St. Louis Graphic Arts Joint Health and Welfare Fund

Summary Plan Description

January 1, 2025

IMPORTANT CONTACT INFORMATION

Fund Office

St. Louis Graphic Arts Joint Health and Welfare Fund.....314-878-1579
The SPD, amendments and important notices can be found on the web at www.slgahw.org

St. Louis Graphic Arts Joint Health and Welfare Fund
1053 Cave Springs Rd., Ste 201
St. Peters, MO 63376

Active Employees: Medical, Prescription Drug, Life and AD&D claims for Active Employees working under a Collective Bargaining Agreement between the Employer and Printing Packaging Production Workers Union (PPPWU)Local 6-505M may be provided by The Chicago Graphic Arts Health and Welfare Fund, TeamCare or another plan as set out in an agreement between the Employer and Local 6-505M. Please contact the Human Resources department of your Employer for information concerning your specific health care plan.

Medicare Retirees: Individuals receiving insured coverage through a Medicare Plan associated with the St. Louis Graphic Arts Welfare Fund should contact the Plan or the Fund Office with questions.

Humana Labor First Medicare Advantage plan with Medicare Part D Prescription Drug coverage

Member Advocacy Line - Local (314) 255-1896 (TTY 711)
Toll-Free (855) 433-1676 (TTY 711)

UnitedHealth Care Medicare Advantage Plan
www.UHCRetiree.com
1-877-714-0178

Grandfathered participants in the PISTL BC/BS
1-800-490-6145

St. Louis Graphic Arts
Joint Health & Welfare Fund

314-878-1579
E-mail: twesthues@slgahw.org
Website: www.slgahw.org

January 1, 2025

TO ALL PARTICIPANTS:

The Trustees of the St. Louis Graphic Arts Joint Health and Welfare Fund (SLGA Joint H&W Fund) worked to maintain the benefits of the Plan without making coverage unaffordable. However, as the number of participants and beneficiaries decreased and medical costs increased, costs exceeded revenue and the assets of the Plan deteriorated. The Plan reached the point where there were not sufficient participants covered by the Plan to spread the risk of large claims. The Trustees of the SLGA Joint H&W Fund, the leadership of Local 6-505M, and the contributing employers explored a number of options.

Effective for hours worked September 1, 2018, the Union reached an agreement with TeamCare, and with the contributing Employers for Employers to begin contributing to TeamCare. Due to actions at the Graphic Arts and Teamster International Unions, starting in the spring of 2023 Employers will stop being able to contribute to TeamCare as their Collective Bargaining Agreements expire. Local 6-505M has entered into an agreement with The Chicago Graphic Arts Health and Welfare Fund to replace TeamCare.

The Trustees determined initially that there are sufficient assets to provide a Health Reimbursement Arrangement (HRA) Account for eligible participants effective September 1, 2018. Allocations have been approved in each subsequent year and in 2021 the Trustees expanded to provide a larger allocation to participants with family coverage. The money in the HRA account is available to the participant to help offset the cost of out-of-pocket expenses. In the future, it is anticipated that Local 6-505M may negotiate for Employers to make additional contributions to the Plan for the purpose of funding additional HRA allocations.

In addition to the HRA, the assets of the Plan are available to help disabled individuals pay premiums to a group health plan to which contributions were being paid under an Agreement between Local 6-505M and an Employer who has agreed to be bound to the SLGA Joint H&W Fund Trust Agreement.

TRUSTEES OF ST. LOUIS GRAPHIC ARTS JOINT HEALTH AND WELFARE FUND

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c. PART I Health Reimbursement Arrangement (HRA)

A. HRA ELIGIBILITY

A-1 Eligibility for HRA Allocations (after 2019)

1) The Trustees determine allocations for each Allocation Year (claims incurred January to December) on an annual basis.

2) An individual is eligible for a full-year (January – December claims) allocation as an Active Participant if the individual either:

a) Was eligible for a September 1, 2018 allocation and on January 1 of the current Allocation Year was eligible for coverage in a group health and welfare plan based upon his or her employment under an Agreement between the Employer and Local 6-505M; or

b) Was not eligible for a September 1, 2018 allocation, but on January 1 of the current Allocation Year was eligible for coverage in a group health and welfare plan based upon his or her employment under an Agreement between an Employer and Local 6-505M, but only if that Employer is one that provided coverage to its employees in August 2018 through contributions to the SLGA Joint H&W Fund pursuant to an Agreement with Local 6-505M and has agreed to be bound to the SLGA Joint H&W Fund Trust Agreement.

3) An individual is eligible for a full-year (January-December claims) allocation as a Disabled Participant if they are receiving coverage as a disabled participant under a group health plan to which an Employer is contributing for its Active employees under an Agreement between the Employer and Local 6-505M;

4) An individual is eligible for a full-year (January – December claims) allocation as a Retired Participant if they are receiving coverage from a Medicare Retiree Plan through the SLGA Joint H&W Fund (for example, Humana Labor First Medicare Advantage plan).

5) July 1 Eligibility: Effective beginning in 2022, an individual who first becomes an eligible Active, Disabled or Retired participant, as set out above, in the period from January 2 to June 30 of the year, and is still eligible on July 1, is eligible for an allocation equal to half (50%) of the individual or family, if applicable, allocation for that calendar year.

a) An individual who first becomes an Active, Disabled or Retired participant in the period from July 1 to December 31 will be eligible for an allocation in the next calendar year but only if they are still eligible on January 1.

b) An individual who received a January 1 allocation as an Active, Disabled or Retired participant on January 1 of any year is not entitled to a second allocation that year based on changing status during the period from January 2 to June 30.

c) In all respects, other than the amount of the allocation, the rules for a July 1 allocation are the same as for a January 1 allocation.

6) If Local 6-505M enters into an Agreement with any employers for additional contributions to the SLGA Joint H&W Fund for the purpose of funding an HRA the eligibility rules will be adjusted to include the employees working under such an Agreement.

7) The Trustees reserve the right to modify the eligibility rules at any time.

A-2 Eligibility for prior Allocations can be found in the prior Summary Plan Descriptions and Amendments.

