IMPORTANT NOTICE TO PLAN PARTICIPANTS

SUMMARY OF MATERIAL MODIFICATIONS TO THE SUMMARY PLAN DESCRIPTION FOR THE PAINTERS AND ALLIED TRADES DISTRICT COUNCIL 82 HEALTH CARE PLAN (Coverage A)

The Board of Trustees for the Painters and Allied Trades District Council 82 Health Care Plan Coverage A ("the Plan"), have made the following change to the Plan as further detailed below:

All Changes Effective July 1, 2023 (unless otherwise noted)

The Board of Trustees have made a number of changes to the Plan as further detailed below. ***Insert this notice into the Plan's Summary Plan Description which you recently received.***

Note: These changes will mean that the Plan is no longer considered a grandfathered health plan under the Affordable Care Act.

Annual Deductible – Medical Benefits

The Plan has made the following changes to the Annual Deductible as detailed in the table below.

Annual Deductible Effective July 1, 2023			**Previous Annual Deductible**		
	In-Network Providers	Out-of-Network Providers		In-Network Providers	Out-of-Network Providers
Individual	$250	$500	Individual	$250	$500
Family	$500	$1,000	Family	$750	$1,500

Annual Out-of-Pocket Maximum – Medical Benefits

The Plan has made the following changes to the Annual Out-of-Pocket Maximum as detailed in the table below.

Annual Out-of-Pocket Maximum Effective July 1, 2023			**Previous Annual Out-of-Pocket Maximum**		
	In-Network Providers	Out-of-Network Providers		In-Network Providers	Out-of-Network Providers
Individual Maximum	$2,250	$3,500	Individual Maximum	$2,000	$3,000

Family Maximum	$4,500	$7,000	Family Maximum	$6,000	$9,000

Additionally, the annual out-of-pocket maximum will include all member cost-sharing such as the Plan deductible, coinsurance and copayments. Previously it did not include the deductible.

Annual Out-of-Pocket Maximum – Prescription Drug Benefits

The Plan has added an Annual Out-of-Pocket Maximum applicable to the Prescription Drug Benefit. This means that once you have reached the annual maximum the Plan will cover benefits at 100%.

Annual Out-of-Pocket Maximum – Prescription Drug Benefits	
Individual	$5,000
Family	$10,000

Previously, there was not a limit to how much a member would have to pay for prescription drugs on an annual basis.

Prescription Drug Benefit

The Plan has modified minimum required copayments for certain prescription drugs as provided in the table below for prescriptions filled by a Member Pharmacy or through the Mail Order Program.

Member Co-Payment	**Retail Benefit**	**Mail Order Benefit**
Generic Drugs: Minimum & Maximum co-payment	10% co-pay with a minimum of $5.00 and a maximum co-pay of $50.00	5% co-pay with a $5.00 minimum and a maximum co-pay of $50.00
Single Source Brand [1] Name Drugs: Minimum & Maximum co-payment	10% co-pay with a minimum of $15.00 and a maximum co-pay of $50.00	5% co-pay with a minimum of $15.00 and a maximum co-pay of $50.00
Multiple-Source Brand [1] Name Drugs: Minimum & Maximum co-payment	10% co-pay with a $15.00 minimum plus the difference between the generic substitute and brand name price	5% co-pay with a $15.00 minimum plus the difference between the generic substitute and brand name price

[1] Specialty drug charges depend upon whether the specialty drug in question is a single or multiple source brand drug.

Previously, there was not a $5.00 minimum copayment for generic drugs under the Mail

Order Benefit. Additionally, the minimum copayment for Retail and Mail Order Brand Name prescription drugs is increased from $5.00 to $15.00.

Additional level of external third-party appeal for certain denied claim appeals

The Plan is amended to add provisions regarding your right to an external review of an adverse appeal decision in circumstances involving medical judgment or a recission of coverage. The following provisions address the new level of appeal.

External Third-Party Review of an Adverse Appeal Decision

If the Board of Trustees denies your claim appeal, you may further elect to have the adverse appeal determination be reviewed by an External Third-Party Review.

