of dependents is effective on a timely or prospective basis, depending upon receipt of the application by the Trust Fund Office.

Dependent children are automatically terminated as of the end of the month they attain age 26 and do not require the completion of an application to delete coverage.

A COBRA notice will be mailed to your dependents to offer continued coverages that are identical to your previous coverage. The cost of COBRA coverages to your dependents will be included with the COBRA notice received.

Employee-Beneficiary Responsibilities

Employee-beneficiaries are responsible for...

- ►Providing current and accurate personal information as prescribed in this booklet
- ►Verifying that a provider is contracted with the Anthem Blue Cross of California PPO network.
- ►Making appropriate self-payments timely to maintain coverage when necessary.
- ►Complying with the Fund's rules.

Change in Coverage

To change your coverage (Medical or Dental Plan), you should contact the Trust Fund Office and complete the Enrollment/ Change Form. You are eligible to change your coverage (Medical or Dental Plan) outside the Open Enrollment period under the following circumstances:

- ►You marry and want to enroll your spouse and newly-eligible dependent children.
- ►You need to enroll a newborn or newly-adopted child.
- ►You have a change in family status involving the loss of eligibility of a family member (separation, divorce, death).
- ►Your spouse's or eligible dependent's employment status changes resulting in a loss of health coverage.
- ►You move out of your plan's service area.

Eligibility

The Southern California Painting and Drywall Industries Health and Welfare Trust Plan provides a health care package to all eligible participants and their eligible dependents. In order to qualify for these benefits, participants and dependents must meet the eligibility requirements of the Health Plan.

The following sections describe the basic eligibility requirements for health plan coverage, how eligibility is maintained and the programs available if eligibility is lost.

If you and your dependents are eligible for coverage, the Trust Fund Office must receive the Enrollment/ Change Form (completed), along with any supporting documents for your dependents. (See Section under Enrollment)

The Health Plan does not cover charges for conditions after eligibility terminates, even if those conditions developed during a period of Health Plan eligibility or if treatment for those conditions began during a period of Health Plan eligibility. The benefits under the Health Plan are not vested or guaranteed. They may be modified, reduced or canceled at any time by the Board of Trustees.

Eligibility Requirements

The work hours paid on your behalf, as a result of Collective Bargaining Agreements between Employers and District Council 36, are used to determine the Contribution Credits. To establish eligibility, a new employee or a member who previously lost eligibility and has no bank hours, will become eligible on the first day of the fifth month of a period that begins with three continuous months during which an employee averages the hours for the coverage level that has been selected, as long as they are credited with at least 25 hours in the first month.

	Level A	Level B	Level C
Benefit Credits/Hours Needed	140	120	100
***Hours Needed x Hourly Contribution (Primary) Rate of $8.85**	1,239	1,062	885
Maximum Hour Bank You Could Earn	4,956	4,248	3,540

* Effective work month of October 2022 and eligibility month of January 1, 2023 (H&W rate of $8.85)

When a member establishes eligibility, he/she will be enrolled in the default Medical Plan, which is the Indemnity Plan Level C. If the eligible member does not want to remain in the Indemnity Plan Level C; an enrollment form must be submitted within 90 days after establishing eligibility, wherein the member selects the desired Medical Plan and Plan Level for the next 12 months. The member has the option of lowering the Plan Level during the year as many times as needed. However, the member can only select a higher Plan Level after been enrolled in their initial or current Plan Level for 12 consecutive months. An Enrollment Form must be submitted selecting the new Plan Level prior to the eligibility month. The Plan Level change will not be done automatically. If the member does not have sufficient credits to remain eligible at the Plan Level selected, he/she will lose coverage. The Plan Level Change will not be granted if requested after coverage is terminated. *(If there is a difference between the hours you have worked and the contribution your employer has made towards your benefits, you may have to submit check stubs to the Trust Fund Office.)*

If a member loses coverage and has bank hours and /or elects COBRA, then returns to work with no lapse or a lapse in coverage, the initial eligibility requirement don't apply if the member reinstates coverage within six (6) months.

The member will have the opportunity to change Medical Plans and to upgrade Plan Levels if he/she has been enrolled in their initial Medical/Dental Plan or current Plan Level for 12 consecutive Months.

Banking Option

A member can accumulate a maximum of four (4) months of Benefit Credits/Hours in their Benefit Credit, Hour Bank. If a member works more hours than are necessary to earn the Benefit Credits/Hours required for the level of coverage he/she selected, he/she will accumulate reserve Benefit Credits/Hours in the Benefit Credits/Hour Bank. These benefit Credits/Hours will be used if the member does not have enough work hours to maintain eligibility, until there are insufficient credits to use for a month's eligibility.

To become eligible for the hour-bank benefit, you must complete the enrollment/change form. This is not an automatic benefit. The Plan will not permit you to bank any excess credits if you do not select a benefit Plan Level

Self-Pay Offset Provision

If an eligible employees work hours drop so that he/she loses eligibility, the employee may qualify for a "Self-Pay Offset." Under this provision, if the employee worked at least 50% of the hours required for coverage in their particular Plan Level, the employee can self-pay the difference between the hour actually worked and the hour required for coverage under the Plan Level selected. The required self-play amount will be the difference between the hours actually worked and the hours required for coverage multiplied by the current contribution rate ($8.85) The Self-Pay Offset Provision is limited to a six (6) month period.

Example: A member is covered under Plan Level B, but his hours dropped to 60. The required number of hours for Plan Level B is 120 hours a month. The member has no bank hours. The difference between the hours worked and hours required is 60 hours. You would multiply 60 hours at $8.85 = $531.00

Required hours for Level B	120 hours
Hours actually worked	60 hours
Difference	60 hours
60 hours x $8.85 = $531.00	self-payment

IMPORTANT NOTICES TO ELIGIBLE RETIREES

The Southern California Painting and Drywall Industry Health and Welfare Trust Fund is now holding its annual Open Enrollment Period. This is the period of time you may change your choice of medical HMO plans for you and your family.

It is very important that you read the following information. Please remember that only once a year you have the opportunity to change HMO plans. Please choose carefully.

Medical Plans Offered

The Health and Welfare Trust Fund currently offers medical coverage to retirees under the following two medical HMO plans: Kaiser Permanente and Blue Shield.

If You Live Outside the Service Areas of HMO Plans

If you live outside of the service areas of Kaiser or Blue Shield, **you may enroll under the Trust's Indemnity/PPO Plan**. Also Participants who are enrolled in the Indemnity Plan before they retired have the option to continue to be enrolled in the Indemnity Plan even if they reside in the HMO service area. The Indemnity Plan **is not available to retirees** who were enrolled in an HMO prior to retiring and who live within the service areas of Kaiser Permanente or Blue Shield.