A-3 Events Resulting in Termination of HRA Eligibility

1) Termination of Eligibility for Allocations for the Employee and all Dependents

The HRA can only be used for reimbursement of claims incurred while covered by a group health plan maintained under an Agreement between Local 6-505M and an Employer that has agreed to be bound to the SLGA Joint H&W Fund Trust Agreement. If you terminate coverage in an eligible health plan, for example if your employment ceases and you do not elect COBRA, then you are not eligible for reimbursements for claims incurred after your coverage ends.

As set out in Part I, Section C, on page 4, allocated amounts are only available for use during the Allocation Year and any amounts remaining after the end of the Allocation Year are no longer designated for reimbursement to that individual.

2) Termination of Dependent Coverage

Only claims incurred by individuals while they are covered as a dependent of an Employee whose coverage is through (1) a group health plan maintained under an Agreement between Local 6-505M and an Employer that has agreed to be bound to the SLGA Joint H&W Fund Trust Agreement or (2) an associated Medicare Retiree Plan are eligible for reimbursement. Claims incurred before coverage began or after an individual ceases to be a covered dependent are not eligible for reimbursement.

3) Other ways benefits may be lost or reduced. Note: This is not an exhaustive list:

a) If you (or your beneficiary) fail to file a timely claim for benefits or fail to appeal a denied claim within the required time you could lose the right to benefits for that claim;

b) If the Trustees decide to terminate the Plan or change, reduce or eliminate some or all of the benefits provided by the Plan those benefits could cease; and

c) If you falsify or withhold material facts concerning your claim you could lose the right to benefits for that claim and for future claims.

A-5 Special Provision for Participants in Active Military Service

Continuation of coverage under this provision is provided pursuant to the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), as amended, and applicable regulations. Any conflict between this provision and USERRA or any other applicable provision of the law shall be reconciled in favor of compliance with USERRA or other applicable law.

If a Participant is engaged in full-time active duty in one of the uniformed services of the United States, the HRA account and any other benefits provided by the Plan will be continued as long as coverage continues (including through extended eligibility or COBRA) in the associated group health plan (eg. The Chicago Graphic Arts Health and Welfare Fund plan, TeamCare or other group health plan maintained pursuant to an Agreement between Local 6-505M and an Employer that has agreed to be bound to the SLGA Joint H&W Fund Trust Agreement).

If eligibility for coverage in the associated group health plan terminated on account of entry into active duty in one of the uniformed services of the United States, then upon the participant's return from such service and renewed coverage, prior to the expiration of his period of re-employment rights under any applicable Federal or State law, in a group health plan maintained pursuant to an Agreement between Local 6-505M and an Employer that has agreed to be bound to the SLGA Joint H&W Fund Trust Agreement, the participant will have an HRA allocation equal to the allocation for that allocation year plus any allocation remaining immediately prior to military leave. If leave begins and ends in the same calendar year then there will not be an allocation larger than the remaining allocation for that year.

Any Participant entering active duty in one of the uniformed services of the United States should notify the Fund Office before leaving for such duty, unless advanced notice is impossible, unreasonable or precluded by military necessity. The Fund Office should also be notified upon return to work and enrollment in an affiliated health plan.

A-6 Health Benefit Continuation for Eligible Employees on Family or Medical Leave

The Family and Medical Leave Act of 1993 (FMLA), a federal law, provides for up to 12 weeks annually of job-protected leave. The law does not require an employer to pay you during FMLA leave. Some Employees and some employers will not be covered. If you qualify for FMLA leave, you are entitled to employer-paid medical benefits for the duration of your leave. It is up to your employer, not any multi-employer welfare fund, to provide legally required FMLA leave. Your eligibility for benefits from the HRA continues as long as your group health benefits continue under FMLA or other continuation coverage.

A-7 Retiree Eligibility

Coverage in the Retiree Only Medical Plans is set out in Part IV on page 8.

B. THE HRA ALLOCATION

The allocations for prior years are set out in the Plan documents applicable to those years.

1) An allocation was made to an HRA for each eligible individual, as set out in Part I, Section A-3 on page 3, on or about January 1, 2025. The allocation was $2,000.00 if the eligible individual (active or retiree) had individual/single coverage and $3,000.00 if the eligible individual had employee plus spouse, employee plus child(ren) or family coverage. Individuals who gain eligibility January 2, 2025 through June 30, 2025 will be eligible for an allocation of $1,000.00 for an individual and $1,500.00 for a family on or about July 1, 2025 for claims incurred July 1 to December 31, 2025.

   If an employee changes from individual to family coverage in the period from January 2 to June 30 of the year, the additional allocation will be the difference between ½ the individual benefit plus ½ the family benefit and the individual benefit allocated at the beginning of the year. For example, in 2025 the individual began the year with a $2,000 allocation. A half year of the single benefit ($1,000) plus a half year of the family benefit ($1,500) is $2,500. Therefore, the family will receive an additional allocation of $500.

2) The Trustees will determine HRA allocations for 2026 and beyond based on the assets in the plan.

C. HRA RULES

1) An individual may apply for reimbursement of the following expenses incurred during the Allocation (calendar) year:

   a) Deductible, co-insurance and co-payments expenses,

a.i. incurred in connection with medical, prescription drug, dental and vision benefits,

a.ii. by the Participant or a family member covered through a plan provided through the Participant's employment under a Collective Bargaining Agreement with Local 6-505M (claims incurred by a person covered only by a non-related individual or group health plan are not eligible for reimbursement).

b) Effective for claims incurred July 1, 2019, an individual may also seek reimbursement for certain expenses not covered by their medical, prescription drug, dental or vision benefits as set out in Appendix A. A current list of reimbursable expenses is available from the Fund Office and on the Fund Website.

c) Effective May 1, 2020, an individual may seek reimbursement of COBRA premiums.

d) Effective January 1, 2023, an individual may seek reimbursement of the cost of hearing aid repair.

2) Allocations are made for claims incurred in a single calendar year (Allocation Year) or half year for July 1 allocations.