Standard External Review for Non-Urgent Claim

You may file a request for an external review within four (4) months after the date of receipt of a notice of an adverse benefit determination or final internal adverse benefit determination.

Within five (5) business days following the date of receipt of the external review request, the Plan Administrator will complete a preliminary review of the request to determine whether:

(A) You are or were covered under the Plan at the time the health care item or service was requested or, in the case of a retrospective review, were covered under the Plan at the time the health care item or service was provided;

(B) The adverse benefit determination or the final adverse benefit determination is not based on the fact that you were not eligible under the Plan;

(C) You have exhausted the Plan's internal appeal process (unless exhaustion is not required); and

(D) You have provided all the information and forms required to process an external review.

Within 1 business day after completion of the preliminary review, the Plan Administrator will notify you in writing regarding whether your claim is eligible for external review. To be eligible for external review, the adverse appeal decision must be based upon a medical judgment, or it must involve a rescission of coverage. If your request was not complete, the notice will describe information or materials needed to complete request. You will have until the end of the 4-month period you had to file a request for an external review or 48 hours (whichever is later) to complete your request. If your request is complete but not eligible for external review, the notice will include the reasons your request was ineligible and contact information for the Employee Benefits Security Administration.

If the request is complete and eligible for external review, the Plan Administrator will assign an accredited independent review organization (IRO) to conduct the external review.

(A) The IRO will utilize legal experts where appropriate to make coverage determinations under the Plan and will notify you in writing of the request's eligibility and acceptance for external review. You may submit additional information in writing to the IRO within 10 business days that the IRO must consider when conducting the external review.

(B) The Plan Administrator will provide documents and any information considered in making the adverse benefit determination or final internal adverse benefit determination to the IRO.

(C) The IRO will review all the information and documents timely received and is not bound by the Plan Administrator's prior determination. The IRO may consider the following in reaching a decision:

(i) Your medical records;

(ii) The attending health care professional's recommendation;

(iii) Reports from appropriate health care professionals and other documents submitted by the Plan Administrator, you, or your treating provider;

(iv) The terms of the Plan;

(v) Evidence-based practice guidelines;

(vi) Any applicable clinical review criteria developed and used by the Plan Administrator; and

(vii) The opinion of the IRO's clinical reviewer or reviewers after considering information noted above as appropriate.

(D) The IRO will provide written notice of the final external review decision within 45 days after the IRO receives the request for external review. The notice will contain a general description of the reason for the request for external review and a discussion of the principal reason or reasons for its decision, including the rationale for its decision and any evidence-based standards that were relied on in making its decision.

Expedited External Review

(A) You may request an expedited external review when you receive:

(i) An adverse benefit determination that involves a medical condition for which the timeframe for completion of an expedited internal appeal under the interim final regulations would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function and you have filed a request for an expedited internal appeal; or

(ii) A final internal adverse benefit determination, if you have a medical condition where the timeframe for completion of a standard external review would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function, or if the final internal adverse benefit determination concerns an admission, availability of care, continued stay, or health care item or service for which you received emergency services, but have not been discharged from a facility.

(B) Immediately upon receipt of the request for expedited external review, the Plan Administrator will determine whether the request meets the reviewability requirements noted above for standard external review and will notify you of its eligibility determination.

(C) When the Plan Administrator determines that your request is eligible for external review an IRO will be assigned. The Plan Administrator will provide all necessary documents and information considered in making the adverse benefit determination or final internal adverse benefit determination to the IRO by any available expeditious method.

(D) The IRO must consider the information or documents provided and is not bound by the Plan Administrator's prior determination. The IRO will provide notice of the final external review decision as expeditiously as your medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request for an expedited external review. If the IRO's notice is not in writing, the IRO must provide written confirmation of the decision within 48 hours to the claimant and the Plan.

The Plan has clarified its rules for Participants Retiring After December 31, 2004 effective January 1, 2023.

For Participants Retiring After December 31, 2004

The following provisions apply to individuals retiring on or after January 1, 2005. These rules and the benefits provided by the Plan are not vested and are subject to change or discontinuance at the discretion of the Trustees.

