# The Lithographers & Photoengravers

# Local 285 Welfare Fund

LOCAL 285M

# SUMMARY PLAN DESCRIPTION

Effective May 2019

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May 2019

To All Eligible Participants:

We are pleased to present you with this Summary Plan Description ("SPD"), which is the document that describes the benefits available under the Lithographers and Photoengravers Local 285 Welfare Fund ("Fund"). Because healthcare is so vitally important to you and your family, we urge you to read this booklet carefully.

This SPD describes the benefits to which you and your family are entitled, the rules governing these benefits, and the procedures that should be followed when filing a claim for benefits or requesting an appeal. The benefits provided by the Fund are insured. Those benefits, including benefits from Kaiser Permanente, National Vision Administrators, L.L.C., Cigna, and Mutual of Omaha, are governed by the terms of the insurance policies and statements of coverage issued by the carriers, and this is only a summary. You will receive additional materials from the carrier. The Fund's eligibility rules are governed by this SPD.

The benefits provided by the Fund comply with the requirements of the Patient Protection and Affordable Care Act ("PPACA"). For example, the Fund provides coverage for comprehensive preventive care without any deductibles or copayments and includes no annual or lifetime limits on essential medical benefits. In addition, dependent children are covered through age 25, regardless of full-time student status, financial dependency on a member, or whether they have health coverage available through their own employer.

The Board of Trustees of the Fund has the sole and exclusive power to make all final determinations regarding eligibility, benefits or any other matter relating to the Fund, including all interpretations of the Fund's governing documents. Those determinations are binding on all parties. Only the administrator and the full Board of Trustees are empowered to speak for the Fund.

The Trustees have the responsibility for overseeing the operation of the Fund. Part of their duty is to seek to maintain the financial stability of the Fund so that it can continue to pay benefits into the future. Consequently, as conditions change, the Board of Trustees may change, modify or eliminate any of the benefits offered by the Fund at any time.

Sincerely,

BOARD OF TRUSTEES

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## HIGHLIGHTS*

The Fund offers comprehensive medical coverage. For active employees and their dependents, as well as retirees and their dependents who are not yet eligible for Medicare who pay the required premium, the Fund provides benefits through Kaiser Permanente. The Fund offers three Kaiser Permanente Plans, a Kaiser Permanente Signature HMO Plan, a Kaiser Permanente Deductible HMO Plan, and a Kaiser Permanente Select Plan. The Kaiser Permanente Signature Plan will give you access to medical care through the Kaiser Permanente Medical Centers located throughout the region. The Kaiser Permanente Deductible HMO and Select Plans give you the option of accessing care either through the Kaiser Permanente Medical Centers or from the thousands of other providers who have joined their network. *See* p. 13. Furthermore, if you live and work more than 50 miles from a Kaiser Permanente facility, you may take advantage of the Kaiser Permanente Flexible Choice (Out-Of-Area) Plan. Retirees and their dependents who are Medicare-eligible and who pay the required premium for a Medicare Advantage plan through Kaiser Permanente can obtain care from any Kaiser Permanente Medical Center. *See* p. 3. In general, Kaiser Permanente provides comprehensive medical care, along with prescription drug coverage. Retirees have the additional option of getting coverage from the Graphic Communications National Health and Welfare Fund. *See* p. 3.

Whichever program of medical benefits you choose, you will also be eligible for the following additional benefits:†

- **Vision Care Benefits** provided through NVA. *See* p. 15.
- **Dental Benefits** provided through Cigna. *See* p. 15.
- **Life Insurance and Accidental Death and Dismemberment Insurance** provided through Mutual of Omaha**.** *See* p. 16.
- Weekly Sickness and Accident Benefits provided through Mutual of Omaha. *See* p. 18.

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* The coverage described here is only a summary provided for your convenience. The actual program of benefits, along with the terms and conditions of coverage, any applicable limitations and exclusions, the required claims and appeals procedures, and other important information is described in separately available materials.

† Retirees and their dependents must pay an additional premium for Vision Care Benefits and Dental Benefits. Retirees may pay an additional premium for a reduced Life Insurance Benefit. Accidental Death and Dismemberment Insurance and Weekly Sickness and Accident Benefits are not available for retirees or their dependents.

## ELIGIBILITY AND COVERAGE

### *WHO IS ELIGIBLE?*

#### *Active Employees – Eligibility and Contributions*

You are eligible for benefits during any month following a month for which a contribution is made by your employer. Except as described below under Termination of Coverage, a Member is eligible for benefits on the first day of any month following a month for which employer contributions are due and made on the Member's behalf, provided the Member makes any required employee contribution. The month for which an employer is required to make a contribution is determined by the applicable collective bargaining agreement.

Your Employer is required to contribute to the Fund at the rates set in its collective bargaining or other agreement. You are responsible for paying the difference between the contributions paid by your Employer and the cost of your coverage, as determined by the Board of Trustees. Ordinarily, the amount of your required contribution will be deducted from each of your paychecks. In the event that you are off work during a period when your Employer is required to make contributions on your behalf, it is your responsibility to make arrangements with your Employer to pay your share of the required contributions. If you fail to pay your required contributions, your coverage will terminate.

#### *Active Employees – Special Enrollment*

Under some collective bargaining agreements (including most of the former Bookbinders contracts), you may elect to decline coverage. Once you have done so, neither you nor any member of your family may reenroll, except as follows:

- You may reenroll during "open season", which is generally conducted in February of each year, with coverage effective March 1.

- If you declined enrollment because you or your family had other health insurance or group health plan coverage, you may enroll yourself and your dependents in this Fund if you or your dependents lose eligibility under that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 30 days after the other coverage ends (or after the employer stops contributing toward the other coverage).[3]

- If you or your dependents' Medicaid or Children's Health Insurance Program (CHIP) coverage is terminated as a result of loss of eligibility for such coverage or you or your dependents are determined to be eligible for employment assistance under Medicaid or CHIP to help pay for coverage under the Fund.

[3] You must provide a written statement, along with evidence of other coverage, in order to receive coverage from the Fund. If you fail to submit such a statement and evidence, you will not receive coverage from the Fund.

- If you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption or placement for adoption.

To request special enrollment, determine whether your CBA allows you to decline coverage, or obtain more information, contact the Fund Office at (866) 559-6512.