3) The application for reimbursement must be received the end of March of the year following the year in which the claims are incurred (for example, reimbursement for claims incurred in 2024 must be filed by March 31, 2025) and must include proof that the individual (or family member) actually paid the provider the amounts for which reimbursement is sought. Reimbursement cannot be made if the amount is still due to the provider, if it is covered by another insurance plan, or if it was paid by a third-party (such as co-pay assistance).

4) Timing of Payment of Reimbursements.

The SLGA Joint H&W Fund will issue reimbursement payments on a regular basis with payments issued no less frequently than quarterly. The quarterly payments will be made as soon as administratively possible after the end of each calendar quarter (March 31, June 30, September 30) based on reimbursement applications received prior to the close of the quarter. Payments for the quarter ending December 31 will be processed for payment after the end of the period for submitting applications for benefits for the Allocation Year (March 31). Payments may be made more frequently during the quarter based on administrative procedures approved by the Trustees.

5) Any part of an allocation for which reimbursement is not sought by the end of March following the end of the Allocation Year, shall be returned to the general assets of the plan.

Examples: In June 2022 Peter Pressman has three $100 co-payments and he submits an application for reimbursement in August which he supports with copies of receipts showing the charges were for medical expenses and that he paid the co-payments. Payment of $300 will be issued no later than shortly after September 2022.

In October 2022 Peter Pressman pays $600 as a co-payment for x-rays, an MRI, and lab charges and he submits an application for reimbursement in November 2022 which he supports with copies of an EOB, receipt, and proof of payment. Payment will be issued no later than 10 days after March 31, 2023.

Pressman submits no other applications for reimbursement for the period from September 1, 2022 through December 31, 2022.

The remainder of his 2022 allocation will be returned to the assets of the Fund.

D. PART II Disability Continuation Coverage

Note: Health and welfare plans maintained pursuant to agreements between employers and unions will often have provisions for employees to continue coverage with a waiver of the premium for some period of disability. The terms of any group health plan coverage during periods of disability and any waiver of premium are controlled by the terms of the group health plan (for example, the Chicago Graphic Arts Health and Welfare Fund plan or TeamCare).

A. THE SLGA JOINT H&W FUND DISABILITY CONTINUATION COVERAGE BENEFIT

Upon notification of the disability and proof of eligibility as set out in Section B, below, the SLGA Joint H&W Fund will pay the premium for the period in which the disability started for up to two weeks of coverage so as to help establish the individual's eligibility for the disability continuation coverage.

The SLGA Joint H&W Fund will pay the premium directly to the group health plan. However, it is the Participant's responsibility to make sure that the SLGA Joint H&W Fund is notified of the situation in a timely manner and to complete all forms necessary for continuation coverage.

B. ELIGIBILITY

An individual is eligible for this benefit if they:

1) Were covered, immediately prior to the start of the disability, by a group health plan pursuant to contributions paid under an Agreement between Local 6-505M and an Employer who has agreed to be bound to the SLGA Joint H&W Fund Trust Agreement;

2) Applied for disability continuation coverage through the group health plan; and

3) If COBRA or self-pay continuation coverage is paid for the period in which disability began then the individual would qualify for disability continuation coverage under the rules of the group health plan.

E. PART III Injury or Illness COBRA Coverage

A. THE BENEFIT

Upon notification of a disability and proof of eligibility as set out in Part III, Section B, below, the SLGA Joint H&W Fund will pay the COBRA premium for the individual for a period of 8 weeks (2 months) starting with the period in which coverage is lost because of the disability.

The SLGA Joint H&W Fund will pay the premium directly to the group health plan and it is the Participant's responsibility to make sure that the SLGA Joint H&W Fund is notified of the situation in a timely manner and to complete all the forms necessary to enroll in the COBRA coverage.

NOTE: The purpose of this benefit is to provide a period of time for the individual to review future coverage options. However, **electing COBRA coverage could limit a person's ability to enroll in disability coverage through their health plan, coverage in a plan through a spouse's employer, or coverage through the ACA exchanges outside the open enrollment period.** Therefore, it is important to review all options before utilizing this benefit.

B. ELIGIBILITY

An individual is eligible for this benefit if he or she:

1) At the time of the work-related injury or illness resulting in a loss of group health coverage, was covered by a group health plan pursuant to contributions paid under an Agreement between Local 6-505M and an Employer who has agreed to be bound to the SLGA Joint H&W Fund Trust Agreement; and

2) The individual applied to the group health plan for disability continuation coverage but was denied on the ground that the injury or illness was a work-related injury or illness not eligible for coverage with a subrogation agreement.

NOTE: If the group health plan offers to continue coverage upon the individual signing a subrogation agreement and the individual fails or refuses to sign the subrogation agreement then this benefit is not available.

F. PART IV Medicare Eligible Retiree Medical Plan Options

A. THE BENEFIT

Medical and prescription drug benefits are available to Medicare Retirees as a fully insured benefit. As of January 1, 2023, the insured benefit is provided through the Fund's arrangement with the Humana Labor First Medicare Advantage plan with Medicare Part D Prescription Drug coverage and other insurers. All ID cards and information about benefits and benefit limits should be obtained directly from the insurance company.

The Trustees reserve the discretion to select different insurers for any of the benefits provided, or to terminate all or part of the Retiree plan.

B. ELIGIBILITY

B-1 Retiree Eligibility

Effective January 1, 2017, a Retired Employee is eligible to enroll if:

1) At the time of retirement, the Employee was enrolled in a group health plan maintained pursuant to an Agreement between Local 6-505M and an Employer that at the time agreed to be bound to the SLGA Joint H&W Fund Trust Agreement. This includes, but is not limited to, individuals who were covered by the PISTL Health and Welfare Fund or the SLGA Joint H&W Fund when they retired prior to August 1, 2018, and individuals covered by TeamCare, the Chicago Graphic Arts Health and Welfare Fund or other plan maintained pursuant to a Collective Bargaining Agreement with Local 6-505M upon retirement on or after August 1, 2018;

2) The Retiree is eligible for and enrolled in Medicare when enrolled in the Retiree Plan; and

3) The Retiree meets one of the following three eligibility tests:

a) An Employee who is eligible for Medicare at that time of retirement may enroll in the Medicare Retiree Plan upon retirement.

b) An Employee who is not eligible for Medicare at retirement and who elects COBRA in the group health plan covering the Employee at the time of Retirement and who becomes eligible for Medicare during the COBRA can enroll in the Medicare Retiree Plan when eligible for Medicare.

c) An Employee who is not eligible for Medicare at retirement or during COBRA coverage can enroll in the Medicare Retiree Plan when he/she becomes Medicare eligible if (1) the Employee lost eligibility in a group health plan maintained pursuant to an Agreement between Local 6-505M and an Employer that at the time agreed to be bound to the SLGA

Joint H&W Fund Trust Agreement after January 1, 2017 and (2) the Employee was age 55 or older at the later of retirement or the end of COBRA coverage.