A retiring active employee who worked under the jurisdiction of The Painters and Allied Trades District Council 82 Health Care Plan or its Constituent Funds may become eligible to self-pay for medical, prescription drug, dental, vision, and hearing aid benefits provided he meets the following requirements:

(a) He had been eligible for benefits in at least thirty-six of the last sixty calendar months preceding his retirement;

(b) He is eligible for benefits on the date of his retirement, meaning that there is no gap in coverage between that as a covered employee and as a covered retiree;

(c) He is at least age 55.

In the event the individual is working in any trade in which Plan participants generally engage in the geographic area covered by the Plan but for which no contributions are being received by the Fund on his behalf, he will not be eligible to receive retiree coverage.

Eligibility for the retiree benefits will occur only after all of a Participant's Continuation Credits have been exhausted in accordance with the rules in Section 5 of this Article.

A Dependent spouse is eligible for coverage to be effective on the date the employee meets the requirements for retiree coverage and has made the required Self-Payments.

An employee must make application to be covered as a retiree by the Plan within three months of the date he becomes eligible. Any employee whose application is accepted by the Trustees will be required to make a monthly contribution in the amount and at such time as may be established by the Trustees from time to time.

Eligibility for retiree benefits will terminate for retirees and eligible Dependents on the last day of the benefit month in which the retired employee:

(a) Becomes eligible for Medicare Part A and B due to age or disability; or

(b) Fails to make the required contribution for the following month; or

(c) Dies.

If retiree benefits are terminated due to the retiree becoming eligible for Medicare or upon the death of the retiree, and the spouse of the retiree is not yet Medicare eligible, coverage may continue for the spouse and eligible dependent children, provided the non-discounted, required contributions are made to the Fund on a timely basis, until the spouse becomes eligible for Medicare or until the death of the spouse, if sooner. Please note that the retiree and/or their spouse must notify the Plan Administrator when they become eligible for Medicare.

The amount of the required Self-Payment will be determined annually by the Board of Trustees.

A discount to the retiree Self-Payment amount is available to some participants covered under the retiree program. The discount shall be based upon a retiree's number of pension credits accrued in the participant's pension fund, excluding any credits earned or credited due solely to a reciprocal agreement entered into by that pension fund. The discount applies only to the cost of the "retiree plan" and, like that plan, terminates at age 65.

A discount will only be provided to those participants who have accrued at least ten (10) pension credits. A discount from the unreduced retiree self-payment amount shall be earned for each pension credit. The discount applies only to the cost of the "retiree plan" described in this section, and like that plan, terminates at age 65. This discount formula, like all provisions affecting retiree coverage, is subject to alteration or termination by the Board of Trustees.

The discount for an individual retiring between the ages of 55 and 59, inclusive, shall be 1 1/2% per pension year of credit. The discount for an individual retiring at or after age 60 shall be 2% per pension year of credit.

The discount will not apply, however, to any increases in the required Self-Payment beginning with any increases effective on March 1, 2010.

Previously the Plan referenced age 65 as a reference to Medicare eligibility instead of Medicare eligibility.

Coverage of Covid-19 At-Home Tests Ends May 12, 2023

The Biden Administration has declared that the national emergency regarding Covid-19 ends on May 11, 2023. During the declared national emergency, the Plan has provided coverage for up to eight (8) Covid-19 At-Home Tests per individual per month. With the end of the national emergency, starting on May 12, 2023, the Plan will no longer cover the costs of Covid-19 At-Home tests.

Coverage of Covid-19 Related Claims as of May 12, 2023

The Biden Administration has declared that the national emergency regarding Covid-19 ends on May 11, 2023. During the declared national emergency, the Plan has provided coverage for Covid-19 related claims with no member cost sharing. With the end of the national emergency,

starting on May 12, 2023, the Plan will cover Covid-19 related claims in the same manner as all other benefits. Note that Covid-19 vaccinations received from an in-network provider will continue to be covered with no member cost sharing under the Affordable Care Act (ACA) preventive coverage guidelines.

Please insert this notice with your Summary Plan Description. If you have any questions regarding this notice, please contact the plan administrator at Wilson-McShane Corporation, 3001 Metro Drive, Suite 500, Bloomington, MN 55425, 952-854-0795.