***Retirees***

The Fund also covers Employees who retire from Covered Employment. A former Employee is considered to have retired from Covered Employment if he or she begins to receive a pension from the Inter-Local Pension Plan, the GCIU Supplemental Retirement and Disability Fund, or any other pension plan sponsored in part by the GCIU or its affiliates, immediately upon terminating Covered Employment at or after reaching age 55.

Retirees have several options, depending upon their ages. Retirees who are not yet Medicare-eligible and non-Medicare-eligible dependents of a retiree may elect to receive medical coverage from the same Kaiser Permanente plans available to active employees. Upon reaching eligibility for Medicare, retirees and dependents may elect between two Medicare Advantage plans offered by Kaiser Permanente, "Plan A" or "Plan C++". Medicare-eligible retirees and dependents may choose between these two plans annually during Kaiser's open season, which normally takes place in October and November.

Alternatively, a Retiree may elect coverage under the Graphic Communications National Health and Welfare Fund ("GCN Fund"). The required contribution rates and the schedules of benefits for the GCN Fund are available upon request.

A Retiree receiving medical coverage may also elect to receive optical and dental care (*see* p. 15) and a reduced life insurance benefit (*see* p. 16), provided he or she pays the required additional premium. No other benefits are available to Retirees or their Eligible Dependents.

A Retiree who wishes to continue coverage under this Fund must elect such coverage immediately upon retirement. Employees who retire and do not immediately elect to continue coverage under this Fund will not be permitted to elect retiree coverage under this Fund at a later time. A Retiree may also elect coverage for his or her Eligible Dependents, but must do so at the same time he or she elects coverage for him- or herself.

Furthermore, a Retiree must elect any available options at the time he or she initially elects retiree coverage. Although some or all coverage may be dropped at any time (including life, dental or optical coverage, or coverage for a dependent), unless specifically provided for otherwise, ***once coverage is dropped, it is permanently lost and may never be resumed.***

A Retiree electing coverage under this Fund must pay the premiums determined by the Trustees by the twenty-fifth day of each month prior to the month for which coverage is sought. Failure to pay a premium by the tenth day of the month for which coverage is sought will result in the permanent termination of coverage for the Retiree and any Eligible Dependents.

Furthermore, the Fund does not send monthly bills. It is your responsibility to make sure all premiums are paid on a timely basis. ***If you fail to pay a premium when due, your coverage will be terminated without notice.***

***Eligible Dependents***

This Fund also covers Eligible Dependents of Active Employees and Retirees. Eligible Dependents include your Spouse and children until they turn age 26.

Coverage for an Eligible Dependent begins when the Employee's coverage begins.

Children are defined as your natural children, adopted children, and stepchildren. An adopted child is covered as of the day the child is placed with you for adoption, even if the adoption is not yet final. The term "placement," as used in this definition, means your assumption and retention of a legal obligation for total or partial support of the child in anticipation of adoption of the child.

Children are eligible for coverage under the Fund up to their 26th birthday. A child who is 26 or older may also be eligible for group coverage if he or she is physically or mentally incapable of self-support, either of which occurred while a dependent, and is not married. To extend a child's coverage under this provision, proof of incapacity must be received by the Fund Office within 30 days after the date coverage would normally terminate. Additional proof will be required each year thereafter.

In order for your Eligible Dependents to receive their coverage, you must submit with your application to the Fund a copy of your marriage certificate (if applying for coverage for your spouse) and copies of birth certificates and other necessary legal documents for your children (if applying for coverage for your eligible children).

The Fund complies with special enrollment rules required by the Health Insurance Portability and Accountability Act.

**Special Rule for Spouses of Retirees:** In general, once a dependent of a retiree drops coverage for any reason, that coverage is permanently lost and may never be resumed. The spouse of a Medicare-eligible retiree may, however, temporarily discontinue coverage from the Fund and later resume coverage provided:

- The spouse is covered under a comparable health plan maintained by his or her employer;
- The spouse remains continuously covered under such health plan during the entire period prior to the resumption of coverage by the Fund; and
- The required monthly premium is paid to the Fund no later than 30 days following the termination of the other coverage.

***Dependents Covered under Qualified Medical Child Support Orders***

The Fund will also enroll any of your natural or adopted children in accordance with a judgment, decree, or order issued by a court of competent jurisdiction or by a state administrative body that has the force of a court judgment, decree, or order that the Fund determines is a "Qualified Medical Child Support Order" ("QMCSO"), as defined in the Employee Retirement Income Security Act of 1974 ("ERISA"). QMCSOs may compel this Fund to provide health benefit coverage for your children even if you do not have custody of them. To be a QMCSO, a judgment, decree, or order must require enrollment in the Fund as a form of child support or health benefit coverage pursuant to state domestic relations law or enforce a state law relating to medical child support and must include:

- Your name and last known mailing address, and the name and mailing address of each child covered by the order,
- A reasonable description of the type of coverage to be provided by the Fund,
- The period of coverage to which the order pertains, and
- The name of the Fund.

Such an order is not a QMCSO if it requires the Fund to provide any type or form of benefit not otherwise provided under the Fund except to the extent necessary to comply with a state law relating to medical child support orders. Upon receipt of an order, the Fund will notify you and each child covered by the order submitted for determination that the order has been received and of the Fund's procedures for determining whether the order is a QMCSO. You may also obtain upon request and without charge a copy of the Fund's QMCSO procedures. The Fund will notify you and each affected child in writing of its determination as to whether an order is a QMCSO.

***Change in Family Status***

You have an obligation to advise the Fund Office in writing of any change in family status (*e.g.*, divorce, addition to or deletion from the family, *etc.*), within 21 days of such change, and provide any documentation deemed necessary by the Fund Office relating to such change.

This information is necessary to avoid any delays in the processing of your claims. Furthermore, it is necessary because members of your family who would otherwise lose coverage may have a right to self-pay for continuing coverage, a right that will be forfeited if the Fund Office does not receive proper notice. *See* pp. 7 - 10. Advising the Fund Office of any change in family status is also important to avoid any mispayment of claims for individuals who are no longer entitled to coverage under the Fund. If the Trustees pay a claim for benefits by or on behalf of you or your family member who is no longer eligible for benefits under the Fund because you have failed to advise the Fund Office in writing of a change in family status as required above, the Trustees will hold you financially responsible. If any benefits are paid to or on behalf of your ineligible family members, you and any Eligible Dependents may be denied all further benefits until restitution of the money improperly obtained (whether by offset or otherwise) is made to the Fund.