4) An Employee who is
   a) Employed by an Employer bound to a CBA with 6-505M that is no longer contributing to a welfare plan pursuant to that CBA,
   b) Eligible for Medicare at the time coverage under a welfare plan to which the Employer is contributing pursuant to the CBA ends, and
   c) Accepted into an Advantage plan offered through the Welfare Plan

will be deemed a Retiree for purposes of this Section B-1.

B-2 Spousal Eligibility

The spouse of a Retiree is eligible to enroll in the Medicare Retiree Plan if

1) The Retiree is enrolled in the Medicare Retiree Plan or provides documentation of COBRA coverage in a plan maintained pursuant to an Agreement between Local 6-505M and an Employer that at the time agreed to be bound to the SLGA Joint H&W Fund Trust Agreement; and

2) The Spouse is eligible for and enrolled in Medicare.

B-3 Termination of Retiree Coverage

Retiree Medicare Plan Coverage will end:

1) The date the premium for the Retiree Coverage is not timely paid as set out in the rules of the insurance plan;
2) The date the Trustees decide to terminate the Plan's involvement with the Medicare plan in which the individual is enrolled and the individual does not enroll in another plan through the SLGA Joint H&W Fund; or
3) The date a retiree's retirement benefits or the individual's eligibility for participation in the Medicare Plan are suspended.

C. ENROLLMENT AND PAYMENT FOR RETIREE ONLY MEDICAL PLANS

Retirees must enroll for retiree coverage in one of the Medicare Retiree Plans by notifying the SLGA Joint H&W Fund Office in writing within 30 days following retirement or Medicare eligibility, whichever is later, and completing forms available from the Fund Office.

Timely payment of Retiree premiums must be made in accordance with the rules set forth by the applicable insurer. To avoid losing coverage by failing to make timely payment of premiums, Retired Participants are encouraged to pay their premiums in one of the following ways:

1) Deduction from Pension Check – A Retired Participant who is receiving benefits from the St. Louis Graphic Arts Pension Fund sufficient to cover the Retiree Plan premium may have the premium withheld by completing an Authorization Form, which is available from the Fund Office.

2) Security Deposit – A Retired Participant whose retirement benefits are insufficient to cover the Retiree Plan premium or who does not wish to have the premium withheld may make a Security Deposit of one month's premium. This Security Deposit will provide a 30day grace period. If the premium has not been paid by the end of the initial 30-day grace period, the Security Deposit will be liquidated. Retirees who do not make a Security Deposit will not have the added protection of the additional 30-day grace period.

G.PART V Definitions

"Allocation Year" means the Calendar Year (January 1 to December 31) in which claims must be incurred to be eligible for reimbursement from the allocation made for that Allocation Year.

"**Covered Employee or Eligible Employee**" means an Employee who has met the eligibility rules for coverage for a benefit under the Plan.

"**Employee**" means a person enrolled in a group health plan maintained pursuant to an Agreement between Local 6-505M and an Employer that has agreed to be bound to the SLGA Joint H&W Fund Trust Agreement.

"**Fund**" means the St. Louis Graphic Arts Joint Health and Welfare Fund, also referred to as "SLGA Joint H&W Fund" or "Plan."

"**Illness**" means a deviation from the normal healthy state resulting from disease which requires treatment by a medical professional.

"**Injury**" means unforeseen bodily harm caused by a sudden, traumatic and external event definite as to time and place.

"**Participant**" means an Employee eligible for benefits under the Plan.

"**Plan**" means the Benefit Plan (described in this Summary Plan Description) provided by the Fund.

"**Plan Year**" means July 1 through June 30 of the next year.

"Spouse" means any individual who is lawfully married to a Participant under any state law, including individuals married to a person of the same sex. A Spouse does not include a person involved in a civil union or other relationship.

H.PART VI Claim Procedures

Note: Falsification or withholding of material facts may result in loss of benefits.

MANY FORMS ARE ALSO AVAILABLE ON THE INTERNET AT WWW.SLGAHW.ORG.

A. FILING A CLAIM

1) Time for Filing a Claim

a) Claims for HRA reimbursements must be received by the Fund Office by the end of March of the year following the Allocation Year. For example, claims incurred in 2024 must be submitted for reimbursement by March 31, 2025. See Part I, Section C, page 5.

b) Claims for Disability Continuation Coverage need to be filed as soon as possible but in no event less than 15 business days before payment is due to the Group Health Plan for the week of continuation coverage. See Part II, page 8.

c) Claims for Work Related Injury or Illness COBRA Coverage need to be filed as soon as possible but in no event less than 15 business days before payment is due to the Group Health Plan for the week of continuation coverage. See Part III, page 9.

d) There are no claims for Retiree Medicare Coverage. However, applications for enrollment, or to continue enrollment, in a Retiree Medicare plan through the SLGA Joint H&W Fund must be received as soon as possible but in no event less than 30 calendar days before payment is due to the Retiree Medicare Plan. See Part IV, page 10.

2) How to File a Claim for an HRA Reimbursement and the Fund's Time to Respond

a) Claims can be filed by mailing to the Fund Office or sending a scanned copy to twesthues@slgahw.org. See the information at the front of this SPD for contact information.

b) The Fund will review requests for allocations as they come in and let participants know if additional information is needed or if the request is not eligible for reimbursement, however, Claims for Reimbursement will be paid no less frequently than quarterly:

- ✓ March 31 for applications received prior to that date for claims incurred during that calendar year;
- ✓ June 30 for applications received between April 1 and June 30 for claims incurred during that calendar year;
- ✓ September 30 for applications received between July 1 and September 30 for claims incurred during that calendar year; and

✓ March 31 for applications received between October 1 of the Application Year and March 31 of the next calendar year for claims incurred during the Allocation Year ending the December 31 prior to payment.

