Puget Sound Benefits Trust

Summary Plan Description

January 2021

Puget Sound Benefits Trust

Physical Address: 7525 SE 24th Street, Suite 200, Mercer Island, WA 98040 • Mailing Address: PO Box 34203, Seattle, WA 98124
Phone: (206) 441-7574 or (800) 732-1121 • Fax: (206) 505-9727 • Website: www.psbenefitstrust.com

Administered by
Welfare & Pension Administration Service, Inc.

July 30, 2024

TO: All Plan Participants
Puget Sound Benefits Trust

RE: Benefit Changes Effective January 1, 2025

This is a Summary of Material Modification describing changes to your health plan recently adopted by the Board of Trustees. Please read this notice carefully and keep this document with your Summary Plan Description Booklet.

The Puget Sound Benefits Trust is providing you with this Notice of Plan changes and clarifications.

Changing Plans

The Puget Sound Benefits Trust offers both a preferred provider plan (PPO) and a health maintenance organization plan (HMO). The PPO plan is a self-funded plan that uses Premera as its preferred provider network and the HMO plan is fully insured with Kaiser.

Unless your collective bargaining identifies a specific plan, you may choose either the PPO plan or the HMO plan when you enroll. If you do not make a choice, you will be enrolled in the PPO plan. Your dependents are always covered under the same plan in which you enroll.

Once you have enrolled in either the PPO or HMO plan, you have limited opportunities to change your plan selection. The following are the times in which you can change your plan selection:

- You can change your plan selection once every year at open enrollment, which typically occurs in the final months of the year for a January 1st effective date.

- You can also change your plan selection outside of open enrollment once every 24-month period, which will be effective on the 1st of the second month following your election.

- You can also change your plan selection outside of open enrollment if you have a special enrollment event, which includes acquiring a new dependent (spouse or child), provided you request to change plans and enroll the new dependent within 31 days of acquiring the new dependent.

Weight Loss (Bariatric) Surgery

As a reminder and for clarification, the Puget Sound Benefits Trust provides benefits for bariatric surgery (open or laparoscopic Roux-en-Y gastric bypass (RYGB) or laparoscopic adjustable silicone gastric banding (LASGB or Lap-Band)) when the criteria listed Premera's medical policy is met. Premera's "Medical Policy – Bariatric Surgery," Policy 7.01.516, can be found online at:

https://www.premera.com/medicalpolicies/7.01.516.pdf

All bariatric surgery must be Prior Authorized and be performed at a Bariatric Surgery Center of Medical Excellence (CME). The Plan does not provide out-of-network benefits for bariatric surgery.

If you have any questions regarding this notice, contact the Administration Office at (800) 331-6158.

Board of Trustees
Puget Sound Benefits Trust

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Important Reminder **-** You must advise the Administration Office of any changes in your basic demographic data, including changes in your name, marital status, dependents, other insurance coverage available, designated beneficiary, home address, email address and telephone number. Provide information changes by completing and sending a new Enrollment Form to the Administration Office. If you have a change in dependents, divorce requires a complete filed copy of your divorce decree along with any accompanying court orders including the parenting plan. Marriage requires a copy of your marriage certificate, the parenting plan for stepchildren and their birth certificates.

Failure to update your information on file may interfere with our ability to process your benefits and provide timely communication of important Plan information.

Puget Sound Benefits Trust

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Phone (206) 441-7574 or (800) 732-1121 • Fax (206) 505-9727 • Website: www.psbenefitstrust.com

Administered by
Welfare & Pension Administration Service, Inc.

December 1, 2023

TO: All Participants and Beneficiaries of the Puget Sound Benefits Trust

RE: Benefit Changes

This is a Summary of Material Modification describing changes to your health plan recently adopted by the Board of Trustees. Please read this notice carefully and keep this document with your Summary Plan Description Booklet.

Benefit Changes

Effective September 1, 2023, the Puget Sound Benefits Trust will provide coverage for the respiratory syncytial virus (RSV) vaccine to the extent recommended by the Centers for Disease Control and Prevention (CDC). The RSV vaccine is generally recommended for people who are 32-36 weeks pregnant and adults age 60 years old or older when recommend by a physician. RSV vaccines are also recommended for babies and toddlers. See https://www.cdc.gov/vaccines/vpd/rsv/index.html for additional information regarding the CDC's recommendation for the RSV vaccine. Benefits will be provided as preventive without cost sharing and not subject to the Plan's deductible.

Effective November 1, 2023, the Puget Sound Benefits Trust will provide coverage of Ozempic for the treatment of Type 2 Diabetes with prior authorization. This coverage is limited to the treatment of Type 2 Diabetes only and not general weight loss.

Questions regarding the Plan should be directed to the Administration Office at (206) 441-7574.

Administration Office
Puget Sound Benefits Trust

Important Reminder - You must advise the Administration Office of any changes in your basic demographic data, including changes in your name, marital status, designated beneficiary, home address, email address and telephone number. Provide information changes by completing and sending a new Enrollment Form or Beneficiary Designation Form to the Administration Office. If you divorce your spouse, please also provide a complete filed copy of your divorce decree and any accompanying court orders.

Failure to update your information on file may delay the timely payment of your benefits, and communication of important Plan information.

Puget Sound Benefits Trust

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Administered by
Welfare & Pension Administration Service, Inc.

August 1, 2023

TO: All Eligible Plan Participants and Dependents
Puget Sound Benefits Trust – PPO Health Plans

RE: End of Public Health Emergency – Effective May 11, 2023
Teladoc

This is a Summary of Material Modification describing changes to your health plan recently adopted by the Board of Trustees. Please read this notice carefully and keep this document with your Summary Plan Description Booklet.

End of Public Health Emergency

As you may be aware, the Biden Administration has announced an end to the COVID-19 National Emergency and the related Public Health Emergency. Following this announcement, the Board of Trustees of the Puget Sound Benefit Trust has adopted the following benefit plan provisions related to the diagnosis and treatment of COVID:

- The Plan will continue to provide benefits for Over the Counter (OTC) COVID testing pursuant to the normal Plan terms. OTC COVID tests are limited to eight tests per covered individual per month.
- The Plan will continue to provide benefits for COVID vaccines as a preventative benefit (paid in-network at 100% without cost sharing).
- The Plan will continue to provide benefits for antiviral medication for the treatment of COVID (such as Paxlovid) under normal Plan provisions (subject to deductive, co-payments, in-network or out-of-network coinsurance).
- Other treatment of COVID and in office diagnostic testing remains covered under normal Plan provisions (subject to deductive, co-payments, in-network or out-of-network coinsurance).

Teladoc

Your access to Teladoc consultations now includes coverage for Mental Health and Dermatologist visits with no cost share for the member. To schedule a Teladoc consultation visit Teladoc.com/Premera or call (855) 332-4059.

New Member Login/Phone System Changes

The way you access your personal information on the Trust website has changed. You no longer need a PIN to log into the secure benefits portal. All members must register and create a new account and password to access the Member Login option.

The Administration Office has a new phone system. Please listen carefully when you call as the menu options have changed. You now have the option to receive a callback if you don't want to wait in line in the queue.

If you have any questions regarding the benefit changes described in this notice, contact the Administration Office at (800) 331-6158.

Board of Trustees
Puget Sound Benefits Trust

Important Reminder **-** You must advise the Administration Office of any changes in your basic demographic data, including changes in your name, marital status, dependents, other insurance coverage available, designated beneficiary, home address, email address and telephone number. Provide information changes by completing and sending a new Enrollment Form to the Administration Office. If you have a change in dependents, divorce requires a complete filed copy of your divorce decree along with any accompanying court orders including the parenting plan. Marriage requires a copy of your marriage certificate, the parenting plan for stepchildren and their birth certificates.

Failure to update your information on file may interfere with our ability to process your benefits and provide timely communication of important Plan information.

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Administered by
Welfare & Pension Administration Service, Inc.

November 22, 2022

TO: All Plan Participants
Puget Sound Benefits Trust

RE: Benefit Changes Effective January 1, 2023

This is a Summary of Material Modification describing changes to your health plan recently adopted by the Board of Trustees. Please read this notice carefully and keep this document with your Summary Plan Description Booklet.

Plan B Out-of-Pocket Maximum Changes
Effective January 1, 2023, the annual out-of-pocket maximums for Premera PPO Plan B will be reduced***.*** The new maximums are listed in the table below:

	Individual OOP	**Family OOP**
Medical	$2,000	$4,000
Prescription Drug	$1,000	$2,000

Infertility Benefit – Kaiser HMO Plan
Effective January 1, 2023, an infertility benefit will be added to the Kaiser HMO Plan***.*** If you are enrolled in the Trust's Kaiser HMO Plan options, the following infertility treatment will be covered at 50% coinsurance in accordance with criteria established by the Kaiser:

- Specific diagnostic services,
- medical and surgical treatment,
- artificial insemination,
- in-vitro fertilization,
- and drug therapy.

The following are excluded from this coverage:

- All charges and related services for donor materials,
- all forms of artificial intervention (except artificial insemination and in-vitro fertilization),
- surrogacy,
- and medications for sexual dysfunction.

Covered infertility treatment is subject to the Kaiser HMO Plan's annual deductible, with the exception of outpatient prescription medications.

Retiree Plan Eligibility
Effective July 1, 2022, the Trust's eligibility criteria for the Retiree Plan is changing as follows:

> Retirees (and any eligible Dependents of a Retiree) are eligible only for medical/prescription drug coverage. Vision, dental, short- and long-term disability, and life insurance coverage terminates when Retiree coverage begins. To be eligible You must be at least age 55 and have been eligible for coverage in this Plan as an active employee for at least 36 months prior to enrolling in the Retiree Plan, including at least six (6) months immediately preceding the date you enroll in the Retiree Plan.

If you have any questions regarding the benefit changes described in this notice, contact the Administration Office at (800) 331-6158, option 0.

Board of Trustees
Puget Sound Benefits Trust

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Important Reminder **-** You must advise the Administration Office of any changes in your basic demographic data, including changes in your name, marital status, dependents, other insurance coverage available, designated beneficiary, home address, email address and telephone number. Provide information changes by completing and sending a new Enrollment Form to the Administration Office. If you have a change in dependents, divorce requires a complete filed copy of your divorce decree along with any accompanying court orders including the parenting plan. Marriage requires a copy of your marriage certificate, the parenting plan for stepchildren and their birth certificates.

Failure to update your information on file may interfere with our ability to process your benefits and provide timely communication of important Plan information.

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Phone: (206) 441-7574 or (800) 732-1121 • Fax: (206) 505-9727 • Website: www.psbenefitstrust.com
Administered by
Welfare & Pension Administration Service, Inc.

June 23, 2021

TO: All Plan Participants
Puget Sound Benefits Trust

RE: New Utilization Management Program Manager

This is a Summary of Material Modification describing changes to your health plan recently adopted by the Board of Trustees. Please read this notice carefully and keep this document with your Summary Plan Description Booklet.

The Board of Trustees has adopted benefit changes to the Puget Sound Benefits Trust (the "Trust"). **Effective July 1, 2021**, Innovative Care Management (ICM) will replace Premera for Preauthorization, Case Management and Utilization Review services. Premera will continue to be the Preferred Provider Network for the Trust.

Services that require preauthorization include all inpatient services, transplant services, bariatric surgery. Inpatient services not preauthorized will be covered at 50% and only services determined medically necessary will be covered. The penalty does not apply to the out-of-pocket limit or deductible.

Preauthorization is required no later than 48 hours following an emergency admission. For a complete list of services requiring preauthorization, contact ICM at (800) 862-3338.

Effective July 1, 2021, participants will no longer be able to access the health resources under the Premera UM Program such as the Care Support 24-hour Nurse Line, Best Beginnings Maternity Program, and Personal Health Support.

New Medical/Prescription Identification (ID) Cards

New Medical/Prescription identification cards with updated information will be mailed to you in late June 2021. Please be sure to present your new ID card to your providers for services received on or after July 1, 2021. If you find errors on your newly issued ID cards or if you do not receive your ID cards by July 1, 2021, please contact the Administration Office at (800) 732-1121, option 4.

If you have any questions regarding the benefit changes described in this notice, contact the Administration Office at (800) 331-6158, option 0.

Board of Trustees
Puget Sound Benefits Trust

Puget Sound Benefits Trust

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Administered by
Welfare & Pension Administration Service, Inc.

March 16, 2021

TO: All Eligible Plan Participants and Dependents
Puget Sound Benefits Trust

RE: PPO Health Plan Benefit Changes

This is a Summary of Material Modification describing changes to your health plan recently adopted by the Board of Trustees. Please read this notice carefully and keep this document with your Summary Plan Description Booklet.

COVID-19 Testing Kits
Effective October 1, 2020, the Plan will cover over-the-counter FDA Approved Home COVID-19 Active Viral Test Kits. Kits may be purchased at a retail pharmacy through the Express Scripts pharmacy benefits program starting April 1st. The kit is covered as a preventive service with no cost sharing. One test kit per month per eligible (including dependents) will be covered by the Plan.

If you purchased a test kit *before* April 1st, please try to have the pharmacy run it through the ESI Rx program. If you have any difficulty, you may purchase and submit your receipt to the Claims Administration Office for reimbursement. The receipt must clearly identify the purchase date, cost, and the name of the item purchased. Be sure to include the Fund name, as well as your name, ID#, and address when you submit the receipt for reimbursement.

Telehealth Care
Since March 23, 2020, the Board of Trustees have approved the use of Telehealth benefits for telephone, internet, or other virtual care consultations where a patient is not physically seen by their physician or other covered provider.

Effective immediately, the Board has added Telehealth as an ongoing benefit option. Telephonic or other virtual care visits (other than the Teladoc services) are subject to the annual deductible and coinsurance benefits. The telehealth/telemedicine consultation must be diagnosis and treatment focused via a live discussion or video exchange with ongoing participation by the patient and the provider throughout the visit.

Teladoc Services
As a reminder, Teladoc visits are covered in full (100%) with no cost to the participant and you do not have to satisfy your annual deductible. To schedule a consultation, visit www.Teladoc.com/Premera or by phone at (855)-332-4059.

NOTE: Missed appointment charges are not covered and are still excluded from Plan coverage.

Transgender Coverage
The Plan included an exclusion related to sex change counseling, therapy, surgery, and charges related to gender reassignment. Effective January 1, 2021, the exclusion for charges related to gender reassignment has been eliminated and the Plan will cover treatment of gender dysphoria pursuant to the Plan terms and any policies utilized under the Plan.

Important Information Relating to COVID-19 and Extension of Deadlines
The Department of Labor, on February 26, 2021, provided new guidance on the suspension of certain employee benefit time limitations during the COVID-19 Outbreak Period, which is the period beginning March 1, 2020 and ending 60 days after the national emergency ends. This supplemental notice explains how this affects your rights under the Plan.

Extensions of Time
Pursuant to federal guidance, the Plan has extended the following deadlines during the Outbreak Period beginning March 1, 2020:

- The 60-day period for individuals to notify the plan of a COBRA qualifying event.
- The 14-day period for plan administrators to provide an individual with a COBRA election notice.
- The 60-day period to elect COBRA continuation coverage after receiving a COBRA election notice.
- The date for making COBRA premium payments.
- The 30-day (or 60-day, as applicable) period to request special enrollment after a special enrollment event.
- The time limit for members to file a benefit claim, an appeal of an adverse benefit determination, or an external review request, under the plan's claims procedures.

The Department of Labor has authority to grant these extensions for **one year** only**.** The new Department of Labor notice dictates that the one-year extension should be applied separately to each deadline during the Outbreak Period. In effect, this adds one year to each one of the above deadlines until the Outbreak Period is over.

COBRA Examples
If you had a qualifying event in April 2020 and received a COBRA election notice on May 1, 2020, your 60-day period to elect COBRA coverage will begin running on May 1, 2021, one year later. You will have until June 29, 2021 to elect COBRA continuation coverage effective back to your qualifying event.

If you had a qualifying event in February 2021 and received a COBRA election notice on March 1, 2021, your 60-day period to elect COBRA coverage will begin one year later, on March 1, 2022, or at the end of the Outbreak period, whichever comes first.

COBRA premiums are generally due on the first of the month and subject to a 30-day grace period. During the Outbreak Period, the 30-day grace period for each monthly payment is extended by one year. For example, if you were receiving COBRA in April 2020, the 30-day grace period for the April premium payment begins on April 1, 2021, so your payment is due on April 30, 2021. The May 2020 premium payment similarly will be due by May 30, 2021, and so on.

Special Enrollment Examples

If you previously declined coverage for a dependent because the dependent had coverage under another employer health plan, but your dependent lost that coverage because of the end of that employment, then you have 30 days from the end of that coverage to request special enrollment for that dependent in the Plan. That 30-day time limit was suspended under the federal rule, but will begin or resume **one year** from the date of the event. For example, if your spouse's other employment-based coverage ended on January 1, 2021, you will have until January 30, 2022 to request special enrollment – one year, plus 30 days – unless the Outbreak Period ends earlier.

Important Note Regarding Retroactivity

Please note that while you may elect COBRA continuation coverage back to your COBRA qualifying event or special enrollment for a new dependent based on birth or adoption back to the date of birth or adoption, you must pay any required premiums for all months before retroactive coverage will be provided. Retroactive coverage must be continuous from the time of first retroactive eligibility. You may submit claims for services during the suspended period, but they will be pended until you make the necessary premium payments.

If you have any questions regarding this notice, contact the Administration Office at (800) 3316158, option 0. Please also reference the Trust website, www.psbenefitstrust.com for additional information.

Board of Trustees
Puget Sound Benefits Trust

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PUGET SOUND BENEFITS TRUST
SUMMARY PLAN DESCRIPTION
SELF-FUNDED PLANS
AND
INSURED PLAN BENEFITS

Amended, Restated and Effective
January 1, 2021

TABLE OF CONTENTS

INTRODUCTION

TO ALL ELIGIBLE INDIVIDUALS

This Plan Document/Summary Plan Description describes the benefits available through the Puget Sound Benefits Trust's ("Trust") Plan. This Booklet provides descriptions of Medical, Prescription Drug, Dental, Vision, Short Term Disability, and Life and Accidental Death and Dismemberment benefits provided by the Plan.

This Plan is established under and subject to the federal law, Employee Retirement Income Security Act of 1974, as amended, commonly known as ERISA. Plan is self-funded with contributions from the Trust and Eligible Employees and Retirees held in a Trust and used to pay Plan benefits. An independent Claims Administrator pays benefits out of Trust assets. The medical, prescription drug, vision, and short term disability benefits provided by the Plan are self-insured. The HMO Medical Plan through Kaiser, dental, life insurance/Accidental Death and Dismemberment (AD&D), and long term disability benefits are fully insured with insurance companies whose names are listed on the Quick Reference Chart in this document.

The Plan described in this document is effective January 1, 2019, and replaces all other plan documents, summary plan descriptions and applicable amendments to those documents previously provided to Plan Participants. Please note that certain benefits such as vision or orthodontic care are only available to Plan Participant's and their eligible Dependents in the event that your Employer offers these options.

ADDITIONAL INFORMATION CONCERNING INSURED BENEFITS

For Plan Participants participating in the insured benefits, such as the dental benefits or the Kaiser plan, this document, together with any Plan booklet issued by the insurers are your Plan Document/Summary Plan Description (SPD). Benefits provided by the insurers, including Kaiser, are not described in detail in this Plan document. If you would like a copy of the plan booklet for the fully insured coverage for which You are eligible, You should contact the Trust Administration Office for a copy of insurer's plan booklet.

IMPORTANT INFORMATION

Puget Sound Benefits Trust is committed to maintaining health care coverage for Employees and their families at an affordable cost, however, because future conditions cannot be predicted, the Board of Trustees reserves the right to amend or terminate coverage at any time and for any reason. As the Plan is amended from time to time, You will be sent information explaining the changes. If those later notices describe a benefit or procedure that is different from what is described here, You should rely on the later information.

The Board of Trustees has the exclusive authority to interpret the provisions of the Plan, to determine eligibility for an entitlement to Plan benefits or to amend the Plan. Any interpretation or determination by the Trustees made in good faith which is not contrary to law is conclusive on all persons affected. The Board of Trustees has also hired various insurance companies to provide benefits to eligible Plan participants. The Board of Trustees has delegated to these insurance agencies and the Trust Administration Office the authority to administer the Plan and provide information relating to the amount of benefits, eligibility, and other Plan provisions.

In administering the Plan, the Trust Administration Office and any medical review organization used by the Trust may utilize its internal guidelines and medical protocols in determining whether or not specific services or supplies are covered under the terms of the Plan. Under the insured option, an interpretation of Plan benefits is subject to review by the relevant insurance carrier and the insurance carrier is responsible for its decision. An interpretation of Plan eligibility, Plan funding, selection of benefit providers or other non-benefit related issues is subject to review by the Board of Trustees. No individual trustee, employer, or employer association, or any individual employed by an employer or employer association, has any authority to interpret or change this SPD or the Plan.

Be sure to keep this document, along with notices of any Plan changes, in a safe and convenient place where You and Your family can find and refer to them.

REQUIREMENT TO FURNISH AND UPDATE INFORMATION

You or Your Dependents must promptly furnish to the Trust Administration Office information regarding change of name, address, marriage, divorce or legal separation, death of any covered family member, change in status of a Dependent Child, Medicare enrollment or disenrollment or the existence of other coverage. Notify the Plan preferably within 31 days, but no later than 60 days, after any of the above noted events.

You can be held liable for benefit payments issued based on any incorrect information about Your family members, such as failing to notify the Trust Administration Office in case of divorce, if Your dependent child changes employment status, or if an adoption is rescinded. In addition, You may be liable for other costs incurred by the Plan as a result of the incorrect information. These costs include, but are not limited to, attorney's fees, administrative costs, and reasonable interest.

FOREIGN LANGUAGE ASSISTANCE

This booklet contains a summary in English of Your rights and benefits under the Puget Sound Benefits Trust. If You have any difficulty in understanding any part of this booklet, You may contact the Trust Administration Office at the address listed on the Quick Reference Chart at the front of this booklet.

AVISO EN ESPAÑOL

Este folleto contiene un resumen en ingles de sus derechos y beneficios bajo el Puget Sound Benefits Trust. Si tiene alguna dificultad en comprender cualquier parte de este folleto, puede comunicarse con Puget Sound Benefits Trust, P.O. Box 34711, Seattle, WA 98124 o llamar a los teléfonos 1-800-331-6158.

QUESTIONS YOU MAY HAVE

If You have any questions concerning eligibility or the benefits that You or Your family are eligible to receive, please contact the Trust Administration Office at their phone number and address located on the Quick Reference Chart in this document. As a courtesy to You, the Trust Administration staff may respond informally to oral questions; however, oral communications are not binding on the Plan and cannot be relied upon in any dispute concerning Your benefits. Your most reliable method is to put Your questions into writing and fax or mail those questions to the Trust Administration Office and obtain a written response from them. In the event of any discrepancy between any information that You receive from the Trust Administration Office, orally or in writing, and the terms of this document, the terms of this document will govern Your entitlement to benefits, if any.

FOR HELP OR INFORMATION

When you need information, please check this document first. If you need further help, call the organization listed in the following Quick Reference Chart:

QUICK REFERENCE CHART	
Information Needed	**Whom to Contact**
Trust Administration Office • Claim Forms and Claim Administrator for the self-funded medical and vision claims • Information about Medical, Vision, Life/AD&D and Short Term Disability Claims and appeals • Eligibility for Coverage • Appeals of Benefit Denials • HIPAA Certificate of Creditable Coverage • Medicare Part D Notice of Creditable Coverage • COBRA Information • Adding or dropping dependents • Cost of COBRA Continuation Coverage • COBRA Premium payments • Second Qualifying Event and Disability Notification • Appeals for self-funded benefits • Vision Claims and Appeals • Short Term Disability • Medical and Prescription ID cards	**Welfare & Pension Administration Service, Inc.** Claims Submission and Correspondence P.O. Box 34711 Seattle, WA 98124-1711 COBRA premiums payments should be sent to: P.O. Box 34203 Seattle, WA 98124-1203 Street Address **Trust Administration Office** 7525 SE 24th St, Suite 200 Mercer Island, WA 98040-2341 **Benefit Information** (206) 441-7574, option 0 (800) 331-6158, option 0 **Eligibility Information** (206) 441-7574, option 4 (800) 732-1121, option 4 **www.psbenefitstrust.com**
PPO Network (for the self-funded medical plan options) • Medical Network Provider Directory • Additions/Deletions of Network Providers • Always check with the providers' office before you visit a provider to be sure they are still contracted and will give you the discounted price	**Premera Blue Cross** (800) 810-BLUE www.premera.com/sharedadmin
Care Management / Utilization Management (UM) • Prior Authorization • Appeals of prior authorization benefit denials • Personal Health Support programs	**Premera Blue Cross** (888) 742-1484
Teladoc • Video or phone physician consult	**Teladoc** (855) 332-4059 www.Teladoc.com/Premera
NurseLine • Referrals for level of care • Health information and self-care education • Assistance with provider referrals	**NurseLine** (800) 274-0411

QUICK REFERENCE CHART	
Information Needed	**Whom to Contact**
Prescription Drug Plan (for individuals covered under any of the self-funded medical Plan options) • Retail Network Pharmacies • Mail Order (Home Delivery) Pharmacy • Prescription Drug Information • Direct Member Reimbursement (for Non-network retail pharmacy use)	**Express Scripts** PO Box 66583 St. Louis, MO 66583 or (800) 467-2006 www.express-scripts.com
Specialty Pharmacy (for individuals covered under any of the self-funded medical Plan options) • Injectable and non-injectable drugs • Exclusive Pharmacy for the treatment of complex medical conditions	**Accredo Specialty Pharmacy** (800) 803-2523 www.accredo.com
Medical HMO Plan (including prescription drugs) • HMO Network Provider Directory • HMO Claims and Appeals • Benefit information	**Kaiser Permanente** PO Box 34750 Seattle WA 98127 or 521 Wall Street Seattle, WA 98121 (888) 901-4636 www.kp.org/wa
Dental Plans • Dental Network Provider Directory • Dental Claims and Appeals	**Delta Dental of Washington** P.O. Box 75983 Seattle, WA 98175-0983 (800) 554-1907 (206) 522-2300 www.deltadentalwa.com
Life, Accidental Death & Dismemberment (AD&D), Short Term Disability (STD) and Long-Term Disability (LTD). • Life, AD&D, STD and LTD Claims and Appeals	**Hartford Life and Accident Insurance Company** One Hartford Plaza Hartford, CT 06155
HIPAA Privacy Official and HIPAA Security Official • HIPAA Notice of Privacy Practice	**Privacy Official** **Puget Sound Benefits Trust** **Welfare & Pension Administration Service, Inc.** Street Address: 7525 SE 24th St, Suite 200 Mercer Island, WA 98040-2341 Mailing Address: P.O. Box 34203 Seattle, WA 98124-1203 (800) 331-6158

PUGET SOUND BENEFITS TRUST WEBSITE

The Puget Sound Benefits Trust has established a website to provide you with immediate access to your plan information. The site located at **www.psbenefitstrust.com** includes the following Trust related material:

- **Forms** – Medical, Vision, Prescription, Short Term Disability, Enrollment, Documents and Notices
- **Benefits information** – Plan Booklets, Summary of Benefits and Coverage for Self-Funded and Kaiser Permanente ("Kaiser") Plans
- **Links** to Health Plan Provider Networks and Other Useful Sites
- **HIPAA Privacy Notice** and Information
- **Local Unions** Contact Information

This site will also provide a link to "My Trust Login" information, which is viewed through a secure location requiring the entry of a personal identification number (PIN) and your social security or WPAS identification number (as printed on your Medical/Rx ID card). A PIN will be assigned and mailed to you upon your written request. To request a PIN, please complete a "PIN REQUEST FORM". Please note that a PIN will be assigned. For security purposes you *may not* choose your own PIN. "My Trust Login" information includes the following data:

- **Personal Information** – name, address, gender, birth date, marital status, etc.
- **Health Insurance Eligibility** – eligibility in the current and past 12 months
- **Contributions** – statement showing employer's reporting and contributions paid on your behalf.
- **Dependent Information**
- **Medical Claims Summary** and Paid Claims Detail

You only have access to your own personal claims history and that of Your dependents under the age of 13. Your Spouses and Dependent children, age 13 and over, must request their own PIN. To request a PIN, go to the website www.psbenefitstrust.com and download a PIN Request form.