## MAINTAINING COVERAGE DURING ABSENCES

### *Short-Term Absences from Covered Employment*

Except as required under the Family and Medical Leave Act, your Employer's obligation to make contributions on your behalf is governed by the terms of the applicable collective bargaining agreement. Under many of those agreements, Employer contributions to the Fund are owed for you if you are absent from Covered Employment due to a disability for up to six months. Additionally, under these contracts, Employer contributions are generally due for you if you experience a second period of absence due to disability, provided that you have returned to full-time employment from a prior absence for a period of at least 30 days.

During any period when you are on unpaid leave and your Employer is required to continue making contributions to the Fund on your behalf, you must make arrangements with your Employer to continue to pay your Employee Contributions. ***Failure to pay your Employee Contributions will result in the termination of your coverage,*** even if your Employer continues making contributions on your behalf. If you are receiving Sickness and Accident Benefits, your Employee Contributions will be automatically deducted from your weekly benefit, so that you will not have to make separate arrangements with your Employer. Once your Sickness and Accident Benefits cease, however, if your Employer continues to be required to make contributions to the Fund on your behalf, you must make arrangements with your Employer for payment of your Employee Contributions or your coverage will be terminated.

### *Family and Medical Leave Act of 1993*

If you are off on leave that qualifies under the Family and Medical Leave Act ("FMLA") of 1993, your Employer will continue to be required to make contributions on your behalf in order to maintain your coverage. That obligation will cease, however, if you fail to pay your required employee contributions. If you do not return to work after your period of leave has ended, your Employer may have the right to recover its share of contributions from you. As with any other form of leave where your Employer is required to make contributions on your behalf, you must make arrangements with your Employer to continue to pay your Employee Contributions or your coverage will be terminated.

The FMLA generally entitles employees to take up to 12 weeks of unpaid leave each year for the employee's own illness, or to care for a seriously ill child, spouse or parent. (State law may provide different leave periods.) In addition, the FMLA provides leave for the birth or placement of a child with the employee in the case of adoption or foster care. Employees eligible for leave under the FMLA are those who have been employed at least 12 months by the Contributing Employer and who have provided at least 1,250 hours of service to the Employer. An employee at a work site at which there are fewer than 50 employees is not eligible for FMLA leave unless the employer's total number of employees within a 75-mile radius of that work site equals or is greater than 50.

Contact the Fund Office if you are planning to take FMLA leave so that the Fund is aware of your Employer's responsibility to report and make contributions for the period of your absence. In addition, if you have any questions about the FMLA, you should contact your Employer or the nearest office of the Wage and Hour Division, listed in most telephone directories under the U.S. Government, Department of Labor, Employment Standards Administration.

### *TERMINATION OF COVERAGE*

The following circumstances will result in termination of your coverage:

- Failure of a Contributing Employer to make contributions on your behalf to the Fund;
- Failure of an Employee to make any required contribution or premium payment for coverage.
- Failure of a Retiree (or his Spouse, where applicable) to make timely contribution or premium payments to the Fund, as required by the Trustees;
- Entry into the Uniformed Services, as defined in the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), for active military duty or training, inactive duty or training, full-time National Guard or Public Health Service duty, or fitness-for-duty examination.

Notwithstanding the above, or any other provision of the Fund to the contrary, contributions, benefits, and service credit with respect to qualified military service will be provided in accordance with Section 414(u) of the Internal Revenue Code. Check with the Fund Office if you believe you may be eligible for benefits or coverage under the Fund in accordance with federal law governing military service.

Effective for members terminating employment on or after June 1, 2014, Fund coverage will terminate on the last day of the month in which the member ceases covered employment with the employer. Additional conditions that can result in termination of coverage, such as the member's failure or an employer's failure to remit monthly contributions, remain in effect. Please consult the section of this Summary Plan Description titled "Continuation of Coverage (COBRA") on pages 7 – 10 for additional information on options for obtaining continued health care coverage after cessation of covered employment.

### CONTINUATION OF COVERAGE (COBRA)

This section has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage by the fund. **This section 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 Fund and under federal law, you should contact the Fund Office.

**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 Fund 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 section. 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 Fund is lost because of the qualifying event. Under the Fund, 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 Fund 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."

- Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to a contributing employer, and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee will become a qualified beneficiary. The retired employee's spouse, surviving spouse, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

***When is COBRA continuation coverage available?***

The Fund 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;
- Commencement of a proceeding in bankruptcy with respect to the employer; 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 Fund Office within 60 days after the qualifying event occurs.**

***How is COBRA continuation coverage provided?***

Once the Fund Office receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries, with information about the cost of the coverage. 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 Fund is determined by Social Security to be disabled and you notify the Fund Office 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. Please provide the Fund Office with a copy of the Social Security disability determination when you give notice about the disability.

**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 Fund Office 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 the Fund or your COBRA continuation coverage rights should be addressed to the Fund Office with the contact information provided in this SPD. 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**.

***Benefit Options***

At the time you are first offered the opportunity to self-pay for COBRA Continuation Coverage, you will be permitted to buy medical coverage bundled with vision and dental coverage if you are an active employee or the spouse or dependent of an active participant. If you are a retiree or the spouse or dependent of a retiree, you will also be permitted to separately buy only medical

coverage or buy various optional forms of coverage (including prescription drug coverage, dental coverage and vision care benefits).

Additionally, you may also buy continued life insurance coverage (for the former Employee only). If you select an optional form of coverage, you will be permitted to drop that coverage at any time. However, once you have dropped any optional form of coverage, or if you do not choose an optional form of coverage when it is first offered to you, you will not be permitted to resume it later.

***Termination of COBRA Continuation Coverage***

COBRA continuation coverage may terminate earlier than the maximum period (18, 29 or 36 months) if:

- All health benefits provided by the Fund terminate;
- An Employee, spouse or dependent child who has elected COBRA continuation coverage does not make the required payments to the Fund on time;
- An Employee becomes covered under Medicare; or
- An Employee, spouse or dependent child becomes covered by another group health plan, unless that replacement plan limits coverage due to pre-existing conditions, and the pre-existing condition limitation actually applies to the individual.
- Failure to pay a premium when due. Furthermore, the Fund does not send monthly bills. It is your responsibility to make sure all premiums are paid on a timely basis. ***If you fail to pay a premium when due, your coverage will be terminated without notice.***

## *COORDINATION WITH OTHER HEALTH BENEFITS*

In general, each of the Fund's benefit providers have their own coordination of benefits policies and procedures. Those rules are explained in materials that have been provided separately to you, and are incorporated here by reference. For additional information on these policies and procedures, please review the materials provided by the particular provider, or call the provider or the Fund Office.