3) How to File a Claim for Disability Continuation Coverage or for Work Related Injury or Illness COBRA Coverage and the Fund's Time to Respond

a) Claims can be filed by mailing to the Fund Office or sending a scanned copy to twesthues@slgahw.org. See the information at the front of this SPD for contact information.

b) Within 10 business days after receipt of a completed request, the Fund will make a determination on the request or provide notice that additional information is needed. If additional information is needed, the Fund will have 10 business days after receipt of the additional information to make a determination.

4) How to submit an application for Retiree Medicare Coverage and the Fund's Time to Respond.

The procedures and time frames for applying for Retiree Medicare Coverage are determined by the various plans (eg Humana Labor First Medicare Advantage plan). The time frame for notifying the pension plan about a deduction for the Medicare Premium is set by the Pension Plan. The SLGA Joint H&W Fund Office will work with you to make sure you have the necessary information in a timely manner. Please note, the time frames for applying are generally 30 calendar days or longer.

B. CLAIM DETERMINATION

A claim for disability continuation coverage will be resolved as soon as possible but no later than 30 calendar days of receipt of the initial claim. A claim for HRA reimbursement will be resolved and paid as set out above. A claimant will be notified in writing of any denial, in whole or in part. If the initial claim does not contain all the necessary information or if for other reasons beyond the control of the Fund the claim cannot be resolved within that 30-day period then the Fund can extend the time period for an additional 15 days. The Fund may extend the time to resolve a claim for only 1 additional 15-day period. The period of time to make a determination, however, may be tolled if the Fund requests additional information.

If the Fund needs to extend the time period to resolve a claim, the claimant will receive a notice of the extension explaining the standards for entitlement to the benefit, why an extension is needed (what issues are unresolved), and what, if any, additional information is needed. If additional information is needed the claimant will have at least 45 days to supply the information. The time to provide this additional information extends the period for the Fund to reach a determination on

the claim.

If the Fund Administrator determines that a person who submits a claim is not entitled to benefits under this Plan or is entitled to a lesser benefit than the amount claimed, then the claimant will be furnished a written statement of the reason or reasons for denial including reference to the Plan provisions, protocols or guidelines on which the denial or reduction is based, a description of any additional material or information necessary for the claimant to establish his right to benefits, and an explanation of why such material or information is necessary. This written notice will also contain an explanation of the appeal procedure which the claimant can follow to have his claim for benefits reviewed.

The written notice of an adverse benefit determination will contain an explanation of the appeal procedure that the claimant can follow to have his or her claim for benefits reviewed. The statement will be written in a culturally and linguistically appropriate manner (as described in 29 C.F.R. § 2560.503-1(o)) that is calculated to be understood by the claimant.

C. HOW TO APPEAL

1) A claimant who receives an adverse determination, or his duly authorized representative, has the right to appeal the Claims Administrator's decision to the Trustees or to an Appeals Committee by submitting a written statement setting forth issues or comments along with any supporting documents related to his appeal. The written statement must be signed by the claimant or his representative and filed with the Fund Office within 180 days of the receipt by the claimant of the denial notice. Upon request and free of charge, the claimant or his representative may review or obtain copies of documents pertinent to the appeal which are in possession the Fund Office, including any internal guideline, protocol or other criteria on which the original benefit determination was based.

2) Appeals will be reviewed by the Trustees (or an Appeal Committee). All appeals will be decided by individuals who were neither involved in the original benefit determination nor subordinates of anyone who was involved in the original benefit determination. The appeal determination will be based on all the evidence related to the claim, including evidence and statements submitted by the claimant, even if such information was not considered in the original benefit determination. In considering the appeal, no deference will be given to the initial adverse benefit determination.

3) The Trustees (or Appeal Committee) will issue a decision in writing within 60 calendar days after receipt of the written statement constituting the appeal. If additional information is needed for the appeal decision, the claimant will be notified and must submit such information within 45 days (which time will toll the time period allowed for the appeal decision).

4) The Plan Administrative Manager will notify the claimant of the Trustees' decision. The notification will be written in a culturally and linguistically appropriate manner (as described in

29 C.F.R. § 2560.503-1(o)) that is calculated to be understood by the claimant. The notification will include the specific reason(s) for the decision, and specific reference(s) to the pertinent Plan provisions on which the decision is based, a statement that the claimant is entitled to receive upon request and free of charge reasonable access to and copies of all documents, records and other information relevant to the claim for benefits; and a statement of the claimant's right to bring a court action under Section 502(a) of ERISA and that such an action must be brought within two years from the date the notification is issued.

5) The Trustees and Claim Appeal Committee appointed by the Trustees have the discretionary authority to rule on all appeals and their decisions shall be final and binding on all parties, including but not limited to Participants, Employees, employers, Local 6-505M, retirees, Dependents and beneficiaries and others. Benefits under this Plan will be paid only if the Trustees, or Appeal Committee, decide in their discretion that the applicant is entitled to them.

6) If the appeal is denied, the claimant has the right to bring a civil suit under ERISA Section 502(a). However, no legal action may be brought to recover from this Plan prior to exhaustion of the claim appeals process described above. No such action may be brought after two years from the Fund's final appeal decision.

I.