ELIGIBILITY

IMPORTANT NOTE ABOUT YOUR COLLECTIVE BARGAINING AGREEMENT: Your Collective Bargaining Agreement describes the benefits to which you are eligible to participate. The cover letter attached to this SPD document summarizes Your classification of benefits as of the date of the cover letter. A copy of your Collective Bargaining Agreement can be requested from Your Employer, Local Union, or the Trust Administration Office. In the event of any conflict between this booklet and the Collective Bargaining Agreement, the most recent Collective Bargaining Agreement will control.

WHO IS ELIGIBLE FOR COVERAGE AND START OF COVERAGE

IMPORTANT: To ensure that you begin to receive benefits as soon as you meet the eligibility requirements, You should submit Your enrollment form and supporting Dependent documentation before you have completed the minimum service requirement. Enrollment forms can be obtained from the Trust Administration Office, online at www.psbenefitstrust.com as well as from your union.

When You first become eligible for the Plan, you must select your medical coverage (unless your Collective Bargaining Agreement does not allow for a choice of coverage.)

- **Medical Coverage Options:** The Trust offers coverage through Kaiser Permanente, an HMO, and through a self-funded medical Plan. The benefits for which you are eligible is determined by the terms of the Collective Bargaining Agreement with your employer. This booklet provides information on how the self-funded medical Plan works. If you are enrolled in the Kaiser Plan, you will receive a benefit plan booklet from Kaiser; it provides a full description of your Kaiser medical benefits and how to file appeals.
- **Other Benefits**: the Trust offers dental, vision, long term disability, short term disability and life insurance if your collective bargaining agreement with your employer provides for the coverage. If your collective bargaining agreement provides the benefits, you will be automatically enrolled.

EMPLOYEE ELIGIBILITY

You must be an active, full-time Employee (or part-time if stated in your Collective Bargaining Agreement) of a Participating Employer who has entered into a Collective Bargaining Agreement (or other Agreement) which requires contributions to be made to the Trust. You must be in a covered classification. You will become eligible for benefits on the first day of the second calendar month following the month employer contributions have been made on your behalf. In order to remain eligible, sufficient employer contributions must be made on your behalf.

Coverage Example		
Month 1	Month 2	Month 3
You work covered hours	Contributions paid by your Employer for hours worked in Month 1	Coverage begins

Some Employees may be required to satisfy a probationary period before coverage becomes effective. You will find more information on this probationary period in your Collective Bargaining Agreement.

Once You have satisfied the initial eligibility requirements, you are automatically enrolled in the Plan. You will continue to be eligible as long as you work sufficient hours each month and your employer makes the necessary contributions to the Trust. The number of hours you must work each month to remain eligible is determined by the Collective Bargaining Agreement between your union and employer. Your eligibility will also continue while you are not working **if** the Collective Bargaining Agreement requires your employer to make payments on your behalf (for example, during a disability leave).

Your eligibility for benefits depends on the continued and timely payment of Employer contributions on your behalf. If your employer fails to make a contribution when it is due, your eligibility will automatically cease.

TERMINATION OF ELIGIBILITY

Employee coverage ends on the earliest of the following dates:

- The date the Plan terminates;
- The date you cease being eligible;
- The last day of the month following the month in which the Participating Employer does not make the required contribution on your behalf;
- The date on which your employer terminates participation in the Plan; or
- The date you enter full time military, naval, or air service, except as shown under Military Service Leave.

DEPENDENT ELIGIBILITY

The eligible Dependents of an Employee or Retired Employee can be covered by the Plan when you initially enroll or, if you are already enrolled in the Plan, when the person becomes an eligible Dependent – for example, through birth, marriage, adoption. You must make sure to request enrollment of your newly eligible Dependents in the Plan as described below.

Your eligible Dependents are your:

- lawful spouse (You will need to provide a marriage certificate). The spouse must be legally married to you as determined under federal law, and must be treated as a spouse under the Internal Revenue Code, including your legally recognized same-sex spouse; and
- each child who is under age 26 (You will need to provide a birth certificate, adoption papers or legal guardianship papers).

"Child" means

- Your natural child or step-child;
- an adopted child, from the date the child is adopted or "placed for adoption" (whichever is earlier). A child is "placed for adoption" with you on the date you first become legally obligated to provide full or partial support of the child whom you plan to adopt;
- a foster child;
- a child who depends on you by virtue of a court order or for whom you have legal custody;
- a child designated as Your dependent in a valid Qualified Medical Child Support Order;
- a child age 26 or older who is currently mentally or physically disabled and that disability existed before the attainment of the Plan's age limit and is incapable of self-sustaining employment as a result of that disability; and is chiefly dependent on You and/or Your Spouse for support and maintenance. The Plan will continue coverage for such a child so long as You remain covered. Proof of such incapacity must be submitted to the Trust Administration Office within 31 days of the date the child's coverage would otherwise terminate.

Enrollment of Dependents and Proof of Dependent Status

If You have eligible Dependents, it will be necessary to complete an enrollment form within 30 days of Your enrollment in order to avoid delay in processing claims. Enrollment forms can be obtained from the Trust Administration Office.

If You acquire a new Dependent while You have coverage, through marriage, birth or adoption, You must submit a new enrollment form must be completed and submitted along with the appropriate documentation. You should complete a new enrollment form and supply an appropriate documentation within 30 days of

your marriage, the birth of the child, or adoption or placement for adoption or as soon as reasonably practicable. If the newly acquired Dependent is enrolled within 60 days of the marriage, birth or adoption, the Dependent will be covered as of the date of the marriage, birth or adoption. If the newly acquired dependent is not enrolled within 60 days, the Dependent will be covered the first of the month following receipt of a properly completed enrollment form and documentation of dependent status.

Additionally, acquiring a new Dependent through marriage, birth or adoption may create a special enrollment right that permits you to enroll other dependents that have not been previously enrolled or to change your coverage options outside of the normal open enrollment period. Please contact the Trust Administrative Agent for more information regarding your special enrollment rights.

Specific documentation to substantiate Dependent status will be required by the Plan, and may include a birth certificate, marriage certificate, proof of the dependent's age, and the dependent's social security number. Enrollment will not be considered completed until all requested supporting documentation is received by the Trust Administration Office. In no event will claims be paid more than 12 months after the claims were incurred.

When Dependent Coverage Begins

Once all enrollment material is received and processed, eligibility for Your dependents will be effective on the date You become covered or the first of the month following receipt of the enrollment documents.

For newly acquired dependents, if enrollment is completed with 60 days of the date of marriage, birth, adoption, placement for adoption, placement of foster child or the date legal custody is awarded, coverage will be effective the date of marriage, birth, adoption, placement for adoption, placement of foster child or the date legal custody is awarded.

If Your coverage has lapsed, Your dependent's coverage will begin on the first day of the month when Your eligibility is reinstated.

QUALIFIED MEDICAL CHILD SUPPORT ORDERS (QMCSO) (SPECIAL RULE FOR ENROLLMENT)

A Qualified Medical Child Support Order is a judgment, decree or order issued by a court or resulting from a state's administrative proceeding that creates or recognizes the rights of a child, also called the "alternate recipient," to receive benefits under a group health plan. The QMCSO requires that the plan recognize the child as a dependent even though the child may not meet the plan's definition of dependent. A QMCSO:

- Provides child support or health benefit coverage to a dependent child or enforces a state law relating to medical child support;
- Indicates the name and last known address of the parent required to provide for the coverage and the name and mailing address of each child covered by the QMCSO or the name and mailing address of the state official issuing the order;
- Contains a reasonable description of the type of coverage to be provided under the designated parent's health care plan;
- States the period for which the QMCSO applies; and
- Identifies each health care plan to which the QMCSO applies.

An order is not a QMCSO if it requires the Plan to provide a benefit that the Plan does not otherwise provide.

If a court or state administrative agency has issued an order with respect to health care coverage for any Dependent Child of the Employee, the Trust Administration Office will determine if that order is a QMCSO as defined by federal law. A properly completed National Medical Support Notice issued by a state agency shall be deemed to be a Qualified Medical Child Support Order. The Trust's determination that an order is a QMCSO will be binding on the Employee, the other parent, the child, and any other party acting on behalf of the child. The Trust Administration Office will notify the parties designated on the QMCSO and advise them of the procedures to be followed to provide coverage of the Dependent Child(ren).

Enrollment Related to a Valid QMCSO: If the Plan determines that an order is a QMCSO it will accept enrollment of the alternate recipient as of the earliest possible date following the date of the determination and receipt of the completed enrollment materials.

TERMINATION OF DEPENDENT ELIGIBILITY

Dependent coverage ends on the earliest of the last day of the month in which:

- the Employee or Retiree's coverage ends;
- Your covered Spouse or Dependent Child(ren) no longer meets the Plan's definition of Spouse or Dependent Child(ren) as provided in the Definitions chapter of this document;
- for Dependents under a QMCSO, the expiration of the period of coverage stated in the QMCSO;
- You cease to make any contributions required for coverage of Your Spouse or Dependent Child(ren);
- the date Your Spouse enters the Armed Forces on full-time active duty;
- the date of the Dependent's death;or
- the date the Plan no longer provides benefits.

RETIREE COVERAGE

Retirees (and any eligible Dependents of a Retiree) are eligible only for medical/prescription drug coverage. Vision, dental, short and long term disability, and life insurance coverage terminates when Retiree coverage begins. To be eligible You must be at least age 55 and an eligible Retiree under a related Pension Plan for which Your Employer makes contribution on Your behalf.

TERMINATION OF RETIREE COVERAGE

Retiree coverage ends on the earliest of the following dates:

- earlier of the last day of the month prior to the month in which You become entitled (eligible and enrolled) to Medicare Part A or B; or the last day of the month in which You no longer meet the definition of a Retiree (e.g. Retiree becomes age 65 years of age) or is no longer eligible to participate in the Plan;
- last day of the month in which You fail to make any required contributions for coverage;
- date of Your death;
- the date the Plan is discontinued; or
- the date You become eligible for coverage under another group health plan. You must notify the Trust Administration Office of any other coverage.

COBRA: TEMPORARY CONTINUATION OF HEALTH CARE COVERAGE

Entitlement to COBRA Continuation Coverage: Pursuant to a federal law known as The Consolidated Omnibus Reconciliation Act of 1985 (COBRA), and under the circumstances described below, the Employee, the Employee's lawful Dependent spouse and Dependent children each have an independent right to elect to continue Trust health coverage beyond the time coverage would ordinarily have ended. The Employee or his spouse may elect COBRA on behalf of other eligible family members. A parent or legal guardian may elect COBRA on behalf of a minor child.

COBRA Qualifying Events -18 Months

COBRA coverage is available to You or Your Dependents for a maximum of 18 months if coverage would otherwise end due to one of the following:

- The Employee's termination of employment for any reason (this includes retirement and voluntarily quitting) other than gross misconduct;
- The Employee's reduction in hours of employment;

COBRA Qualifying Events -29 Months

If You or Your Dependent is determined by the Social Security Administration to be disabled either before an 18 month qualifying event or within 60 days of COBRA coverage, You and Your Dependents may extend their COBRA coverage an additional 11 months to a maximum of 29 months. In order to qualify for the extension, the individual or qualified beneficiary must provide the Trust Administration Office with proof of the Social Security disability determination no later than the date that the initial 18 month COBRA continuation ends.

COBRA Qualifying Events -36 Months

Your Dependent (lawful spouse or dependent child) may elect COBRA continuation coverage for the maximum of 36 months if their coverage would otherwise end due to one of the following events:

- Death of the Employee or Retiree;
- The Employee or Retiree becomes entitled to Medicare;
- Divorce or legal separation between the Employee or Retiree and their spouse; or,
- For a Dependent child, ceasing to meet the Plan's definition of an eligible dependent.

A child of the participating employee who is covered under the Trust's health plan pursuant to a qualified medical child support order (QMCSO) received during the Employee's period of covered employment is entitled to the same rights to elect continuation coverage as an eligible dependent child of the Employee.

Second Qualifying Event

An 18 month COBRA period may be extended to 36 months for the affected Dependent (lawful spouse or dependent child) if one of the 36 month qualifying events occurs during the first 18 months of COBRA continuation coverage. In no event will COBRA continuation coverage extend beyond 36 months from the date coverage was first lost due to the qualifying event.

COBRA Notification Responsibilities

For any initial or second qualifying event, You or Your Dependents must notify the Trust Administration Office:

- Within 60 days of a death, divorce, legal separation, or child losing dependent status prior to age 26;
- Upon becoming covered under any other group health plan, including Medicare, after electing COBRA coverage;

- For a Social Security disability extension, within 60 days of Social Security determining an individual is disabled, but not later than the date the initial 18-month COBRA period ends; and,
- Within 30 days of Social Security determining an individual is no longer disabled.

The employer has the responsibility to notify the Trust Administration Office of the employee's termination of employment or reduction in hours.

Election of COBRA Coverage

Upon receiving notification that a qualifying event may have occurred, the Trust Administration Office will notify You, Your lawful spouse, and each of Your covered Dependents of their right to elect continuation coverage. The participants must then select continuation coverage by the later of:

- 60 days after the participant's coverage ends; or
- 60 days after the participant receives notification of the continuation rights from the Trust Administration Office.

Failure to elect COBRA within this 60-day period will cause eligibility to end as it normally would under the terms of the Plan, and You and Your Dependents will lose the right to elect continuation coverage.

Newly Acquired Dependents during COBRA Coverage

If you acquire an eligible dependent while eligible for COBRA continuation coverage you may elect to enroll the dependent for continuation coverage in accordance with the Plan's normal enrollment rules. However, only child(ren) born to, adopted by or placed for adoption with you (the covered employee) during the 18-month period of COBRA Continuation Coverage are qualified beneficiaries entitled to an extension of coverage as a result of a second qualifying event. Spouses and stepchildren acquired after a qualifying event are not eligible for 36 months of coverage due to a second qualifying event.

Available Coverage

The Employee or the Employee's or Retiree's Dependents may elect the following coverage options, depending on the coverage You had prior to the qualifying event:

- Medical and Prescription Drug
- Medical, Prescription Drug, Dental and Vision
- Medical, Prescription Drug, Dental, Vision, Life Insurance and Accidental Death and Dismemberment Insurance.

Once the coverage option is selected, and the 60-day window for making the selection closes, the selection cannot be changed. COBRA coverage is not available for time loss benefits.

Continuous Coverage Required

Your coverage under COBRA must be continuous from the date your Trust coverage would have ended if monthly self-payments were not made.

Monthly Self-Payments for COBRA Coverage Required

You and your covered dependents are responsible for the full cost of continuation coverage. The first payment is due 45 days from the date the election form is sent to the Trust Administration Office. The first payment must cover all months since the date coverage would have otherwise terminated. Thereafter, payments are due on the first day of each month for that month's coverage. Eligibility will not be granted until payment is received. Failure to make timely payments within 30 days from the beginning of the coverage month, will result in the permanent loss of continuation coverage.

The cost for the COBRA coverage available through the Trust is set annually. Information regarding the cost will be sent with the COBRA election forms.

End of COBRA Coverage

Continuation coverage will end on the earliest of the following dates:

- 18 months from the date continuation began for individuals whose coverage ended because of a reduction of hours or termination of employment.
- 29 months from the date continuation began if the individual was disabled as of the time their eligibility ended, or within 60 days thereafter, and they provide proof of the Social Security Administration's disability determination within both 60 days of their receipt of it and during the initial 18-month continuation period.
- 36 months from the date continuation began for individuals whose coverage ended because of the death of the employee, divorce or legal separation from the employee, the dependent ceasing to meet the definition of an eligible dependent, or the employee's entitlement to Medicare. If an employee has an 18-month qualifying event after becoming entitled to Medicare, continuation coverage for dependents (lawful spouse or dependent child) will end on the later of 18 months from the date continuation began because of a reduction of hours or termination of employment, or 36 months from the date the employee becomes entitled to Medicare.
- End of any month for which the required premium for your COBRA coverage is not paid within 30 days of the first of the month for which the payment applies. Checks returned for non-sufficient funds will be treated as failing to make a self-payment and if not reissued by the end of the coverage period, coverage will terminate.
- The date the individual becomes covered under any other group health plan (except to the extent the other group health plan limits benefits for preexisting conditions that affects the individual's coverage).
- The date the individual becomes entitled to Medicare.
- The date this Plan ends.

Relationship Between COBRA and Medicare or Other Health Coverage

Your COBRA coverage will terminate if you become entitled to Medicare or other group health coverage after your COBRA election. If your Medicare or other group health coverage already existed when you elected COBRA, however, you can be eligible for both.

If you have Trust coverage based on COBRA and you are entitled to Medicare based on age or disability and no longer have current employment status, Medicare will pay first and the Trust will only pay secondary and coordinate with Medicare. Current employment status means you are still at work or have received short-term disability benefits for six months or less. If you have Medicare coverage based on end stage renal disease and have Trust coverage (based on COBRA or otherwise), the Trust will pay primary during the 30-month coordination period provided for by statute.

If you have other group health coverage, it will pay primary and the Trust's COBRA coverage will be secondary.

Other Coverage Options

There may be other more affordable 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 should compare your other coverage options with COBRA continuation coverage and choose the coverage that is best for you. For example, if you move to other coverage you may pay more out of pocket than you would under COBRA because the new coverage may impose a new deductible. When you lose job-based health coverage, it's important that you choose carefully between COBRA continuation coverage and other coverage options, because once you've made your choice, it can be difficult or impossible to switch to another coverage option.

OTHER CONTINUATION OF COVERAGE

FAMILY AND/OR MEDICAL LEAVE (FMLA)

You may be entitled to continue coverage under the Family Medical Leave Act or similar state law. It is not the role of the Trustees or the Trust Administration Office to determine whether You are entitled to leave with continuing medical care under the FMLA, similar state statutes, or Your Collective Bargaining Agreement. Disputes over entitlement to FMLA leave must be resolved between You, Your union and Your Employer. The Plan will provide continuing medical care under the FMLA so long as required monthly contributions are received from the Employer.

Coverage During an FMLA Leave Of Absence

Under the Family and Medical Leave Act ("FMLA"), an Employee may be entitled to:

- Twelve workweeks of leave in a 12-month period for:
    - The birth of a child and to care for the newborn child within one year of birth;
    - The placement with the employee of a child for adoption or foster care and to care for the newly-placed child within one year of placement;
    - The care of the Employee's spouse, child, or parent who has a serious health condition;
    - To care for the Employee's own serious health condition that makes him unable to perform the essential functions of your job;
    - Any qualifying exigency arising out of the fact that the Employee's spouse, son, daughter, or parent is a covered military member on "covered active duty" (a qualifying exigency include things such as needing to make arrangements for child or parental care, financial support or counseling, or attend ceremonies, rest and recuperate); or
- Twenty-six workweeks of leave during a single 12-month period to care for a covered servicemen with a serious injury or illness if the Employee is the service member's spouse, son, daughter, parent, or next of kin (military caregiver leave).

If You think You are eligible for FMLA leave, You should contact Your Employer as soon as possible. Your Employer can tell You of any other obligations under the FMLA.

While You are on FMLA leave, Your employer is required to continue contributions for Your medical, dental, and vision coverage during leave.

The FMLA applies directly to employers, not to this Trust. For clarification and/or additional information on your rights under the FMLA, contact the Department of Labor, Wage and Hour Division, at http://www.dol.gov/whd or call 1-866-487-9243. State law may provide additional entitlements and protections.

Once You have exhausted Your FMLA leave, You may be eligible for COBRA continuation coverage, as described above. For more information on FMLA rights, contact Your Employer.

LEAVE FOR MILITARY SERVICE/UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT (USERRA)

Under the Uniformed Services Employment and Reemployment Rights Act (USERRA) You have certain rights to continue coverage under this Plan if you enter military service. You are responsible for notifying the Trust Administration Office that You are entering military service.

Notice of Military Service

You are responsible for notifying the Trust Administration Office that you are entering military service and electing USERRA continuation coverage. You must notify the Trust Administration Office of your military service within 60 days of entering military service. If you fail to notify the Trust Administration Office within the 60-day time period, you will not be entitled to elect USERRA continuation coverage.

Election of USERRA Continuation Coverage

After timely notification to the Trust Administration Office of military service, You will be sent an election form to affirmatively elect USERRA continuation coverage. Your completed election form must be sent to the Trust Administration Office, and postmarked or received within 60 days from the later of the date coverage would otherwise end, or 60 days from the date the notification is furnished. If you do not return your election forms by the due date, you will not be allowed to elect USERRA continuation coverage.

Length of USERRA Continuation Coverage

If You properly elect USERRA continuation coverage, the USERRA continuation coverage will begin on the first day of the month following the month in which you begin military service, provided the required self-payments are made.

USERRA continuation coverage will end on the first of the dates indicated below:

- 24 months following the date of your entry into military service.
- The last day of the month in which you fail to return to employment or apply for a position of reemployment within the time required by USERRA.
- The last day of the month for which a timely self-payment is not received or postmarked.

Available Coverage

You may elect to self-pay for USERRA continuation coverage for Yourself, Yourself and Your Dependents, or only Your Dependents. Depending on the terms of your collective bargaining agreement, you may elect the following coverage options:

- Medical and Prescription Drug
- Medical, Prescription Drug, Life and AD&D
- Medical, Prescription Drug, Dental, Vision
- Medical, Prescription Drug, Dental, Vision, Life and AD&D

USERRA continuation coverage is not available for time loss benefits. Once You elect a coverage option, that election cannot be changed for the duration of USERRA continuation coverage. Benefits are the same as those provided to similarly situated Active Employees. If the Trust changes its benefits, USERRA continuation coverage will also change.

Monthly Self-Payments

If the Employee's military leave is less than 31 days, coverage is continued at no cost. The Employee will be credited with the hours necessary to keep coverage in effect as if he worked in covered employment with a contributing employer during the period of service.

If the Employee's USERRA military leave is for 31 days or more, a monthly self-payment is required for USERRA continuation coverage. The Trust Administration Office will notify the Employee of the self-payment amount when it sends him the election forms. The rate for USERRA coverage is the same as the COBRA continuation coverage rate.

The initial payment for USERRA coverage is due within 45 days from the date the Trust Administration Office receives a completed election form. The first payment must cover all months for which coverage is sought through the month in which the first payment is made. Eligibility will not commence, nor will claims be processed until the initial payment has been made.

After the initial payment, monthly payments are due on the first of each month for that month's coverage. USERRA continuation coverage terminates if a monthly payment is not postmarked or received by the Trust Administration Office within 30 days from the beginning of the month to be covered.

USERRA continuation coverage must be continuous and must immediately follow the date your active coverage.

Reinstatement of Eligibility Following Military Service

If the Employee returns to employment with a contributing employer immediately following a qualifying discharge from military service and within the time period required by USERRA, the Employee's eligibility will be reinstated the first of the month in which he returns to employment. If the Employee is on the out-of-work list at the local union, it is considered a return to employment with a contributing employer for purposes of reinstatement of eligibility.

The Employee is responsible for immediately notifying the Trust Administration Office of his discharge from military service. The Employee should also notify the Trust Administration Office if he is reemployed within the time required by USERRA, so that the employee's eligibility can be reinstated without waiting periods.

Relationship of USERRA Continuation Coverage to COBRA

The Employee may have the right to elect COBRA continuation coverage in lieu of USERRA continuation coverage. The length of USERRA continuation coverage may be different from that of COBRA continuation coverage. See the COBRA Continuation Coverage section.

Reinstatement of Eligibility following Uniformed Service

If You were eligible for benefits on the date of entry into the Uniformed Services of the United States, and upon completion of service You notify Your employer of Your intent to return to employment as specified in USERRA and you are re-employed with Your Employer or another Contributing Employer, Your eligibility, coverage and all rights and benefits will be reinstated as if You remained continuously employed with Your employer. Upon release from military duty, you must return or apply to return to covered employment or hiring hall status within the following time limits:

- Less than 31 days of military service – next calendar day following completion of service time plus time required for safe transportation to your residence plus eight hours.
- 31-180 days of military service – within 14 days.
- More than 180 days of military service – within 90 days.

The Plan, at its own expense, will advance the first month of coverage after your return to employment.

CONTINUATION OF COVERAGE DURING A LABOR DISPUTE

If, because of a labor dispute, You stop working for an Employer who is contributing towards the cost of Your coverage under a Collective Bargaining Agreement, You may continue Your coverage by exercising Your COBRA rights and paying the required contributions Yourself. Refer to the chapter on COBRA for additional information.

SELF-FUNDED MEDICAL PLAN OPTIONS

ABOUT YOUR MEDICAL PLAN

This Plan provides coverage for a wide range of medical expenses for the treatment of illness or injury. The Plan also provides coverage for certain preventive and wellness benefits. Coverage is subject to all the terms, policies and procedures outlined in this Booklet. Exclusions and limitations apply to certain medical services, supplies and expenses. Refer to the *What the Plan Covers, Exclusions, and Limitations* sections to determine if medical services are covered, excluded or limited.

The following are important terms and components of this Plan and discussed more fully in the following sections:

- Annual Deductible
- Copays
- Coinsurance
- Annual Out-of-Pocket Maximum
- PPO Network
- Utilization Management/Precertification

ANNUAL DEDUCTIBLE

The annual deductible is the amount of covered medical expenses you and your dependents must pay each calendar year before the plan begins to pay benefits. Once the family deductible is met, no further deductible amounts are required for any family member for the rest of that year. Non-covered charges and copays you make do not apply to the deductible. The Plan's annual deductibles are:

	Plan A	**Plan A1**	**Plan B**	**Plan C**
Individual Deductible	$150		$250	
Family Deductible	$450		$500	

If you incur charges during the last 3 months of a calendar year that are applied toward satisfying the deductible, those charges will also be applied toward your deductible for the next calendar year.

The following services are not subject to the annual deductible:

- Immunizations
- Preventive care services
- Physical exams (including well baby exams)

COPAYS

The plan requires you to pay a Copay for each physician office visit, emergency room visit and non-emergency inpatient stay as follows:

	Plan A	**Plan A1**	**Plan B**	**Plan C**
Copayment	$15		$20	$30

The Copays generally apply to all PPO provider visits and non-PPO provider visits; however, the copays may be different than what is set forth above, depending on the nature of the services and where they are received. See the Plan's summaries of benefits and coverage for additional Copay information.