In the event one of the Fund's benefit providers does not have its own coordination of benefits policies and procedures, or if the benefit is provided directly by the Fund, the following policy applies. A plan is considered to be any group insurance coverage or other arrangement of coverage for individuals in a group which provides medical or dental benefits or services on an insured or self-insured basis, and any government program providing benefits or services of a similar nature, including insurance which you are required by law to purchase, *e.g.*, state mandated no-fault auto insurance. An "allowable expense" is any necessary, reasonable and customary item of expense covered in full or in part under any one of the plans involved. A plan also includes any individual contract of insurance which covers a participant of this plan or a dependent.

The Fund Office may exchange benefit information with other insurance companies, organizations and individuals, and has the right to recover any overpayment made to you if you neglect to report coverage under any plan. In order to obtain all benefits available to you, a claim should be filed under each plan.

With respect to any two plans which provide coverage, one is primary, the other is secondary. The primary plan pays benefits first and without consideration of the other plans. The secondary plan or plans, in order of priority, then makes up the difference up to the total allowable expenses. No plan will pay more than it would have paid without this special provision.

A government or tax supported plan (unless otherwise required by applicable federal law), or a plan which has no coordination of benefits provision, is automatically primary.

A plan is primary if it covers the individual as a present employee and secondary if it covers the individual as a dependent or otherwise. However, if the individual is covered as a dependent under two or more plans, the primary coverage is that of the parent whose birthday is earlier in the calendar year. In the event there is a coordination rule conflict, the Fund will use the rules adopted by the National Association of Insurance Commissioners.

In the event that the Fund is secondary with respect to a particular claim, and the primary plan will not pay as a result of your failure to properly follow the procedures of the primary plan (including the failure to use participating providers, etc.), the Fund will pay no more than the amount it would have paid had you followed the primary plan's procedures. Information necessary to the administration of this provision will be required at the time a claim is submitted.

## *SUBROGATION*

Benefits provided are generally subject to each of the Fund's benefit providers' respective subrogation rules. Those rules are explained in materials that have been provided separately to you, and are incorporated here by reference.

The following rules apply if you receive benefits from the Fund directly or from a Fund provider that does not have subrogation rules:

If someone else (including an insurance company) is responsible for paying your medical expenses, in order to receive any benefits from the Fund, you must assign and subrogate your right to collect from that person to the Fund. To that end, if someone else is responsible for your expenses, each of the Fund's benefit providers will generally have their own subrogation forms and procedures that you must follow in order to be eligible to receive benefits from that provider. Those procedures are described in more detail in the materials provided by each such provider. In the event that the individual provider does not have such forms or procedures, or in the case of benefits provided directly by the Fund, before receiving any benefits in such a case, you and your attorney are required to complete a subrogation form supplied by the Fund Office. In all such cases (regardless of whether you actually sign a subrogation agreement), the Fund is only

providing benefits for your convenience, and retains the right to recoup what it has paid from any amounts you may receive from the responsible person.

## MEDICAL BENEFITS
## KAISER PERMANENTE SIGNATURE, SELECT AND OUT-OF-AREA PLANS

The following is a general description of the benefits, services, exclusions, and limitations provided under the Kaiser Permanente Signature Plan, the Kaiser Permanente Deductible HMO Plan ("Deductible Plan"), the Kaiser Permanente Select health benefit Plan ("Select Plan") and the Kaiser Permanente Flexible Choice ("Out-of-Area Plan"). This is only a summary and does not fully describe your benefit coverage. For details on your benefit coverage, please refer to the Group Agreement Face Sheet, Group Evidence of Coverage and applicable Riders. The Evidence of Coverage is the legally binding document between Kaiser Permanente and its members. In the event of ambiguity, or a conflict between this summary and the Evidence of Coverage, the Evidence of Coverage shall control. Additionally, you should have received additional materials from Kaiser Permanente describing its Deductible Plan, Select Plan and Out-of-Area Plan, which are incorporated here by reference.

- **If you are an active employee or an eligible retiree not yet eligible for Medicare, or a dependent not yet eligible for Medicare, your benefits will be provided through one of the Kaiser Permanente Plans.**
- **If you or a dependent live and work more than 50 miles from a Kaiser Permanente center, you may have the option to enroll in the Kaiser Permanente Out-of-Area Plan.**
- **If you are a retiree or dependent and you are eligible for Medicare, your benefits will be provided by a Kaiser Permanente Medicare Plus Plan. (*See* p. 14.)**

The Kaiser Signature, Deductible, Select and Out-of-Area Plans each use different groups of providers. Benefits under the Kaiser Permanente Signature Plans, as well as the Kaiser Permanente Medicare Plus Plans, are provided through the Kaiser Permanente Health Centers. If you elect to use the Deductible or Select Plans, you have your choice of using a Kaiser Permanente Health Center or any of the thousands of participating providers located throughout the region. You can locate the nearest Health Center and find participating providers by consulting the directory provided in your enrollment materials or, for more up-to-date information, by calling Kaiser at (301) 468-6000, toll free at (800) 777-7902, or by visiting them on the web at www.kp.com.

Under the Out-of-Area Plan, you have your choice of an even larger, nation-wide network of providers to choose from. The Kaiser Out-of-Area Plan uses the Private Healthcare Systems ("PHCS") Network. To find providers in this network, visit them on the web at www.multiplan.com/kpmas.

With the exception of Emergency Services and Out-of-Area Urgent Care Services, all covered in-plan services must be provided by, or authorized and arranged by, your Plan Primary Care Physician. Gynecology, behavioral health, substance abuse, and optometry services may be obtained without a referral from your Primary Care Physician; however, they must be provided by a Plan Physician or other Plan Provider.

Because the Out-of-Area Plan uses providers who are not part of Kaiser's own network, you are also responsible for precertifying all hospital admissions by calling SHPS at (800) 448-9776 prior to your admission. In case of emergency, you must notify SHPS within 48 hours of admission or by the end of the first business day following treatment (whichever is later). SHPS is open 24 hours a day, 7 days a week. Failure to precertify may result in penalties.