Summary Charts of Kaiser Permanente and of Blue Shield are located in this booklet to help you decide which Plan may better help you with your medical needs,if any.

If you wish to change medical benefit plans at this time, you may follow the Enrollment Instructions on Pages 2 and 3.

Prescription Coverages Through Kaiser Permanente

Eligible retired members and their eligible dependents in the Kaiser Permanente Plan will be able to receive prescription benefits through Kaiser (Plan) facilities. Show your Kaiser ID card with your Medical Record Number on it. This card will also serve as your prescription ID card. For generic drugs, your copay will continue to be $10 per medical or dental prescription or the actual cost of the prescription, whichever is less. **For brand name drugs, your copay will be $20 per medical or dental prescription or the actual cost of the prescription, whichever is less.**

Indemnity Plan and Blue Shield Plan

Those who are eligible for the medical benefits under the Indemnity Plan or Blue Shield Plan through the Trust will be able to receive prescription benefits through the Optum RX Program.

Prescription benefits are under the 3-tier program with a different copayment. (See Page 5 for more information on how this program works)

Prescription benefits are available to you at a cost of $10 per prescription for generic drugs, $15 per prescription for formulary drugs and $20 per prescription for brand-name drugs.

When the Coverage Terminates for Eligible Retirees

It is very important to remember that the Plan only covers eligible retirees from age 55 to age 64 for retirees who do not become eligible for Medicare. When you have reached age 65 and your coverage terminates under this Plan, you may continue to self-pay for coverage on behalf of your eligible spouse and dependents until your spouse reaches age 65. Your spouse must be eligible for health insurance under the Trust at the time your coverage terminates. However, once your spouse reaches 65, any remaining dependents will be eligible for COBRA continuation coverage.

Eligibility Rules for Senior Members

A retired member and his eligible dependents shall be eligible for benefits as a Senior Member if:

1. He is at least age 50, has not yet reached his 65th birthday, and
   a. he was covered under this Plan as a Working Member for at least 10 years with 1,000 hours or more of the 15 years immediately before his retirement date and
   b. eligible 12 months out of the 24 months prior to loosing eligibility or

(The term “Working Member” does not include contributing employers or their employees who are not covered under the terms collective bargaining agreement requiring contributions to this Trust) or

2. he/she is eligible for a benefit under the Painters International Pension Plan or
3. he/she is not eligible for Medicare (this applies to each dependent separately)

Dental Coverage

Dental benefits are offered through Delta Dental Plan of California. If you are a Plan Level A participant, You may enroll in either the DeltaCare USA Plan or the DELTA PREFERRED OPTION (DPO).

DeltaCare USA (PMI) is a large network of dentists with most services at no cost to you and includes orthodontic coverage. This is the only dental plan available for participants in Plan Level B.

DELTA PREFERRED OPTION (DPO) features the largest network of dentists in California for in network benefits and allows you to go to any dentist of your choice for out-of-network benefits. However, only 70% of DPO approved fees will be covered to a dentist out-of-the network instead of the 80% DPO approved fees to an in-network dentist.

Participants in Plan Level A

If you are eligible to receive dental coverage and have not made a dental selection, you may select the DeltaCare USA Plan or the DPO plan in the back of the Enrollment/ Change Form sent by the Trust Fund Office.

If you have any questions about the enrollment procedure, please call the Trust Fund Office at 1.800.752.2394 or 626.279.3020.

DeltaCare USA (PMI) Benefit Highlight for Participants in Plan Levels A and B (No Dental Coverage for Plan Level C) Principal Benefits and Covered Services	
Treatment must be provided by a DeltaCare Panel Dentist	Member Pays
Deductibles	None
Maximum Benefits	None
Diagnostic and Preventive Benefits*– oral examinations, cleaning, x rays, biopsy/tissue examinations, fluoride treatment, space maintainers, specialist consultations	No cost
Basic Benefits*- oral surgery (extraction), fillings, endondontics (root canals) periodontic (gum treatment and sealants)	No cost
Crowns, jackets and other cast restorations*	No cost
Prosthodontic benefits-bridges, partial dentures and full dentures	No cost
Orthodontic benefits-bridges, partial dentures and full dentures	$1,600 children up to age 19; $1,800 adults; $350 start up

* Please refer to your *Evidence of Coverage* for limitations on these benefits.

Delta Preferred Option USA (DPO) Benefit Highlight for Participants in Plan Level A (No Dental Coverage for Plan Level C) Principal Benefits and Covered Services		
When Treatment is Provided by...	A DPO In-Network Dentist for Level A (Participants save more using In-Network (providers)	An Out-of-Network Dentist for Eligible Participants in Plan Levels A.
Covered Participants	Primary enrollee and spouse and eligible dependent children to age 26	Primary enrollee and spouse and eligible dependent children to age 26
Deductibles per person per calendar year and maximum benefit per calendar year	**Plan Level A Participants** $25 per person Maximum benefit is $3,000	**Plan Level A Participants** $25 per person Maximum benefit is $3,000
Deductibles per person per calendar year and maximum benefit per calendar year Diagnostic and Preventive benefits* -oral examinations of tissue biopsy, fluoride treatment,space maintainers, specialist consultations	80% of DPO approved fee no deductible applies for these services)	70% of Delta approved fee
Basic Benefits-oral surgery (extraction), fillings, root canals, periodontic (gum) treatment, tissue removal (biopsy), sealants	80% of DPO approved fee	70% of Delta approved fee
Crowns, jackets and other cast restorations*	80% of DPO approved fee	70% of Delta approved fee
Prosthodontic Benefits* bridges, partial dentures, full dentures	80% of DPO approved fee (denture subject to a maximum allowance)	70% of DPO approved fee (denture subject to a maximum allowance
Child Orthodontia Adult Orthodontia (The orthodontic benefits are available to Participants and their eligible dependents after at least 12 months of eligibility under the Trust.)	50% of the approved amount with a lifetime maximum benefit of $3,000.00 for both child and adult orthodontia.	50% of the approved amount with a lifetime maximum benefit of $3,000.00 for both child and adult orthodontia.

* Please refer to your *Evidence of Coverage* for limitations on these benefits.

VISION COVERAGE

Coverage is directly through the Trust and applies to members in both the Indemnity Plan and the HMO Plans-Kaiser and Blue Shield.

HMO Participants please read - Members enrolled in Kaiser Permanente or in Blue Shield must get an eye exam done by your particular HMO panel provider. Only your lens and frames will be covered under the Indemnity Plan and will be paid according to the maximum allowed.