The following services are not subject to copays when performed by a PPO provider:

- Immunizations performed
- Preventive care services

- Physical exams (including well baby exams)

COINSURANCE

Once you have met the deductible and any applicable copays, the Plan typically covers 80% to 100% of the Allowed Amount for covered services from PPO providers and 60% to 70% of the Allowed Amount for covered services from Non-PPO providers. The Plan pays the following percentages of the Allowed Amounts for covered services:

	Plan A	Plan A1	Plan B	Plan C
PPO	100%		90%	80%
Non- PPO	70%		60%	

Non-PPO providers do not provide discounted rates. They are reimbursed at a lower level of benefits and benefits are only paid on charges up to the Allowed Amount. If you obtain services from Non-PPO providers, you may be balance billed (responsible for any amount above the Allowed Amount) for the amounts charged by the Non-PPO provider.

The following services are not subject to coinsurance when performed by a PPO provider:

- Immunizations performed
- Preventive care services
- Physical exams (including well baby exams)

ANNUAL OUT-OF-POCKET MAXIMUM

Once your total out of pocket expenses (including deductibles, coinsurance and copays) for PPO providers reaches the amounts below, all deductibles, coinsurance and copays are waived for PPO providers for the remainder of the calendar year. There is no Out-of-Pocket Maximum for Non-PPO providers.

	Plan A	Plan A1	Plan B	Plan C
Per Individual	$2,650		$3,500	$4,800
Per Family	$10,000		$7,000	$9,600

The following expenses do not apply to your out-of-pocket maximum:

- Out-of-network charges
- Charges the Plan does not cover
- Penalties for failure to follow preauthorization

IN-NETWORK AND OUT-OF-NETWORK SERVICES

Plan participants may obtain health care services from In-Network or Out-of-Network Health Care Providers.

In-network Services (PPO)

In-Network Health Care Providers have agreements with Premera Blue Cross, the Plan's Preferred Provider Organization (PPO), under which they provide health care services and supplies for a favorable negotiated discount fee for plan participants. When a plan participant uses the services of a PPO Provider, the plan participant is responsible for paying the applicable deductible, copayment and coinsurance on the discounted fees for any Medically Necessary services or supplies, subject to the Plan's limitations and exclusions. The PPO Provider generally deals with the Plan directly for any additional amount due.

Show your ID card to the health care provider every time you use services so they know that you are enrolled under this Plan and where to send their bills.

You may also verify if your health care provider is an In-Network provider by calling the phone number or visiting the website listed on the Quick Reference Chart in the front of this document.

Pursuant to this PPO network contract, the Plan pays benefits based on the Allowed Amount for both network "PPO" providers and out-of-network "non-PPO" providers.

Allowed Amounts for PPO Providers: the Allowed Amount is the provider's discounted charge which it has contractually agreed to in its contract with the Plan's PPO network on an appropriately billed charge. A preferred provider has agreed to accept this amount in full as payment for covered health care services or supplies.

Accessing Network Providers and Benefits

You may select any network provider from the Premera provider directory by logging on to Premera's website at www.premera.com/sharedadmin. You can search Premera's online directory for names and locations of physicians, hospitals and other health care providers and facilities. You can change your health care provider at any time.

IMPORTANT NOTE

Because providers are added to and dropped from the PPO network periodically throughout the year, you should ask your health care provider IF they are still a PPO provider or contact the network each time BEFORE you seek services.

Out-of-network Services (Non-PPO)

Non-PPO providers have no agreements with the Plan and are generally free to set their own charges for the services or supplies they provide. The Plan will reimburse the Plan participant for the Allowed Amount based on the Usual, Customary, and Reasonable (UCR) charge determined by the Plan for any Medically Necessary services or supplies, subject to the Plan's deductibles, copayments, coinsurance, limitations and exclusions. Plan participants must submit proof of claim before any such reimbursement will be made.

CAUTION: Non-PPO Providers may bill for any balance due in addition to the Allowed Charge amount payable by the Plan (called balance billing). You can avoid balance billing by using PPO Providers.

Your coinsurance will generally be lower when you use PPO providers and facilities. You always have the choice to access all licensed providers and facilities; however, your out-of-pocket costs will generally be higher when you use non-PPO provider. Additionally, non-PPO providers have not agreed to accept the negotiated charge and may bill you for charges over the Allowed Amount.

If a service or supply is provided from a non-PPO provider and Premera determines that a network provider is not available to provide the service or supply, the Allowed Amount for that service or supply is the lesser of:

- What the provider bills or submits for that service or supply; or
- For professional services, the 90th percentile of the UCR rate for the geographic area where the service is furnished.

This includes situations in which you are admitted to a network hospital and non-network physicians, who provide services to you during your stay, bill you separately from the network hospital. If Premera has an agreement with a provider (directly, or indirectly through a third party) which sets the rate that Premera will pay for a service or supply, then the Allowed Amount is the rate established in such agreement.

MEDICAL EXPENSES INCURRED OUTSIDE THE U.S.

If you incur medical expenses outside the U.S. (including hospital expenses), you will be required to pay the bills and submit claims for reimbursement, in accordance with the Plan's rules for submitting out-of-network claims. In addition, all materials relating to your expenses must be translated into English (before being submitted to this Plan) and you must submit proof of payment with your claim. Reimbursement is subject to all other Plan provisions and limitations.

UTILIZATION MANAGEMENT (UM)/PRIOR AUTHORIZATION

The Plan's Utilization Management Program is administered by Premera Blue Cross operating under a contract with the Plan (hereafter referred to as the UM Company). The name and telephone number of the UM Company appears in the Quick Reference Chart in the front of this document. The health care professionals in the UM Company focus their review on the necessity and appropriateness of Hospital stays and the necessity, appropriateness and cost-effectiveness of proposed medical or surgical services.

The fact that your Physician recommends Surgery or Hospitalization or that your Physician proposes or provides any other medical services or supplies doesn't mean that the recommended services or supplies will be considered Medically Necessary. The UM Company's certification is not a guarantee of payment of Plan benefits. Eligibility for and actual payment of benefits are subject to the terms and conditions of the Plan as described in this document. All treatment decisions rest with you and your Physician. The UM Company is not engaged in the practice of medicine, and is not responsible for the quality of health care services actually provided or for the results, regardless of whether the patient chooses to receive health care services that have or have not been certified by the UM Company as Medically Necessary.

Premera Blue Cross has developed or adopted guidelines and medical policies that outline clinical criteria used to make Medical Necessity determinations. The criteria are reviewed annually and are updated as needed to ensure our determinations are consistent with current medical practice standards and follow national and regional norms. Practicing community doctors are involved in the review and development of our internal criteria. You or your provider may review Premera's medical policies a at **www.premera.com**.

SERVICES THAT MUST BE PRIOR AUTHORIZED BY THE UM COMPANY:

- Planned admission into hospitals or skilled nursing facilities
- Some inpatient surgeries
- Non-emergency air ambulance transport
- Advanced imaging, such as MRIs, CT scans, and cardiac imaging
- Transplant and donor services
- Some planned outpatient procedures and surgeries
- Some injectable medications you get in a healthcare provider's office
- Prosthetics and orthotics other than foot orthotics or orthopedic shoes
- Reconstructive surgery
- Home medical equipment costing $500 or more

This is not a complete list and shows just some of the services that require prior authorization. A complete list can be found at **Premera.com. Keep in mind, your Premera preferred provider has the most current list and medical information needed to request prior authorization on your behalf.*

How Prior Authorization Works: Prior authorization is a process, administered by the UM Company, to assure that health care services meet or exceed accepted standards of care and that the admission and length of stay in a Hospital or Health Care Facility, Surgery, and other health care services are Medically Necessary.

HOW TO REQUEST PRIOR AUTHORIZATION (PRE-SERVICE REVIEW):

It is your responsibility to assure that prior authorization occurs when it is required by this Plan. Any penalty for failure to prior authorize is your responsibility.

To request prior authorization you must submit all of the following information: the Plan name; the employee's name; the patient or covered individual's name (if not the employee); the patient's address, phone number and social security number or Plan identification number; Physician's name, and phone number or address; the name of any hospital or outpatient facility or any other health care provider that will

be providing services; the reason for the health care services or supplies; and the proposed date for performing the services or providing the supplies.

A decision on a request for services that requires prior authorization will be sent in writing within 5 calendar days of receipt of all information necessary to make the decision.

Prior Authorization for Benefit Coverage for Medical Services, Supplies or Equipment and Inpatient Admissions

The Plan has a list of services, equipment, and facility types that must have prior authorization before you receive the service or are admitted as an inpatient at the facility (see the sample list in the prior section). Please contact your in-network provider before you receive a service to find out if your service requires prior authorization.

- **In-network providers or facilities** are required to request prior authorization for the service.
- **Out-of-network and out-of-area providers and facilities** will not request prior authorization for the service. You have to ask Premera to prior authorize the service.

All inpatient hospital admissions require notification, including emergency inpatient hospitalization, as soon as reasonably possible.

FAILURE TO PRIOR AUTHORIZE/RETROSPECTIVE (POST-SERVICE) REVIEW

Premera PPO providers are familiar with the process for obtaining prior authorization and will contact Premera on your behalf.

If your Premera PPO provider fails to preauthorize services, a retrospective review will be conducted. If the service is found to be medically necessary, Plan benefits will be allowed. However, if the services are not determined to be medically necessary, no Plan benefits will be payable for those services.

If you use the services of a non-Premera PPO provider and services are not prior authorized, but found medically necessary upon retrospective review, a penalty equal to 50% of the allowed charges will be imposed. However, if the services are not determined to be medically necessary, no Plan benefits will be payable for those services.

To avoid extra costs always ask your healthcare provider to request prior authorization before you have a medical service. See also the Claim Filing and Appeals Information chapter of this document.

WHAT THE PLAN COVERS

Unless otherwise specified, the Plan's standard Deductible, Copays and Coinsurance apply.

Ambulance Services

Expenses for ambulance services are covered only when those services are for an Emergency Medical Condition as that term is defined in the Definitions chapter of this document or for Medically Necessary inter-facility transport.

The Plan pays the following Coinsurance on the Allowed Amount charged for both PPO and Non-PPO providers:

	Plan A	Plan A1	Plan B	Plan C
Coinsurance	70%		60%	

Ground Ambulance Covered expenses include charges for professional ambulance transportation:

- To the nearest appropriate facility where treatment of the medical emergency can be delivered.
- From one hospital to another hospital in a medical emergency when the first hospital does not have the required services or facilities to treat your condition.
- From hospital to home or to another facility when other means of transportation would be considered unsafe due to your medical condition.
- From home to hospital for covered inpatient or outpatient treatment when other means of transportation would be considered unsafe due to your medical condition. Transport is limited to 100 miles.
- When during a covered inpatient stay at a hospital, skilled nursing facility or acute rehabilitation hospital, an ambulance is required to safely and adequately transport you to or from inpatient or outpatient medically necessary treatment.

Air or Water Ambulance Covered expenses include charges for emergency transportation to a hospital by professional air or water ambulance when necessary. The Allowed Amount for non-PPO air ambulance services will be based on UCR charges determined by the Plan for Medically Necessary Emergency Transportation.

Behavioral Health Services

(Mental Health, Alcoholism and Chemical Dependency Treatment)

Coverage is provided for Inpatient Acute hospital admission and Outpatient treatment.

Inpatient care is subject to the preauthorization requirements of the Plan.

Clinical Trials

The Plan will cover routine patient costs for items and services furnished in connection with an approved phase I, II, III, or IV clinical trial or a clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition that would otherwise be covered by the Plan. The Plan generally will not cover:

- The investigational item, device, or service itself (except as provided below);
- Items and services solely for data collection that are not directly used in the clinical management of the patient; or
- Services that are clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

That Plan will cover the investigational item, device, or service itself if it is part of an approved clinical trial and meets the criteria in either Category 1 or 2 below:

Category 1

- The trial is a Phase III or Phase IV trial approved by the National Institutes of Health, the FDA, the Department of Veteran Affairs or an approved research center;
- The trial has been reviewed and approved by a qualified institutional review board; and
- The facility and personnel have sufficient experience or training to provide the treatment or use the supplies

Category 2

- The trial is to treat a condition too rare to qualify for approval under Category 1;
- The trial has been reviewed and approved by a qualified institutional review board;
- The facility and personnel have sufficient experience or training to provide the treatment or use the supplies;
- The available clinical or preclinical data provide a reasonable expectation that the trial treatment will be at least as effective as non-investigational therapy; and
- There is no therapy that is clearly superior to the trial treatment

Corrective Appliances

(Prosthetic & Orthotic Devices, other than Dental)

Covered expenses include charges made for internal and external prosthetic devices and special appliances, if the device or appliance improves or restores body part function that has been lost or damaged by illness, injury or congenital defect. Covered expenses also include instruction and incidental supplies needed to use a covered prosthetic device.

The Plan covers the first prosthesis you need that temporarily or permanently replaces all or part of a body part lost or impaired as a result of disease or injury or congenital defects for an:

- Internal body part or organ; or
- External body part.

Covered expenses also include replacement of a prosthetic device if:

- The replacement is needed because of a change in your physical condition; or normal growth or wear and tear; or
- It is likely to cost less to buy a new one than to repair the existing one; or
- The existing one cannot be made serviceable.

Covered expenses may include one pair of supportive devices for the feet per calendar year as Medically Necessary.

The Plan will not cover expenses and charges for, or expenses related to:

- Orthopedic shoes, therapeutic shoes, or other devices to support the feet, except as provided above; unless required for the treatment of or to prevent complications of diabetes; or if the orthopedic shoe is an integral part of a covered leg brace; or
- Dental prosthetics; or
- Trusses, corsets, and other support items; or
- Any item listed in the *Exclusions* section.

The Plan pays the following Coinsurance rates on the Allowed Amount charged for Corrective Appliances:

Coinsurance	Plan A	Plan A1	Plan B	Plan C
PPO	80%	80%	80%	80%
Non-PPO	70%	70%	60%	60%

Cosmetic Surgery

Cosmetic surgery, any procedure performed mainly to improve the appearance of the covered person is excluded from coverage under the Plan, unless it is:

- reconstructive surgery following a mastectomy;
- for cosmetic surgery for repair of damage sustained in an accident that occurred while covered by the Plan and the charges are incurred within 12 months from the date of the accident applied without respect to when the individual is enrolled in the Plan. In such cases where there are documented medical reasons why repair cannot be completed within one year of the injury, the benefit period may be extended at the discretion of the Trustees for successive one-year periods, beginning with the end of the first one-year period. You will be required to submit substantiating medical documentation to the Plan prior to consideration of any one-year extension;
- Treatment of a child to correct a congenital diseases or anomaly.

Dental Services

Covered Medical Expenses include:

- Treatment of accidental injury to teeth that occurred while covered by the Plan, including replacement of teeth within 12 months of the accident, unless unable to complete the surgery within 12 months due to Medical Necessity.
- Oral or craniofacial surgery is limited to cutting procedures to remove tumors, cysts, abscess, acute injury and for reconstructive but not cosmetic purposes.
- General anesthesia and associated hospital or outpatient surgical facility charges in connection with dental care for an eligible dependent who is age 7 years or younger, or who is physically or developmentally disabled or who cannot expect a successful result under local anesthesia because of a medical condition.

The Plan pays the following Coinsurance rates on the Allowed Amount charged for Medically Necessary Dental services:

Coinsurance	Plan A	Plan A1	Plan B	Plan C
PPO	100%		90%	80%
Non-PPO	70%		60%	

Diabetes Management

Covered Expenses include charges for Medically Necessary equipment, supplies and care for the treatment of diabetes.

The Plan also covers outpatient self-management training education, including medical nutrition therapy, as ordered by the health care provider and rendered only by health care providers with expertise in diabetes.

If not covered by your prescription drug benefit, the Plan may provide coverage for:

- insulin,
- syringes,
- blood glucose monitors,
- test strips for blood glucose monitors,
- urine test strips,
- insulin pumps and infusion devices,
- foot care appliances for prevention of complication associated with diabetes; and
- glucagon emergency kits.

Durable Medical and Surgical Equipment (DME)

Covered expenses include charges by a DME supplier for the rental of equipment or, in lieu of rental:

The initial purchase of DME if:

- Long term care is planned; and
- The equipment cannot be rented or is likely to cost less to purchase than to rent.
- Repair of purchased equipment. Maintenance and repairs needed due to misuse or abuse are not covered.

Replacement of purchased equipment if:

- The replacement is needed because of a change in your physical condition; and
- It is likely to cost less to replace the item than to repair the existing item or rent a similar item.

The plan limits coverage to one item of equipment, for the same or similar purpose and the accessories needed to operate the item. You are responsible for the entire cost of any additional pieces of the same or similar equipment you purchase or rent for personal convenience or mobility. The plan reserves the right to limit the payment of charges up to the most cost efficient and least restrictive level of service or item which can be safely and effectively provided. Durable Medical Equipment is covered only when its use is Medically Necessary and it is ordered by a Physician or Health Care Practitioner.

The Plan pays the following Coinsurance rates on the Allowed Amount charged for Medically Necessary Durable Medical Equipment:

Coinsurance	Plan A	Plan A1	Plan B	Plan C
PPO	80%			
Non-PPO	70%	60%	60%	60%

Emergency Medical Conditions

Covered expenses include charges made by a hospital or a physician for services provided in an emergency room to evaluate and treat an emergency medical condition.

The emergency care benefit may cover:

- Use of emergency room facilities;
- Emergency room physicians services;
- Hospital nursing staff services;
- Radiologists and pathologists services; and
- Expenses for Emergency Services are covered for the treatment of a medical emergency within 48 hours of the onset of an acute illness or the occurrence of an accidental injury which is a medical emergency as defined in the Definitions chapter.

The following Copays apply for both PPO and Non-PPO services:

	Plan A	Plan A1	Plan B	Plan C
Copayment	$50	$50	$250	$250

The Copayment per visit will be waived if subsequent Hospitalization is required within 24 hours. There is no requirement to receive preauthorization for the use of a hospital-based emergency room visit.

If you receive emergency medical services or emergency supplies from a Non-PPO provider within the emergency department of a hospital, , such charges may be paid or reimbursed up to UCR at the PPO coinsurance rate and out-of-pocket limit. In order to be eligible for this benefit, your condition must meet the Plan's definition of an Emergency Medical Condition.

Please contact a network provider after receiving treatment for an emergency medical condition.

With the exception of Urgent Care described below, if you visit a hospital emergency room for a non-emergency condition, the plan will not cover your expenses. No other plan benefits will pay for non-emergency care in the emergency room.

Home Health Care

Covered expenses include part-time or intermittent (4 hours or less per day) nursing service by an R.N. or L.P.N., rental of durable medical equipment and medical supplies, physical, occupational, respiratory and speech therapy services and lab services ordered by the attending physician.

Services must be prescribed by a physician and must be in lieu of inpatient care in a hospital or skilled nursing facility. Physician must review the treatment plan at least every 4 weeks or as requested by the Trust Administration Office. Services must be performed by an allied health professional that is under the supervision of a Home Health Agency.

The following services are not covered:

- Twenty-four hour private duty nursing;
- housekeeping services;
- custodial care; and
- Services of any person related to you or your dependents by blood or marriage or any person who resides in your home.

The Plan pays the following coinsurance for these services:

Coinsurance	Plan A	Plan A1	Plan B	Plan C
PPO	100%	100%	90%	80%
Non-PPO	70%	70%	60%	60%

Hospice

Hospice Services are covered if a person is terminally ill with a life expectancy of 6 months or less. Services must be supervised by the attending physician.

The Plan covers expenses for palliative and supportive services rendered by a Hospice Agency licensed by the appropriate agency and approved by the federal Medicare program. The Plan covers expenses for inpatient hospice care not to exceed 30 days and for home hospice care. Hospice services include the following types of services:

- Medically Necessary professional nursing services up to four hours per day,
- home health aide,
- physical therapy services,
- nutrition counseling and medically necessary meals,
- durable medical equipment,
- respite care given in the most appropriate setting to provide temporary relief to the family or other care givers, limited to five days in any three-month period, and
- medical social services for the terminally ill patient or his or her family. The Plan also covers bereavement counseling for family members until the end of the six-month bereavement period following death.

The Plan does not cover expenses for services or supplies for personal comfort or convenience, such as homemaker, companion sitting or meals.

The Plan pays the following coinsurance for these services:

Coinsurance	Plan A	Plan A1	Plan B	Plan C
PPO	100%	100%	90%	80%
Non-PPO	70%	70%	60%	60%

Hospital Expenses

Room and Board

Covered expenses include charges for inpatient room and board provided during your stay. Private room charges that exceed the hospital's semi-private room rate are not covered unless a private room is required because of a contagious illness or immune system problem. Covered expenses may vary depending on the level of care received.

Room and board charges may also include:

- Services of the hospital's nursing staff;
- Admission and other fees;
- General and special diets; and
- Sundries and supplies.

Other Hospital Services and Supplies

Covered expenses include charges made by a hospital for services and supplies furnished to you in connection with your stay. Covered expenses include hospital charges for other services and supplies provided, such as:

- Ambulance services.
- Physicians and surgeons.
- Pre-admission lab tests and x-rays performed on an outpatient basis within 7 days before the patient is admitted to the hospital will be paid on the same basis as inpatient hospitalization.
- Operating and recovery rooms.
- Intensive or special care facilities.
- Administration of blood and blood products, but not the cost of the blood or blood products.
- Radiation therapy.
- Speech therapy, physical therapy and occupational therapy.
- Non-routine oxygen and oxygen therapy.
- Radiological services, laboratory testing and diagnostic services.
- Medications.
- Intravenous (IV) preparations.
- Discharge planning.

Not covered expenses include:

- Undocumented and unbundled charges for any services provided, even if Medically Necessary.

The Plan pays the following coinsurance for these services:

Coinsurance	Plan A	Plan A1	Plan B	Plan C
PPO	100%	100%	90%	80%
Non-PPO	70%	70%	60%	60%

Laboratory, Radiology (X-Ray), Nuclear Medicine and Radiation Therapy Services (Outpatient)

Covered expenses for laboratory and radiology services associated with diagnostic and curative radiology services include technical and professional fees only when ordered by a Physician or Health Care Practitioner.

Inpatient Laboratory Services are covered under the Hospital Services section.

Massage Therapy and Acupuncture

Covered expenses are limited to the lesser of:

- $1,000 Maximum payable per Calendar Year; or
- 15 visits for each benefit.

Covered expenses include the cost of prescription drugs furnished to you while you are in the hospital or Skilled Nursing Facility Medical Foods

Coverage provided for formulas necessary for the treatment of phenylketonuria (PKU) when recommended by a Physician.

Outpatient (Ambulatory) Surgical Center

Covered expenses include charges for services and supplies furnished in connection with outpatient surgery made by:

- A physician or dentist for professional services;
- Ambulatory (Outpatient) Surgical Facility (e.g. surgicenter, same day surgery, outpatient surgery);
- The outpatient department of a hospital; or
- General anesthesia and associated hospital or outpatient surgical facility care charges in connection with dental care for a participant who is age 7 years or younger, or who is physically or developmentally disabled or who cannot expect a successful result under local anesthesia because of a medical condition.

The surgery must meet the following requirements:

- The surgery can be performed adequately and safely only in a surgery center or hospital; and
- The surgery is not normally performed in a physician's or dentist's office.

The following Copays and coinsurance apply for these services:

Copayments and Coinsurance	Plan A	Plan A1	Plan B	Plan C
PPO	You pay $15 and the Plan pays 100%	You pay $15 and the Plan pays 100%	You pay $20 and the Plan pays 90%	You pay $30 and the Plan pays 80%
Non-PPO	70%	70%	60%	60%

Physician and Other Health Care Practitioner Services

Covered medical expenses include charges made by a physician or other covered Health Care Practitioner during an office, hospital, emergency room or urgent care facility visit to treat an illness or injury. The visit may be at the practioner's office, in your home, in a hospital or other facility during your stay or in an outpatient facility.

Covered expenses include charges made by a Health Care Practitioner for:

- Performing your surgical procedure;
- Pre-operative and post-operative visits; and
- Consultation with another Health Care Practitioner to obtain a second opinion prior to the surgery.

Covered expenses also include charges for the administration of anesthetics and oxygen by a Health Care Practitioner, other than the operating physician, or Certified Registered Nurse Anesthetist (C.R.N.A.) in connection with a covered procedure.

Physician Office Visit Alternatives

Walk-In Clinic Visits

Covered expenses include charges made by walk-in clinics for unscheduled, non-emergency illnesses and injuries.

Not all services are available at all Walk-In Clinics. The types of services offered will vary by the provider and location of the clinic.

Virtual Care Visits

The Plan provides a 24/7 Nurseline and Teladoc services, which are not subject to the annual deductible or coinsurance. Teladoc can be used to diagnose and treat acute, non-emergent medical issues that may arise. Teladoc visits are covered in full (100%) and you have $0 copay and no annual deductible. Teladoc doctors can also write short term prescriptions and will send the script electronically to your pharmacy.

The Plan also covers telephone, internet, or other virtual care consultations where a patient is not physically seen by their physician or other covered provider the same as if the service was rendered in the physician or provider's office. Telephonic or other virtual care visits (other than Teladoc) are subject to the annual deductible and coinsurance benefits.

Telehealth or virtual care consultations must be for the purpose of diagnosis and treatment via a live and verifiable discussion or video exchange with ongoing participation by the patient and licensed provider throughout the visit. Claims must be billed correctly to be covered.

Prescription Drugs

Covered expenses include the cost of prescription drugs furnished to you while you are in the hospital or Skilled Nursing Facility.

See the Prescription Drug section for medications covered under the Prescription Drug program. Radiology (X-Ray), Nuclear Medicine and Radiation Therapy Services (Outpatient) Benefits are payable for technical and professional fees associated with diagnostic and curative radiology services, including radiation therapy only when ordered by a Physician or Health Care Practitioner.

Preventive Care

The Plan covers the expenses for preventive care listed in this section at 100% without deductibles or copays if provided by a PPO provider. Preventive care provided by Non-PPO providers is subject to the Plan's normal deductible, copays and coinsurance. Coverage is subject to all the terms, policies and procedures outlined in this Booklet.

Coverage will be limited to Medically Necessary and appropriate services. Where the Preventive Benefit has recommendations regarding coverage or frequency, these will be followed. In all other cases, the Plan will utilize reasonable medical management techniques to determine the coverage and frequency limit. Deductible, copayments and coinsurance are waived for PPO providers.

The Plan will cover expenses for additions to the list of Preventive Care Benefits issued by United States Preventive Services Task Force or other controlling agency the first day of the Plan year in the year following the date of adoption.

Routine Physical Exams

A routine physical exam is a medical exam given by a physician for a reason other than to diagnose or treat a suspected or identified illness or injury. Covered expenses may include charges for:

- Evidence-based items that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force.
- Screenings and counseling services as provided for in the comprehensive guidelines recommended by the Health Resources and Services Administration. These services may include but are not limited to:

- Interpersonal and domestic violence;
- Sexually transmitted diseases;
- Human Immune Deficiency Virus (HIV) infections;
- Gestational diabetes for women;
- High risk Human Papillomavirus (HPV) DNA testing for women age 30 and older;
- X-rays, lab and other tests given in connection with the exam;
- Routine vision and hearing screenings; or
- For covered newborns, an initial hospital check-up.