A schedule of benefits, along with a listing of the terms and conditions of coverage for each (sometimes known as the "Certificate of Insurance" or "Evidence of Coverage"), has been provided to you and is incorporated here by reference. If you need an additional copy of any of these documents, please contact the Fund Office or Kaiser Permanente.

**KAISER PERMANENTE MEDICARE PLUS PLAN**

If you are an eligible retiree who is also eligible for Medicare, or if you are the dependent of an eligible retiree and are also eligible for Medicare, you may enroll in the Kaiser Permanente Medicare Plus Plan A ("Medicare Plan A") or the Kaiser Permanente Medicare Plan C++ ("Medicare Plan C++") (collectively the "Medicare Plans"). Under the Medicare Plans, you will generally use one of the Kaiser Permanente Health Centers located throughout the region, unless you are referred to an outside provider. Detailed information on Kaiser's Medicare Plans is available from the Fund Office, and is incorporated herein by reference.

## VISION CARE BENEFITS

Vision Care Benefits are provided through National Vision Administrators, L.L.C. (NVA). NVA maintains a network of providers, who offer complete eye examinations, as well as frames and corrective lenses, subject to the Fund's copayments, deductibles and maximum benefits. A listing of network providers is available from the Fund Office. In addition, you can obtain an up-to-date listing of providers by calling NVA at (800) 672-7723, or by visiting their Web site at www.e-nva.com. You are also permitted to use non-network providers. However, if you do, you will end up paying more out of your own pocket.

The terms of the benefit, including any applicable limitations, restrictions, exclusions and pre-authorization requirements are detailed in the separate booklet provided by NVA, which is incorporated by reference. If you do not already have a copy of that booklet, you may receive one upon request, either directly from NVA or from the Fund Office. Additional information is available on the NVA Web site at www.e-nva.com.

## DENTAL BENEFITS

Dental benefits are provided through Cigna Health and Life Insurance Company ("Cigna"). The Fund offers two Plans through Cigna, an HMO Plan and for an additional cost, a PPO Plan. The HMO Plan requires you to choose a primary care dentist from the Cigna Dental Care network and you may only receive care from the primary care dentist listed on your dental Identification Card. The HMO Plan follows a Patient Charge Schedule which lists the benefits of the Dental Plan included covered procedures and patient charges. Procedures listed on the Patient Charge Schedule are subject to the plan limitations and exclusions described in your Certificate of Coverage Booklet. The PPO Plan is available for an extra fee and does not require a primary care dentist. You may choose any dentist; however, to take advantage of the in-network benefit you must use a Cigna DPPO Advantage Provider. You are not required to have an Identification Card in order to see a provider.

To find a conveniently located participating dentist for either Plan, you may call Cigna at (800) 244-6224 or go to www.my.Cigna.com.

The terms of the benefit, including and any applicable limitations, restrictions, exclusions and pre-authorization requirements are detailed in the separate booklet provided by Cigna, which is incorporated here by reference. If you do not already have a copy of that booklet, you may receive one upon request, either directly from Cigna or from the Fund Office.

## LIFE AND ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE

Life Insurance and Accidental Death and Dismemberment (AD&D) Insurance provides you and your family with financial protection in the event of your death or serious injury. The Policy is underwritten by Mutual of Omaha Insurance Company. Life Insurance benefits are available only to active, full-time Employees and to Retirees. Life Insurance coverage is not provided to Dependents. AD&D Benefits are only available to active, full-time Employees. AD&D Benefits are not available to Retirees or Dependents. Furthermore, your coverage does *not become effective* until you have properly filled out an enrollment form provided by Mutual of Omaha. If you do not have a form, it will be provided to you by the Fund Office. Once you have enrolled, you will receive a Certificate of Insurance from Mutual of Omaha.

### SCHEDULE OF BENEFITS

| | **Active Employee** | **Retiree** |
|---|---|---|
| Life Insurance Benefit | $20,000 | $4,000 |
| AD&D Maximum Benefit | $20,000 | None |

This description provides only a brief summary of the benefits under the Policy and is provided for your convenience. The actual terms of the benefits, including any applicable limitations, restrictions, exclusions, and requirements are detailed in the policy itself available from Mutual of Omaha, and in the Certificate of Insurance, which are incorporated here by reference. If you do not already have a copy of the Policy or Certificate, you may receive one upon request, either directly from Mutual of Omaha or from the Fund Office.

#### *Living Benefit*

If you suffer from a condition that is expected to result in your death within 12 months, and from which there is no reasonable prospect of recovery, you or your legal representative may request Living Benefits in an amount up to one-half of your life insurance amount. Living Benefits will be paid in a lump sum, and the amount of your Life Insurance will be reduced by the amount you receive.

#### *Exclusions*

Life Insurance and AD&D Benefits are generally not payable for a loss that results from an intentionally self-inflicted injury, while sane or insane; any act of war, declared or undeclared; participating in a riot or civil disorder of any kind; engaging in an illegal occupation; any attempt to commit, or commission of, a felony; active military duty; release of nuclear energy; flying in an aircraft other than as a fare-paying passenger; or being under the influence of any drug (other than one prescribed by a licensed physician that was used as prescribed).

#### *Beneficiary*

In order to name a beneficiary to receive the proceeds of your life insurance policy following your death, you must properly fill in and return the form provided by Mutual of Omaha.

Generally, a beneficiary designation does not become effective until it is actually received by Mutual of Omaha. If you do not properly designate a beneficiary before your death (or if you are predeceased by all of your designated beneficiaries), your life insurance benefit will be paid to your estate.

***Conversion Privilege***

If your coverage ends for any reason except non-payment of premiums, you may contact Mutual of Omaha regarding the issuance of a policy of individual life insurance.

***Accidental Death & Dismemberment Insurance Benefit***

AD&D Benefits are available only to Active Employees and are payable if you suffer the loss of a limb, eyesight, hearing, etc., as the result of an accident or other injury not subject to an exclusion. This benefit is *in addition* to any life insurance benefit you may be entitled to receive, and does not reduce the amount of any life insurance benefit to which you may ultimately become entitled.

## SICKNESS AND ACCIDENT BENEFIT

If, while you are covered and actively at work, you become unable to work due to accidental bodily injury, disease or pregnancy, the Fund will pay you a weekly Sickness and Accident Benefit of $200 per week. Benefits will begin after you are forced to miss work, subject to a five-day waiting period for disabilities due to sickness, and will continue until you are well enough to return to work up to the maximum duration. If you remain unable to return to work as the result of a separate accidental bodily injury, disease or pregnancy occurring while you are off work, your benefits may continue, but not beyond the original 26-week period.