Indemnity Plan Participants - You may go to the vision provider of your choice. Your claim may be submitted directly to the Trust Fund Office, for reimbursement of covered services. The maximum amount the Plan will cover is described in the Vision Plan's Schedule of Benefit Chart found below.

Members enrolled in an HMO plan – Kaiser Permanente or Blue Shield must have their eye exams done by their HMO panel provider. If your eye exam is for contact lenses, your exam will be covered under the Indemnity Plan.

Schedule of Benefits
Vision Plan

Levels A and B only
(No coverage for Level C)

No deductible

One exam every 12 months (From the last date of purchase)

One set of frames every 24 months (From the last date of purchase)

One pair of corrective lenses every 12 months (From the last date of purchase)

Transitional lenses are not covered

Benefit	Coverage	Maximum Allowance Plan will pay...
Refraction/Eye Exam	One exam every 12 months	*$50.00
Frames	One set every 24 months	*$110.00
Corrective Lenses	One pair every 12 months Single Bifocal Trifocal Lenticular Contacts	 *$70.00 per set *$90.00 per set *$110.00 per set *$140.00 per set *$120.00 per set

* These limitations do not apply to Pediatric Vision Benefits for dependent children under Age 19

COBRA Rates, Effective May 1, 2022 (These rates are subject to change on May 1, 2023)			
PLAN A			
Actives (Core Benefits – Medical and Prescription Only)			
	Indemnity Plan	**Kaiser Permanente**	**Blue Shield**
Composite	$753.00	$1,308.00	$1,532.00
Retirees (Core Benefits – Medical and Prescription)			
Single	$409.00	$582.00	$643.00
Two Party	$638.00	$1,163.00	$1,246.00
Three or More	$862.00	$1,646.00	$1,881.00
Actives (Core Plus Non-Core Benefits – Medical, Prescriptions, Dental and Vision)			
Composite – DPO	$847.00	$1,403.00	$1,627.00
Composite – PMI	$799.00	$1,355.00	$1,579.00
Retirees (Core Plus Non-Core Benefits – Medical, Prescriptions, Dental, DPO and Vision)			
Single	$503.00	$676.00	$738.00
Two Party	$732.00	$1,258.00	$1,340.00
Three or More	$956.00	$1,740.00	$1,975.00
Retirees (Core Plus Non-Core Benefits – Medical, Prescriptions, Dental, PMI and Vision)			
Single	$453.00	$626.00	$688.00
Two Party	$682.00	$1,208.00	$1,290.00
Three or More	$906.00	$1,690.00	$1,925.00
PLAN B			
Actives (Core Benefits – Medical and Prescription Only)			
Composite	$743.00	$1,284.00	$1,525.00
Retirees (Core Benefits – Medical and Prescription)			
Single	$399.00	$540.00	$641.00
Two Party	$628.00	$1,080.00	$1,240.00
Three or More	$852.00	$1,528.00	$1,872.00
Actives (Core Plus Non-Core Benefits – Medical, Prescriptions, Dental and Vision)			
Composite – PMI	$789.00	$1,330.00	$1,572.00
Retirees (Core Plus Non-Core Benefits – Medical, Prescriptions, Dental, PMI and Vision)			
Single	$445.00	$586.00	$687.00
Two Party	$674.00	$1,126.00	$1,287.00
Three or More	$898.00	$1,575.00	$1,919.00
PLAN C			
Actives (Medical and Prescription only)			
Composite	$732.00	$1,259.00	$1,518.00
Retirees (Core Benefits – Medical and Prescription Only)			
Single	$388.00	$526.00	$598.00
Two Party	$618.00	$1,053.00	$1,234.00
Three or More	$842.00	$1,489.00	$1,863.00

Self-Pay Rates, Effective May 1, 2022 (These rates are subject to change on May 1, 2023			
PLAN A			
Plan A — Actives DPO (Dental Preferred Providers)			
	Indemnity Plan	**Kaiser Permanente**	**Blue Shield**
Composite	$835.00	$1,379.00	$1,599.00
PLAN A – Actives PMI (Delta Care USA)			
Composite	$788.00	$1,332.00	$1,552.00
Retirees (Medical, Prescription, Dental and Vision)			
PLAN A – Non-Medicare			
DPO (Dental Preferred Provider)			
Single	$497.00	$667.00	$727.00
Two Party	$722.00	$1,237.00	$1,318.00
Three or More	$942.00	$1,710.00	$1,941.00
PMI (Delta Care USA)			
Single	$447.00	$617.00	$677.00
Two Party	$675.00	$1,187.00	$1,268.00
Three or More	$892.00	$1,660.00	$1,891.00
PLAN B			
PLAN B – Actives PMI (Delta Care USA)			
Composite	$778.00	$1,308.00	$1,545.00
Retirees (Medical, Prescription, Dental and Vision)			
PLAN B (Non-Medicare)			
PMI (Delta Care USA)			
Single	$440.00	$579.00	$678.00
Two Party	$665.00	$1,109.00	$1,266.00
Three or More	$885.00	$1,548.00	$1,885.00
PLAN C			
PLAN C – Actives (Medical, Prescription, and Life)			
Composite	$722.00	$1,238.00	$1,492.00
Retirees (Medical, Prescription)			
PLAN C (Non-Medicare)			
Retirees (Medical, Prescription, and Life)			
Single	$385.00	$520.00	$590.00
Two Party	$610.00	$1,036.00	$1,214.00
Three or More	$829.00	$1,464.00	$1,831.00

Southern California Painting & Drywall Industries Health & Welfare Fund
Comparison of Medical Benefit Plan Charts

Indemnity PPO Plan

Kaiser Permanente (HMO) Plan

Blue Shield (HMO) Plan

Level A Plan

Level B Plan

Level C Plan

Comparison of Benefits

Plan Level A

Plan Options Offered to Eligible Members in Plan Level A	Indemnity Plan		Kaiser Permanente Plan	Blue Shield Plan
Annual Calendar Year Maximum	None		None	None
Calendar Year Deductible Deductible must be met before reimbursement of expenses is made by Plan	$250/Individual $750/Family		None	None
Annual Copay Limit Individual	$4,000/person		$1,500/Individual $3,000/Family	$1,000/Individual (1) $3,000/Family
Type of Organization	PPO Provider	Non-PPO Provider (Benefits are reduced when services are received by providers and at facilities outside of Anthem Blue Cross of California)	Health Maintenance Organization (HMO) $ Copays - Payable by Member Percentages listed - Payable by Plan	Health Maintenance Organization (HMO) All services are coordinated by primary care physician and copays are member liability when they apply
Services	All services are subject to the deductible. Percentages payable by Plan are shown below. If pre-admission review requirements are not followed, the Plan will reduce the amount it pays by 10 percentage points.		The Plan does not cover all health care expenses and includes exclusions and limitations. (Refer to Kaiser Permanente's *Evidence of Coverage*)	All medically necessary services are covered and are limited to exclusions and limitations
Hospital Inpatient Care	Room and board, surgery, anesthesia, X-rays, lab tests and medications that are medically necessary		100% per admission during a member's inpatient stay	100%
	90% of PPO Rate	70% of UCR		
Hospital Outpatient Care	90% of PPO Rate	70% of UCR	$25 copay per visit	100%
Hospice Care	90% of PPO Rate	70% of UCR	100%	100%

