

## **QUICK PAINTING INDUSTRY INSURANCE FUND COVERAGE SUMMARY**

**\*\*Please refer to the Summary Plan Description complete information. You may pick one up at the Painting Industry Insurance Fund office at 8257 Dow Circle, Strongsville, OH 44136\*\***

### **ELIGIBILITY**

In order to qualify for insurance, you need to work 135 hours in a work month. There is a two month lag between the work month and the corresponding coverage month as illustrated below:

| <b>WORK MONTH</b> | <b>REQUIRED HOURS</b> | <b>COVERAGE MONTH</b> |
|-------------------|-----------------------|-----------------------|
| January           | 135                   | April                 |
| February          | 135                   | May                   |
| March             | 135                   | June                  |
| April             | 135                   | July                  |
| May               | 135                   | August                |
| June              | 135                   | September             |
| July              | 135                   | October               |
| August            | 135                   | November              |
| September         | 135                   | December              |
| October           | 135                   | January               |
| November          | 135                   | February              |
| December          | 135                   | March                 |

Once you have insurance, you can maintain it by working 135 hours PER MONTH. In the event that you are short hours, you will be able to make a self-payment equal to the shortage amount to maintain coverage. In addition, if you do not maintain continuous eligibility as provided herein and your eligibility for participation terminates, you must become initially qualified for coverage under the Plan as provided for in the above table.

### **BANKING OF ELIGIBILITY**

Contributions are banked for each month that you exceed 146 hours up to a maximum of \$3,200.00 at any one point in time. Contributions are kept in the bank until used to offset self-payments and will not expire.

### **COBRA COVERAGE**

Upon expending all unused Banked Money, if any, you may make self-pay contributions at the Fund's current uniform contribution rate for a maximum period of 6 months without hours being contributed *on your behalf*.

Thereafter, you may elect COBRA coverage to continue your and/or your Eligible Dependent's health coverage. However, if you lose your Union Membership pursuant to the Union Constitution and/or Collective Bargaining Agreement or Bylaws, then immediately as of the date of the loss of Union Membership, you will not be eligible to make self-pay contributions and will forfeit all banked money. Thereafter, you may elect COBRA coverage to continue your health coverage and/or your Eligible Dependent's coverage. (see The Summary Plan Description for details)

### **MEDICAL**

The medical network effective January 1 2018 is Anthem Blue Cross Blue Shield ([www.anthem.com](http://www.anthem.com)). A provider listing can be found at the website. It is extremely important to go to a network provider at all possible times. This will save the FUND money and most importantly will save you significant money in out-of-pocket expensed and deductibles. (SEE NEXT PAGE FOR DETAILS)

## **ANNUAL DEDUCTIBLE**

### **TIER 1 IN-NETWORK**

\$280.00 per individual/\$560 Family

- Plan year is from January 1 through December 31.
- The deductible amounts are not counted towards your Out-of-Pocket maximum.
- The In-Network and Out-of-Network deductibles are separate and distinct. It is important to try and stay within the network to reduce your own out-of-pocket expenses.

### **OUT-OF-NETWORK**

\$1,000.00 per individual/\$2,000.00 Family

### **Percentage Covered Care & Treatment:**

#### **In-Network**

80% after deductible

#### **Out-of-Network**

60% after deductible

### **Out of Pocket Maximum**

#### **In-Network**

\$1,400.00 per individual/\$2,800.00 family

#### **Out-of Network**

\$5,000.00 per individual/\$10,000 family

- Plan year is from January 1 through December 31.
- The deductible amounts are not counted towards your out-of-pocket maximum.
- The In-Network and Out-of-Network out-of-pocket maximums are separate and distinct. It is important to try and stay within the network to reduce your own out-of-pocket expenses.

### **Co-Payments for Visits:**

|                 |          |
|-----------------|----------|
| Doctor's Office | \$20.00  |
| Urgent Care     | \$35.00  |
| Emergency Room  | \$100.00 |

*Please note: These co-pays DO NOT COUNT towards the out-of-pocket maximum.*

## **DENTAL INSURANCE**

**NETWORK** – DELTA DENTAL OF OHIO PPO – [WWW.DELTADENTALOH.COM](http://WWW.DELTADENTALOH.COM) or on your mobile app: [http://delivr.com/2c9vx\\_qr](http://delivr.com/2c9vx_qr)

Pays 100% of the first \$1,000 per individual from July 1 through June 30 of the following year based on Negotiated Rates. Member will not be billed by dentist unless he exceeds the \$1,000 and will still receive the discounted rate even if paying for it themselves after the Plan paid \$1,000. DELTA DENTAL PREMIER-80% of the first \$1,000 per individual from July 1 through June 30 of the following year based on Negotiated Rates.