Successive absences from work separated by fewer than two weeks of continuous full-time active work will be considered as one period in determining the benefits available to you, unless the subsequent absence is due to an injury or disease entirely unrelated to the causes of the previous absence and commences after you return to full-time active work. Sickness and Accident Benefits are not assignable, and may only be paid to the disabled employee.

This benefit is provided through an insurance policy with Mutual of Omaha. This is only a brief summary of the benefit, which is subject to the terms of that policy. The policy is incorporated here by reference. You may get a copy of the policy from the Fund Office.

### *LIMITATIONS*

Sickness and Accident Benefits will not be payable for disability due to any of the following causes:

- Injury, disease or pregnancy for which you are not under treatment by a physician.
- Disease or injury that are work-related, regardless of whether you are entitled to benefits under any Workers' Compensation Law or Act.
- Benefits cease to be payable once you have retired under any pension plan maintained wholly or in part by your employer, including the Inter-Local Pension Plan and the GCIU Supplemental Retirement and Disability Fund.

## CLAIMS AND APPEALS PROCEDURES

All claims and appeals relating to your benefits under the following programs are subject to the claims and appeals procedures (including any pre-service procedures) of the organization providing the benefit:

- Kaiser Permanente
- Graphic Communications National Health and Welfare Fund
- National Vision Administrators, L.L.C.
- Cigna
- Mutual of Omaha

Information and procedures about how to make and file claims and appeals with each of these organizations are detailed in the materials provided from those organizations. You may obtain those materials directly from the organization or from the Fund Office. You should be aware that it is important that you follow the procedures in making your claims and appeals. Otherwise, your claims will not be paid.

Claims and appeals relating to the following are to be sent directly to the Fund Office:

- General Eligibility/Participation
- Other Issues Not Governed by the Insurance Contracts

### *THE CLAIM FORM*

When required, claim forms are generally provided by the organization delivering the benefit. Contact the organization or the Fund Office for a claim form. A new claim cannot be processed without a FULLY COMPLETED claim form. So make sure you answer all the questions. Unanswered questions will delay benefit consideration until the missing information is obtained.

### *PAYMENT OF CLAIM*

No action at law or in equity may be brought to recover from the Fund prior to 60 days after proof of expense has been furnished in accordance with these provisions, and until the administrative remedies provided under the Fund have been exhausted, nor may such action be brought at all unless brought within 3 years following the time the service is, or would have been, provided. If any time limitation specified above is less than that permitted by federal law, such limitation is hereby extended to agree with the minimum period permitted by such law.

Address of Fund Office and Trustees:

Lithographers and Photoengravers Local 285 Welfare Fund
911 Ridgebrook Road
Sparks, MD 21152
(866) 559-6512

## ***NOTICE OF FUND DETERMINATIONS***

For claims concerning general eligibility or participation, the Fund Office will notify you of its decision regarding such claim within a reasonable period of time, but no later than 45 days from receipt of the claim. The Fund Office may extend the period to notify you of its decision for up to an additional 30 days if the extension is necessary due to matters beyond the plan administrator's control. If the Fund Office decides to extend the notification period, it will notify you of that decision prior to the expiration of the initial expiration period, including the reason for the extension and the date it expects to make its determination. The Fund Office may extend the date for responding to your claim for a second 30-day period, if required due to matters beyond the control of the Fund Office. If an extension is required because you have failed to submit all necessary information, the Fund Office will specifically describe the information needed from you and you will be allowed 45 days to provide any necessary information not included in the initial claim.

## ***FUND REVIEW PROCEDURE***

If a claim to the Fund Office is denied or partly denied, you will be notified in writing within the applicable time period and given the opportunity for a full and fair review.

The written denial will give: (a) specific reason(s) for denial, (b) a reference to the specific Plan provision(s) on which the denial is based, (c) a description of any additional material or information necessary to perfect the claim and the reason why such material or information is needed, (d) an explanation of the Fund's claim review procedure, including a statement of your right to bring a civil action under Section 502(a) of ERISA following a denial by the Board of Trustees, and (e) if any internal rule, guideline, protocol or other similar criterion was relied on in making the denial, either the specific rule, guideline, protocol or other similar criterion, or a statement that such a rule, guideline, protocol or other similar criterion was relied upon in making the denial and that a copy of such rule, guideline, protocol or other similar criterion will be provided to you free of charge upon request.

If your claim is not acted on within a reasonable time, you may proceed to the appeal procedure, described below, as if the claim had been denied.

## ***FUND APPEAL PROCEDURE***

When a claim has been denied or partly denied, you may appeal the denial to the Board of Trustees.

Within one hundred eighty (180) days after you receive written notice of a denial, you or your representative may make a written request for an appeal to:

Board of Trustees of the Lithographers and
Photoengravers Local 285 Welfare Fund
911 Ridgebrook Road
Sparks, MD 21152-9451
(866) 559-6512

You may obtain pertinent documents relating to the denial and you may submit issues and comments in writing. You may also provide the Trustees with any additional documents you consider relevant to your appeal.

If you do not submit a written request for review to the Board of Trustees within 180 days of notice of the denial, you will waive your right to appeal and the denial will be final and binding.

*Trustees' Review*

The Trustees' review of your appeal will consider all comments and documents that support your position, even if the initial determination did not include such information.

The review on appeal is made by the Trustees, none of whom decided the initial claim for benefits or is the subordinate of any individual who decided the initial claim. In deciding the appeal, the Trustees will give no deference to the initial denial or adverse determination. In case of a claim based in whole or in part on a medical judgment, a health care professional who has appropriate training and expertise in the field of medicine, and who was not consulted in connection with the initial claim, will be consulted. The medical or vocational expert(s) whose advice was obtained by the Plan in connection with the adverse determination will be identified upon request.

*Timing of Trustees' Decision*

For urgent care claims, which are claims involving a medical emergency that endangers your life or your ability to regain physical function or that in your advising medical practitioner's opinion will cause you severe pain if you do not receive the care in an expedited amount of time, the Trustees will provide their decision as soon as possible, but no later than 72 hours after receiving your appeal. In the case of an urgent care claim, you may request review orally or in writing, and communications between you and the Plan may be made by telephone, facsimile, or other similar means.

For pre-service claims, which are claims for benefits for which you have not yet received treatment, the Trustees will provide a decision not later than 15 days after receiving your appeal.