Unless specified above, not covered under the Preventive Care benefit are charges for:

- Exams given during your stay for medical care; or,
- Services which are for diagnosis or treatment of a suspected or identified illness or injury.

Preventive Care Immunizations

Covered expenses include charges made by your physician or a facility for immunizations for infectious diseases; and the materials for administration of immunizations that have been recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.

Not covered under this Preventive Care benefit are charges incurred for immunizations that are not considered Preventive Care such as those required due to your employment or travel.

Well Woman Preventive Visits

A routine well woman preventive exam is a medical exam given by a physician for a reason other than to diagnose or treat a suspected or identified illness or injury. Covered expenses include charges made by your physician for a routine well woman preventive exam office visit, including Pap smears, in accordance with the recommendations by the Health Resources and Services Administration.

Routine Cancer Screenings

Covered expenses include, but are not limited to, charges incurred for routine cancer screening as follows:

- Mammograms;
- Fecal occult blood tests;
- Digital rectal exams;
- Prostate specific antigen (PSA) tests;
- Sigmoidoscopies;
- Double contrast barium enemas (DCBE); and
- Colonoscopies.

These benefits will be subject to any age; family history; and frequency guidelines that are:

- Evidence-based items or services that have in effect a rating of A or B in the recommendations of the United States Preventive Services Task Force; and
- Evidence-informed items or services provided in the comprehensive guidelines supported by the Health Resources and Services Administration.

Screening and Counseling Services

Covered expenses include charges made by your physician in an individual or group setting for the following:

- Obesity screening and counseling services to aid in weight reduction due to obesity.

- Screening and counseling services to aid in the prevention or reduction of the use of an alcohol agent or controlled substance. Coverage includes preventive counseling visits, risk factor reduction intervention and a structured assessment.
- Screening and counseling services to aid in the cessation of the use of tobacco products. Tobacco product means a substance containing tobacco or nicotine including: cigarettes, cigars; smoking tobacco; snuff; smokeless tobacco and candy-like products that contain tobacco.

Prenatal Care and Maternity Services

Prenatal care will be covered as Preventive Care for services received by a pregnant female in a physician's, obstetrician's, or gynecologist's office. Coverage for prenatal care under the Preventive Care benefit is limited to pregnancy-related physician office visits including the initial and subsequent history and physical exams of the pregnant woman (maternal weight, blood pressure and fetal heart rate check).

The Plan provides maternity benefits for you or your spouse on the same basis as any other illness or injury. The Plan does not restrict hospital benefits for covered mothers and newborns to less than 48 hours after normal delivery or 96 hours after a cesarean.

The Plan limits maternity benefits for a pregnant dependent child to preventive prenatal and post-natal treatment and treatment of a complication of pregnancy. The Plan does not provide any benefits for the child of a dependent child.

Maternity Services and Birthing Center

Covered expenses include charges made by a birthing center for services and supplies related to your care in a birthing center for:

- Prenatal care;
- Delivery; and
- Postpartum care within 48 hours after a vaginal delivery and 96 hours after a Cesarean delivery.

Maternity/Family Planning/Contraceptive Exclusions

The Plan does not provide benefits for:

1. Home Delivery: Expenses for pre-planned home delivery.
2. Expenses for childbirth education, Lamaze classes, breast-feeding classes. This exclusion does not apply to the extent that breastfeeding support, supplies and counseling are covered for women as discussed under the Wellness and Preventive Services row of the Covered Medical Benefits.
3. Expenses related to the maternity care and delivery expenses associated with a pregnant dependent child except for complications of the pregnancy. Voluntary elective induced abortion is not covered for a dependent child. This exclusion of maternity care for a pregnant dependent child does not apply to the extent the expenses qualify as prenatal and postnatal care for your dependent child provided under the Wellness and Preventive Services row in the Schedule of Medical Benefits, but the exclusion does apply to delivery expenses and any expenses for the newborn child.
4. Any services or supplies received in connection with a participant or dependent acting as a Surrogate Mother, regardless of whether a participant or dependent is a biological parent. This exclusion applies to services or supplies related to the Surrogate Mother becoming pregnant, pregnancy and delivery charges. Additionally, a child of a Surrogate Mother shall not be considered an eligible dependent if the child is not the biological child of a participant or adult dependent or if the Surrogate Mother has entered into a contract or has an understanding prior to becoming pregnant that she will relinquish the child following its birth. The plan also does not cover services or supplies provided to an individual not covered by the plan who acts as a Surrogate Mother for a participant or dependent. "Surrogate Mother" is defined as a woman who becomes pregnant through artificial or assisted methods for the purpose of carrying the fetus to term for a third party.

Comprehensive Lactation Support and Counseling Services

Covered expenses include comprehensive lactation support (assistance and training in breast feeding) and counseling services provided to females during pregnancy and in the postpartum period by a certified lactation support provider. The "postpartum period" means the one-year period directly following the child's date of birth. Lactation support and lactation counseling services are covered expenses when provided in either a group or individual setting.

Breast Feeding Durable Medical Equipment

Coverage includes the rental or purchase of breast feeding durable medical equipment for the purpose of lactation support (pumping and storage of breast milk). Covered expenses include the following:

- The rental of a hospital-grade electric breast pump for a newborn child when the newborn child is confined in a hospital.

The purchase of:

- An electric breast pump (non-hospital grade) or a manual breast pump.
- Coverage is provided as Medically Necessary.
- Breast pump supplies.

Coverage for the purchase of breast pump equipment is limited to one item of equipment, for the same or similar purpose, and the accessories and supplies needed to operate the item. You are responsible for the entire cost of any additional pieces of the same or similar equipment you purchase or rent for personal convenience or mobility.

Family Planning Services - Female Contraceptives

Covered expenses include charges incurred for services and supplies that are provided to prevent pregnancy approved by the U.S. Food and Drug Administration (FDA).

Coverage includes counseling services on contraceptive methods provided by a physician, obstetrician or gynecologist. Such counseling services are covered expenses when provided in either a group or individual setting.

The following contraceptive methods are covered expenses under this Preventive Care benefit:

- Voluntary Sterilization - Covered expenses include charges billed separately by the provider for female voluntary sterilization procedures and related services and supplies including, but not limited to, tubal ligation and sterilization implants.
- Contraceptives - charges made by a physician for female contraceptives that are brand name and generic prescription drugs or female contraceptive devices, including the related services and supplies needed to administer the device.

Family Planning Services - Other

Covered expenses include charges for certain family planning services, including:

- Voluntary sterilization for males
- Voluntary termination of pregnancy

Not covered are:

- Reversal of voluntary sterilization procedures, including related follow-up care.

Reconstructive Services and Breast Reconstruction After Mastectomy

This Plan complies with the Women's Health and Cancer Rights Act (WHCRA) that states for any covered individual receiving benefits in connection with a mastectomy who elects breast reconstruction in

connection with it, coverage will be provided in a manner determined in consultation with the attending Physician and the patient, including:

- reconstruction of the breast on which the mastectomy was performed;
- surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- prostheses and physical complications for all stages of mastectomy, including lymphedemas.

The Plan covers expenses for reconstructive Surgery if such procedures or treatment are intended to improve bodily function and/or to correct deformity resulting from disease, infection, trauma, or congenital anomaly that causes a functional defect.

Rehabilitation and Habilitative Services (Physical, Respiratory, Occupational & Speech Therapy)

The Plan covers expenses for habilitative therapy services, including occupational therapy, speech therapy, physical therapy and related therapies, to improve a mental health condition or congenital birth defect.

The Plan covers expenses for rehabilitative therapy services on an outpatient basis, including occupational therapy, speech therapy and physical therapy, to the extent that the therapy will significantly restore or improve a lost function(s) following a severe illness, injury or surgery. The therapy must be shown to be progressive therapy and not maintenance therapy and it must not be performed for the purpose of occupational rehabilitation.

Habilitative, occupational and rehabilitative services are subject to the following conditions:

- The service must be necessary to improve function or to maintain function where significant deterioration in function would result without the therapy;
- The services must be prescribed by the attending physician and administered by a physician or covered licensed therapist. The Plan may periodically request a review of the services by a physician and the patient must continue under the care of the attending physician during the time the therapy is being provided; and
- The services must not be custodial in nature.

Benefits for rehabilitative and habilitative therapy services will end when the Plan determines that no additional clinical improvement is expected as a result of the therapy. Benefit is subject to Medical Necessity and all other provisions of the Plan.

The Plan does not cover expenses for speech or occupational therapy or any other treatment for educational purposes, learning disabilities (such as attention deficit disorders) or treatment of development delay (such as delays in the development of language, cognitive, motor or social skills), except as specifically provided. This does not exclude Medically Necessary treatment ordered by a physician to restore a functional loss that was the direct result of an injury of illness.

Skilled Nursing Facility (SNF)

Covered expenses include the cost of benefits for inpatient care in a licensed Skilled Nursing Facility that is primarily engaged in providing skilled nursing care and related therapeutic services for individuals who require medical, nursing and rehabilitation care that cannot be provided in the home or in an outpatient setting to regain function lost due to an acute injury or illness. The facility must be eligible to participate under the federal Medicare program as a Skilled Nursing Facility. Benefits will not exceed 90 days per period of disability. The confinement must be preauthorized and Medically Necessary.

Confinements separated by less than 7 days will be considered as one period of confinement. Benefits are provided only as long as the patient is shown to be making demonstrable progress toward regaining physical function lost due to the injury or illness.

Spinal Column Treatment

Annual Maximum Plan Benefit for all Spinal Manipulation services (PPO and Non-PPO combined) is 10 visits per person per calendar year.

Transplants (Organ and Tissue)

Covered expenses include the cost of eligible services directly related to Medically Necessary and non-experimental transplants (see also Clinical Trials) of human organs or tissue including along with the facility and professional services, FDA approved drugs, and Medically Necessary equipment and supplies.

Transplant services including pre-transplant workup tests must be Preauthorized. If the services are not Preauthorized (or Preauthorization requirements are not followed), the Plan will only cover the expenses at 50% of the Allowed Amount (in a PPO or a Non-PPO facility).

Benefits for an organ donor are covered only if the recipient is an eligible covered participant under this Plan and the donor does not have access to any other medical coverage. Charges for the acquisition cost of any organ or bodily tissue is not covered.

The Plan does not provide benefits for:

1. Expenses for human organ and/or tissue transplants that are Experimental and/or Investigational, including, but not limited to, except as covered by the Plan;
2. or screening, acquisition and selection, organ or tissue removal, transportation, transplants, postoperative services and drugs/medicines and all complications thereof, except those Transplant Services and their complications that are listed as payable under "Transplants" in the Schedule of Medical Benefits Covered Medical Benefits; and
3. See the specific exclusions related to Experimental and Investigational Services and Transplants in the Exclusions chapter and provisions related to Clinical Trials.

Urgent Care

Covered expenses include charges made by a hospital or urgent care provider to evaluate and treat an urgent condition.

Your coverage includes:

- Use of emergency room facilities when network urgent care facilities are not in the service area and you cannot reasonably wait to visit your physician;
- Use of urgent care facilities;
- Physicians services;
- Nursing staff services; and
- Radiologists and pathologists services.

Please contact a network provider after receiving treatment of an urgent condition.

If you visit an urgent care provider for a non-urgent condition, the plan will not cover your expenses.

Weight Loss (Bariatric) Surgery

All bariatric surgery must be Prior Authorized and be performed at a Bariatric Surgery Center of Medical Excellence (CME). The Plan does not provide out-of-network benefits for bariatric surgery.

The Plan considers open or laparoscopic Roux-en-Y gastric bypass (RYGB) or laparoscopic adjustable silicone gastric banding (LASGB or Lap-Band) medically necessary when the selection criteria listed in the medical policy are met.

MEDICAL PLAN EXCLUSIONS

Not every medical service or supply is covered by the plan, even if prescribed, recommended, or approved by your physician or dentist. The plan covers only those services and supplies that are medically necessary. Charges made for the following are not covered except to the extent otherwise provided for in this booklet.

EXCLUSIONS (applicable to all medical services and supplies)

1. Any claim, and its supporting documentation, received more than twelve (12) months after the date the claim was incurred unless, through no fault of your own, you were unable to meet the 12 month claim filing deadline. Unless you are legally incapacitated, late claims for health benefits will not be covered if they are filed more than 12 months after they were incurred.
2. Any Charges for:
   - Missed appointments or completing forms.
   - Service or supply furnished by a network or out-of-network provider in excess of the Allowed Amount.
   - Services that are not rendered, or rendered to a person not eligible for coverage under the plan.
   - Services by an unlicensed hospital, physician or other provider or not within the scope of the provider's license.
   - Services or supplies related to complications from a non-covered service or treatment.
3. Any charges in excess of the benefit, dollar, day, visit or supply limits stated in this Plan.
4. Charges for services or supplies which are not provided or billed in accordance with generally accepted professional standards and/or medical practice, including up-coding, unbundling, duplication, excessive or improperly coded billing charges.
5. Charges that are not permitted by the provider's network agreement or charges made in violation of the provider's network agreement.
6. Cosmetic services and plastic surgery: any treatment, surgery (cosmetic or plastic), service or supply to alter, improve or enhance the shape or appearance of the body whether or not for psychological or emotional reasons including:
   - Face lifts, body lifts, tummy tucks, liposuctions, removal of excess skin, removal or reduction of non-malignant moles, blemishes, varicose veins, cosmetic eyelid surgery and other surgical procedures;
   - Procedures to remove healthy cartilage or bone from the nose (even if the surgery may enhance breathing) or other part of the body;
   - Expenses for and related to hair removal or hair transplants and other procedures to replace lost hair or to promote the growth of hair, including prescription and non-prescription drugs such as Minoxidil, Propecia, Rogaine, Vaniqa; or expenses for and related to hair replacement including, but not limited to, devices, wigs, toupees and/or hairpieces or hair analysis chemical peels, dermabrasion, laser or light treatments, bleaching, creams, ointments or other treatments or supplies to alter the appearance or texture of the skin;
   - Insertion or removal of any implant that alters the appearance of the body (such as breast or chin implants); except removal of an implant will be covered when medically necessary;
   - Removal of tattoos (except for tattoos applied to assist in covered medical treatments, such as markers for radiation therapy);
   - Repair of piercings and other voluntary body modifications, including removal of injected or implanted substances or devices;
   - Surgery to correct Gynecomastia;
   - Breast augmentation, except as described above; and

- Otoplasty.

7. Counseling: services and treatment for marriage, religious, family, career, social adjustment, pastoral, or financial counselor.
8. Court ordered services, including those required as a condition of parole or release.
9. Custodial care.
10. Dental Services: any treatment, services or supplies related to the care, filling, removal or replacement of teeth and the treatment of injuries and diseases of the teeth, gums, and other structures supporting the teeth, except as described above. This includes but is not limited to:
    - services of dentists, oral surgeons, dental hygienists, and orthodontists including apicoectomy (dental root resection), root canal treatment, soft tissue impactions, removal of bony impacted teeth, treatment of periodontal disease, alveolectomy, augmentation and vestibuloplasty and fluoride and other substances to protect, clean or alter the appearance of teeth;
    - dental implants, false teeth, prosthetic restoration of dental implants, plates, dentures, braces, mouth guards, and other devices to protect, replace or reposition teeth; and
    - non-surgical treatments to alter bite or the alignment or operation of the jaw, including treatment of malocclusion or devices to alter bite or alignment.
11. Disposable outpatient supplies: Any outpatient disposable supply or device, including sheaths, bags, elastic garments, support hose, bandages, bedpans, syringes, blood or urine testing supplies, and other home test kits; and splints, neck braces, compresses, and other devices not intended for reuse by another patient.
12. Drugs, medications and supplies:
    - Over-the-counter drugs, biological or chemical preparations and supplies that may be obtained without a prescription including vitamins;
    - Any services related to the dispensing, injection or application of a drug;
    - Any prescription drug purchased illegally outside the United States, even if otherwise covered under this plan within the United States;
    - Immunizations related to work;
    - Needles, syringes and other injectable aids, except as covered for diabetic supplies;
    - Drugs related to the treatment of non-covered expenses;
    - Performance enhancing steroids;
    - Injectable drugs if an alternative oral drug is available;
    - Outpatient prescription drugs;
    - Self-injectable prescription drugs and medications;
    - Any prescription drugs, injectables, or medications or supplies provided by the customer or through a third-party vendor contract with the customer; and
    - Any expenses for prescription drugs, and supplies covered under an Express Scripts Pharmacy plan will not be covered under this medical expense plan. Prescription drug exclusions that apply to the Express Scripts Pharmacy plan will apply to the medical expense coverage; and
    - Charges for any prescription drug for the treatment of erectile dysfunction, impotence, or sexual dysfunction or inadequacy.
13. Expenses related Corrective Appliances, Orthotic Devices, Prosthetic Appliances and Durable Medical Equipment, except as otherwise covered by the Plan:
    - For the replacement of lost, missing, or stolen, duplicate or personalized equipment.
    - to the extent the expenses exceed the cost of standard models of such appliances or equipment.
14. Educational Services, except as covered by the Habilitative Benefits:

- Any services or supplies related to education, training or retraining services or testing, including: special education, remedial education, job training and job hardening programs;
- Evaluation or treatment of learning disabilities, learning and communication disorders, behavioral disorders, training or cognitive rehabilitation, except as otherwise covered by the Plan; and
- Educational testing and training related to behavioral (conduct) problems, learning disabilities and delays in developing skills.

15. Examinations. Any health examinations required:
    - by a third party, including examinations and treatments required to obtain or maintain employment, or which the Trust is required to provide under a labor agreement;
    - by any law of a government;
    - for securing insurance, school admissions or professional or other licenses;
    - to travel; or
    - to attend a school, camp, or sporting event or participate in a sport or other recreational activity.
16. Experimental or investigational drugs, devices, treatments or procedures, except as otherwise covered by the Plan.
17. Food items, except as otherwise covered by the Plan: Any food item, including infant formulas, nutritional supplements, vitamins, including prescription vitamins, medical foods and other nutritional items, even if it is the sole source of nutrition. This exclusion does not apply to specialized medical foods delivered enterally (only when delivered via a tube directly into the stomach or intestines) or parenterally.
18. Growth/Height: Any treatment, device, drug, service or supply (including surgical procedures, devices to stimulate growth and growth hormones), solely to increase or decrease height or alter the rate of growth.
19. Hearing aids, any examination for hearing aids, or the fitting of hearing aids or any charges incurred for the cost of surgical implants to stimulate hearing, such as cochlear implants.
20. Home and mobility: Any addition or alteration to a home, workplace or other environment, or vehicle and any related equipment or device, such as exercise equipment, air purifiers, water purifiers, waterbeds, swimming pools; stair-glides, elevators, wheelchair ramps, or other additions or alterations to your home, workplace or other environment, including room additions, changes in cabinets, countertops, doorways, lighting, wiring, or furniture.
21. Home births: Any services and supplies related to births occurring in the home or in a place not licensed to perform deliveries.
22. Infertility: except as otherwise covered by the Plan, any services, treatments, procedures or supplies that are designed to enhance fertility or the likelihood of conception, including but not limited to:
    - Injectable infertility medications, including but not limited to menotropins, hCG, GnRH agonists, and IVIG;
    - Artificial Insemination;
    - Any advanced reproductive technology (“ART”) procedures or services related to such procedures, including but not limited to in vitro fertilization (“IVF”), gamete intra-fallopian transfer (“GIFT”), zygote intra-fallopian
    - transfer (“ZIFT”), and intra-cytoplasmic sperm injection (“ICSI”); Artificial Insemination for covered females attempting to become pregnant who are not infertile as defined by the plan;
    - Infertility services for couples in which 1 of the partners has had a previous sterilization procedure;
    - Infertility services for females with FSH levels 19 or greater mIU/ml on day 3 of the menstrual cycle;
    - Sperm or egg donors or any charges related to sperm or egg donation;
    - Surrogacy; or

- Charges associated with cryopreservation or storage of cryopreserved eggs and embryos (e.g., office, hospital, ultrasounds, laboratory tests, etc.).

23. Miscellaneous charges for services or supplies including:
    - Annual or other charges to be in a physician's practice;
    - Charges to have preferred access to a physician's services such as boutique or concierge physician practices;
    - Charges the recipient has no legal obligation to pay; or the charges would not be made if the recipient did not have coverage (to the extent exclusion is permitted by law) including:
        - Charges when the out-of-pocket maximum is waived by the provider; or
        - Care while in the custody of a governmental authority;
24. Non-emergency charges incurred outside of the United States if you traveled to such location to obtain medical services, prescription drugs, or supplies, even if otherwise covered under this plan. This also includes prescription drugs or supplies if:
    - such prescription drugs or supplies are unavailable or illegal in the United States; or
    - the purchase of such prescription drugs or supplies outside the United States is considered illegal.
25. Nursing and home health aide services provided outside of the home (such as in conjunction with school, vacation, work or recreational activities).
26. Non-Medically Necessary services. This applies even if they are prescribed, recommended or approved by your physician or dentist.
27. Personal comfort and convenience items: Any service or supply primarily for your convenience and personal comfort or that of a third party, including, but not limited to: telephone, television, internet, barber or beauty service or other guest services; housekeeping, cooking, cleaning, shopping, monitoring, security or other home services; and travel, transportation, or living expenses, rest cures, recreational or diversional therapy.
28. Private duty nursing during your stay in a hospital
29. Expenses for Corrective Appliances, Orthotic Devices, Prosthetic Appliances, or Durable Medical Equipment, that:
    - Cover the replacement cost of lost, missing, or stolen appliances or equipment;
    - Are duplicate or personalized appliances or equipment; or
    - Exceed the cost of standard models of such appliances or equipment.
30. Reports: Any special medical reports not directly related to treatment except when provided as part of a covered service.
31. Sexual dysfunction/enhancement: Any treatment, drug, service or supply to treat sexual dysfunction, enhance sexual performance or increase sexual desire, including:
    - Surgery, drugs, implants, devices or preparations to correct or enhance erectile function, enhance sensitivity, or alter the shape or appearance of a sex organ; and
    - Sex therapy, sex counseling, marriage counseling or other counseling or advisory services.
32. Speech therapy for treatment of delays in speech development, except as otherwise covered by the plan.
33. Spinal disorder, including care in connection with the detection and correction by manual or mechanical means of structural imbalance, distortion or dislocation in the human body or other physical treatment of any condition caused by or related to biomechanical or nerve conduction disorders of the spine including manipulation of the spine treatment, except as otherwise covered by the plan.
34. Therapies for the treatment of delays in development, unless resulting from acute illness or injury, or congenital defects amenable to surgical repair (such as cleft lip/palate), are not covered, except as otherwise covered by the plan.
35. Third-Party Injuries: Any expense or charge for injuries or illness caused by the act or omission of another person (known as a third-party) for which there is a potential opportunity to recover from the

third-party, the third-party's insurer or any other liability policy including but not limited to an automobile policy, commercial premises policy, homeowner's policy, medical malpractice policy, renter's policy, or any other liability policy, including first-party uninsured or underinsured motorist policy. The plan may agree to advance benefits if the participant agrees to reimburse the plan as set forth in the plan's provisions.

36. Transplant: The transplant coverage does not include charges for:
    - Outpatient drugs including bio-medicals and immunosuppressants not expressly related to an outpatient transplant occurrence;
    - Services and supplies furnished to a donor when recipient is not a covered person;
    - Home infusion therapy after the transplant occurrence;
    - Harvesting and/or storage of organs, without the expectation of immediate transplantation for an existing illness;
    - Harvesting and/or storage of bone marrow, tissue or stem cells without the expectation of transplantation within 12 months for an existing illness; and
    - Cornea (corneal graft with amniotic membrane) or cartilage (autologous chondrocyte or autologous osteochondral mosaicplasty) transplants, unless otherwise preauthorized.
37. Transportation costs, including ambulance services for routine transportation to receive outpatient or inpatient services except as otherwise covered by the plan.
38. Unauthorized services, including any service obtained by or on behalf of a covered person without precertification when required. This exclusion does not apply in a Medical Emergency or in an Urgent Care situation.
39. Vision-related services and supplies, except as otherwise covered by the plan. The plan does not cover:
    - Special supplies such as non-prescription sunglasses and subnormal vision aids;
    - Vision service or supply which does not meet professionally accepted standards;
    - Eye exams during your stay in a hospital or other facility for health care;
    - Eye exams for contact lenses or their fitting;
    - Eyeglasses or duplicate or spare eyeglasses or lenses or frames;
    - Replacement of lenses or frames that are lost or stolen or broken;
    - Acuity tests;
    - Eye surgery for the correction of vision, including radial keratotomy, LASIK and similar procedures;
    - Services to treat errors of refraction; and
    - Eye refractions, orthoptics, glasses, contact lenses, or the fitting of glasses or contact lenses, except for the first pair of glasses or first pair of lenses for use after cataract surgery or as specifically listed under "Vision" as a covered service or supply.
40. Weight: Any treatment, drug service or supply intended to decrease or increase body weight, control weight or treat obesity, including morbid obesity, regardless of the existence of comorbid conditions; except as specifically provided in the *What the Plan Covers* section, including but not limited to:
    - Liposuction, banding, gastric stapling, gastric by-pass and other forms of bariatric surgery; surgical medical treatments, weight control/loss programs and other services and supplies that are primarily intended to treat, or are related to the treatment of obesity, including morbid obesity;
    - food addictions or other eating disorders (except for documented cases of bulimia or anorexia that meet standard diagnostic criteria and present significant symptomatic medical problems);
    - Drugs, stimulants, preparations, foods or diet supplements, dietary regimens and supplements, food or food supplements, appetite suppressants and other medications;
    - Counseling, coaching, training, hypnosis or other forms of therapy; and

- Exercise programs, exercise equipment, membership to health or fitness clubs, recreational therapy or other forms of activity or activity enhancement.

41. Work related: Any illness or injury related to employment or self-employment including any illness or injury that arises out of (or in the course of) any work for pay or profit, unless no other source of coverage or reimbursement is available to you for the services or supplies.
42. Charges related to sickness or injury caused by war, insurrection, international armed conflict or riot or charges incurred as the result of the covered person's participation in or attempt to commit a felony or assault unless such Illness or Injury is the result of being a victim of domestic violence**.**

PRESCRIPTION DRUG BENEFITS

The Plan's prescription drug benefits are provided through an agreement with Express Scripts. You may contact Express Scripts directly for information about participating pharmacies, mail order prescriptions and to order refills:

- By phone at (800) 467-2006; or
- By visiting www.express-scripts.com

Coverage is provided only for drugs and medicines approved by the US Food and Drug Administration (FDA) as requiring a prescription and are FDA approved for the condition, dose, route, duration and frequency, if prescribed by a Physician authorized by law to prescribe them. Charges for prescription drugs apply toward the prescription drug Out-of-Pocket Maximum Rather than the medical Out-of-Pocket Maximum.

HIGH PERFORMANCE FORMULARY

The Plan uses a prescription drug formulary plan design. A formulary is a list of drugs that have been determined by the Plan's prescription drug benefit manager, Express Scripts, to be the most clinically and/or cost effective for each disease or condition. The formulary contains both generic and preferred brand drugs.