J. PART VII GENERAL INFORMATION

A. NAME OF PLAN.

St. Louis Graphic Arts Joint Health and Welfare Fund

B. PLAN SPONSOR AND ADMINISTRATOR

The Plan is sponsored and administered by the Board of Trustees of the St. Louis Graphic Arts Joint Health and Welfare Fund. There is an equal number of Management and Union Trustees on the Board. Management Trustees are selected by contributing employers. Union Trustees are selected by the Graphic Communications Conference Local 6-505M of the International Brotherhood of Teamsters. The current Trustees are:

Union Trustees
Mr. Gary Adams
PPPWU Local 6-505M
1977 Schuetz Road
Saint Louis, MO 63146

Mr. Mike Jones
PPPWU Local 6-505M
1977 Schuetz Road
Saint Louis, MO 63146

Management Trustees
Mr. Steve Lander
Lander Binding & Finishing
1439 Hanley Industrial Court
St. Louis, MO 63144

Mr. Robert Ebel
11469 Olive Blvd.
Suite 299
St. Louis, MO 63141

C. NAME AND ADDRESS OF PLAN ADMINISTRATOR

The Board of Trustees is the Plan Administrator. The Trustees maintain a Fund Office where the day-to-day business of Trust Fund is handled. All communications and notices should be addressed to:

Trustees of the St. Louis Graphic Arts Joint Health and Welfare Fund
1053 Cave Springs Rd., Ste 201
St. Peters, MO 63376
Telephone: (314) 8781579

Claims for medical, prescription drug and other benefits should be directed to the applicable group health plan.

D. PLAN IDENTIFICATION NUMBERS

The IRS Identification Number of the Fund is: 431178602; the Plan Number is 501.

E. TYPE OF PLAN

This Plan is a welfare benefit plan that provides a Health Reimbursement Arrangement (HRA) and subsidy of premiums in circumstances related to disability. The Plan also facilitates enrollment in a number of Medicare Retiree plans.

F. SERVICE OF LEGAL PROCESS

Serve the Administrative Manager as agent of the Trust Fund at 1053 Cave Springs Rd., Ste 201 St. Peters, MO 63376, or any of the Trustees of the Fund.

G. DESCRIPTION OF COLLECTIVE BARGAINING AGREEMENTS

The Plan is maintained pursuant to Agreements between Local 6-505M and Employers contributing to group health plans pursuant to those agreements.

H. SOURCE OF CONTRIBUTIONS, ACCUMULATION OF ASSETS, AND PAYMENT OF BENEFITS

The reserves of the Plan as of September 1, 2018 were established through Employer contributions and Employee share of premiums paid pursuant to Agreements with Local 6-505M, self-pay contributions from participants, COBRA participants, and Retirees, and investment income. Effective with work performed in August 2018, the obligation for Employer and Employee contributions for medical, prescription and other benefits provided by the SLGA Joint H&W Plan through August 31, 2018 ceased. Those reserves were used first to pay claims incurred prior to September 1, 2018, then to pay administrative expenses of the SLGA Joint H&W Plan, and finally to provide the benefits set out in this SPD. Retirees continue to pay a monthly administrative fee. In the future there may be additional Employer contributions paid pursuant to Agreements with Local 6-505M. The Trustees will continue to invest any reserves not currently needed for administering the Fund and providing benefits.

I. NAMES OF EMPLOYERS WHO HAVE AGREED TO BE BOUND BY THE SLGA JOINT H&W FUND TRUST AGREEMENT.

Upon written request by a Participant or Beneficiary to the Plan Administrator, information will be supplied as to whether an Employer is party to an Agreement between Local 6-505M requiring contributions to a group health plan and whether the Employer has agreed to be bound to the SLGA Joint H&W Fund Trust Agreement.

J. END OF PLAN YEAR

The Plan operates on a fiscal year basis, ending on June 30 of each year.

K. CONTROLLING DOCUMENTS

The language in this Summary Plan Description fully describes the eligibility rules and benefits offered by the Plan. The related Group Health Plans and Medicare Plans have their own controlling documents. There is a Trust Agreement establishing the trust but there is no separate Plan Document describing the benefits provided by this Fund.

L. PLAN DOCUMENTS ARE AVAILABLE TO PARTICIPANTS AND BENEFICIARIES

Any Plan Document is available for inspection at the Fund Office during regular business hours. The Plan document include: Reports filed with the Federal Government describing the Plan and describing the financial status of the Fund, the trust agreement, collective bargaining agreements, the group insurance and service contracts, and regulations of the trustees pertaining to the administration of the Plan. These documents will also be made available for your inspection at the office of the Union, PPPWU Local 6-505M, 1977 Schuetz Road, St. Louis, Missouri 63146 or, within 10 days after receipt of a written request at the Fund Office, at the premises of any employer who has agreed to be bound to the Trust Agreement and has 50 or more Participants working at those premises. You should notify your Employer of such a request and then you or the Employer should put the request in writing.

Upon written request to the Fund Office, you will be furnished with any Plan Document or part of any Document that you specify. There may be a small charge to you for the cost of reproducing the requested material. You may contact the Fund Office to learn what, if any, charge will be made.

M. RESERVATION OF AUTHORITY

No active or retired Employee or Dependent is entitled to any vested right under this Plan. The Trustees retain the authority to change the eligibility rules and to change, reduce or eliminate benefits at any time. In the Trustees' discretion, such changes may include but are not limited to: increasing or decreasing any of the benefits, the time or other requirements relating to eligibility or the classes of persons who may become or remain eligible.

The Trustees or the duly authorized Claim Appeal Committee have the discretionary authority to interpret the Trust Agreement, this Summary Plan Description, Regulations, and all other Plan Documents and to decide claims, claim appeals, and issues of fact. The decisions of the Trustees, in exercising their discretionary authority, shall be final and binding on all parties, including but not limited to Participants, Employees, Employers, Local 6-505M, Retirees, dependents and beneficiaries. Benefits under this Plan will be paid only if the Trustees, or a duly authorized Committee or representative of the Trustees, decide in their discretion that the applicant is entitled to them.

No entity, including the Administrative Manager, the Claims Administrator, the Fund Office or any other party, has any authority to do or approve anything that is contrary to the written terms of the governing Plan Documents.

N. LIMITATION OF AUTHORITY

No agent, representative, office, or other party from the Union or from any Employer, or any individual Trustee has the authority to speak on behalf of the Trustees of this Fund. If you have any questions pertaining to your eligibility, the only party authorized to answer such questions for the Board of Trustees is the Administrative Manager, at the Fund Office, 1053 Cave Springs Rd., Ste 201, St. Peters, MO 63376; (314) 8781579. Matters that are not clear or which require interpretation are to be referred by the Administrative Manager or Fund Office to the Board of Trustees.