For post-service claims, which are claims for benefits for which you have already received treatment, the Trustees will make a decision no later than the next scheduled meeting of the Board of Trustees that immediately follows receipt of your request for a review, unless the request for review is filed within thirty (30) days preceding the date of such meeting. In such case, a

decision by the Board of Trustees will be made no later than the date of the second meeting of the Board of Trustees following receipt of the appeal. If special circumstances require a further extension of time for processing, the Board of Trustees will decide your appeal no later than the third meeting of the Board of Trustees following receipt of the request for review. If such an extension of time for review is required because of special circumstances, you will be provided with written notice of the extension, a description of the special circumstances, and the date the decision will be made, prior to the commencement of the extension. Once the Trustees have made a decision, you will receive notice of it within five (5) days.

*Content of Decision*

You will receive written notice of the Trustees' decision that describes the specific reasons for the decision and the specific plan provisions upon which the determination was made. The decision will include a statement that you are entitled to receive, upon request and without charge, all documents, records and other information relevant to the appeal. The notice will also include a statement of your right to bring a civil action under Section 502(a) of ERISA.

If the Trustees relied on any internal rule, guideline, protocol or other similar criterion to make their decision, the notice of the decision will include a statement that such a rule, guideline, protocol or other similar criterion was relied upon in making the determination on review and that a copy of such rule, guideline, protocol or other similar criterion will be provided to you free of charge upon request. If the determination on review is based on a determination of medical necessity, experimental treatment, or a similar exclusion or limit, the denial will provide either an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to your medical circumstances or a statement that such explanation will be provided free of charge of charge upon request. If the Fund consulted with any medical or vocational experts on your case, the identity of such experts will be disclosed to you upon request. The decision by the Board of Trustees will be final and binding on all parties, and in the event you seek judicial review, their decision will be subject to limited review to determine only whether such decision was arbitrary and capricious.

## PRIVACY AND SECURITY INFORMATION

## NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. **PLEASE REVIEW IT CAREFULLY.**

This Notice is effective March 1, 2019 and will remain in effect until the Fund publishes a revised Notice as explained below.

***Your Rights***

**When it comes to your health information, you have certain rights.** This section explains your rights and some of the Fund's responsibilities to help you.

**Get a copy of health and claims records**

- You can ask to see or get a copy of your health and claims records and other health information the Fund has about you. Ask the Fund Office how to do this.

- We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

**Ask us to correct health and claims records**

- You can ask us to correct your health and claims records if you think they are incorrect or incomplete. Ask us how to do this.

- We may say "no" to your request, but we'll tell you why in writing within 60 days.

**Request confidential communications**

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.

- We will consider all reasonable requests, and must say "yes" if you tell us you would be in danger if we do not.

**Ask us to limit what we use or share**

- You can ask us not to use or share certain health information for treatment, payment, or our operations.

- We are not required to agree to your request, and we may say “no” if it would affect your care.

**Get a list of those with whom we’ve shared information**

- You can ask for a list (accounting) of the times we’ve shared your health information for six years prior to the date you ask, who we shared it with, and why.

- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We’ll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

**Get a copy of this privacy notice**

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

**Choose someone to act for you**

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.

- We will make sure the person has this authority and can act for you before we take any action.

**File a complaint if you feel your rights are violated**

- You can complain if you feel we have violated your rights by contacting us using the information on page 27.

- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling (877) 696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.**

- We will not retaliate against you for filing a complaint.

**Your Choices**

**For certain health information, you can tell us your choices about what we share.** If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in payment for your care

- Share information in a disaster relief situation

*If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.*

In these cases we *never* share your information unless you give us written permission:

- Marketing purposes

- Sale of your information

**Our Uses and Disclosures**

**How do we typically use or share your health information?**

We typically use or share your health information in the following ways.

**Help manage the health care treatment you receive**

We can use your health information and share it with professionals who are treating you.

*Example: A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services.*

**Run the Fund**

- We can use and disclose your information to run the Fund and contact you when necessary.

- We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage. This does not apply to long term care plans.

*Example: We use health information about you to develop better services for you.*

**Pay for your health services**

We can use and disclose your health information as we pay for your health services.

*Example: We share information about you with your dental plan to coordinate payment for your dental work.*

**Administer your plan**

We may disclose your health information to your health plan sponsor for plan administration.

*Example: Your company contracts with us to provide a health plan, and we provide your company with certain statistics to explain the premiums we charge.*

**How else can we use or share your health information?**

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html**.**

**Help with public health and safety issues**

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

**Do research**

We can use or share your information for health research.

**Comply with the law**

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

**Respond to organ and tissue donation requests and work with a medical examiner or funeral director**

- We can share health information about you with organ procurement organizations.
- We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

**Address workers' compensation, law enforcement, and other government requests**

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

**Respond to lawsuits and legal actions**

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

**Our Responsibilities**

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html**.**

**Changes to the Terms of this Notice**

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, on our web site, and we will mail a copy to you.

If you have any questions or complaints about the Fund's privacy practices or this Notice or if you wish to obtain additional information about the Fund's privacy practices, please contact:

HIPAA Privacy Officer
Lithographers and Photoengravers Local 285 Welfare Fund
911 Ridgebrook Road
Sparks, MD 21152-9451
(866) 559-6512

## DATA SECURITY POLICY

The Trustees have a duty to:

1. Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the electronic protected health information that it creates, receives, maintains, or transmits on behalf of the group health plan;

2. Ensure that the adequate separation required by HIPAA privacy rules (42 CFR § 164.504(f)(2)(iii)) is supported by reasonable and appropriate security measures; and

3. Ensure that any agent, including a subcontractor, to whom the Board of Trustees provides this information agrees to implement reasonable and appropriate security measures to protect the information; and

   Report to the Fund any security incident of which they become aware.

## BASIC PLAN INFORMATION

### 1. TYPE OF PLAN

This Fund provides coverage for hospitalization, physician's care, disability income, life insurance benefits, dental care, vision care, and prescription benefits to eligible participants and their qualified dependents.

### 2. PLAN IDENTIFICATION NUMBER

Employer Identification Number: 23-7237228
IRS Plan Number: 501

### 3. PLAN ADMINISTRATOR

Board of Trustees
Lithographers and Photoengravers Local 285 Welfare Fund
911 Ridgebrook Road
Sparks, MD 21152
(866) 559-6512

The Trustees have the authority to contract and manage the operation and administration of the Fund.