(1) Member cost sharing for certain services may not apply toward the Out-of-Pocket Maximum. Only those participating providers/referred out of pocket expenses resulting from the application of coinsurance percentage and copays (except any penalty amounts and pharmacy cost sharing) may be used to satisfy the Out-of-Pocket Maximum. Once Family Out-of-Pocket Maximum is met, all family members will be considered as having met their Out-of-Pocket Maximum for the remainder of the calendar year.

Plans Offered Plan Level A	Indemnity Plan		Kaiser Permanente Plan	Blue Shield Plan
	PPO Provider	Non-PPO Provider	Health Maintenance Organization (HMO)	Health Maintenance Organization (HMO)
Outpatient Care	Primary and specialty care visits for internal medicine, family practice, maternity care visits, pediatrics and gynecology visits include routine and urgent care appointments		Refer to Kaiser Permanente's *Evidence of Coverage (EOC)*	Benefits are provided for home services when ordered and authorized through member's primary care physician
	90% of PPO Rate	70% of UCR	$25 copay	$25 copay
Hearing Exam	90% of PPO Rate	70% of UCR	$25 copay	$25 copay
Hearing Aid Benefits (for Indemnity and HMO Plans)	Hearing Aids Aid replacement Exams* Molds Mold replacement	Up to $1,500 per Aid Every 4 years, if needed Up to $75 per year Up to $50 per Mold Twice per year if needed		* Applies to Indemnity Plan eligible only; HMO eligible must receive hearing exams through their HMOs
Outpatient Surgery	90% of PPO Rate	**Non-PPO rates by county — Plan A** **County (where facility located:** / **Maximum Rate Per Surgery** Los Angeles/ Orange/San Diego — $2,900 (Plan pays 70%) Riverside/ San Bernardino — $2,450 (Plan pays 70%) San Luis Obispo/ Santa Barbara/Kern — $1,910 (Plan pays 70%) Ventura — $2,340 (Plan pays 70%)	$25 copay	100%
Routine Care	The Plan allows routine physical examination, gynecological visits every 12 months		Refer to Kaiser Permanente's *Evidence of Coverage (EOC)*	Refer to Blue Shield's *Evidence of Coverage (EOC)*
	90% of PPO Rate	70% of UCR	$25 copay	$25 copay

Plans Offered Plan Level A	Indemnity Plan		Kaiser Permanente Plan	Blue Shield Plan
	PPO Provider	Non-PPO Provider	Health Maintenance Organization (HMO)	Health Maintenance Organization (HMO)
Well Baby Care and Immunizations	**Immunization** – as medically necessary **Well-Baby Care** – as medically necessary		No Charge	No Charge
Adult Immunizations	90% of PPO Rate	70% of UCR	100%	100%
Allergy Injection Visits	Mandatory Pre-authorization			
	90% of PPO Rate	0% of UCR	$25 copay	$25 office visit copay
Physical Therapy, Chiropractic Care and Acupuncture Treatments	90% of PPO Rate — This is a combined benefit. Maximum of 25 visits per calendar year.	70% of UCR — This is a combined benefit. Maximum of 25 visits per calendar year.	Chiropractic and Acupuncture treatments are not covered	Chiropractic and Acupuncture treatments are not covered
	90% of PPO Rate	70% of UCR	$25 copay for physical therapy	$25 copay for physical therapy
Emergency Services	90% of PPO Rate	70% of UCR	$50 copay/waived if admitted	$50 copay/waived if admitted
Additional Benefits				
Skilled Nursing Facility/ Convalescent Hospital Daily Rate and Home Health Care 60 Day Maximum per admission	90% of PPO Rate with a $100 maximum per day This is a combined benefit. The $100 maximum does not apply for convalescent services rendered at a Skilled Nursing Facility	70% of UCR with a $100 maximum per day This is a combined benefit. The $100 maximum does not apply for convalescent services rendered at a Skilled Nursing Facility	100% — up to 100 visits per calendar year	100% — up to 100 visits per calendar year
Ambulance Services	90% of PPO Rate	70% of UCR	100%	100%

Plans Offered Plan Level A	Indemnity Plan		Kaiser Permanente Plan	Blue Shield Plan
	PPO Provider	Non-PPO Provider	Health Maintenance Organization (HMO)	Health Maintenance Organization (HMO)
Coordination of Benefits	**Call the Trust Fund Office for information as to how this Plan may pay if you are enrolled in other Plans**		Included —Refer to Kaiser Permanente's *Evidence of Coverage (EOC)*	Refer to Blue Shield's *Evidence of Coverage (EOC)*
Other Services MRI/SCAN	90% of PPO Rate	70% of UCR	100%	100%
Outpatient X-Ray and Lab	90% of PPO Rate	70% of UCR	100%	100%
Durable Medical Equipment	All rental equipment and all purchases of medical supply or equipment in excess of $1,000 must be approved in advanced by the Trust Fund Office. **Call 1.800.752.2394**		Covered durable medical equipment in accord with Kaiser Permanente's formulary	100% services must be provided by participating network provider
	90% of PPO Rate	70% of UCR	100%	100%
Mental Health Services Inpatient	90% of PPO Rate	70% of UCR	100%	100%
Outpatient Psychotherapy	90% of PPO Rate	70% of UCR	$25 copay per visit $12 copay per group therapy visit	$25 copay per visit
Substance Abuse Inpatient (Detox Only)	90% of PPO Rate	70% of UCR	100%	100%
Outpatient	90% of PPO Rate	70% of UCR	$25 copay per individual $5 copay per group	$25 copay
Dental Benefits	Plan Level A — see page 11		Not covered Plan Level A — see page 11	Not covered Plan Level A — see page 11
Vision Benefits	Plan Level A — see page 13		$25/eye exam only (See Schedule of Vision Benefits)	$10/eye exam only at participating network provider (See Schedule of Vision Benefits)

Your Rights and Protections Against Surprise Medical Bills
When you get emergency care (other than ground ambulance services) or get treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from surprise billing or balance billing.