The formulary is maintained by Express Scripts and updated periodically. However, inclusion on the formulary is not a guarantee that the drug will be covered by the Plan. Coverage will ultimately be determined when you request your prescription be filled. Please note that if you are on a non-formulary drug and your doctor determines that your non-formulary drug is medically necessary, your doctor must contact Express Scripts to request and exception to allow you to remain on your prescribed medication. If an exception is approved you pay the formulary drug copayment. If an exception is not approved and you choose to remain on the non-formulary drug, you will pay 50% of the cost for that drug. For a current list of medications on the formulary, visit www.express.scripts.com.

The Copayment is waived for generic FDA approved contraceptives with a physician prescription when purchased at a network retail or Mail Order location.

RETAIL PHARMACIES

The prescription drug program features a custom network of pharmacies for your convenience. All maintenance medications must be purchased through Express Scripts Smart90 program or through the Express Scripts home delivery program as discussed below. If you elect to use a retail pharmacy that does not offer Smart90, you will be responsible for 100% of the costs.

The following copayments apply for a 30-day prescription supply at a network retail location:

	Plan A	**Plan A1**	**Plan B**	**Plan C**
Preferred Generic Drug	$10	$10	$15	$20
Preferred Brand Drug	$10	$10	$15	$20
Non-Preferred Brand Drug	50% coinsurance	50% coinsurance	50% coinsurance	50% coinsurance
Specialty Drugs	Same as Generic/Brand benefit			

FILING A CLAIM

When you use an Express Scripts network participating pharmacy, you have the advantage or receiving discounted prices and there are no claim forms to file. Simply present your prescription card and make your appropriate copay.

If you use a non-participating pharmacy or a pharmacy that does not offer the Smart90 program, you will have to pay the full cost of the prescription and file a claim with Express Scripts for reimbursement. You

will be reimbursed according to a formula determined by the contract between the Trust Fund and the prescription drug plan (which may be less than the amount charged by the pharmacy) or the actual amount charged, whichever is less. The normal copay will be applied.

Claim forms may be obtained by contacting Express Scripts or the Trust Administration Office. A claim form must be submitted with copies of the prescription receipt and sent to the address on the form.

MAIL ORDER (HOME DELIVERY) DRUG SERVICE

The mail order service is the easiest and least expensive way to obtain many drugs, plus the medications are mailed directly to Your home. You may use the mail order service to receive up to a 90-day supply of non-emergency, extended-use "maintenance" prescription drugs, such as for high blood pressure or diabetes. Note that not all medicines are available via mail order.

Generic drugs, if available, will always be dispensed when ordered through the mail service program. The following copayments apply for a 90-day supply prescription through mail order:

	Plan A	Plan A1	Plan B	Plan C
Preferred Generic Drug	$10	$10	$15	$20
Preferred Brand Drug	$10	$10	$15	$20
Non-Preferred Brand Drug	50% coinsurance	50% coinsurance	50% coinsurance	50% coinsurance
Specialty Drugs	Same as generic/brand benefit			

For information on how to set up Mail Order, contact Express Scripts.

PRESCRIPTION DRUG OUT-OF-POCKET MAXIMUM

Each Calendar Year, after an individual or family has incurred a maximum Out-of-Pocket cost for Formulary prescription drugs, no further copayments and/or coinsurance will apply for that individual or family for the rest of the Calendar Year:

	Prescription Drug Out-of-Pocket Maximum			
	Plan A	**Plan A1**	**Plan B**	**Plan C**
Per Person	$1,500	$1,500	$1,500	$1,500
Per Family	$3,000	$3,000	$3,000	$3,000
Non- Formulary Drugs	Not Included	Included	Not Included	Not included

COVERED PREVENTIVE PRESCRIPTION DRUGS

With a prescription from your physician, the following are covered at a network pharmacy with no copay:

- Aspirin – Limited to under age 70
- Folic Acid – Limited to females under age 51
- Oral Fluoride – limited to children up to age 17
- Contraceptives – limited to women (no age limit), covered for barrier (diaphragms), hormonal, emergency, and implant (Mirena only).
- Smoking Cessation – limited to medically appropriate coverage for FDA approved smoking cessation drugs. All generic prescriptions and over the counter products are covered with a dispensing limit of 90 days per 12-month period. Chantix is covered with dispensing limit of 180 days per 12-month period. Coverage is not available to individuals under age 18. Medical necessity review is mandatory for any treatment over the recommended dispensing limits.
- Influenza Immunization – covered annually over 6 months of age.
- Zoster Immunization – limited to one dose per lifetime for adults age 50 and over.

- Tamoxifen, Raloxifene, Soltamox for women age 35 years or older subject to medical necessity and all other provisions of the Plan
- Additional preventive medications as recommended by the U.S. Preventive Care Task Force – Recommendations A and B (provided that new recommendations will not be covered until the first of the plan year following one year after the date the recommendation is adopted.)

PRESCRIPTION DRUG EXCLUSIONS

Drugs, Outpatient Medicines and Nutrition Exclusions

1. Drugs and medicines which can be obtained without a doctor's prescription (over-the-counter) even if ordered by a physician except as otherwise specifically listed as an Allowed Charge.
2. All non-prescription birth control including but not limited to contraceptive jellies, ointments, foams, or other devices.
3. Infertility medication.
4. Medication for the treatment of sexual dysfunction, unless related to a diagnosed covered mental health condition.
5. Drugs or medicines prescribed to primarily improve or otherwise modify the member's external appearance (Avage, Rogaine, Renova, Vaniqa, Pigmenting products, Depigmenting products, etc.).
6. Anorexiants/anti-obesity medication.
7. Dental related products (oral and topical fluoride, Peridex, Periostat, Atridox, etc.), except for specific age groups.
8. Immunization agents; biological sera, blood or blood plasma, except for specific age groups.
9. Appliances and other non-drug items.
10. Multiple and non-therapeutic vitamins and dietary supplements (except as otherwise listed as an Allowed Charge), cosmetics, or health and beauty aids.
11. Nutritional supplements, vitamins or other items purchased pursuant to a written order of a physician, but which may be purchased without a written prescription, unless the item is specifically listed as an Allowed Charge.
12. Drugs for which reimbursement is provided or paid for by any other group plan or federal, state, county, or municipal government program.
13. Prescription charges due to occupational injuries or due to sickness covered by Workers' Compensation laws or similar legislation.
14. Drugs not approved by the FDA or labeled "Caution - limited by federal law to investigational use Experimental drugs," unless required to be covered by federal law.
15. Any refill of a prescription which exceeds the number of refills ordered by a physician.
16. Any refill dispensed more than one year after the date of the prescription.
17. Drugs purchased outside the U.S. which are not legal inside the U.S.

VISION BENEFITS

Please note: Vision Benefits are available only if the Collective Bargaining Agreement with Your Employer provides for Vision Benefits and Your Employer makes contributions to the Trust on Your behalf.

OVERVIEW OF THE VISION PLAN

The Vision Plan is designed to provide for standard vision examinations and eyewear materials such as eyeglasses or contact lenses. The Vision Plan can detect individuals who have chronic diseases that can affect the eye such as diabetes, high blood pressure (hypertension), glaucoma, and cataracts. Vision benefits are administered by the Trust Administration Office whose name and address are listed on the Quick Reference Chart in the front of this document.

ELIGIBILITY FOR VISION PLAN BENEFITS

You (and Your eligible Dependents) are entitled to participate in the Vision Plan if You work under one of the collective bargaining agreements providing coverage and Your Employer makes contributions to the Trust on Your behalf. If you are eligible for vision benefits, these benefits are effective on the date Your medical plan benefits are effective.

VISION PROVIDERS

The Plan has contracted with Premera to provide you a network of vision providers, but you may also achieve cost savings from other non-network vision providers, such as Costco. You are free to seek care from any vision provider although using network providers may save You on out of pocket costs because network providers agree to discount their services. If your vision provider doesn't submit the claim to the Trust Fund, You pay for the service and later send Your claims to the Trust Administration Office for reimbursement. Services may be received from any licensed optometrist, ophthalmologist and/or dispensing optician; and this Plan will reimburse as noted in the Schedule of Vision Benefits. When self-submitting Your claim, the itemized bill reflecting the provider's fees must be submitted to the Trust Administration Office for reimbursement.

SCHEDULE OF VISION BENEFITS
This chart shows what the Plan pays.

Covered Vision Benefits	Explanations and Limitations *See also the Vision Plan Exclusions section.*	Plan Pays
Vision Examination (includes a professional eye exam and a refraction) [1]	• One vision exam is payable each calendar year.	100% up to $60
Frames for Eyeglasses	• One frame is payable each two calendar years.	100% up to $100
Lenses for Eyeglasses [1]	• One pair of lenses per calendar year.	Per Pair Single Vision: 100%, up to $60 Bifocals: 100%, up to $85 Trifocals or Progressives: 100%, up to $120 Lenticular: 100%, up to $135 Special Tints/Lens Extras: $20 annual maximum

SCHEDULE OF VISION BENEFITS This chart shows what the Plan pays.		
Covered Vision Benefits	**Explanations and Limitations** *See also the Vision Plan Exclusions section.*	**Plan Pays**
Contact Lenses: Contact lenses are considered Medically Necessary when prescribed by a Physician for one of the following: • Visual acuity cannot be improved to at least 20/70 with the use of eyeglasses. • After cataract surgery; • With certain conditions of Anisometropia; or • With certain conditions of Keratoconus. Contact lenses that do not meet the above criteria are considered "not Medically Necessary" or "Elective (Cosmetic)".	• One set of elective or medically necessary contact lenses are payable each calendar year, in lieu of all other lens and frame benefits. • You must secure prior approval from the Trust Administration Office for Medically Necessary contact lenses.	Elective or Medically Necessary contact lenses may be chosen instead of glasses. The standard eye exam is covered as outlined above. **Elective Contact Lenses**: 100% up to $120 per set **Medically Necessary Contact Lenses:** Paid in full up to the Allowed Charge.

1. Maximums do not apply to children under age 18.

FILING A VISION CLAIM

If your provider does not bill the Plan directly with an assignment of benefits, You will need to pay the provider for all services and then, at a later date but within 12 months of the date of service, submit the bill to the Trust Administration Office (whose name and address are listed on the Quick Reference Chart in the front of this section of the handbook). You will be reimbursed up to the amount noted in the Schedule of Vision Benefits if your expenses are determined to be eligible expenses. Vision claims submitted beyond 12 months of the date of service may not be considered for reimbursement.

VISION PLAN LIMITATIONS

The following is a list of services and supplies or expenses **not covered (excluded) by the Vision Plan**:

1. Orthoptics or vision training and any associated supplemental testing.
2. Plano Lenses (non-prescription).
3. Two pair of glasses in lieu of bifocals.
4. Lenses and frames furnished under this program, which are lost or broken, will not be replaced except at the normal intervals when services are otherwise available.
5. Medical or surgical treatment of the eyes.
6. Any eye examination, or any corrective eyewear, required by an employer as a condition of employment.
7. Safety glasses.
8. Lens fitting fee.
9. Contact lens cleaning kits.
10. Warranties.
11. Contact lens fitting fees.

DENTAL BENEFITS

Please note: Dental Benefits are available only if the collective bargaining agreement with Your Employer provides for Dental Benefits and Your Employer makes contributions to the Trust on Your behalf.

This SPD/Plan Document provides a summary of the dental and orthodontic benefits available under the Plan. For a more complete description, Delta Dental of Washington has created and distributed a SPD/Plan Document. If you do not have the booklet prepared by Delta Dental of Washington describing the dental and orthodontic benefits available, please call the Trust Administration Office and they will send you a copy.

ELIGIBILITY FOR DENTAL PLAN BENEFITS

You (and Your eligible Dependents) are entitled to participate in the Dental Plan if You work under one of the collective bargaining agreements providing coverage and Your Employer makes contributions to the Trust on Your behalf. If you are eligible for Dental benefits, these benefits are effective on the date Your medical plan benefits are effective.

Note: Certain dental benefits are available only under certain conditions of oral health. For extensive or expensive treatment (such as crowns, root canals, surgeries and night guards) it is strongly recommended that you have your dentist submit a Confirmation of Treatment and Cost request to determine if the treatment is a covered dental benefit. A Confirmation of Treatment and Cost is not a guarantee of payment. See the "Confirmation of Treatment and Cost (Formerly Predeterminations) section" for additional information.

DENTAL PREFERRED PROVIDER (DPPO) NETWORK

The Plan has a dental preferred provider (DPPO) network arrangement with Delta Dental of Washington ("Delta"). Under this arrangement, Delta contracts with a network of dental providers to provide services and supplies at a reduced fee for you and your eligible dependents. To locate a DPPO provider, log on to www.DeltaDentalWA.com or call (800) 554-1907.

You may use the services of any licensed dental provider. However, if you use a Delta DPPO provider your out-of-pocket costs will typically be lower. Non-DPPO providers have not contracted with Delta to charge Delta's PPO fees for covered services and you may be balance billed for any amounts exceeding the amount paid by the Plan. Please also be aware that you are responsible for ensuring that your non-DPPO provider submit any claim forms to the Plan for payment of benefits.

In Network – Delta Dental PPO Dentists	
Benefit	**The Plan Pays**
Class I & II	70-100%
Class III	60%
Optional Orthodontic Procedures	50%
Annual Plan Maximum per Person	$2,500
Annual Deductible per Person/Family	$0
Lifetime Optional Orthodontic Benefits per Person	$1,500

In Network – Non-Network Dentists	
Benefit	**The Plan Pays**
Class I & II	70-100%
Class III	50%
Optional Orthodontic Procedures	50%
Annual Plan Maximum per Person	$2,000

In Network – Non-Network Dentists	
Annual Deductible per Person/Family	$0

The Plan maximum for Delta Dental PPO Dentists and Non-Delta Dental PPO Dentists will not be paid as two (2) separate annual maximums. The charges will be determined based on the provider's participation with Delta Dental and benefits remaining when a claim is processed.

Unlike your medical benefits, all claims and supporting information must be submitted within six (6) months of the date of treatment to be eligible for payment. For orthodontia claims, the initial banding date is the treatment date used to start the six (6) month period.

HOW YOUR BENEFITS WORK

The Plan is a group based incentive plan. The annual incentive period is August 1 through the last day of July. The Plan encourages prevention by rewarding you for receiving the maximum preventive care and other covered services. When you first start using your benefits, the Plan pays 70% of the benefits for Class I (diagnostic and preventive) and Class II (basic) benefits. This payment level increases ten percentage (10%) points each successive incentive period in which you use the maximum benefits under the Plan up to the maximum incentive level (100%). Once you reach the maximum incentive level (100%) the Plan continues to pay at that benefit level until you fail to use the benefits.

If you fail to obtain your annual Class I or II benefits, the Plan's payment level will be decreased by ten percentage points (10%) from the level you were at when you last used your benefits. An additional ten percent (10%) decrease will happen for each incentive period that you do not use your benefits until you reach the minimum payment level.

COVERED SERVICES

Class I Diagnostic - Covered Benefits

- X-rays and Diagnostic evaluation for routine or emergency purposes

Limitations

- Comprehensive or detailed and extensive oral evaluation is covered once in the patient's lifetime by the same dentist. Subsequent comprehensive or detailed and extensive oral evaluation from the same dentist is paid as a periodic oral evaluation.
- Routine evaluation is covered twice in a benefit period. Routine evaluation includes all evaluations except limited, problem-focused evaluations.
- Limited problem-focused evaluations are covered twice in a benefit period.
- A complete series or a panoramic X-ray is covered once in a 5 year period from the date of service.
    - Any number or combination of X-rays, billed for the same date of service, which equals or exceeds the allowed fee for a complete series, is considered a complete series for payment purposes.
    - Supplementary bitewing X-rays are covered once in a benefit period.
- Diagnostic services and X-rays related to temporomandibular joints (jaw joints) are not a paid covered benefit under Class I benefits.

Exclusions

- Consultations
- Study models

Class I Preventive - Covered Benefits

- Prophylaxis (cleaning)
- Periodontal maintenance
- Sealants
- Topical application of fluoride including fluoridated varnishes

- Space maintainers
- Preventive resin restoration

Limitations

- Any combination of prophylaxis and periodontal maintenance is covered twice in a benefit period.
- Periodontal maintenance procedures are covered only if a patient has completed active periodontal treatment.
- Under certain conditions of oral health, prophylaxis or periodontal maintenance (but not both) may be covered up to a total of 4 times in a benefit period.
- Topical application of fluoride is limited to 2 covered procedures in a benefit period through age 18
- Payment for application of sealants will be for permanent molars with no restorations (includes preventive resin restorations) on the occlusal (biting) surface. The application of a sealant is a covered dental benefit once in a 2-year period per tooth from the date of service.
- Space maintainers are covered once in a patient's lifetime for the same missing tooth or teeth through age 17.
- Payment for a preventive resin restoration will be for permanent molars with no restorations on the occlusal (biting) surface. The application of a preventive resin restoration is a covered dental benefit once in a 2-year period per tooth from the date of service. The application of preventive resin restoration is not a paid covered benefit for 2 years after a sealant or preventive resin restoration on the same tooth from the date of service. The application of preventive resin restoration is not a paid covered benefit after a sealant or preventive resin restoration on the same tooth.

Exclusions

- Plaque control program (oral hygiene instruction, dietary instruction and home fluoride kits)

Class I Periodontics - Covered Benefits

- Prescription-strength fluoride toothpaste
- Antimicrobial rinse dispensed by the dental office

Limitations

- Prescription-strength fluoride toothpaste and antimicrobial rinse are covered dental benefits following periodontal surgery or other covered periodontal procedures when dispensed in a dental office.
- Proof of a periodontal procedure must accompany the claim or the patient's Delta history must show a periodontal procedure within the previous 180 days.
- Antimicrobial rinse may be dispensed once per course of periodontal treatment, which may include several visits.
- Antimicrobial rinse is available for women during pregnancy without any periodontal procedure.

Class II Sedation/Palliative Treatment - Covered Benefits

- General Anesthesia and Intravenous Sedation
- Palliative treatment for pain

Limitations

- General Anesthesia and Intravenous Sedation is a Covered Dental Benefit when administered by a licensed Dentist or other Licensed Professional who meets the educational, credentialing and privileging guidelines established by the Dental Quality Assurance Commission of the state of Washington or as determined by the state in which the services are provided.
- General anesthesia is covered in conjunction with certain covered endodontic, periodontic and oral surgery procedures, as determined by Delta, or when medically necessary, for children through age 6, or a physically or developmentally disabled person, when in conjunction with Class I, II, III or Optional

Orthodontic covered dental benefits.

- Intravenous sedation is covered in conjunction with certain covered endodontic, periodontic and oral surgery procedures, as determined by Delta.
- Either general anesthesia or intravenous sedation (but not both) are covered when performed on the same day.
- General anesthesia or intravenous sedation is only a paid covered benefit as specifically allowed above.

Class II Restorative – Covered Benefits

- Restorations (fillings)
- Stainless steel crowns

Limitations

- Restorations on the same surface(s) of the same tooth are covered once in a 2-year period from the date of service
- Restorations are covered for the following reasons:
  - Treatment of carious lesions (visible destruction of hard tooth structure resulting from the process of dental decay)
  - Fracture resulting in significant loss of tooth structure (missing cusp)
  - Fracture resulting in significant damage to an existing restoration
- If a resin-based composite or glass ionomer restoration is placed in a posterior tooth (except those placed in the buccal (facial) surface of bicuspids), it will be considered an elective procedure and an amalgam allowance will be made, with any difference in cost being the responsibility of the patient.
- Restorations necessary to correct vertical dimension or to alter the morphology (shape) or occlusion are not a paid covered benefit
- Stainless steel crowns are covered once in a 2-year period from the seat date.

Exclusions

- Overhang removal
- Copings
- Re-contouring or polishing of restoration

Class II Oral Surgery Covered benefits

- Removal of teeth
- Preparation of the mouth for insertion of dentures
- Treatment of pathological conditions and traumatic injuries of the mouth

Exclusions

- Bone replacement graft for ridge preservation
- Bone grafts, of any kind, to the upper or lower jaws not associated with periodontal treatment of teeth
- Tooth transplants
- Materials placed in tooth extraction sockets for the purpose of generating osseous filling

Class II Periodontics Covered Benefits

- Surgical and nonsurgical procedures for treatment of the tissues supporting the teeth
- Periodontal scaling/root planning
- Periodontal surgery
- Limited adjustments to occlusion (8 teeth or fewer)

- Localized delivery of antimicrobial agents
- Gingivectomy

Limitations
- Periodontal scaling/root planing is covered once in a 36-month period from the date of service.
- Limited occlusal adjustments are covered once in a 12-month period from the date of service.
- Periodontal surgery (per site) is covered once in a 3-year period from the date of service.
- Periodontal surgery must be preceded by scaling/root planing a minimum of 6 weeks and a maximum of 6 months, or the patient must have been in active supportive periodontal therapy, prior to such treatment.
- Soft tissue grafts (per site) for implants and natural teeth are covered once in a 3-year period from the date of service.
- Localized delivery of antimicrobial agents is a covered dental benefit under certain conditions of oral health.
- Localized delivery of antimicrobial agents is limited to 2 teeth per quadrant and up to 2 times (per tooth) in a benefit period.
- Localized delivery of antimicrobial agents must be preceded by scaling and root planing a minimum of 6 weeks and a maximum of 6 months, or the patient must have been in active supportive periodontal therapy, prior to such treatment.

Class II Endodontics Covered Benefits

- Procedures for pulpal and root canal treatment, services covered include:
- Pulp exposure treatment
- Pulpotomy
- Apicoectomy

Limitations
- Root canal treatment on the same tooth is covered only once in a 2-year period from the date of service.

Exclusions
- Bleaching of teeth

Class III Periodontics Covered Benefits

- Under certain conditions of oral health, services covered are:
  - Occlusal guard (nightguard)
  - Repair and relines of occlusal guard
  - Complete occlusal equilibration

Limitations
- Occlusal guard (nightguard) is covered once in a 3-year period from the date of service.
- Repair and relines done more than 6 months after the date of initial placement are covered.
- Complete occlusal equilibration is covered once in a lifetime.

Class III Restorative Covered Benefits

- Crowns, veneers, or onlays for treatment of carious lesions (visible destruction of hard tooth structure resulting from the process of removing dental decay) or fracture resulting in significant loss of tooth structure (e.g., missing cusps or broken incisal edge)
- Crown buildups
- Post and core on endodontically treated teeth

Limitations

- A crown veneer or onlay on the same tooth is covered once in a 7-year period from the seat date.
- An implant-supported crown on the same tooth is covered once in a 7-year period from the seat date of a previous crown on that same tooth.
- An inlay (as a single tooth restoration) will be considered as elective treatment and an amalgam allowance will be made once in a 2-year period, with any difference in cost being the responsibility of the covered person.
- Payment for a crown, veneer, inlay, or onlay shall be paid based upon the date that the treatment or procedure is completed.
- A crown buildup is a covered dental benefit when more than 50 percent of the natural coronal tooth structure is missing and there is less than 2 mm of vertical height remaining for 180 degrees or more of the tooth circumference and there is evidence of decay or other significant pathology.
- A crown buildup or a post and core are covered once in a 7-year period on the same tooth from the date of service.
- Crown buildups or post and cores are not a paid covered benefit within 2 years of a restoration on the same tooth from the date of service.
- A crown used for purposes of re-contouring or repositioning a tooth to provide additional retention for a removable partial denture is not a paid covered benefit unless the tooth is decayed to the extent that a crown would be required to restore the tooth whether or not a removable partial denture is part of the treatment.
- A crown or onlay is not a paid covered benefit when used to repair micro-fractures of tooth structure when the tooth is asymptomatic (displays no symptoms) or there is an existing restoration with no evidence of decay or other significant pathology.
- A crown or onlay placed because of weakened cusps or existing large restorations without overt pathology is not a paid covered benefit.

Exclusions

- Copings

Class III Prosthodontics Covered Benefits

- Full and immediate dentures
- Removable and fixed partial dentures (fixed bridges)
- Inlays when used as a retainer for a fixed partial denture (fixed bridge)
- Adjustment or repair of an existing prosthetic appliance
- Surgical placement or removal of implants or attachments to implants

Limitations

- Replacement of an existing prosthetic appliance is covered once every 7 years from the delivery date and only then if it is unserviceable and cannot be made serviceable.
- Payment for dentures, fixed partial dentures (fixed bridges); inlays (only when used as a retainer for a fixed bridge) and removable partial dentures shall be paid upon the delivery date.
- Implants and superstructures are covered once every 7 years.
- Temporary dentures — Delta will allow the amount of a reline toward the cost of an interim partial or full denture. After placement of the permanent prosthesis, an initial reline will be a benefit after 6 months.
- Denture adjustments and relines — Denture adjustments, relines, repairs and rebases done more than 6 months after the initial placement are covered.
- Subsequent adjustments and repairs are covered.

- Subsequent relines or rebases will be covered once in a 12-month period.
- An adjustment or reline performed more than 6 months after a rebase will be covered.

Exclusions
- Duplicate dentures
- Personalized dentures
- Maintenance or cleaning of a prosthetic appliance
- Copings
- Crowns in conjunction with overdentures are not a paid covered benefit

GENERAL DENTAL EXCLUSIONS

The dental plan does not provide benefits for the following:

1. Dentistry for cosmetic reasons.
2. Restorations or appliances necessary to correct vertical dimension or to restore the occlusion. Such procedures, which include restoration of tooth structure lost from attrition, abrasion or erosion and restorations for malalignment of teeth, are not a paid covered benefit.
3. Services for injuries or conditions that are compensable under Worker's Compensation or Employers' Liability laws, and services that are provided to the covered person by any federal or state or provincial government agency or provided without cost to the covered person by any municipality, county, or other political subdivision.
4. Application of desensitizing agents (treatment for sensitivity or adhesive resin application).
5. Procedures, services or supplies are those whose use and acceptance as a course of dental treatment for a specific condition is still under investigation/observation.
6. Analgesics such as nitrous oxide, conscious sedation, euphoric drugs or injections of anesthetic not in conjunction with a dental service; or injection of any medication or drug not associated with the delivery of a covered dental service.
7. Prescription drugs.
8. Hospitalization charges and any additional fees charged by the dentist for hospital treatment.
9. Charges for broken appointments or completing claim forms.
10. Habit-breaking appliances.
11. TMJ services or supplies.
12. All other services not specifically included in this Plan as Covered Dental Benefits.

The Plan shall determine whether services are Covered Dental Benefits in accordance with standard dental practice and the Limitations and Exclusions shown their booklet. Should there be a disagreement regarding the interpretation of such benefits, the participant has the right to appeal the determination in accordance with the non-binding appeals process in Delta’s booklet and may seek judicial review of any denial of coverage of benefits.

ESTIMATE OF BENEFITS

If your dental care is going to be extensive, ask your dentist to complete and submit a standard claim form for an estimate. This way you will know in advance exactly what procedures are covered, the amount the Plan will pay toward the treatment, and your financial responsibility.

ORTHODONTIC BENEFITS FOR ELIGIBLE EMPLOYEES AND CHILDREN

Orthodontic benefits are available only if your employer has agreed to provide orthodontic benefits and agreed to contribute the appropriate monthly premium. Orthodontic treatment is defined as the necessary procedures of treatment, performed by a licensed dentist, involving surgical or appliance therapy for movement of teeth and post-treatment retention.

SHORT TERM DISABILITY BENEFITS

You are eligible for these Short Term Disability (STD) benefits if You work under one of the Collective Bargaining Agreements providing this coverage and Your employer makes contributions to the Trust on Your behalf.