**NON-NETWORK** – Pay based on a fixed schedule which typically amounts to 30% to 60% of what a dentist charges (depending on their fee base) and still subject to the \$1,000 maximum from July 1 through June 30. The member IS responsible for the balance of what the PLAN doesn't pay. Amounts that members pay out-of-pocket for Dental DO NOT apply to the maximum out-of-pocket for Medical.

**ORTHODONTIA** - \$1,500 lifetime for dependent children under age 19 only.

## **LIFE INSURANCE**

Life Insurance benefits only apply to the covered MEMBER, not a spouse or other dependent. The following schedule applies to the benefit payable in the event of a **MEMBER'S death while ELIGIBLE for medical coverage:** Active & Retired Members: \$10,000 payable to named beneficiary

*In addition, we have an Accidental Death & Dismemberment policy, which would double the amount paid in the event of an Accidental Death.*

## ACCIDENT AND SICK BENEFITS

For extended periods of illness or loss of work due to a **NON WORKERS COMP** injury, accident & sick benefits are available as follows:

Amount: \$36 a day (\$252 a week)  
Maximum # of weeks payable: 18 weeks

There is a one-week waiting period for an illness, immediate for an accident.

These benefits are available to the MEMBER only, not dependent spouses or other dependents.

*Please do not apply if you became sick or injured at work, you are only hurting yourself and your brotherhood by doing so.*

## VISION

Reimbursement plan, you pay doctor/provider and get reimbursed from the FUND by using the FUND'S reimbursement form and including an itemized receipt.

Fee Schedule:

| <b>BENEFIT</b>                | <b>MAX.ALLOWED</b> | <b>FREQUENCY</b>       |
|-------------------------------|--------------------|------------------------|
| Exam                          | \$75.00            | ONCE per calendar year |
| FRAMES & Single Vision Lenses | \$275.00           | EVERY TWO (2) YEARS    |
| FRAMES & Bi-Focal Lenses      | \$325.00           | EVERY TWO (2) YEARS    |
| FRAMES & Tri-Focal Lenses     | \$345.00           | EVERY TWO (2) YEARS    |
| FRAMES & Lenticular Lenses    | \$365.00           | EVERY TWO (2) YEARS    |
| Contact Lenses                | \$240.00           | EVERY TWO (2) YEARS    |

One LASIK corrective eye surgery per lifetime is also covered for Participants and eligible dependents age 19 and over with a maximum coverage of \$750.00

## PRESCRIPTION DRUG (RX Program)

For preferred drug listing – go to the following web page:

<http://www.envisionrx.com/resources/druglist.aspx>

You can choose from an Alphabetical or Therapeutic Version

### RETAIL PHARMACY:

TIER 1 - Generic - \$10 co-pay for 30-day supply  
TIER 2 - Preferred Brand - \$30 co-pay for 30-day supply  
TIER 3 - Non-Preferred Brand - \$60 co-pay for 30-day supply

**OTC CLARITEN OR PRILOSEC - \$0 co-pay for 30-day supply**

**MAIL ORDER – (FOR MAINTENANCE DRUGS) Please call the FUND office to receive a mail-order application**

TIER 1 - Generic - \$20 co-pay for 90-day supply  
TIER 2 - Preferred Brand - \$60 co-pay for 90-day supply  
TIER 3 - Non-Preferred Brand - \$120 co-pay for 90-day supply

Injectible Drugs – 20% co-pay by member – Mail order required

We cover Smoking Cessation Products (patches & prescription drugs) with a lifetime maximum amount covered of \$600 by the PLAN. Chiropractic Services are covered subject to the Summary Plan Description Fourth Summary Description of Material Modification.

## HEARING CARE BENEFITS

The following schedule lists the maximum hearing care benefits payable under the Plan:

|                        |          |
|------------------------|----------|
| Audiometric Evaluation | \$25     |
| Hearing Aid Evaluation | \$35     |
| Hearing Aid            | \$2,000. |

The benefit maximums set forth above are measured over every three calendar years. For example, the Hearing Aid benefit maximum is not to exceed \$2,000.00 during every three calendar years.

## RETIREE SUBSIDY

A member is subsidized, if retired between ages 55 and 65 and had insurance for 16 of the last 20 quarters or 30 of the last 40 quarters prior to retirement date. The current amount is \$620.35.

Therefore, a current retiree that qualifies pays \$278.75 a month for insurance. This is phenomenal as retirees often are paying approximately \$1,000 or more to carry coverage for themselves and a spouse.