Comparison of Benefits

Plan Level B

Plan Options Offered to Eligible Members in Plan Level B	Indemnity Plan		Kaiser Permanente Plan	Blue Shield Plan
Annual Calendar Year Maximum	None		None	None
Calendar Year Deductible Deductible must be met before reimbursement of expenses is made by Plan	$250/Individual $750/Family		None	None
Annual Copay Limit Individual	$4,000/person		$1,500/Individual $3,000/Family	$1,000/Individual (1) $3,000/Family
Type of Organization	PPO Provider	Non-PPO Provider (Benefits are reduced when services are received by providers and at facilities outside of the Prudent Buyer Plan network)	Health Maintenance Organization (HMO) $ Copays - Payable by Member Percentages listed - Payable by Plan	$ Copays - Payable by Member Percentages listed - Payable by Plan
Services	All services are subject to the deductible. Percentages payable by Plan are shown below If pre-admission review requirements are not followed, the Plan will reduce the amount it pays by 10 percentage points		The Plan does not cover all health care expenses and includes exclusions and limitations. (Refer to Kaiser Permanente's *Evidence of Coverage*)	All medically necessary services are covered and are limited to exclusions and limitations
Hospital Inpatient Care	Room and board, surgery, anesthesia, X-rays, lab tests and medications that are medically necessary		100% per admission during a member's inpatient stay	100%
	80% of PPO Rate	60% OF UCR		
Hospital Outpatient Care	80% of PPO Rate	60% OF UCR	$25 copay per visit	100%
Hospice Care	80% of PPO Rate	70% OF UCR	100%	100%

(1) Member cost sharing for certain services may not apply toward the Out-of-Pocket Maximum. Only those participating providers/referred out of pocket expenses resulting from the application of coinsurance percentage and copays (except any penalty amounts and pharmacy cost sharing) may be used to satisfy the Out-of-Pocket Maximum. Once Family Out-of-Pocket Maximum is met, all family members will be considered as having met their Out-of-Pocket Maximum for the remainder of the calendar year.

Plans Offered Plan Level B	Indemnity Plan		Kaiser Permanente Plan	Blue Shield Plan
	PPO Provider	**Non-PPO Provider**	**Health Maintenance Organization (HMO)**	**Health Maintenance Organization (HMO)**
Outpatient Care	Primary and specialty care visits for internal medicine, family practice, maternity care visits, pediatrics and gynecology visits include routine and urgent care appointments		Refer to Kaiser Permanente's *Evidence of Coverage (EOC)*	Benefits are provided for home services when ordered and authorized through member's primary care physician
	80% of PPO Rate	60% of UCR	$25 copay	$25 copay
Hearing Exam	80% of PPO Rate	60% of UCR	$25 copay	$25 copay
Hearing Aid Benefits (for Indemnity and HMO Plans		Hearing Aids — Up to $1,500 per Aid Aid replacement — Every 4 years, if needed Exams* — Up to $75 per year Molds — Up to $50 per Mold Mold replacement — Twice per year if needed		* Applies to Indemnity Plan eligible only; HMO eligible must receive hearing exams through their HMOs
Outpatient Surgery	80% of PPO Rate	**Non-PPO rates by county — Plan B** **County (where facility located:** / **Maximum Rate Per Surgery** Los Angeles/ Orange/San Diego — $2,900 (Plan pays 60%) Riverside/ San Bernardino — $2,450 (Plan pays 60%) San Luis Obispo/ Santa Barbara/Kern — $1,910 (Plan pays 60%) Ventura — $2,340 (Plan pays 60%)	$25 copay	No Charge
Routine Care	The Plan allows routine physical examination, gynecological visits every 12 months		Refer to Kaiser Permanente's Evidence of Coverage (EOC)	Refer to Blue Shield's Evidence of Coverage (EOC)
	80% of PPO Rate	60% of UCR	$25 copay	$25 copay
Well-Baby Care and Immunizations	**Immunization** – as medically necessary **Well-Baby Care** – as medically necessary		No Charge	No Charge
Adult Immunizations	80% of PPO Rate	60% of UCR	100%	100%

Plans Offered Plan Level B	Indemnity Plan		Kaiser Permanente Plan	Blue Shield Plan
	PPO Provider	**Non-PPO Provider**	**Health Maintenance Organization (HMO)**	**Health Maintenance Organization (HMO)**
Allergy Injection Visits	Mandatory Pre-authorization			
	80% of PPO Rate	60% of UCR	$25 copay	$25 copay
Physical Therapy, Chiropractic Care and Acupuncture Treatments	80% of PPO Rate This is a combined benefit. Maximum of 25 visits per calendar year.	60% of UCR Rate This is a combined benefit. Maximum of 25 visits per calendar year.	Chiropractic and Acupuncture treatments are not covered	Chiropractic and Acupuncture treatments are not covered
	80% of PPO Rate	60% of UCR	$25 copay for physical therapy	$25 copay for physical therapy
Emergency Services	80% of PPO Rate	60% of UCR	$50 copay/ waived if admitted	$50 copay/ waived if admitted
Additional Benefits				
Skilled Nursing Facility/ Convalescent Hospital Daily Rate and Home Health Care 60 Day Maximum per admission	80% of PPO Rate with a $100 maximum per day This is a combined benefit. The $100 maximum does not apply for convalescent services rendered at a Skilled Nursing Facility	60% of UCR with a $100 maximum per day This is a combined benefit. The $100 maximum does not apply for convalescent services rendered at a Skilled Nursing Facility	100% — up to 100 visits per calendar year	100% — up to 100 visits per calendar year
Ambulance Services	80% of PPO Rate	60% of UCR	100%	100%
Coordination of Benefits	Call the Trust Fund Office for information as to how this Plan may pay if you are enrolled in other Plans.		Included — Refer to Kaiser Permanente's *Evidence of Coverage (EOC)*	Refer to Blue Shield's *Evidence of Coverage (EOC)*
Other Services MRI/SCAN	80% of PPO Rate	60% of UCR	100%	100%
Outpatient X-Ray and Lab	80% of PPO Rate	60% of UCR	100%	100%