Any question pertaining to your group health plan benefits or Medicare Insured Benefit should be addressed to the appropriate group health plan or insurance company. The Administrative Manager will help any Participant or beneficiary in communicating with the appropriate Medicare insurance company, but the Administrative Manager is not authorized to make decisions for any insurance company.

O. TERMINATION OF THE PLAN

1) The Trust Fund may be terminated by consent of Local 6-505M or if there is no Union Agreement requiring contributions to this Fund at a date agreed upon by the Trustees;
2) In the event of such termination, after providing for payment of administrative expenses, the Trustees are required to use remaining assets for the benefit of one or more classes of Employees and their Dependents who were employed by contributing employers or otherwise covered by the Trust Fund at the date of such termination, this is the current basis for the continuing benefits being provided by the Plan;
3) No refund of contributions may be made to any employer except in the case of a bona fide overpayment in which case there may be a refund to the extent permitted by law.

P. RECOVERY OF OVERPAYMENTS – TERMINATION FOR FRAUD

To the extent that the Fund may have made payments for which it was not obligated, either under the prior group health plan or the current HRA and disability benefits, the Participant is obligated to reimburse the Fund. In the event of such an overpayment, the Fund will notify the Participant that reimbursement will occur by either voluntary direct payments from the Participant or the offset of future benefit payments. The Trustees reserve the right to refer recovery to a private agency for collection, or to file a lawsuit.

Any person who intends to defraud, knowingly facilitates a fraud, or submits an application, or files a claim with a false or deceptive statement, is guilty of fraud. Such an act is grounds for immediate termination of the right to current and future benefits.

K. PART VIII STATEMENT OF RIGHTS UNDER ERISA

ERISA Rights

As a Participant in St. Louis Graphic Arts Joint Health and Welfare Fund, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan Participants shall be entitled to:

Receive Information About Your Plan and Benefits

Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Plan Administrator may make a reasonable charge for the copies.

Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each Participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

Continue health care coverage for yourself, Spouse or Dependents if there is a loss of coverage under the Plan as a result of a Qualifying Event. You or your Dependents may have to pay for such coverage. Review this summary plan description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

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

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

Assistance with Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the 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.

L. PART IX NOTICE OF PRIVACY PRACTICES

Your Information. Your Rights. Our Responsibilities.

The St. Louis Graphic Arts Joint Health and Welfare Fund (the Fund) has a duty under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) as amended by Health Information Technology for Economic and Clinical Health Act (HITECH), Title XIII of Division A of the American Recovery and Reinvestment Act (ARRA), to outline our legal obligations regarding your private medical information. In general, the Plan is required by this law to maintain the privacy of your health information. The Plan must also provide you with a Notice of its legal duties and its current privacy practices.

In the course of business practices, the Plan or Claims Administrator may disclose information to the Board of Trustees of the St. Louis Graphic Arts Joint Health and Welfare Fund, acting as Plan Sponsor, for reviewing and making determinations regarding an appeal or for monitoring benefit claims or analyzing benefit structure and claim experience including those that may or do involve stop-loss insurance. Generally, the Plan or Claims Administrator will disclose PHI to the Plan Sponsor only if necessary for Plan operations and only after receipt of a certification from the Plan Sponsor that the Plan documents have been amended to incorporate the following provisions.

With respect to electronic PHI (ePHI), the Plan Sponsor agrees to the preceding protections and to:

- Implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the ePHI that it creates, receives, maintains, or transmits on behalf of the Plan.
- Ensure "adequate separation" supported by reasonable and appropriate security measures. "Adequate separation" means the Plan Sponsor will use ePHI only for Plan administration activities and not for employment-related actions or for any purpose unrelated to Plan administration. Any employee or fiduciary of the Plan or Plan Sponsor who uses or discloses ePHI in violation of the Plan's security or privacy policies and procedures shall be subject to the Plan's disciplinary procedure.
- Ensure that any agent or subcontractor to whom it provides ePHI agrees to implement reasonable and appropriate security measures to protect the information.
- Report to the Plan Security Officer any Security Incident of which it becomes aware.

The Plan has the legal obligation to abide by the terms of the following Notice, but retains the right to change the terms of this notice. Any changes may be effective for any current health information about you and any information that may be obtained in the future. Such changes will be appropriately reflected in this Notice of Privacy Practices. The most recent version of the Notice will always be available to you through the Fund Office.

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our 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 we have about you. Ask us 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 at:
  St. Louis Graphic Arts Joint Health and Welfare Fund
  Attn: Privacy Officer
  1053 Cave Springs Rd. Suite 201,
  St. Peters, MO, 63376Telephone: (314) 8781579
- 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 1-877-696-6775, 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 our organization

- We can use and disclose your information to run our organization 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 for plan administration.

Example: We share information with an insurance company to obtain life insurance and AD&D policies.

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 requests for PHI that is related or potentially related to reproductive health care

! We will not use or disclose PHI for the purpose of investigating or imposing liability related to reproductive health care that is legally provided under state or federal law.

! We will not use or disclose PHI potentially related to reproductive health care for health oversight activities, judicial and administrative proceedings, law enforcement purposes, or to

coroners and medical examiners, without obtaining a valid attestation that the use or disclosure is not for a prohibited purpose.

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.

M.

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.

N. Appendix A

To be reimbursable an expense must be

a.i. incurred in connection with medical, prescription drug, dental and vision benefits,

a.ii. by the Participant or a family member covered through a plan provided through the Participant's employment under a Collective Bargaining Agreement with Local 6-505M (claims incurred by a person covered only by a non-related individual or group health plan are not eligible for reimbursement).

Effective for claims incurred from September 1, 2018, the following types of expenses were reimbursable:

1) Deductible, co-insurance and co-payments expenses (reimbursable even if incurred prior to July 1, 2019)

Effective for claims incurred from July 1, 2019, the following additional types of expenses are reimbursable:

1) Prescription drugs other than Over the Counter (OTC) Drugs and Diabetic monitors, test strips and supplies not covered by your prescription drug plan, for example a non-preferred medication or non-preferred monitor.
   - ! Amounts reimbursed by third parties, for example through copay assist or a coupon from the pharmaceutical manufacturer, cannot also be reimbursed from the HRA.
   - ! For prescription drugs you will need to submit a copy of your prescription with your proof of payment.