WHEN BENEFITS START

Benefits are paid, subject to the provisions shown below, if an eligible Employee (a) becomes disabled, (b) is unable to work, and (c) is under the care of a licensed physician practicing within the scope of their license.

Benefits for a disability if due to an accident, will begin on the first calendar day of Your disability. Otherwise, benefits will begin on the eighth calendar day of your disability.

WHEN BENEFITS STOP

Your benefits will terminate immediately upon the earliest of the following:

- The date following 26 weeks of benefits under the Plan.
- The date on which any group long-term disability benefits become payable.
- Termination of employment.
- The date on which any retirement benefits become payable.
- The date on which the attending physician (or physician the Trust chooses) releases You to return to work.
- The date of Your death.
- Termination of the plan by the Trustees.
- The date you are eligible for or receive any form of unemployment compensation.

AMOUNT OF BENEFITS

The standard weekly benefit amounts are $80, $110, $150, $200, $300 or $350 depending on the Collective Bargaining Agreement with Your Employer. Benefits will be prorated over five days for benefits payable for less than a full week.

Please note: The actual amount of Your weekly short-term disability benefits will be determined by the Collective Bargaining Agreement applicable to your Employer, and your Employer's required contributions made to the Plan on Your behalf. The benefits shown above are the standard benefits for this Plan. Your Employer's Collective Bargaining Agreement may not provide any of these benefits, or it may provide for greater or lesser benefits than the standard benefits shown above.

DEFINITION OF DISABILITY

Benefits will be payable for any non-work-related accident or sickness, or any pregnancy, provided You are under the continuous care of a licensed Physician who attests to Your disability to perform any and every duty pertaining to Your occupation or employment. The Board of Trustees has the right to have a physician of its choosing examine You for purposes of determining Your initial and ongoing eligibility for STD benefits.

RECURRENT DISABILITY

Successive periods of disability that are separated by less than two weeks of continuous active employment will be considered as one continuous period of disability, unless they are due to different, unrelated causes.

EXCLUSIONS

Benefits are not payable for disabilities caused by or resulting from the following:

- Attempted suicide or intentionally self-inflicted injuries.
- War or acts of war, whether declared or not.
- Injuries or sicknesses incurred while the employee is on full-time, active duty in any armed forces.
- Injuries or sicknesses beginning prior to the effective date of coverage or incurred during periods of time in which You are not eligible for benefits under the Plan.
- Injury sustained while committing or attempting to commit a felony.
- Work-related causes, which are compensable under applicable workers compensation laws.

TAXATION OF BENEFITS

Short Term Disability Benefits are subject to both federal income tax and FICA taxes. The Plan will automatically withhold the appropriate FICA tax from your weekly check and the Plan will pay the corresponding employer portion. The Plan will withhold federal income tax from your weekly check. The Plan will provide you a W-2 form at year-end for use in filing your federal income tax return.

LONG TERM DISABILITY BENEFITS

You are eligible for this benefit if You work under one of the Collective Bargaining Agreements providing this coverage and Your Employer makes contributions to the Trust on Your behalf. Dependents and retirees are not eligible for Long Term Disability Benefits.

This is only a brief summary of the Long Term Disability Benefits available for Employees. Long Term Disability Benefits is provided under a group insurance policy issued by an insurance company ("Policy").

An Employee must be eligible at the time of the loss. The amount of insurance on any person is determined in accordance with the following Schedule of Benefits. Please contact the Trust Administration Office for a copy of the entire Certificate of Coverage for the Policy.

SCHEDULE OF BENEFITS

The Monthly Income Benefit for total disability is calculated as follows:

<table>
<tr><td>Disability Income Insurance

Long Term Disability Benefits is limited to Eligible Employees.</td><td>Long Term Disability Benefits equal to the lesser of 50% of your pre-disability monthly earnings or $2,000 subject to a minimum of $100, less other income as defined in the Policy</td></tr>
<tr><td colspan="2">Basic Monthly Earnings is the monthly salary or wage on the day before the date you become disabled. It does not include bonuses, commissions or overtime pay.</td></tr>
<tr><td colspan="2">Benefit Waiting Period is the period is 90 days from the date you initially become disabled.</td></tr>
<tr><td colspan="2">Maximum Benefit Period
<table><tr><th><u>Age at Disability</u></th><th><u>Maximum Benefit Period</u></th></tr><tr><td>Less than Age 63</td><td>Normal Retirement Age or 48 months, if greater</td></tr><tr><td>63</td><td>Normal Retirement Age or 42 months, if greater</td></tr><tr><td>64</td><td>36 months</td></tr><tr><td>65</td><td>30 months</td></tr><tr><td>66</td><td>27 months</td></tr><tr><td>67</td><td>24 months</td></tr><tr><td>68</td><td>21 months</td></tr><tr><td>69 or older</td><td>18 months</td></tr></table></td></tr>
<tr><td colspan="2">Survivor Benefit
Three (3) times the lesser of: Your monthly income benefit in effect the last full calendar month prior to the date of Your death; or $2,000.</td></tr>
</table>

QUALIFYING FOR BENEFITS

To qualify for benefits, all of the following conditions You must –

- Become disabled while covered under the Trust;
- Remain disabled through the Benefit Waiting Period;
- Submit an application for benefits; and
- Not otherwise be excluded from coverage.

Disability or Disabled means You are prevented from performing one or more of the essential duties of:

1) Your Occupation during the Elimination Period;

2) Your Occupation, for the 2 year(s) following the Elimination Period, and as a result Your Current Monthly Earnings are less than 80% of Your Indexed Pre-disability Earnings; and
3) after that, Any Occupation.

If at the end of the Elimination Period, You are prevented from performing one or more of the Essential Duties of Your Occupation, but Your Current Monthly Earnings are equal to or greater than 80% of Your Pre-disability Earnings, Your Elimination Period will be extended for a total period of 12 months from the original date of Disability, or until such time as Your Current Monthly Earnings are less than 80% of Your Pre-disability Earnings, whichever occurs first. For the purposes of extending Your Elimination Period, Your Current Monthly Earnings will not include the pay You could have received for another job or a modified job if such job was offered to You by Your Employer, or another employer, and You refused the offer.

Your Disability must result from:

1) accidental bodily injury;
2) sickness;
3) Mental Illness;
4) Substance Abuse; or
5) pregnancy.

Your failure to pass a physical examination required to maintain a license to perform the duties of Your Occupation, alone, does not mean that You are Disabled.

Benefit Payments

Monthly income benefits are paid at the end of each month for the period for which you qualified. If you are disabled for a part of a month, the benefit payable is $1/30^{th}$ of your monthly income benefit for each day you are disabled.

Benefits continue while you are disabled up to the maximum benefit period shown on the Schedule of Benefits. You must complete the benefit waiting period before any benefits are payable.

Survivor Benefit

The Plan pays the Survivor Benefit shown on the Schedule of Benefits if you die,

- While receiving monthly income benefits, and
- Before the end of the maximum benefit period.

The Plan will pay the Survivor Benefit to your lawful spouse. If you do not have a spouse, the Plan will pay the benefit in equal shares to your eligible children, if any. If you do not have a spouse or eligible children at the time of death, the Plan will not pay a Survivor Benefit.

DATE BENEFITS END

If you are receiving Long Term Disability Benefits, your benefits will end on the earliest of the following:

1) the date You are no longer Disabled;
2) the date You fail to furnish proof of loss;
3) the date You are no longer under the regular care of a physician;
4) the date You refuse the insurance carrier's request that You submit to an examination by a physician or other qualified medical professional;
5) the date of Your death;
6) the date You refuse to receive recommended treatment that is generally acknowledged by Physicians to cure, correct or limit the disabling condition;
7) the last day benefits are payable according to the maximum duration of benefits table;

8) the date Your current monthly earnings:
   a) are equal to or greater than 80% of Your indexed pre-disability earnings if You are receiving benefits for being Disabled from Your occupation; or
   b) are greater than the lesser of the product of Your indexed pre-disability earnings and the benefit percentage or the maximum monthly benefit if You are receiving benefits for being Disabled from any occupation;
9) the date no further benefits are payable under any provision in the Policy that limits benefit duration; or
10) the date You refuse to participate in a rehabilitation program, or refuse to cooperate with or try:
   a) modifications made to the work site or job process to accommodate Your identified medical limitations to enable You to perform the essential duties of your occupation;
   b) adaptive equipment or devices designed to accommodate Your identified medical limitations to enable You to perform the essential duties of your occupation;
   c) modifications made to the work site or job process to accommodate Your identified medical limitations to enable You to perform the essential duties of any occupation, if You were receiving benefits for being disabled from any occupation; or
   d) adaptive equipment or devices designed to accommodate Your identified medical limitations to enable You to perform the essential duties of any occupation, if You were receiving benefits for being disabled from any occupation; provided a qualified physician or other qualified medical professional agrees that such modifications, Rehabilitation program or adaptive equipment accommodate Your medical limitation.

CLAIM PROCEDURES

How to file a claim

To file a claim for benefits under this Plan, complete a claim form which can be secured from your local union or from the Trust Administration Office.

In the event your claim for benefits is denied for any reasons, contact the Trust Administration Office to request information regarding the procedures to appeal benefit claim denials. An Employee or dependent who is eligible may be denied benefits if a claim for benefits is not submitted within 12 months of the date the Employee became disabled.

Exclusions

The Plan will not pay benefits if your disability results from any of the following:

- Sickness or injury which occurs in any armed conflict, whether declared as war or not, involving any country or government.
- Intentionally self-inflicted injury, whether you are sane or insane.
- Injury which occurs when you commit or attempt to commit a felony.
- You are not under the regular care of a Physician
- Your being engaged in an illegal occupation.

LIFE INSURANCE AND ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS

LIFE INSURANCE FOR ACTIVE EMPLOYEES, DEPENDENTS OF ACTIVE EMPLOYEES

The following is a brief summary of the Life Insurance benefits available for Employees and their Dependents. Retirees and their dependents are not eligible for Life Insurance. You must be eligible at the time of the loss. The amount of insurance on any person is determined in accordance to Your Collective Bargaining Agreement. Please contact the Trust Administration Office for a copy of the entire Certificate of Coverage for the Life Insurance.

Employee Life Insurance Benefit

Class	*Amount of Insurance*
1	$20,000
2	$15,000
3	$10,000

Dependent Life Insurance

Class 1 and 2	
Spouse	$1,000
Dependent Child (age 15 days to age 26)	$1,000
Class 3	
Spouse	$500
Dependent Child (age 15 days to age 26)	$500

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT

The following is a brief summary of the Accidental Death and Dismemberment Benefit that may be available to You if You, while eligible, sustain any of the losses mentioned below as a result of purely accidental means. The Covered Loss must take place within 365 days from the date of the accident for the benefits to be payable. Please contact the Trust Administration Office for a copy of the entire Certificate of Coverage for the Accidental Death and Dismemberment Insurance.

Accidental Death and Dismemberment Benefit

Class	*Principal Sum*
1	$20,000
2	$15,000
3	$10,000

A “Covered Loss” means permanent loss of

1. Life;
2. A hand, by complete severance at or above the wrist joint;
3. A foot, by complete severance at or above the ankle joint;
4. An eye, speech or hearing, involving irrecoverable and complete loss;
5. Thumb and index finger, actual several through or above the metacarpophalangeal joints; or
6. Movement, complete and irreversible paralysis of such limbs.

Except as excluded under the Exclusions section, and subject to all the terms and conditions of the policy. The amount of benefit to be paid for a Covered Loss is determined as follows:

Schedule of Losses

For Loss of:	*The Benefit is:*
Life	The Principal Sum
Two hands	The Principal Sum
Two feet	The Principal Sum
Sight of both eyes	The Principal Sum
One hand and one foot	The Principal Sum
One hand and sight of one eye	The Principal Sum
One foot and sight of one eye	The Principal Sum
Speech and hearing in both ears	The Principal Sum
Quadriplegia	The Principal Sum
Paraplegia or Triplegia	Three Quarters of Principal Sum
One hand or one foot	One-Half of Principal Sum
Sight of one eye	One-Half of Principal Sum
Hemiplegia	One-Half of Principal Sum
Speech or hearing in both ears	One-Half of Principal Sum
Movement of one limb	One-Quarter of Principal Sum
Thumb and index finger	One-Quarter of Principal Sum

If the Person suffers more than one loss in any one accident, payment shall be made only for that loss for which the largest amount is payable.

ADDITIONAL BENEFITS

The Accidental Death and Dismemberment Insurance includes a number of additional benefits that are detailed in the Certificate of Coverage. These include: Seat Belt Benefit; Air Bag Benefit, Repatriation Benefit; Felonious Assault Benefit; Child Education Benefit; Day Care Benefit; Rehabilitation Benefit; Spouse Education Benefit; Adaptive Home and Vehicle Benefit; Coma Benefit; Critical Burn Benefit and Therapeutic Counseling Benefit. Please request a Certificate of Coverage for additional information regarding these benefits.

FILING A CLAIM (APPLIES TO BOTH LIFE INSURANCE AND ACCIDENTAL DEATH & DISMEMBERMENT)

You must give written notice to the Trust Administration Office of the claim for benefits within 30 days after the date of death of the date of loss. If notice cannot be given within 30 days, it must be given as soon as reasonably possible after that. Once the Trust Administration Office receives notice of the claim, it will provide you a form to submit your written Proof of Loss. Written Proof of Loss for which a claim is made must be given to the Trust Administration Office no later than 90 days after the date of loss. A claim will not be invalidated or reduced for failure to provide proof within this time, if it is shown that it was not reasonably possible to furnish proof, and provided such proof was furnished as soon as it was reasonably possible. However, no claim will be paid if the Proof of Loss is received more than one year after date of loss, unless the Person was legally unable to notify the Trust Administration Office.

The Proof of Loss must include all information necessary for the Trust Administration Office to determine the:

1. Nature of the loss; and
2. Date of the loss.

The Trust Administration Office will notify the Person of any additional information required to process a claim.

To request a claim form, contact the Trust Administration Office.

Payment of Claims

For a covered loss, benefits shall be paid directly to the Employee. In case of loss of life, benefits will be made to the Employee's Designated Beneficiary.

Designation of Beneficiary

A Designated Beneficiary is the party or parties named by the Person to receive the benefits payable upon the Person's death. The Person may name one or more Beneficiaries to receive the death benefit.

The Person may change the Beneficiary at any time, without the consent of the previously named Beneficiary. Such change must be requested in writing on a form furnished by or satisfactory to the Administration Office. Such change will take effect upon receipt of the signed form.

Upon receipt of satisfactory proof of Claim, the Trust Administration Office will pay the death benefit due under the Life Insurance and Accidental Death and Disbursement Benefits to the Person's name Beneficiary as follows:

1. If the Person has named more than one Beneficiary, each surviving Beneficiary will share equally, unless otherwise indicated by the Person when the Beneficiaries were named.
2. If there is no named Beneficiary, or if no named Beneficiary is surviving at the time of death of the Person, payment will be made to the first surviving class in the following order of preference:
    a. the executors or administrators of the Person's estate;
    b. the surviving spouse;
    c. the Person's children, in equal shares;
    d. the Person's parents, in equal shares; or
    e. the Person's brothers and sisters, in equal shares.

In order to determine which class of individuals is entitled to the death benefit, the Trust Administration Office may rely on an affidavit made by any individual listed above. If payment is made based on such affidavit, the Company will be discharged of its liability for the amount so paid, unless written notice of claim by another individual listed above is received before payment is made.

If the Beneficiary is a minor or someone not able to give a valid release for payment, the Trust Administration Office will pay the benefit to his or her legal guardian. If there is no legal guardian, the Trust Administration Office may pay the individual or institution who has, in its opinion, custody and principal support of such Beneficiary. The Company will be fully discharged of its liability for any amount of benefit so paid in good faith.

Exclusions

No Accidental Death and Dismemberment benefits will be paid for any loss that is caused directly or indirectly, or in whole or in part, by any of the following:

1. intentionally self-inflicted Injury;
2. suicide or attempted suicide, whether sane or insane;
3. war or act of war, whether declared or not;
4. Injury sustained while on full-time active duty as a member of the armed forces (land, water, air) of any country or international authority;
5. Injury sustained while taking drugs, including but not limited to sedatives, narcotics, barbiturates, amphetamines, or hallucinogens, unless as prescribed by or administered by a Physician;
6. Injury sustained while committing or attempting to commit a felony; or Injury sustained while intoxicated (exceed the legal presumption of intoxication, or under the influence, under the state law where the accident occurred).

CLAIM FILING AND APPEALS INFORMATION

This chapter provides information on claims procedures and how to appeal a claim for benefits that is denied. The information only applies to eligibility determinations and the following benefits that are provided directly by the Trust Fund:

- Self-Funded Medical Plans
- Prescription Drug Benefits for participants covered under the Self-Funded Medical Plans
- Self-Funded Short Term Disability Benefits
- Vision Plan

The following benefits are fully insured. If you are eligible for these benefits you will receive a booklet from the insurance company that provides all of the benefits you are entitled to and the procedures for filing claims and appealing benefit decisions. There is no appeal to the Board of Trustees for denial of claims for any insured benefits.

- Delta Dental Plan of Washington
- Kaiser Permanente of Washington
- Life Insurance and Accidental Death & Dismemberment – Hartford Life and Accident Insurance Company
- Long Term Disability - Hartford Life and Accidental Insurance Company

WHAT IS NOT A CLAIM

The following are examples of interactions you may have with the Trust Administration Office or the Pharmacy Benefit Manager (PBM) that are not "claims" and therefore are not subject to the timelines and procedures described in this Chapter.

- Simple inquiries about the Plan's provisions that are unrelated to any specific benefit claim will not be treated as a claim for benefits.
- A request for a determination regarding the Plan's coverage of a medical treatment or service that your physician has recommended is not a "claim" under these procedures if the treatment or service has not yet been provided and the treatment or service is for non-urgent care for which the Plan does not require preauthorization.
- When you present a prescription to a participating pharmacy to be filled under the terms of this Plan, that request is not a "claim" under these procedures. However, if your request for a prescription is denied, in whole or in part, you may file a claim and appeal the denial by using these procedures.

ADDITIONAL INFORMATION NEEDED

There may be times during the filing or appeal of a claim that you are asked to submit additional information. You will be told how much time is allowed for you to submit this additional information. The Plan is not legally required to consider information submitted after these stated time frames.

FILING CLAIMS FOR HEALTH CARE BENEFITS (MEDICAL, DENTAL, VISION, PRESCRIPTION DRUG)

Under the Plan, you may file claims for Plan benefits and appeal adverse claim determinations. Any reference to "you" in this Claims and Appeals section includes you and your Authorized Representative. An "Authorized Representative" is a person you authorize, in writing, to act on your behalf. The Plan will also recognize a court order giving a person authority to submit claims on your behalf. In the case of an urgent care claim, a health care professional with knowledge of your condition may always act as your Authorized Representative.

Claims received by the Trust Administration Office more than 12 months after the date services are received are not covered by the Plan and will not be reimbursed. In order for a claim to be considered received, all required information must be received within the 12 months from the date the claim is incurred.

The claims procedures you follow will depend on whether your claim for benefits is a claim involving urgent care, a pre-service claim, or a post-service claim.

A ***pre-service claim*** is any claim for services not yet performed and which the Plan requires Preauthorization in order for you to receive maximum benefits and which are not urgent care claims. ***Concurrent care claims*** may be pre-service claims if prior authorization is required to receive maximum benefits.

An ***urgent care claim*** is a claim for medical care or treatment that if delayed could seriously jeopardize your life or health or your ability to regain maximum function, or would, in the opinion of your physician, subject you to severe pain that can only be effectively managed through the requested course of treatment.

Any claim for health care benefits under the Plan that is not an urgent care claim or a pre-service claim is considered a ***post-service claim***.

PRE-SERVICE CLAIMS

Please refer to the section of this booklet titled "Utilization Management/Preauthorization" for a list of services which must be authorized by the Utilization Management Company before services are received in order to receive maximum benefits. You or your provider must contact the Utilization Management Company by phone at the number listed on the Quick Reference Chart in the front of this booklet. These claims should ***not*** be sent by US postal service.

URGENT CARE CLAIMS

You or your provider must contact the Utilization Management Company by phone or fax at the numbers show in the Quick Reference Chart in the front of this booklet. These claims should ***not*** be sent by US postal service.

The Utilization Management Company will issue a decision as soon as possible and within 72 hours after receipt of the claim. If more information is required to make a determination on the claim, you and/or your provider will be notified as soon as possible but within 24 hours, and given at least 48 hours to provide the requested information. If you and/or your provider do not provide the requested information within the 48-hour period, your claim will be denied.

POST-SERVICE CLAIMS

The procedures for filing post service claims for medical, prescription drugs or vision benefits are shown at the end of each chapter of this booklet describing these benefits. Decisions will be provided by the Trust Administration Office for medical and vision claims and by the PBM for prescription drug claims. The decision will be issue within 30 days after receipt of the claim, unless an extension is necessary, in which case a decision will be issued within 45 days. Written notice of the extension will be provided to you before the end of the initial 30-day period and will state the reason(s) for the extension and the date you can expect a decision. If an extension is necessary because you failed to submit all necessary information, the notice will describe the required information, and you will have 45 days to provide the requested information. The time period in which a decision will be issued is delayed from the date the request for additional information was sent out until you respond. If you do not provide the requested information within the 45-day period, your claim will be denied.

CONCURRENT CARE CLAIMS

Any appeal of a concurrent claim is treated as a post-service, pre-service or urgent care claim appeal, as appropriate.

In the case of a concurrent care claim, where health care treatment is reduced or terminated before the end of the previously approved period of time or number of treatments, the Utilization Management Company

or the Trust Administration Office, whichever made the decision to reduce or terminate the care, will notify you sufficiently in advance of the reduction or termination to allow you to appeal the decision if you choose to do so and have the appeal decided before the benefit is reduced or terminated.

If an ongoing course of treatment was previously approved for a specific period of time or number of treatments, and you request to extend treatment in a non-urgent circumstance, your request will be considered a new claim and decided according to the pre-service time frames. If the request involves urgent care, any claim to extend a course of treatment will be decided as soon as possible but within 24 hours, provided the claim is submitted at least 24 hours prior to the prescribed end of the course of treatments.

DISABILITY BENEFITS

The Trust Administration Office will issue a decision within 45 days after receipt of the claim. This period may be extended twice, up to 30 days for each extension. Written notice of the extension will be provided to you before the end of the initial 45-day period and will state the reason(s) for the extension and the date you can expect a decision. If an extension is necessary because you failed to submit all necessary information, the notice will describe the required information, and you will have 45 days to provide the requested information. The time period in which a decision will be issued is delayed from the date the request is made until you respond. If you do not provide the requested information within the 45-days, your claim will be denied.

IF YOUR CLAIM IS DENIED

If any claim under the Plan is denied, you will receive written notice of the decision of the right to appeal the denial. The notice will include a description of (1) the specific reasons for the denial and reference to the specific Plan provisions on which the denial is based; (2) a description of any additional information required and why that information is required to perfect your claim; (3) the Plan's appeal procedures, including applicable time limits and your right to submit written comments, documents, and other information relating to the claim and to request in writing the opportunity to review or receive copies, free of charge, of Plan documents, records, or other relevant and non-privileged information related to your claim; and (4) your right to file suit if your claim is denied on upon exhaustion of the appeal procedures.

In addition you will be notified if an internal rule, guideline, or similar criterion was relied on by the Trust Administration Office and, at your written request, will be provided with a copy, free of charge, of such rule, guideline, or similar criterion. If your claim is denied based on a medical necessity or other similar exclusion or limit, you will be notified that you may request, free of charge, an explanation of how that exclusion or limit and any clinical judgments apply to your medical circumstances. In the case of a denial of an urgent care claim, a description of the expedited review process applicable to such claims will be included.

APPEALING A DENIED CLAIM

If you want to file an appeal of a claim denial, (also known as an adverse benefit determination) it is important that you do so within the applicable time period specified below. If you do not appeal on time, you may lose your right to file suit in a state or federal court, because you have not exhausted your internal administrative appeal rights (which is generally a requirement before you can sue in state or federal court).

You (or your authorized representative) may appeal a complete or partial denial of the claim by filing a written appeal within *180 days* after your receipt of the claim denial. A form for designating an Authorized Representative is available from the Trust Administration Office.

For prescription drug claims denied by the Prescription Drug Plan, you must first exhaust the appeals procedures of the PBM before making an appeal directly to the Board of Trustees.

You should include the reasons you believe the claim was improperly denied and all additional facts and documents you consider relevant in support of your appeal. As you prepare your appeal, you may make written request to receive, free of charge, reasonable access to all documents, records and other information relevant to your claim. You may also request the identity of any medical and/or vocational experts whose

advice was obtained in connection with the adverse benefit determination, even if that advice was not relied upon in the claim denial.

Requests for appeal should be submitted to the Trust Administration Office at the following address:

Appeals Department
c/o WPAS, Inc.
PO Box 34711
Seattle WA 98124-1711

TIMING OF NOTICE OF DECISION ON APPEAL

Pre-Service and Urgent Care Health Claims

You will receive notice of the decision on your appeal from the Utilization Management Company within *30 days* for Pre-Service Claims. You may request expedited review of urgent care claim denials by telephone or in writing and submit information in support of your appeal by facsimile and/or telephone, as appropriate. You will receive notice of the decision within *72 hours* of receipt of the appeal.

How an Appeal is Decided when referred to the Board of Trustees

The Plan's Board of Trustees or Appointed Committee will make the final decision on appeal for all Post Service Claims or Disability Claims. They will not defer to the initial adverse benefit determination and will consider all comments, documents, and records and other information you submit, even if they were not submitted or considered during the initial claim decision. Its decision on your appeal will be made based on the record, including any additional documents and comments you submit.

If your claim was denied on the basis of a medical judgment (such as the absence of medical necessity or the use of an experimental or investigational treatment), the Board may consult a health care professional with training and experience applicable to the relevant field of medicine. The professional shall not have been involved in the claim denial nor be the subordinate of any person involved in the denial. Upon request, you can obtain the name of any professional consulted and the advice (if any) given concerning your claim (even if the Board did not rely on this advice in making its decision).

Appeals of Post-Service Claims will be decided at the next regularly scheduled meeting of the Board of Trustees following receipt of the appeal. If, however, your request for review is received within 30 days of the next regularly scheduled Board meeting, your appeal may be decided at the second regularly scheduled Board meeting following receipt of your appeal. In special circumstances, review of your appeal may be delayed until the third regularly scheduled Board meeting following receipt of your appeal. You will be notified in writing if an extension is necessary. You will be notified of the decision on your appeal as soon as possible but no later than five days after a decision on your appeal is reached.

Notice of Denial of a Claim On Appeal

If your claim is denied on appeal, you will receive a written notice stating (1) the specific reasons for the decision and specific references to the relevant Plan provisions on which the Trustees' decision is based; (2) your right to receive, on written request and free of charge, access to and copies of all documents, records, and other relevant information; and (3) your right to file suit under section 502(a) of ERISA. Any suit must be brought no later than one year after the date of the issuance of the Trustee's decision on the appeal. If your claim is for medical or disability benefits, you will be notified if an internal rule, guideline, or other similar criterion was relied on by the Trustees and will be provided with a copy of such rule, guideline, or other criterion free of charge at your request. If your claim is denied based on a medical necessity or other similar exclusion or limit, you will be provided, free of charge at your written request, an explanation of how that exclusion or limit and any clinical judgments apply to your medical circumstances, including information relating to medical or vocational experts whose advice was obtained on behalf of the Trustees in connection with the denial, without regard to whether the advice was relied upon in making the benefit determination.