Plans Offered Plan Level B	Indemnity Plan		Kaiser Permanente Plan	Blue Shield Plan
	PPO Provider	Non-PPO Provider	Health Maintenance Organization (HMO)	Health Maintenance Organization (HMO)
Durable Medical Equipment	All rental equipment and all purchases of medical supply or equipment in excess of $1,000 must be approved in advanced by the Trust Fund Office. **Call 1.800.752.2394**		Covered durable medical equipment in accord with Kaiser Permanente's formulary	Covered durable medical equipment must be provided by participating network provider
	90% of PPO Rate	70% of UCR	100%	100%
Mental Health Services Inpatient	80% of PPO Rate	60% of UCR	100%	100%
Outpatient Psychotherapy	80% of PPO Rate	60% of UCR	$25 copay per individual $12 copay per group therapy visit	$25 copay
Substance Abuse Inpatient (Detox Only)	80% of PPO Rate	60% of UCR	100%	100%
Outpatient	80% of PPO Rate	60% of UCR	$25 copay per individual $5 copay per group	$25 copay
Dental Benefits	Plan Level B — see page 12		Not covered Plan Level B — see page 12	Not covered Plan Level B — see page 12
Vision Benefits	Plan Level B — see page 13		$25 copay/eye exam only (See Schedule of Vision Benefits)	$10/eye exam only at participating network provider (See Schedule of Vision Benefits)

Your Rights and Protections Against Surprise Medical Bills
When you get emergency care (other than ground ambulance services) or get treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from surprise billing or balance billing.

Comparison of Benefits

Plan Level C

Plan Options Offered to Eligible Members in Plan Level C	Indemnity Plan		Kaiser Permanente Plan	Blue Shield Plan
Annual Calendar Year Maximum	None		None	None
Calendar Year Deductible Deductible must be met before reimbursement is made	$250/Individual $750/Family		None	None
Annual Copay Limit Individual	$4,000/person		$1,500/Individual $3,000/Family	$1,000/Individual (1) $3,000/Family
Type of Organization	PPO Provider	Non-PPO Provider (Benefits are reduced when services are received by providers and at facilities outside of the Prudent Buyer Plan network)	Health Maintenance Organization (HMO)	Health Maintenance Organization (HMO)
Services	All services are subject to the deductible. Percentages payable by Plan are shown below. If pre-admission review requirements are not followed, the Plan will reduce the amount it pays by 10 percentage points.		Health Maintenance Organization (HMO) $ Copays - Payable by Member Percentages listed Payable by Plan	Health Maintenance Organization (HMO) All services are coordinated by primary care physician and copays are member liability when they apply
Hospital Inpatient Care	Room and board, surgery, anesthesia, X-rays, lab tests and medications that are medically necessary			
	70% of PPO Rate	50% OF UCR	100% per admission during a member's inpatient stay	100%
Hospital Outpatient Care	70% of PPO Rate	50% OF UCR	$25 copay per visit	100%
Hospice Care	70% of PPO Rate	50% OF UCR	100%	100%

(1) Member cost sharing for certain services may not apply toward the Out-of-Pocket Maximum. Only those participating providers/referred out of pocket expenses resulting from the application of coinsurance percentage and copays (except any penalty amounts and pharmacy cost sharing) may be used to satisfy the Out-of-Pocket Maximum. Once Family Out-of-Pocket Maximum is met, all family members will be considered as having met their Out-of-Pocket Maximum for the remainder of the calendar year.

Plans Offered Plan Level C	Indemnity Plan		Kaiser Permanente Plan	Blue Shield Plan
	PPO Provider	**Non-PPO Provider**	**Health Maintenance Organization (HMO)**	**Health Maintenance Organization (HMO)**
Outpatient Care	Primary and specialty care visits for internal medicine, family practice, maternity care visits, pediatrics and gynecology visits include routine and urgent care appointments		Refer to Kaiser Permanente's *Evidence of Coverage (EOC)*	Benefits are provided for home services when ordered and authorized through member's primary care physician.
	70% of PPO Rate	50% of UCR	$25 copay	$25 copay
Hearing Exam	70% of PPO Rate	50% of UCR	$25 copay	$25 copay
Hearing Aid Benefits (for Indemnity and HMO Plans)		Hearing Aids — Up to $1,500 per Aid Aid replacement — Every 4 years, if needed Exams* — Up to $75 per year Molds — Up to $50 per Mold Mold replacement — Twice per year if needed		* Applies to Indemnity Plan eligible only; HMO eligible must receive hearing exams through their HMOs
Outpatient Surgery	70% of PPO Rate	**Non-PPO rates by county — Plan C** **County (where facility located:** / **Maximum Rate Per Surgery** Los Angeles/ Orange/San Diego — $2,900 (Plan pays 50%) Riverside/ San Bernardino — $2,450 (Plan pays 50%) San Luis Obispo/ Santa Barbara/Kern — $1,910 (Plan pays 50%) Ventura — $2,340 (Plan pays 60%)	$25 copay	No charge
Routine Care	The Plan allows routine physical examination, gynecological visits every 12 months		Refer to Kaiser Permanente's Evidence of Coverage (EOC)	Refer to Blue Shield's *Evidence of Coverage (EOC)*
	70% of PPO Rate	50% of UCR	$25 copay	$25 copay
Well-Baby Care and Immunizations	**Immunization** — as medically necessary **Well-Baby Care** — as medically necessary		No Charge	No Charge
Adult Immunizations	70% of PPO Rate	50% of UCR	100%	100%

Plans Offered Plan Level C	Indemnity Plan		Kaiser Permanente Plan	Blue Shield Plan
	PPO Provider	Non-PPO Provider	Health Maintenance Organization (HMO	Health Maintenance Organization (HMO
Allergy Injection Visits	Mandatory Pre-authorization			
	70% of PPO Rate	50% of UCR	$25 copay	$25 copay
Physical Therapy, Chiropractic Care and Acupuncture Treatments	This is a combined benefit. Maximum of 25 visits per calendar year..	This is a combined benefit. Maximum of 25 visits per calendar year..	Chiropractic and Acupuncture treatments are not covered	Chiropractic and Acupuncture treatments are not covered
	70% of PPO Rate	50% of UCR	$25 copay for physical therapy	$25 copay for physical therapy
Emergency Services	70% of PPO Rate	50% of UCR	$50 copay/ waived if admitted	$50 copay/ waived if admitted
Additional Benefits				
Skilled Nursing Facility/ Convalescent Hospital Daily Rate and Home Health Care 60 Day Maximum per admission	70% of PPO Rate with a $100 maximum per day This is a combined benefit. The $100 maximum does not apply for convalescent services rendered at a Skilled Nursing Facility	50% of UCR with a $100 maximum per day This is a combined benefit. The $100 maximum does not apply for convalescent services rendered at a Skilled Nursing Facility	100% — up to 100 visits per calendar year	100% — up to 100 visits per calendar year
Ambulance Services	70% of PPO Rate	50% of UCR	100%	100%
Coordination of Benefits	**Call the Trust Fund Office for information**		Included —Refer to Kaiser Permanente's *Evidence of Coverage (EOC)*	Refer to Blue Shield's *Evidence of Coverage (EOC)*
Other Services MRI/SCAN	70% of PPO Rate	50% of UCR	100%	100%
Outpatient X-Ray and Lab	70% of PPO Rate	50% of UCR	100%	100%