2) Charges for Chiropractic visits which were denied because you exhausted the maximum benefit allowed by your medical plan.
   - ! Chiropractic visits still need to be medically necessary.

3) Removal of mole, cyst or tumor, varicose vein removal surgery, and reconstructive surgery following accident, medical procedure or illness not covered by your medical plan.
   - ! Procedures deemed to be cosmetic are <u>not</u> eligible for reimbursement. You will need to submit documentation as to why the claim was denied by your medical plan and that the procedure was not cosmetic in nature.

4) Hearing aids, hearing aid repair and batteries for hearing aids.
   - ! Hearing aids need to be prescribed by a physician, generally an ENT.
   - ! For batteries you may be required to provide documentation that the hearing aids for which you have purchased batteries was prescribed for you by a physician.

5) C-pap machine and supplies for sleep apnea and similar devices.
   - Requires prescription for initial c-pap machine; and
   - For supplies you may be required to provide documentation that the c-pap machine for which you have purchased supplies was prescribed for you by a physician.

6) Orthotics, canes, walkers, crutches and similar Durable Medical Equipment not covered by your medical plan.
   - Orthotics must be medically necessary as shown by a prescription or letter from the physician directing the use of the orthotic. There is no limit on the number or frequency of orthotics purchased.
   - Canes, walkers and crutches must be medically necessary as shown by a prescription of letter from the physician directing the use of the device for stability.

7) Acupuncture not covered by your medical plan.
   - Acupuncturists need to be licensed to perform services by the state in which the services are being provided.

8) Alcohol and drug dependency treatment not covered by your medical plan.
   - You will need to submit proof that the facility or provider is a licensed or certified medical facility/provider and that you are receiving treatment under the direction or supervision of a licensed medical professional.

9) Smoking cessation programs, counseling, and prescription medications not covered by your medical plan (for example if your plan covers 2 sessions in a period of time and you need to attend a third session).
   - Programs must be licensed or certified or run by a medical professional and medications must be prescription.
   - Items such as nicotine gum and patches obtained without a prescription are not covered.

10) Reimbursable Vision Benefits include:
   - Lasik, vision correction, and other eye surgery not covered by your Medical Plan;
   - Prescription eyeglasses including prescription sunglasses without limitation on the frequency of new glasses; and
   - prescription contact lenses without limitation on the frequency of new lenses.

11) Reimbursable Dental Benefits include:
   - Cleanings and preventive services without limitation on the number per year or the time between visits;
   - Orthodontic treatment and braces; and
   - Mouth guards recommended and provided by a dentist or oral surgeon.
   - Does not include teeth whitening.

12) Effective May 1, 2020, COBRA premiums are a reimbursable expense.

13) Effective January 1, 2024, dental and vision charges incurred by a Participant or a family member covered through a group health plan provided through the Participant's employment under a Collective Bargaining Agreement with Local 6-505M that does not include integrated dental and vision benefits as long as the charges are not covered by another group dental/vision plan.

Discrimination is Against the Law

The St. Louis Graphic Arts Joint Health and Welfare Fund complies with all applicable Federal civil rights laws, including Section 1557 of the Affordable Care Act (Section 1557). The St. Louis Graphic Arts Joint Health and Welfare Fund does not discriminate on the basis of race, color, national origin (including limited English proficiency and primary language), age, disability, or sex (consistent with the scope of sec discrimination described at 45 CFR § 92.101(a)(2).

In compliance with Section 1557 and other federal civil rights laws, the St. Louis Graphic Arts Joint Health and Welfare Fund provides individuals the following in a timely manner and free of charge:

- **Appropriate auxiliary aids and services.** We will provide appropriate auxiliary aids and services for individuals with disabilities to communicate effectively with us, such as:
  - Qualified interpreters, including American Sign Language interpreters
  - Video remote interpreting
  - Information in alternate formats (including but not limited to large print, audio, and accessible electronic formats)

- **Language assistance services.** We will provide free language assistance services for individuals with limited English proficiency (including individuals' companions with limited English proficiency) to ensure meaningful access to our programs, activities, services, and other benefits. Language assistance services may include:
  - Qualified interpreters
  - Electronic and written translated documents

! **Reasonable modifications.** We will provide reasonable modifications for qualified individuals with disabilities, when necessary to ensure accessibility and equal opportunity to participate in our programs, activities, services, or other benefits.

If you need these services, contact Tammy Westhues.

If you believe that the St. Louis Graphic Arts Joint Health and Welfare Fund has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Tammy Westhues, Civil Rights Coordinator, 1053 Cave Springs Rd. Suite 201, St. Peters, MO, 63376 1-314-878-1579, twesthues@slgahw.org. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Tammy Westhues, Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/smartscreen/main.jsf, or by mail at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building

Washington, D.C. 20201

Complaint forms are available at http://www.hhs.gov/civil-rights/filing-a-complaint/complaint-process/index.html. See also http://www.hhs.gov/ocr/office/file/index.html.

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-314-878-1579.

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-314-878-1579。

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-314-878-1579.

OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 1-314-878-1579.

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-314-878-1579.

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم1-314-878-1579

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-314-878-1579 번으로 전화해 주십시오.

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-314-878-1579.

ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-314-878-1579.

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-314-878-1579.

Wann du [Deitsch (Pennsylvania German / Dutch)] schwetzscht, kannscht du mitaus Koschte ebber gricke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff: Call 1-314-878-1579.

توجه : اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با1-314-878-1579 تماس بگیرید.

XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1-314-878-1579.

ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-314-878-1579.

į ʼnƀ Njŏ: Ǫļ ŊÕĽБ ȘѲȘ fį Łƥ VĚŧ ǪБŁôı UŁǵƀ ắŁî БƊɑ ŭŧœ Ğǭȓ ǟ ǑБ ŽűȑÊŽă ġ⊙NjDʐ̧ VŽĜї ŕ ɠŁ ǯDž ĝ 1-314-878-1579.

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