EXTERNAL REVIEW

External reviews are available for appeals involving medical judgment or the retroactive rescission of coverage. There is no external review for weekly disability, accidental death and dismemberment or life insurance benefits. If you remain dissatisfied after the Board of Trustees issues its decision on appeal and your claim is eligible for an external review, you may request an external review with an Independent Review Organization or bring a civil action under ERISA § 502(a). If you request an external review, such request is subject to the following:

- The Plan's claim appeal process must be exhausted before external or judicial review can be sought.
- You have four months from the date of the final adverse benefit determination to file a request for external review. Failure to request an external review within the four-month period will end your ability to seek external review.
- Requests for external review should be sent to the Trust Administration Office at the following address:

Appeals Department / External Review
c/o WPAS, Inc.
P.O. Box 34711
Seattle, WA 98124-1711

PRELIMINARY REVIEW OF EXTERNAL REVIEW REQUEST

Within five business days of receipt of a request for external review, the Plan will complete a preliminary review of the external review request. The preliminary review will be expedited if the request satisfies the requirements for an expedited external review. Within one business day after completion of this review, the Plan will notify you of its decision. If the request is not eligible for external review, the Plan will notify you. If the request for external review is incomplete, the Plan will identify what is needed and you will have the longer of 48 hours or the remaining portion of the four-month external review request period to provide the information. If the external review request is complete and eligible for external review, the Plan will refer the matter to an Independent Review Organization.

EXPEDITED EXTERNAL REVIEW

You may request an expedited external review if you received:

- an adverse denial of benefits which involves a medical condition for which the timeframe for completing an expedited appeal to the Board of Trustees would seriously jeopardize your life or health or your ability to regain maximum function and you have filed a request for an expedited appeal to the Board of Trustees; or
- an adverse decision on appeal to the Trustees which involves a medical condition for which the timeframe for completion of a standard external review would seriously jeopardize your life or health or your ability to regain maximum function, or the decision concerns an admission, availability of care, continued stay, or health care item or service for which you received emergency services, but has not been discharged from a facility.

REVIEW BY INDEPENDENT REVIEW ORGANIZATION

If a properly filed request for external review is received, the Plan will provide the Independent Review Organization with the required documentation in the time required by applicable federal regulations. The Independent Review Organization will provide a response to you within 45 days after it has received the request to review.

If a claim satisfies the requirements for an expedited external review, the Independent Review Organization will provide a response to you within 72 hours after it has received the request to review, provided that written confirmation may be provided within 48 hours after the date the response is provided.

JUDICIAL REVIEW OF APPEAL

If a claimant remains dissatisfied after the issuance of the Trustees' decision on appeal, or issuance of the Independent Review Organization's decision, you may bring a civil action under ERISA § 502(a). Any civil action must be brought no later than one year after the date of issuance of the Trustees' decision on an appeal. The question on review will be whether, in the particular instance, the Trustees:

- were in error upon an issue of law;
- acted arbitrarily or capriciously in the exercise of their discretion; or
- whether their findings of fact were supported by substantial evidence.

Right to Sue

A lawsuit to obtain benefits will be deemed untimely if it is filed before:

- you have appealed the denial of your claim to the Board of Trustees, or
- the Board of Trustees has issued a decision on appeal; or
- you have exhausted the Plan's appeals processes for every issue you deem relevant.

The ERISA Statement of Rights provides additional information on legal action you can take if you feel your right to a benefit has been improperly denied.

DISCRETIONARY AUTHORITY OF BOARD OF TRUSTEES

The Board of Trustees has the exclusive authority to interpret the provisions of the Plan, to determine eligibility for entitlement to Plan benefits or to amend the Plan. Any interpretation or determination by the Trustees made in good faith which is not contrary to law is conclusive on all persons affected. No employee, dependent, beneficiary or other person shall have any right or claim to benefits under the Plan other than as specified in policies or contracts procured by the Board of Trustees or in the rules and regulations of the Board, or any right or claim to payments from the Trust Fund other than as specified therein. Any dispute as to eligibility, type, amount or duration of benefits or any right or claim to payments from the Trust Fund shall be resolved by the Board under and pursuant to the Collective Bargaining Agreements, contract, the Plan document and the Trust Agreement; and its decision of the dispute, right or claim shall be final and binding upon all parties thereto, subject only to judicial review as provided by federal law. No action may be brought for benefits provided by the Plan or to enforce any right under the Plan until after a claim therefore has been submitted to and determined by the Board of Trustees, and thereafter the only action which may be brought is one to enforce the decision of the Board or clarify your rights under such decision.

CLAIM DETERMINATIONS BY AN HMO OR INSURANCE COMPANY

The decision of the Board of Trustees, with respect to any appeal, shall be final and binding on all persons, except in the following instance: If the benefits involved are provided by an insurance company, HMO or other similar organization, the decision of the insurer or HMO is final and no appeal of benefit determination can be made to the Board of Trustees except for eligibility.

ASSIGNMENT

Coverage and your rights under this plan may not be assigned. A direction to pay a provider is not an assignment of any right under this plan or of any legal or equitable right to institute any court proceeding.

All payments for services by PPO providers will be made directly to such providers. In the case of non-PPO providers payments will be made, at the Trust's option, to the participant, to his or her estate, to the provider or as required under federal law, including qualified medical child support orders. No assignment whether made before or after services are provided, of any amount payable according to this Plan shall be recognized or accepted as binding upon the Trust, unless otherwise required by federal law.

Right to Examine

The Plan, at its own expense, shall have the right and opportunity to examine the person of any participant when and as often as it may reasonably require during the pendency of any claim, and also the right and opportunity to make an autopsy in case of death where it is not forbidden by law.

Payments Made in Error/Overpayments

If the Plan mistakenly makes a payment for you or your dependents to which they are not entitled, if the Plan pays an individual who is not eligible for benefits at all or if an eligible individual fails to observe a Plan provision, such as the Third-Party Reimbursement provisions, the Plan has the right to recover the payment from the eligible individual paid or anyone else who benefited from it, including the individual or the provider of services. The Plan may also pursue recovery from any individual or entity responsible for providing misinformation to or failing to provide necessary information to the Plan that has resulted in the payment of improper benefits. The Plan's right of recovery includes the right to deduct the amount paid by mistake from future benefits payable to the affected eligible individual or any other individual where eligibility is established through the same eligible individual. The Plan may also recover benefits from the person responsible for misreporting any person for eligibility purposes. By accepting benefits from the Plan, you agree that any court proceeding with respect to this provision may be brought in any court of competent jurisdiction as the Plan may elect. By accepting such benefits, you hereby submit to each such jurisdiction, waiving whatever rights may correspond by reason of your present or future domicile. By accepting such benefits, you also agree to pay all attorneys' fees the Plan incurs in successful attempts to recover amounts the Plan is entitled to under this section.

Facility of Payment

If the Trust Administration Office or its designee determines that you cannot submit a claim or prove that you or your covered dependent paid any or all of the charges for health care services that are covered by the Plan because you are incompetent, incapacitated or in a coma, the Plan may, at its discretion, pay Plan benefits directly to the Health Care Provider(s) who provided the health care services or supplies, or to any other individual who is providing for your care and support. Any such payment of Plan benefits will completely discharge the Plan's obligations to the extent of that payment. Neither the Plan, Board of Trustees, claims administrator nor any other designee will be required to see to the application of the money so paid.

COORDINATION OF BENEFITS (COB)

This Coordination of Benefits (COB) provision applies to This Plan when you or your covered dependent has health coverage under more than one plan. This chapter describes the circumstances when you or your covered dependents may be entitled to health care benefits under this Plan and may also be entitled to recover all or part of your health care expenses from some other source. "Plan" and "This Plan" are defined herein. The Order of Benefit Determination Rules below determines which plan will pay as the primary plan. The primary plan pays first without regard to the possibility that another plan may cover some expenses. A secondary plan pays after the primary plan and may reduce the benefits it pays so that payments from all group plans do not exceed 100% of the total allowable expense.

Getting Started - Important Terms

Allowable Expense means a health care service or expense, including, coinsurance and **copayments** and without reduction of any applicable **deductible**, that is covered at least in part by any of the Plans covering the person. When a Plan provides benefits in the form of services (for example an HMO), the reasonable cash value of each service will be considered an allowable expense and a benefit paid. An expense or service that is not covered by any of the Plans is not an allowable expense. Any expense that a health care provider by law or in accordance with a contractual agreement is prohibited from charging a covered person is not an allowable expense. The following are examples of expenses and services that are not allowable expenses:

1. If a covered person is confined in a private **hospital** room, the difference between the cost of a semi-private room in the **hospital** and the private room is not an allowable expense. This does not apply if one of the Plans provides coverage for a private room.
2. If a person is covered by 2 or more Plans that compute their benefit payments on the basis of reasonable or Recognized Charges, any amount in excess of the highest of the reasonable or Recognized Charges for a specific benefit is not an allowable expense.
3. If a person is covered by 2 or more Plans that provide benefits or services on the basis of negotiated charges, an amount in excess of the highest of the negotiated charges is not an allowable expense.
4. The amount a benefit is reduced or not reimbursed by the primary Plan because a covered person does not comply with the Plan provisions is not an allowable expense. Examples of these provisions are second surgical opinions, precertification of admissions, and preferred provider arrangements.
5. If all Plans covering a person are high deductible Plans and the person intends to contribute to a health savings account established in accordance with section 223 of the Internal Revenue Code of 1986, the primary high deductible Plan's deductible is not an allowable expense, except as to any health expense that may not be subject to the deductible as described in section 223(c)(2)(C) of the Internal Revenue Code of 1986.

If a person is covered by one Plan that computes its benefit payments on the basis of reasonable or Recognized Charges and another Plan that provides its benefits or services on the basis of negotiated charges, the primary plan's payment arrangements shall be the allowable expense for all the Plans. However, if the secondary plan has a negotiated fee or payment amount different from the primary plan and if the provider contract permits, that negotiated fee will be the allowable expense used by the secondary plan to determine benefits.

When a plan provides benefits in the form of services, the reasonable cash value of each service rendered shall be deemed an allowable expense and a benefit paid.

Closed Panel Plan(s). A plan that provides health benefits to covered persons primarily in the form of services through a panel of providers that have contracted with or are employed by the plan, and that limits or excludes benefits for services provided by other providers, except in cases of emergency or referral by a panel member.

Custodial Parent. A parent awarded custody by a court decree. In the absence of a court decree, it is the parent with whom the child resides more than one half of the calendar year without regard to any temporary visitation.

Plan. Any Plan providing benefits or services by reason of health care or treatment, which benefits or services are provided by one of the following:

- Group or nongroup, blanket, or franchise health insurance policies issued by insurers, including health care service contractors;
- Other prepaid coverage under service Plan contracts, or under group or individual practice;
- Uninsured arrangements of group or group-type coverage;
- Labor-management trustee Plans, labor organization plans, employer organization Plans, or employee benefit organization Plans;
- Medical benefits coverage in a group, group-type, and individual automobile "no-fault" and traditional automobile "fault" type contracts;
- Medicare or other governmental benefits;
- Other group-type contracts. Group type contracts are those which are not available to the general public and can be obtained and maintained only because membership in or connection with a particular organization or group.

If the Plan includes medical, prescription drug, dental, vision and hearing coverage, those coverages will be considered separate plans. For example, Medical coverage will be coordinated with other Medical plans, and dental coverage will be coordinated with other dental plans.

This Plan is any part of the contract that provides benefits for health care expenses.

Primary Plan/Secondary Plan. The order of benefit determination rules state whether This Plan is a Primary Plan or Secondary Plan as to another Plan covering the person. When This Plan is a primary Plan, its benefits are determined before those of the other Plan and without considering the other Plan's benefits. When This Plan is a Secondary Plan, its benefits are determined after those of the other Plan and may be reduced because of the other Plan's benefits. When there are more than two Plans covering the person, this Plan may be a Primary Plan as to one or more other Plans, and may be a Secondary Plan as to a different Plan or Plans.

Which Plan Pays First

When two or more **plans** pay benefits, the rules for determining the order of payment are as follows:

- The primary plan pays or provides its benefits as if the secondary plan or plans did not exist.
- A plan that does not contain a coordination of benefits provision that is consistent with this provision is always primary. There is one exception: coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits may provide that the supplementary coverage shall be excess to any other parts of the plan provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base plan **hospital** and surgical benefits, and insurance type coverages that are written in connection with a closed panel plan to provide out-of-network benefits.
- A plan may consider the benefits paid or provided by another plan in determining its benefits only when it is secondary to that other plan.
- The first of the following rules that describes which plan pays its benefits before another plan is the rule to use:
    1. Non-Dependent or Dependent. The plan that covers the person other than as a dependent, for example as an employee, member, subscriber or retiree is primary and the plan that covers the person as a dependent is secondary. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the plan covering the person as a dependent; and

primary to the plan covering the person as other than a dependent (e.g. a retired employee); then the order of benefits between the two plans is reversed so that the plan covering the person as an employee, member, subscriber or retiree is secondary and the other plan is primary.

2. Child Covered Under More than One Plan. The order of benefits when a child is covered by more than one plan is:

   A. The primary plan is the plan of the parent whose birthday is earlier in the year if:
      - The parents are married or living together whether or not married;
      - A court decree awards joint custody without specifying that one party has the responsibility to provide health care coverage or if the decree states that both parents are responsible for health coverage, the plan that covers the parent whose birthday falls earlier in the calendar year pays first, and the plan covers the parent whose birthday falls later in the calendar year pays second. If both parents have the same birthday, the plan that covered either of the parents longer is primary.

   B. If the specific terms of a court decree state that one of the parents is responsible for the child's health care expenses or health care coverage and the plan of that parent has actual knowledge of those terms, that plan is primary. If the parent with responsibility has no health coverage for the dependent child's health care expenses, but that parent's spouse does, the plan of the parent's spouse is the primary plan. However, this provision does not apply during any Plan Year during which any benefits were actually paid or provided before the plan had actual knowledge of the specific terms of that court decree.

   C. If the parents are separated or divorced or are not living together whether or not they have ever been married and there is no court decree allocating responsibility for health coverage, the order of benefits is:
      - The plan of the custodial parent;
      - The plan of the spouse of the custodial parent;
      - The plan of the noncustodial parent; and then
      - The plan of the spouse of the noncustodial parent.

   D. If there is no custodial parent (i.e. the child is over age 18), the plan that covers the parent whose birthday falls earlier in the calendar year pays first, and the plan that covers the parent whose birthday falls later in the calendar year pays second.

      For a dependent child covered under more than one plan of individuals who are not the parents of the child, the order of benefits should be determined as outlined above as if the individuals were the parents.

      The word "birthday" refers only to the month and day in the calendar year, not the year in which the person was born.

3. Active Employee or Retired or Laid off Employee. The plan that covers a person as an active employee who is neither laid off nor retired or as a dependent of an active employee, is the primary plan. The plan covering that same person as a retired or laid off employee or as a dependent of a retired or laid off employee is the secondary plan. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored. If a person is covered as a laid-off or retired employee under one plan and as a dependent of an active employee under another plan, the order of benefits is determined by the Non-Dependent or Dependent rules listed above.

4. Continuation Coverage. If a person whose coverage is provided under a right of continuation provided by federal or state law is also covered under another plan**,** the plan covering the person as an employee, member, subscriber or retiree (or as that person's dependent) is primary, and the continuation coverage is secondary. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored. If a person is covered other than as a dependent (that is, as an employee, former employee retiree, member or subscriber) under a right

of continuation of coverage under federal or state law under one plan and as a dependent of an active employee under another plan, the order of benefits is determined by the Non-Dependent or Dependent rules above.

5. If none of the four previous rules determines the order of benefits, the plan that covered the person for the longer period of time pays first; and the plan that covered the person for the shorter period of time pays second.
   A. To determine how long a person was covered by a plan, two plans are treated as one if the person was eligible for coverage under the second plan within 24 hours after the first plan ended.
   B The start of a new plan does not include a change:
      - In the amount or scope of a plan's benefits;
      - In the entity that pays, provides or administers the plan; or
      - From one type of plan to another (such as from a single employer plan to a multiple employer plan).
   C. The length of time a person is covered under a plan is measured from the date the person was first cover under that plan. If that date is not readily available, the date the person first became a member of the group will be used to determine the length of time that person was covered under the plan presently in force.
6. If the other coverage has not Coordination of Benefit rules, this Plan will always pay secondary.

How Coordination of Benefits Works

In determining the amount to be paid when this plan is secondary on a claim, the secondary plan will calculate the benefits that it would have paid on the claim in the absence of other health insurance coverage and apply that amount to any allowable expense under this plan that was unpaid by the primary plan. The amount will be reduced so that when combined with the amount paid by the primary plan, the total benefits paid or provided by all plans for the claim do not exceed 100 percent of the total allowable expense.

In addition, a secondary plan will credit to its plan deductible any amounts that would have been credited in the absence of other coverage.

Under the COB provision of this plan, the amount normally reimbursed for covered benefits or expenses under this plan is reduced to take into account payments made by other plans. The general rule is that the benefits otherwise payable under this plan for all covered benefits or expenses will be reduced by all other plan benefits payable for those expenses. When the COB rules of this plan and another plan both agree that this plan determines its benefits before such other plan, the benefits of the other plan will be ignored in applying the general rule above to the claim involved. Such reduced amount will be charged against any applicable benefit limit of this coverage.

If a covered person is enrolled in two or more closed panel plans COB generally does not occur with respect to the use of panel providers. However, COB may occur if a person receives emergency services that would have been covered by both plans.

Right To Receive And Release Needed Information

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits under this plan and other plans. The Trust has the right to release or obtain any information and make or recover any payments it considers necessary in order to administer this provision.

Facility of Payment

Any payment made under another plan may include an amount, which should have been paid under this plan. If so, the Trust may pay that amount to the organization, which made that payment. That amount will then be treated as though it were a benefit paid under this plan. The Trust will not have to pay that amount

again. The term "payment made" means reasonable cash value of the benefits provided in the form of services.

Right of Recovery

If the Trust pays more than it should have paid under this COB provision, it may recover the excess from one or more of the persons it has paid or for whom it has paid; or any other person or organization that may be responsible for the benefits or services provided for the covered person. The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

HOW MUCH THIS PLAN PAYS WHEN IT IS SECONDARY

Secondary Liability of this Plan: When this Plan pays second, it will pay the same benefits that it would have paid had it paid first, **less** whatever payments were actually made by the plan (or plans) that paid first. In no case will this Plan pay more in benefits for each claim as it is submitted than it would have paid had it been the Plan that paid first. This has the effect of maintaining this Plan's deductibles, coinsurance and exclusions. As a result, when this Plan pays second, you may not receive the equivalent of 100% of the total cost of the health care services.

Benefit Reserve: This Plan administers a benefit reserve (also called a benefit bank, credit balance, credit reserve or credit savings) calculation in the coordination of benefits.

ADMINISTRATION OF COB

1. To obtain all the benefits available to you, you should file a claim under each plan that covers the person for the expenses that were incurred. However, any person who claims benefits under this Plan must provide all the information the Plan needs to apply COB.
2. If this Plan is primary, and if the coordinating secondary plan is an HMO, EPO or other plan that provides benefits in the form of services, this Plan will consider the reasonable cash value of each service to be both the allowable expense and the benefits paid by the primary plan. The reasonable cash value of such a service may be determined based on the Plan's Allowed charge.
3. If this Plan is secondary, and if the coordinating primary plan does not cover health care services because they were obtained Out-of-Network, benefits for services covered by this Plan will be payable by this Plan subject to the rules applicable to COB, but only to the extent they would have been payable if this Plan were the primary plan.
4. If this Plan is secondary, and if the coordinating plan is also secondary because it provides by its terms that it is always secondary or excess to any other coverage, or because it does not use the same order of benefit determination rules as this Plan, this Plan will not relinquish its secondary position. However, if this Plan advances an amount equal to the benefits it would have paid had it been the primary plan, this Plan will be subrogated to all rights the Plan participant may have against the other plan, and the Plan participant must execute any documents required or requested by this Plan to pursue any claims against the other plan for reimbursement of the amount advanced by this Plan.

PRESCRIPTION DRUG COORDINATION OF BENEFITS

If you have other prescription drug coverage and you (or your dependents) have unpaid expenses, the Trust will consider those expenses under the self-funded medical plan. When submitting expenses for consideration, be sure to include:

- Identifying information;
- Pharmacy receipt showing the drug name, quantity, strength, date of service, pharmacy name, the original cost of the drug and the amount not covered by the primary insurance.

COORDINATION OF BENEFITS WITH MEDICARE

When You Have Medicare Coverage

This section explains how the benefits under this Plan interact with benefits available under Medicare.

Which Plan Pays First

The Plan is the primary payor when your coverage for the Plan's benefits is based on current employment with your employer.

The Plan is also primary if you are covered by Medicare due to a diagnosis of end stage renal disease, but only during the first 30 months of such eligibility for Medicare benefits. This provision does not apply if, at the start of eligibility, you were already eligible for Medicare benefits, and the Plan's benefits were payable on a secondary basis.

The Plan is the secondary payor in all other circumstances. For retired employees age 65 age and over and their dependents age 65 and over, or other Medicare eligible individuals based disability or end stage renal disease, benefits will be coordinated with Medicare as the primary insurer and this Plan as the secondary insurer, whether the retired person has enrolled in Medicare B or not.

How Coordination With Medicare Works

When the Plan is Primary – The Plan pays benefits first when it is the primary payor. You may then submit your claim to Medicare for consideration.

When Medicare is Primary – Your health care expense must be considered for payment by Medicare first. You may then submit the expense to the Trust for consideration.

The Trust will calculate the benefits the Plan would pay in the absence of Medicare:

The amount will be reduced so that when combined with the amount paid by Medicare, the total benefits paid or provided by all plans for the claim do not exceed 100 percent of the total allowable expense.

This review is done on a claim-by-claim basis.

Charges used to satisfy your Part B deductible under Medicare will be applied under the plan in the order received by the Trust. The Trust will apply the largest charge first when two or more charges are received at the same time.

The Trust will apply any rule for coordinating health care benefits after determining the benefits payable.

Motor Vehicle Coverage Required by Law:

Most motor vehicle liability policies are required by law to provide liability insurance, primary medical payment insurance and uninsured motorist insurance, and many motor vehicle policies also provide underinsurance coverage.

The plan will not pay benefits for health care costs to the extent that the eligible individual is able to, or is entitled to, recover from motor vehicle insurance, including payments under a PIP policy. Benefits will not be provided to the extent an eligible individual has failed to acquire PIP coverage where required to do so by law or PIP coverage has been terminated before being exhausted for failure to cooperate or otherwise for cause. The plan will pay benefits toward expenses over the amount covered by motor vehicle insurance subject to the plan's Third-Party Reimbursement Provision.

If the plan pays benefits before motor vehicle insurance payments are made, the plan is entitled to reimbursement out of any subsequent motor vehicle insurance payments made to the eligible individual and, when applicable, the plan may recover benefits the plan has paid directly from the motor vehicle insurer or out of any settlement or judgment which the eligible individual obtains in accordance with the plan's Third-Party Reimbursement Provisions.

WORKERS' COMPENSATION

This Plan **does not provide** benefits if the expenses are covered by workers' compensation or occupational disease law. If the individual's employer contests the application of workers' compensation law for the illness or injury for which expenses are incurred, this Plan may advance benefits if the individual agrees to reimburse the Trust the advanced benefits if and when it is determined that they are covered under a

workers' compensation or occupational disease law. Before the Plan will advance benefits, the individual and the individual's legal representative must execute a promissory note or reimbursement agreement acceptable to the Board of Trustees or its designee. However, the failure of the individual to sign such an agreement will not constitute a waiver by the Plan, the Board of Trustees or the Trust Administration Office of their rights to recover any payments that the Plan has advanced.

RIGHT TO REIMBURSEMENT

The provisions of this section apply to all current or former Plan participants and also to the parents, guardian, or other representative of a dependent child who incurs claims and is or has been covered by the Plan. The Plan's right to reimbursement shall apply to the personal representative of your estate, your decedents, minors, and incompetent or disabled person. "You" or "your" includes anyone on whose behalf the Plan pays benefits. No adult covered person hereunder may assign any rights that it may have to recover medical expenses from any tortfeasor or other person or entity to any minor child or children of said adult covered person without the prior express written consent of the Plan.

The Plan's right of reimbursement, as set forth below, extends to all insurance coverage available to you due to an injury, illness or condition for which the Plan has paid medical claims (including, but not limited to, liability coverage, uninsured motorist coverage, underinsured motorist coverage, personal umbrella coverage, medical payments coverage, workers' compensation coverage, no-fault automobile coverage or any first party insurance coverage).

Your health Plan is always secondary to automobile no-fault coverage, personal injury protection coverage, or medical payments coverage.

1. The Plan excludes medical, prescription drug, dental and time loss benefits for any injury or illness caused by the act or omission of another person, (known as the "third party"), where a potential opportunity for recovery exists from the third party, including, but not limited to, an injury or illness potentially covered by any liability policy of a third party or first party coverage available under an automobile insurance policy (including coverage for underinsured or uninsured motorist), homeowners policy or commercial premises policy. If an eligible individual has a potential right of recovery for which a third party or insurer may have legal responsibility, the Plan, as a convenience to the eligible individual, may advance benefits pending the resolution of the claim. However, the Plan's payment of benefits is conditioned upon reimbursement from any judgment, settlement, disputed claim settlement, or other recovery, up to the full amount of all benefits provided by the Plan, but not to exceed the amount of the recovery.
2. If the Plan provides benefits, the Plan is entitled to reimbursement of all benefits paid, regardless of whether the eligible individual is made whole by the recovery, and regardless of the characterization of the recovery, except that if the eligible individual complies with the terms of the Plan and any agreement to reimburse, the Plan will deduct reasonable attorney fees and a pro rata share of the costs from the reimbursement amount, as described below. Costs incurred solely for the benefit of the eligible individual shall be the responsibility of the eligible individual. The Plan's deduction for attorney fees and costs is contingent on compliance with the Plan's reimbursement provisions and/or the agreement to reimburse.
3. Prior to advancing funds on the eligible individual's behalf, the Plan can require that an eligible individual and the eligible individual's attorney execute an agreement acknowledging this Plan's reimbursement right, and provide the name and address of the party at fault, the name of any insurance company through which coverage may be available, the name of any other lien holders involved, a factual description of the accident and/or injury or illness, and any other information requested by the Plan to protect its reimbursement interest.
4. When any recovery is obtained from a third party or insurer, an amount sufficient to satisfy the Plan's reimbursement amount must be paid into a trust account or escrow and held there until the Plan's claims are resolved by mutual agreement or court order. The eligible individual shall request written permission from the Plan prior to distribution of any settlement funds prior to satisfaction of the Plan's

reimbursement interest. The obligation to place the reimbursement amount in trust is independent of the obligation to reimburse the plan. If the funds necessary to satisfy the Plan's reimbursement amount are not placed in trust, the eligible individual, or the individual who receives or distributes the recovery funds shall be liable for any loss the plan suffers as a result.