Plans Offered Plan Level C	Indemnity Plan		Kaiser Permanente Plan	Blue Shield Plan
	PPO Provider	Non-PPO Provider	Health Maintenance Organization (HMO	Health Maintenance Organization (HMO
Durable Medical Equipment	All rental equipment and all purchases of medical supply or equipment in excess of $1,000 must be approved in advanced by the Trust Fund Office. **Call 1.800.752.2394**		Covered durable medical equipment in accord with Kaiser Permanente's formulary	Durable medical equipment must be provided by participating network provider
	70% of PPO Rate	50% of UCR	100%	100%
Mental Health Services Inpatient	70% of PPO Rate	50% of UCR	100%	100%
Outpatient Psychotherapy	70% of PPO Rate	50% of UCR	$25 copay per visit $12 copay per group therapy visit	$25 copay
Substance Abuse Inpatient (Detox Only)	70% of PPO Rate	50% of UCR	100%	100%
Outpatient	70% of PPO Rate	50% of UCR	$25 copay per individual $5 copay per group	$25 copay
Dental Benefits	Not covered		Not covered	Not covered
Vision Benefits	Not covered		$25 copay /eye exam only Materials not covered	$10/eye exam only at participating network provider

Your Rights and Protections Against Surprise Medical Bills
When you get emergency care (other than ground ambulance services) or get treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from surprise billing or balance billing.

Important Notices

Many federal and state laws guide the administration of all health benefit plans. While the plan actually governs your rights and benefits under each plan in which you are enrolled, the following information is provided to help you understand your statutory rights and benefits. If any discrepancy exists between the information provided in this section and the Plan, the Plan will prevail.

If you have any questions about this section, please call the Trust Fund Office at 1.800.752.2394 or 626.279.3020.

GRANDFATHERED STATUS NOTICE

The Southern California Painting & Drywall Industries Health & Welfare Plan believes this 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 plan administrator at 1.800.752.2394 or at 626.279.3020. 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.

ANNUAL LIMIT NO LONGER APPLIES AND ENROLLMENT OPPORTUNITY

The annual limit on the dollar value of benefits under Southern California Painting & Drywall Industries Health & Welfare Plan no longer applies. Individuals whose coverage ended by reason of reaching the annual limit under the plan are eligible to enroll in the plan. Individuals have 30 days from the date of this notice to request enrollment. For more information contact the Trust Fund Office at 1.800.752.2394 or at 626.279.3020.

NOTICE THAT PRE-EXISTING CONDITION EXCLUSIONS DO NOT APPLY

Effective January 1, 2014, individuals are protected from being denied coverage for a preexisting condition.

For more information about any of these notices, contact the Trust Office at 626.279.3020.

WOMEN'S HEALTH AND CANCER RIGHTS ACT (WHCRA)

Your health plan is required by the Women's Health and Cancer Rights Act of 1998 to provide benefits for mastectomy-related services, including the following services:

- ►Reconstruction of the breast on which the mastectomy has been performed.
- ►Surgery and reconstruction of the other breast to produce a symmetrical appearance.
- ►Prostheses and physical complications for all stages of a mastectomy, including lymph-demos (swelling associated with the removal of lymph nodes).

Your plan will provide coverage in consultation with the attending physician and patient.

Coverage for breast reconstruction and related services will be subject to deductible, copayments and coinsurance amounts that are consistent with those that apply to other benefits under the Plan. If you have any questions about the Women's Health and Cancer Rights Act, please call the Trust Fund Office at 1.800.752.2394 or 626.279.3020

NEWBORN'S AND MOTHER'S HEALTH PROTECTION ACT

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 normal vaginal delivery, or

►96 hours following a cesarean section.

However, federal law generally does not prohibit the mother's or newborn's attending provider (physician), after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable).

In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a hospital stay not in excess of 48 hours (or 96 hours). However, the Plan may still require precertification or preauthorization from the Plan or the issuer for prescribing a length of stay in excess of 48 hours (or 96 hours.)

The Mental Health Parity Act of 1996

The Mental Health Parity Act (MHPA) was signed into law on September 26, 1996. MHPA provides for parity in the application of aggregate lifetime and annual dollar limits on mental health benefits with dollar limits on 31 medical/surgical benefits. MHPA's provisions are subject to concurrent jurisdiction by the Departments of Labor, the Treasury, and Health and Human Services.

On December 22, 1997, the Departments of Labor, the Treasury, and Health and Human Services issued interim regulations that interpret MHPA. The regulations clarify the statutory requirements and provide information valuable to employers and employees in understanding their obligations and rights under the law.

QUALIFIED MEDICAL CHILD SUPPORT ORDER (QMCSO)

Your health benefit plan honors qualified medical child support orders (QMCSOs). This means that if a QMCSO issued a divorce or legal separation proceeding requires you to provide medical coverage to a child who is not in your custody, you may do so under the Plan. To be qualified, a medical child support order must include the following information:

►Name and last known address of each child to be covered under the Plan.

►Name and last know address of the parent who has been granted legal custody.

►Type of coverage to be provided to each child and period of time coverage will be provided.

Send QMCSOs to the Trust Fund Office, which is your Plan administrator. Upon receipt, the Trust Fund Office will notify you and give you the procedures for determining if the order is qualified. If the order is qualified, you may cover your child/children under the Plan.

COBRA

You're getting this notice because you recently gained coverage under the Southern California Painting & Drywall Industries Health & Welfare Plan ("Plan"). **This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it.** When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs.

Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

What is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you're an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- ►Your hours of employment are reduced, or
- ►Your employment ends for any reason other than your gross misconduct.

If you're the spouse of an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- ►Your spouse dies;
- ►Your spouse's hours of employment are reduced;
- ►Your spouse's employment ends for any reason other than his or her gross misconduct;
- ►Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- ►You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:

- ►The parent-employee dies;
- ►The parent-employee's hours of employment are reduced;
- ►The parent-employee's employment ends for any reason other than his or her gross misconduct;
- ►The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- ►The parents become divorced or legally separated; or
- ►The child stops being eligible for coverage under the Plan as a "dependent child."

When is COBRA Continuation Coverage Available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:

- ►The end of employment or reduction of hours of employment;
- ►Death of the employee; or
- ►The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to the Trust Fund Office at 1.800.752.2394 or 626.279.3020.