### 4. SERVICE OF LEGAL PROCESS

Service of legal process may be made upon any Trustee.

### 5. TYPE OF ADMINISTRATION OF THE FUND

The Fund is administered by the Board of Trustees.

Kaiser Permanente administers the benefits provided through the Kaiser Permanente Select Plan, Kaiser Permanente HMO and Kaiser Permanente Out-of-Area PPO on an insured basis.

Dental benefits are provided on an insured basis through an agreement with Group Dental Services of Maryland, Inc. Vision care benefits are provided on an insured basis from NVA. The life insurance, accidental death and dismemberment benefits and sickness and accident benefits are provided through an insurance agreement with Mutual of Omaha Insurance Company.

Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.
2101 East Jefferson Street
Rockville, MD 20849

Cigna
11400 Rockville Pike
Suite 500
Rockville, MD 20852

Graphic Communications National Health and Welfare Fund
60 Boulevard of the Allies, 5th Floor,
Pittsburgh, PA 15222-1219

National Vision Administrators, L.L.C.
1200 Route 46 West
Clifton, NJ 07013

Mutual of Omaha Insurance Company
Mutual of Omaha Plaza
Omaha, NE 68175
Policy No.: GLUG-ADJN – Life/AD&D Policy
No.: GUG-ADJN – Sickness & Accident

## 6. LABOR ORGANIZATIONS REPRESENTING PARTICIPANTS IN PLAN

This Fund is maintained by collective bargaining agreements between Lithographers and Photoengravers Local 285, GCC, IBT and participating employers. A copy of any such agreement may be obtained upon written request to the Fund Office. Also, collective bargaining agreements are available for examination by a Participant at the Fund Office. A complete list of Employers participating in the Fund may be obtained upon written request to the Fund Office. You may also receive from the Fund Office, upon written request, information as to whether a particular Employer or Union is a sponsor of the Fund and if the Employer or Union is a Fund Sponsor, the address of such Employer or Union.

## 7. SOURCE OF CONTRIBUTIONS TO THE PLAN

Individual Employers contribute to the Fund pursuant to collective bargaining agreements with Lithographers and Photoengravers Local 285, GCC, IBT, which also generally provide for Employee contributions. Contributions are also made pursuant to written participation agreements approved by the Board of Trustees.

## 8. DATE OF THE END OF THE PLAN YEAR

The Plan Year ends on the last day of February of each year.

## 9. MODIFICATION OF BENEFIT SCHEDULES, OR TERMINATION OF BENEFIT, OR TERMINATION OF THE FUND

The Board of Trustees has complete discretion, subject to the Trust Agreement and applicable law, to terminate, suspend, withdraw, amend or modify Fund benefits in whole or in part at any time. Within this broad grant of discretion, the Trustees have (among other powers) the authority to reduce, eliminate, improve or modify benefits. They may do so for some or all categories of participants and beneficiaries (Active Employees, Retirees, and eligible Dependents). They may also modify the eligibility requirements for coverage.

Although it is the intention to continue the Fund indefinitely, the Fund may be terminated by a document in writing adopted by Trustees. The Trustees have complete discretion to determine when and if the Fund should be terminated.

If the Fund is terminated, the Trustees will: (a) pay the expenses of the Fund incurred up to the date of the termination as well as the expenses in connection with the termination; (b) arrange for a final audit of the Fund; (c) give any notice and prepare and file any reports which may be required by law; (d) apply the assets of the Fund in accordance with the Plan of Benefits including amendments adopted as part of the termination until the assets of the Fund are distributed.

No part of the assets or income of the Fund will be used for purposes other than for the exclusive benefit of the Employees and the Beneficiaries or the administrative expenses of the Fund. Under no circumstances will any portion of the Fund revert or inure to the benefit of any contributing Employer or the Union either directly or indirectly.

## 10. ACTION OF TRUSTEES

The Trustees shall be, subject to the requirements of the Employee Retirement Income Security Act of 1974, as amended ("ERISA"), the sole judges of the standard of proof required in any case and the application and interpretation of this Fund and its governing documents, and decisions of the Trustees shall be final and binding on all parties. The Trustees shall have the exclusive right and discretionary authority to construe the terms of the Fund and its governing documents, to resolve any ambiguities, and to determine any questions which may arise with the Fund's application or administration, including but not limited to determination of eligibility for medical, life insurance, disability insurance, dental, vision, and prescription drug benefits.

Wherever in the Plan the Trustees are given discretionary powers, the Trustees shall exercise such powers in a manner permitted by law.

## 11. NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT OF 1996

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

## 12. WOMEN’S HEALTH AND CANCER RIGHTS ACT OF 1998

As required by the Women’s Health and Cancer Rights Act (WHCRA) of 1998, this plan provides coverage for:

1. All stages of reconstruction of the breast on which the mastectomy has been performed;

2. Surgery and reconstruction of the other breast to produce a symmetrical appearance; and

3. Prostheses and physical complications of mastectomy, including lymphedemas, in a manner determined in consultation with the attending physician and the patient.

Such coverage may be subject to annual deductibles and coinsurance provisions as may be deemed appropriate and are consistent with those established for other benefits under the plan or coverage. Written notice of the availability of such coverage shall be delivered to the participant upon enrollment and annually thereafter. Contact the Fund Office or Kaiser Permanente for more information.

## YOUR RIGHTS UNDER ERISA

As a participant in the Fund, you are entitled to certain rights and protections under ERISA. ERISA provides that all plan participants shall be entitled to:

- Receive Information About Your Plan and Benefits.
- Examine, without charge, at the Fund Office and at other specified locations, such as work sites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Fund with the U.S. Department of Labor.
- Obtain, upon written request to the Board of Trustees, copies of documents governing the operation of the Fund, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and the updated summary plan description. The Fund may make a reasonable charge for the copies.
- Receive a summary of the Fund's annual financial report. The Fund is required by law to furnish each participant with a copy of this summary annual report.
- Continue health care coverage for yourself, spouse, or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the Fund on the rules governing your COBRA continuation coverage rights. *See*, pp. 7 - 10.
- Reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA Continuation Coverage, when your COBRA Continuation Coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to preexisting

condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

Prudent Action by Plan Fiduciaries

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

Enforce Your Rights

If your claim for a welfare benefit is denied in whole or in part, you must receive a written explanation for the reason for the denial. You have the right to have the Plan review and reconsider your claim. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Fund Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

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


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