How is COBRA Continuation Coverage Provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

Disability extension of 18-month period of COBRA continuation coverage

If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage.

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Are There Other Coverage Options Besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

If You Have Questions

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

Keep Your Plan informed of Address Changes
To protect your family's rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Plan Contact Information
Southern California Painting & Drywall Industries Health & Welfare Plan
1055 Park View Drive., Suite 111
Covina, CA 91724

1.800.752.2394 or 626.279.3020

HIPAA Law

Title II of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) includes, among others, the Privacy Rule, which was effective April 14, 2003. This federal law was enacted to protect your health information.

The Privacy Rule gives Plan participants increased knowledge about the uses and disclosures of their Protected Health Information **(PHI), which is defined under Definition of PHI**. Plan Participants (employees and covered dependents) have specific rights with regards to their PHI, which include the right to—

- ►Receive a paper copy of the Fund's Privacy Notice
- ►Request restrictions on the uses and disclosures of PHI
- ►Receive confidential communication
- ►Request access to their PHI
- ►Request amendment of inaccurate or incomplete PHI
- ►Request an accounting of disclosures of PHI

Definition of PHI

The Privacy Rule defines PHI as a health information, no matter what its form—electronic, written or oral, that meets all the following criteria:

- ►Information a Health Plan creates or receives about an individual;
- ►Information relating to the individual's past, present or future health condition or past, present or future payment for health care services; and
- ►Information that either identifies the individual or creates a basis upon which to identify a person.

This means the Health Plan is not as free to respond to inquiries made on your behalf by family, friends and business agents unless you authorize in writing that they may receive your protected health information (PHI). This does not mean that one of these individuals cannot assist you if they provide us with specific PHI. In the absence of an Authorization, Health Plan staff will research the information provided. In many cases, your family, friend or business agent may be told that the Health Plan Office will respond directly to you, the Participant or your dependent, in answer to the question or to resolve an outstanding issue.

Authorization Forms

A properly, completed and signed Authorization Form, when approved and recorded by the Privacy Office, will permit the Health Plan to discuss "minimum necessary" PHI with the individual you name. All Authorization forms must be forwarded to the Privacy officer who reviews each request and responds in writing to the Participant.

Authorization Forms are available from the Trust Fund Office or from the Privacy Office. Please direct inquiries with regards to privacy issues to the Fund's Privacy Office:

Privacy Officer
Southern California Painting & Drywall Industries Health & Welfare Trust
P.O. Box 1679
Covina, CA 91722-0679

(800) 752-2394
(626) 279-3020

PrivacyOfficer@pswadmin.com

Claims and Appeals

Claims submitted will be processed by the Trust Fund's Claims Office. An Explanation of Benefits (EOB) will be mailed to the last known address filed with the Trust Fund Office after a claim has been processed. Claims should be filed with the Trust Fund Office within 90 days and no later than 1 year after expenses have been incurred. Benefits will be denied for claims submitted beyond 1 year of the incurred date.

You have the right to appeal a claim that has been denied in whole or in part if you are not satisfied or if you do not agree with the reason for denial. You may appeal the denial in writing to the Plan's Appeals Committee.

Your appeal, along with all of your supporting documents that may help the Appeals Committee reconsider the denial, should be addressed to the Appeals Committee and mailed to the Trust Fund Office at 1055 Park View Drive., Suite.111 Covina, CA 91722.

All appeals must be submitted within 180 days of receipt of a claim denial. Appeals submitted 30 days prior to a scheduled Appeals Committee meeting will be considered at that meeting. Appeals submitted less than 30 prior to a scheduled Appeals Committee meeting may be considered at the next scheduled meeting of the benefits Committee.

Your Rights and Protections against Surprise Medical Bills

When you get emergency care, use an out-of-network air ambulance provider, or get treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from surprise billing or balance billing. *If you believe you've been wrongly billed,* you may contact the federal government's No Surprises Help Desk at 1 (800) 985-3059.

Visit https://www.cms.gov/nosurprises/consumers for more information about your rights under federal law.

Help Identify Fraudulent or Abusive Claims

Protect your Trust Fund by identifying and reporting fraudulent or abusive claims!

What to look out for:

- Billing for services that were never provided.
- Billing for medically unnecessary services.
- Duplicate submission of claims for the same service or supply
- Misrepresenting the service provided through:
  - Changing the service to a more expensive type of service.
  - Reporting the wrong diagnosis or service.
- Misrepresenting the dates, location or provider of the service.
- Soliciting, offering, or receiving a kick-back.
- Waiving or reducing deductibles/copayments.
- Intentionally omitting other coverage or supporting false injury claims for higher reimbursement levels.
- Shaping the diagnosis, treatment and/or billing coding to fit plan reimbursement provisions, for example:
  - Plastic surgery "nose job" billed as a deviated septum.
  - Altering the diagnosis code order for greater benefit.
  - Ordering tests inconsistent with diagnosis indicated.
  - Extensive testing for multiple family members.

If you identify any possible fraud or abuse in the claims submitted for services rendered for you or your eligible dependents, please notify the Trust Fund Office immediately

If you have any questions, please call the Trust Fund Office at (800) 752-2394 or (626) 279-3020 and/or visit our website, www.paintinganddrywalltrustfund.com.

Important Notice
About Your Privacy Practices For Protected Health Information
Southern California Painting and Drywall Industries Health & Welfare Trust Fund

We are required by law to remind you of the availability of the Fund's Notice of Privacy Practices issued in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA). A copy of the Notice of Privacy Practices was provided to you previously. Requests for copies of the Notice of Privacy Practices may be made to the Fund's Privacy Officer in writing, by email or by telephone at the address and telephone number listed below:

Contact information
Via e-mail: privacyofficer@pswadmin.com
Customer Service #: (626) 279-3020
Website: www.paintinganddrywalltrustfund.com

We will send a hard copy of the Notice to you by mail or, upon request, we can send you the notice electronically via e-mail.

Member notes

Southern California Painting and Drywall Industries Health & Welfare Fund
CHANGE OF ADDRESS NOTIFICATION FUND

Social Security Number

Employee's Last Name	First Name	M.I.	Date of Birth (mm/dd/yyyy)

Employee's OLD Address

Employee's NEW Address (provide Street, Apt. No., City, State, Zip Code)

Employee's NEW Mailing Address (if different from the line above)

Contact Telephone Number (include area code)	Preferred Language
☐ Daytime No _____	☐ English ☐ Spanish

Signature_____Date _____

Southern California Painting and Drywall Industries Health & Welfare Fund
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Signature_____Date _____