5. The Plan may cease advancing benefits, if there is a reasonable basis to determine that the eligible individual or the eligible individual's attorney will not honor the terms of the plan or the agreement to reimburse, or there is a reasonable basis to determine that the agreement is not enforceable.
6. After recovery by the eligible individual, and pending reimbursement to the Plan, the Plan may elect to recoup the reimbursement amount from benefit payments, including benefit payments for the eligible individual's family members, by denying such payments until the amount of benefits provided has been recovered. The Plan may also seek to recoup the reimbursement amount from the source to which benefits were paid.
7. If the Plan is not reimbursed, it may bring an action against the eligible individual to enforce its right to reimbursement and/or the agreement to reimburse, or to seek a constructive trust, or in the alternative may elect to recoup the reimbursement amount by offsetting future benefits. If the Plan is forced to bring a legal action, it shall be entitled to its reasonable attorney fees, costs of collection and court costs.

GENERAL PROVISIONS AND INFORMATION REQUIRED BY ERISA

NAME OF THE PLAN

Puget Sound Benefits Trust

NAME AND ADDRESS OF PLAN SPONSOR MAINTAINING THE PLAN

Puget Sound Benefits Trust
7525 SE 24th St, Suite 200
Mercer Island, WA 98040-2341

Mailing Address:
P.O. Box 34203
Seattle, WA 98124-1203
(206) 441-7574

A complete list of the employers sponsoring the Plan may be obtained by participants upon written request to the Trust Administration Office, and is available for examination by Plan participants.

IDENTIFICATION NUMBER

The Employer Identification Number assigned to the Plan by the Internal Revenue Service is:

EIN 91-6028312. The Plan Number is: PN 501.

TYPE OF PLAN

This Plan can be described as an employee welfare benefit plan which provides Medical, Prescription Drug, Life, Accidental Death and Dismemberment, Short Term Disability, Long Term Disability, Dental, Hearing and Vision Benefits.

TYPE OF ADMINISTRATION

This Plan is administered by the Board of Trustees, with the assistance of Welfare & Pension Administration Service, Inc., a contract administration organization.

The Plan is funded by monthly contributions from Participating Employers paid on behalf of eligible employees and their eligible dependents. The amount of the contribution is determined by the Collective Bargaining Agreements between signatory employers and the unions that participate in the Puget Sound Benefits Trust. A copy of the Collective Bargaining Agreement(s) may be obtained by participants and beneficiaries upon written request to the Trustees. A copy of any Collective Bargaining Agreement which provides for contributions to the Trust Fund will also be available for inspection within ten (10) calendar days after written request at the Local Union office or at any office of any contributing employer to which at least 50 Plan participants report each day. The Trustees may impose a reasonable charge to cover the cost of furnishing the agreement. Participants and beneficiaries may wish to inquire as to the amount of the charges before requesting copies.

PARTICIPATION AND ELIGIBILITY

Assets of the Plan are held in trust, and benefits are funded through the Puget Sound Benefits Trust. Eligibility for benefits under the Plan (except in circumstances where you may be entitled to extended coverage) depends on continued receipt of employer contributions on your behalf. If your employer stops making contributions, you lose your eligibility for benefits. In addition, the Trust's obligation to provide benefits is limited to the extent the Collective Bargaining Agreements provide for funding of the Trust sufficient to provide benefits.

The Trustees retain the right and authority to determine eligibility under the plan and to interpret the terms of the benefit plan sponsored by the Trust.

TERMINATION OF ELIGIBILITY

Circumstances that may result in termination of eligibility are set forth beginning on page 10.

The Board of Trustees has the authority to terminate the Trust Fund and Plan. They will also terminate upon the expiration of all collective bargaining agreements requiring the payment of contributions to the Trust Fund.

In the event of termination of the Trust Fund any and all monies and assets remaining in the Trust Fund, after payment of expenses, shall be used for the continuance of the benefits provided by the then existing benefit plans until such monies and assets have been exhausted.

FUNDING MEDIUM

The Trust is funded through employer contributions, the amount of which is determined through the collective bargaining agreements. Self-payments are also permitted as outlined in this Summary Plan Description.

The Self-Funded Medical, Prescription and Vision benefits are funded directly by the Puget Sound Benefits Trust. These benefits are not insured by any contract of insurance and there is no liability on the Trustees or any other individual or entity to provide payment over and beyond the amounts in the Puget Sound Benefits Trust collected and available for such purpose.

HMO coverage, dental care benefits, short term and long term disability benefits and life insurance and AD&D benefits are funded through contracts between, respectively, Kaiser Permanente, Delta Dental Plan of Washington, and Hartford Life and Accident Insurance Company. Under these contracts, these providers assume the risk for payment of claims.

AVAILABILITY OF INFORMATION

Plan documents and all other pertinent documents required to be made available under ERISA are available for inspection at the Trust Administration Office during regular business hours. Upon written request, copies of these documents will be provided. However, the Trustees may make a reasonable charge for the copies; the Plan Administrator will state the charge for specific documents on request, so you can find out the cost before ordering.

TYPES OF BENEFITS

All of the types of benefits provided by insurance policies, service agreements or the Plan are summarized in this booklet and your benefit inserts. The complete terms of the benefits provided are set forth in the group insurance policies or service agreements with the following organizations:

Delta Dental of Washington
Customer Service Department
P.O. Box 75983
Seattle, WA 98175-0983
cservice@DeltaDentalWA.com

Life, Accidental Death & Dismemberment, STD and Long Term Disability
Hartford Life and Accident Insurance Company
One Hartford Plaza
Hartford, CT 06155

Medical HMO
Kaiser Permanente of WA
521 Wall Street
Seattle, WA 98121

Prescription Drugs
Express Scripts
PO Box 66583
St. Louis, MO 66583
www.express-scripts.com

PLAN SPONSOR AND ADMINISTRATOR

The Plan Sponsor is the Board of Trustees for the Puget Sound Benefits Trust.

CLAIMS ADMINISTRATOR

Welfare & Pension Administration Service, Inc.
7525 SE 24th St, Suite 200
Mercer Island, WA 98040-2341

Mailing Address:
P.O. Box 34711
Seattle, WA 98124-1711

AGENT FOR SERVICE OF LEGAL PROCESS

The person designated as Agent for Service of legal process is:

Puget Sound Benefits Trust
c/o Welfare & Pension Administration Service, Inc.
7525 SE 24th St, Suite 200
Mercer Island, WA 98040-2341

Mailing Address:
P.O. Box 34203
Seattle, WA 98124-1203

Legal process may also be served on any current member of the Board of Trustees.

PLAN TRUSTEES

The Trustees of the Plan are:

Labor	Management
Suzanne Mode, Chairperson Office Employees Local No. 8 2800 First Avenue, Room 304 Seattle, WA 98121	Richard B Kafer, Secretary WPAS, Inc. PO Box 34203 Seattle, WA 98124
Diane Arnold Office Employees Local No. 8 2800 1st Ave. Room 304 Seattle, WA 98121	Frank Benish PO Box 103 Nine Mile Falls, WA 99026

PLAN'S REQUIREMENTS FOR ELIGIBILITY AND BENEFITS

The Plan's requirements with respect to eligibility as well as circumstance that may result in disqualification, ineligibility or denial or loss of benefits are described in the Eligibility chapter in this document. The benefits provided by the Plan are described in the remaining chapters of this SPD/Plan Document (see the Table of Contents) such as in the Medical Expense Benefits, Covered Medical Benefits, Medical Exclusions and the Claim Filing and Appeals Information chapters.

CONTRIBUTION SOURCE

The contributions necessary to finance the Plan are made by the employers sponsoring the Plan pursuant to the terms of their Collective Bargaining Agreements with participating unions. A complete list of the employers and unions sponsoring the Plan may be obtained upon written request to the Trust Administration Office and is available for inspection at the Trust Administration Office. The benefits provided by this Plan, while intended to remain in effect indefinitely, can be guaranteed only so long as the parties to the Collective Bargaining Agreements continue to require contributions into the Trust Fund sufficient to underwrite the cost of the benefits. Should contributions cease and the reserves be expended, the Trustees would no longer be obligated to furnish coverage. These are not guaranteed lifetime benefits. Assets of the Welfare Trust Fund are held in Trust and benefits are funded through the Trust.

PLAN YEAR

The Plan's fiscal records are kept on a Calendar Year basis beginning on January 1 and ending on December 31.

STATEMENT OF ERISA RIGHTS

As a participant in the Puget Sound Benefits Trust, 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 Trust Administration Office 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 (formerly known as the Pension and Welfare Benefit Administration).

Obtain, upon written request to the Board of Trustees, 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 Board of Trustees may make a reasonable charge for the copies.

Receive a summary of the plan's annual financial report. The Board of Trustees 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, as described in the COBRA chapter. You and/or your dependents may have to pay for such coverage, if it is elected. 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 a welfare benefit 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, as discussed in the Claims Filing and Appeals Information chapter of this document.

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 Board of Trustees 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 have the right to a hearing before the Trustees at which you may present your position and any supporting evidence. You also have the right to be represented by an attorney or any other representative of your choosing. If you are dissatisfied with the Trustees' determination, you may also file suit in 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 (QMCSO), 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, contact the Department of Labor at one of the following addresses:

Employee Benefits Security Administration U.S. Department of Labor Seattle District Office 300 Fifth Avenue, Suite 1110 Seattle, WA 98104 Phone: 206-757-6781	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 at (866) 444-3272.

PLAN INTERPRETATION, AMENDMENTS AND TERMINATION OF PLAN

The Board of Trustees has the exclusive authority to interpret the provisions of the Plan, to determine eligibility for an entitlement to Plan benefits or to amend the Plan. Any interpretation or determination by the Trustees made in good faith which is not contrary to law is conclusive on all persons affected. The Board of Trustees has delegated to the Trust Administration Office the authority to administer the Plan and provide information relating to the amount of benefits, eligibility, and other Plan provisions. In administering the Plan, the Trust Administration Office and any medical review organization used by the Trust may utilize its internal guidelines and medical protocols in determining whether or not specific services or supplies are covered under the terms of the Plan. The Trust Administration Office does not have the authority to change the provisions of the Plan. An interpretation of the Plan by the Trust Administration Office is subject to review by the Board of Trustees. No individual trustee, Employer, Employer association, labor organization, or any individual employed by an Employer or labor organization, has any authority to interpret or change the Plan.

The Board expressly reserves the right, in its sole discretion at any time and from time to time:

- To terminate or amend either the amount or conditions with respect to any benefit even though such termination or amendment affects claims which have already accrued; and

- To alter or postpone the method or payment of any benefit; and
- To amend or rescind any other provisions of the Plan.

The benefits of this Plan are provided on a month-to-month basis to the extent that employer contributions and self-payments continue to be sufficient for such purpose. There is no long-range funding or reserve program. The Trustees reserve the right to change the eligibility rules, reduce the benefits, increase the required self-payments, amend or eliminate retiree coverages or eliminate the Plan entirely, as may be required by future circumstances.

Future of the Plan and Trust

The Board of Trustees is providing this program of benefits, including the retiree benefits, to the extent that monies are currently available to pay the cost of such programs. The Board of Trustees retains full and exclusive authority, at its discretion, to determine the extent to which monies are available for this program and to determine the expenditures of such monies for the program. The program is not guaranteed to continue indefinitely. The program may be terminated or modified at any time by the Board of Trustees.

The Trust Fund will terminate upon the expiration of all collective bargaining agreements requiring the payment of contribution to the Trust Fund. In the event of the termination of the Trust Fund, any and all monies and assets remaining in the Trust Fund, after payment of expenses, shall be used for the continuance of the benefits provided by the then existing benefit plans, until such monies and assets have been exhausted.

Protection of Trust Fund, Contributions, and Benefits.

No part of the Trust Fund (including the contributions) or the benefits payable under the Plan shall be subject in any manner by an employee, retiree or dependent or other beneficiary to anticipation, alienation, sale, transfer, assignment, encumbrance, or charge, and any such attempt shall be null and void, provided that the Trustees may recognize assignment of benefits from an employee, retiree or dependent or other beneficiary to a doctor, hospital, or other person or institution that has treated or cared for, or provided services or goods to the employee, dependent or other beneficiary, and provided further that the Trustees shall recognize the assignment of benefits under a State Medicaid Plan, or an alternate payee's right to receive benefits, under a Qualified Medical Child Support Order. No part of the Trust Fund (including contributions, or the benefits payable under the Plan) shall be liable for the debts of an employee, dependent or beneficiary, nor be subject in any manner to garnishment, attachment, lien, charge or any other legal process brought by any person against an employee, dependent or other beneficiary and any attempt shall be null and void.

In the event the Trust determines that an individual is incompetent or incapable of executing a valid receipt and no guardian has been appointed, or in the event an individual has not provided the Trust with an address at which he can be located for payment, the Trust may during the lifetime of the individual, pay any amount otherwise payable to the individual to the husband or wife or relative by blood or to any other person or institution determined by the Trust to be equitably entitled thereto; or in the case of the death of the individual before all amounts payable under the Plan have been paid, the Trust may pay any such amount to any person or institution determined by the Trust to be equitably entitled thereto. The remainder of such amount shall be paid to one or more of the following surviving relatives of the individual: lawful spouse, child or children, mother, father, brothers or sisters, or to the estate, as the Board in its sole discretion may designate. Any payment in accordance with this provision shall discharge the obligation of the Trust hereunder.

Availability of Fund Resources

Benefits provided by the Plan can be paid only to the extent that the Trust has available adequate resources for such payments. No contributing employer has any liability, directly or indirectly, to provide benefits beyond the obligation to make contributions as stipulated in the Collective Bargaining Agreement. In the event that at any time the Trust does not have sufficient assets to permit continued payments, nothing in the

Plan shall be construed as obligating any contributing employer to make payments in order to provide Plan benefits.

A portion of the benefits available to you are paid directly from the assets of the Trust. There is no liability on the Trustees, individually or collectively, or upon any employer, the Union, signatory association or other person or entity to provide benefits if the Trust does not have sufficient assets to pay premiums due or to make benefit payments.

ALLOCATION AND DISPOSITION OF ASSETS UPON TERMINATION

The Trust may be terminated by the Board of Trustees, provided that the termination is not effective until 60 days after the mailing of such notice. In the event the Plan terminates, the Trustees, by unanimous agreement and in their full discretion, will determine the disposition of any assets remaining after all expenses of the Trust have been paid; provided that any such distribution will be made only for the benefit of former participants and for the purposes set forth in the Plan. Upon termination of the Plan, the Trustees (with full power) will continue in such capacity for the purpose of dissolution of the Trust.

Right to Recover Excess Payments

In the event that through mistake or inadvertence or any other circumstance, an eligible individual or other individual has been paid or credited with more than he is entitled to under the Plan or under the law, the payment or credit will not constitute a waiver of applicable Plan provisions, including any limitation or exclusion. The Trust may set off, recoup or recover the amount of overpayment or excess credit accrued or thereafter accruing from the eligible individual or other individual, or from the service provider, or it may offset future benefit payments due to the eligible individual or the eligible individual's family members by the amount paid in error. The Trust may also take such further action as the Board shall determine.

Misrepresentation

An individual who knowingly presents a false or fraudulent claim for payment or knowingly misrepresents facts relating to eligibility for benefits will be subject to liability for reimbursement of the claim, for audit fees, attorney fees, and costs incurred by the plan on account of such misrepresentation, as well as potential criminal liability.

Administration and Operation of Plan

The Board of Trustees shall administer the Plan and serve as named fiduciaries pursuant to the Employee Retirement Income Security Act of 1974, as amended. The Trustees may establish rules for the transaction of their business and the administration of the Plan. The Trustees have the exclusive right to determine eligibility under the Plan, to construe the provisions of the Plan, and to determine any and all questions arising under the Plan or in connection with its administration, including the right to remedy possible ambiguities, inconsistencies, or omissions and any construction or determination by the Trustees made in good faith shall be binding upon the Union, employees, Retired employees, employers, and any association signatory to the Trust Agreement.

The Trust recognizes that new technologies may develop which are not specifically addressed in the Plan. The Trust reserves the right to determine whether or not a service or supply is covered, and if covered, to determine Covered Expense. If an employee, retiree, or dependent selects a more expensive service or supply than is customarily provided, or specialized techniques rather than standard procedures, the Trust reserves the right to consider alternate professionally acceptable services and supplies as the basis for benefit consideration under the Plan.

The Board of Trustees may engage employees, accountants, actuaries, consultants, investment managers, attorneys and other professionals or persons to render advice and/or perform services with regard to any of its responsibilities under the Plan, as determined to be necessary and appropriate.

HIPAA PRIVACY DISCLOSURES AND CERTIFICATION

Protected Health Information

For purposes of this Article, the term "Protected Health Information" ("PHI") shall have the same meaning as in 45 CFR § 164.501. This Article shall be administered by the Trustees in accordance with regulations adopted by the Department of Health and Human Services at 45 CFR Part 164.

Request, Use and Disclosure of PHI by Trustees

The Trustees are permitted to receive PHI from the Plan, and to use and/or disclose PHI only to the extent necessary to perform the following Administration functions:

- To make or obtain payment for care received by Eligible Individuals.
- To facilitate treatment which involves the provision, coordination or management of health care or related services.
- To conduct health care operations to facilitate the administration of the Plan and as necessary to provide coverage and services to Eligible Individuals.
- In connection with judicial or Administration proceedings in response to an order of a court or Administration tribunal as expressly authorized by such order or in response to a subpoena, discovery request or other lawful process.
- If legally required to do so by any federal, state or local law, or as permitted or required by law for law enforcement purposes.
- To review enrollment and eligibility information or claim appeals, solicit bids for services, modify, amend or terminate the Plan, or perform other plan Administration functions. The Board of Trustees may also receive summary health information for purposes of obtaining premium bids or setting or evaluating rates, or for evaluating, modifying or terminating benefits.
- For authorized activities by health oversight agencies, including audits, civil, Administration or criminal investigations, licensure or disciplinary action.
- To prevent or lessen a serious and imminent threat to an Eligible Individual's health or safety, or the health and safety of the public, provided such disclosure is consistent with applicable law and ethical standards of conduct.
- For specified government functions under 45 CFR Part 164.
- To the extent necessary to comply with laws related to workers' compensation or similar programs.

Trustee Certification

The Plan will only disclose PHI to a Trustee upon receipt of a certification that these procedures have been adopted and the Trustees, as Plan sponsor, agree to the following:

- The Trustees will not use or disclose any PHI received from the Plan, except as permitted in these procedures or as required by law.
- The Trustees will ensure that any of their subcontractors or agents to whom they may provide PHI that was received from the Plan, agree to written contractual provisions that impose at least the same obligations to protect PHI as are imposed on the Trustees.
- The Trustees will not use or disclose PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Trustees.
- The Trustees will report to the Plan any known impermissible or improper use or disclosure of PHI not authorized by these procedures of which they become aware.
- The Trustees will make their internal practices, books, and records relating to the use and disclosure of PHI received from the Plan available to the Department of Health and Human Services ("DHHS") or its designee for the purpose of determining the Plan's compliance with HIPAA.

- When the PHI is no longer needed for the purpose for which disclosure was made, the Trustees must, if feasible, return to the Plan or destroy all PHI that the Trustees received from or on behalf of the Plan. This includes all copies in any form, including any compilations derived from the PHI. If return or destruction is not feasible, the Trustees agree to restrict and limit further uses and disclosures to the purposes that make the return or destruction infeasible.

Minimum Necessary Requests

The Trustees will use best efforts to request only the minimum necessary type and amount of PHI to carry out the functions for which the information is requested.

Adequate Separation

The Trustees represent that adequate separation exists between the Plan and the Trustees so that PHI will be used only for Plan administration. Each Trustee will certify that he has no employees, or other persons under his control that will have access to PHI.

Effective Mechanism for Resolving Issues of Noncompliance

Anyone who suspects an improper use or disclosure of PHI may report that occurrence to the Plan Privacy Official.

HIPAA Security

In compliance with HIPAA Security regulations, the Plan Sponsor will:

- Implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of electronic PHI that it creates, receives, maintains or transmits on behalf of the group health plan,
- Ensure that the adequate separation discussed above, specific to electronic PHI, is supported by reasonable and appropriate security measures,
- Ensure that any agent, including a subcontractor, to whom it provides electronic PHI agrees to implement reasonable and appropriate security measures to protect the electronic PHI, and
- Report to the Plan any security incident of which it becomes aware concerning electronic PHI.

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

Pursuant to regulations issued by the federal government, the Puget Sound Benefits Trust is providing you this Notice about the possible uses and disclosures of your health information. Your health information is information that constitutes protected health information as defined in the Privacy Rules issued by the Department of Health and Human Services pursuant to the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). As required by law, the Trust has established a policy to guard against unnecessary disclosure of your health information. This Notice describes the circumstances under which and the purposes for which your health information may be used and disclosed and your rights in regard to such information.

This notice is also available at the Trust's website www.psbenefitstrust.com.

USE AND DISCLOSURE OF HEALTH INFORMATION

Your health information may be used and disclosed without an authorization in the following situations:

To Make or Obtain Payment. The Trust may use or disclose your health information to make payment to or collect payment from third parties, such as other health plans or providers, for the care you receive, to determine benefit responsibility under the Trust's Plan or to coordinate Plan coverage. For example, the Trust may use health information to pay your claims or share information regarding your coverage or health care treatment with other health plans to coordinate payment of benefits. The Trust may also share your protected health information with another entity to assist in the adjudication or reimbursement of your health claims.

To Facilitate Treatment. The Trust may disclose information to facilitate treatment which involves providing, coordinating or managing health care or related services. For example, the Trust may disclose the name of your treating physician to another physician so that the physician may ask for your x-rays.

To Conduct Health Care Operations. The Trust may use or disclose health information for its own operations, to facilitate the administration of the Trust and as necessary to provide coverage and services to all of the Trust's participants. Health care operations includes: making eligibility determinations; contacting health care providers; providing participants with information about health-related issues or treatment alternatives; developing clinical guidelines and protocols; conducting case management; medical review and care coordination; handling claim appeals; reviewing health information to improve health or reduce health care costs; participating in drug or disease management activities; conducting underwriting; premium rating or related functions to create, renew or replace health insurance or health benefits; and performing the general administrative activities of the Trust (such as providing customer service, conducting compliance reviews and auditing, responding to legal matters and compliance inquiries, handling quality assessment and improvement activities, business planning and development including cost management and planning related analyses and formulary development, and accreditation, certification, licensing or credentialing activities). For example, the Trust may use your health information to conduct case management of ongoing care or to resolve a claim appeal you file.

If the Trust discloses protected health information for underwriting purposes, the Trust is prohibited from using or disclosing protected health information that is genetic information of an individual for such purposes.

For Disclosure to the Plan Trustees. The Trust may disclose your health information to the Board of Trustees (which is the plan sponsor), or any insurer or HMO with which the Trust contracts, and to necessary advisors which assist the Board of Trustees in performing plan administration functions, such as handling claim appeals. The Trust also may provide summary health information to the Board of Trustees so that it may solicit bids for services or evaluate its benefit plans. Summary health information is

information that summarizes participants' claims information but from which names and other identifying information have been removed. The Trust may also disclose information about whether you are participating in the Trust or one of its available options.

For Disclosure to You or Your Personal Representative. When you request, the Trust is required to disclose to you or your personal representative your protected health information that contains medical records, billing records, and any other records used to make decisions regarding your health care benefits. Your personal representative is an individual designated by you in writing as your personal representative, attorney-in-fact. The Trust may request proof of this designation prior to the disclosure. Also, absent special circumstances, the Trust will send all mail from the Trust to the individual's address on file with the Trust Administration Office. You are responsible for ensuring that your address with the Trust Administration Office is current. Although mail is normally addressed to the individual to whom the mail pertains, the Trust cannot guarantee that other individuals with the same address will not intercept the mail. You have the right to request restrictions on where your mail is sent as set forth in the request restrictions section below.

Disclosure Where Required By Law. In addition, the Trust will disclose your health information where applicable law requires. This includes:

a. In Connection With Judicial and Administrative Proceedings

The Trust will in response to an order from a court or administrative tribunal disclose protected health information in accordance with the express terms of such an order. The Trust may also disclose protected health information in response to a subpoena or other lawful process if the Trust receives satisfactory documentation that you have received notice of the subpoena or legal process, the notice provided sufficient information to allow you to raise an objection and the time for raising an objection has passed and either no objections were filed or were resolved by the court or administrative tribunal. Alternatively, the party requesting disclosure may provide satisfactory documentation you have agreed to the disclosure or that it has obtained a qualified protective order which meets the requirements of the Privacy Rules and which allows for disclosure. For example, if the Trust receives a court order requiring it to disclose certain information, it will respond to the court order.

b. When Legally Required and For Law Enforcement Purposes

The Trust will disclose your protected health information when it is required to do so for law enforcement purposes. This may include compliance with laws which require reporting certain types of injuries, pursuant to court issued legal process; or a grand jury subpoena or other administrative requests if satisfactory documentation is provided that the request is relevant to a legitimate law enforcement purpose, the request is reasonably tailored to meet this legitimate law enforcement purpose and de-identified individual cannot be reasonably provided as an alternative. Additionally, limited disclosure may be made for purposes of identifying or locating a suspect, fugitive, material witness or missing person, identifying a victim of a crime or in connection with a criminal investigation that occurred on Trust premises. For example, the Trust could upon request of a law enforcement agency provide information concerning the address of a fugitive.

c. To Conduct Public Health and Health Oversight Activities

The Trust may disclose your health information to a health oversight agency for authorized activities (including audits, civil administrative or criminal investigations, inspections, licensure or disciplinary action), government benefit programs for which health information is relevant, or to government agencies authorized by law to receive reports of abuse, neglect or domestic violence as required by law. The Trust, however, may not disclose your health information if you are the subject of an investigation and the investigation does not arise out of or is not directly related to your receipt of health care or public benefits.

d. In the Event of a Serious Threat to Health or Safety

The Trust may, consistent with applicable law and ethical standards of conduct, disclose your health information if the Trust, in good faith, believes that such disclosure is necessary to prevent or lessen a serious and imminent threat to your health or safety or to the health and safety of the public. For example, the Trust may disclose evidence of a threat to harm another person to the appropriate authority.

e. For Specified Government Functions

In certain circumstances, federal regulations require the Trust to use or disclose your health information to facilitate specified government functions related to the military and veterans, national security and intelligence activities, protective services for the president and others, and correctional institutions and inmates.

f. For Workers Compensation

The Trust may release your health information to the extent necessary to comply with laws related to workers compensation or similar programs.

AUTHORIZATION TO USE OR DISCLOSE HEALTH INFORMATION

Other than as stated above, the Trust will not disclose your health information without your written authorization. Generally**,** you will need to submit an Authorization if you wish the Trust to disclose your health information to someone other than yourself. Authorization forms are available from the Privacy Contact Person listed below. If you have authorized the Trust to use or disclose your health information, you may revoke that Authorization in writing at any time. The revocation should be in writing, include a copy of or reference to your Authorization and be sent to the Privacy Contact Person listed below.

Special rules apply about disclosure of psychotherapy notes. Your written Authorization generally will be required before the Trust will use or disclose psychotherapy notes. Psychotherapy notes are a mental health professional's separately filed notes which document or analyze the contents of a counseling session. They do not include summary information about your mental health treatment or information about medications, session stop and start times, the diagnosis and other basic information. The Trust may use and disclose psychotherapy notes when needed to defend against litigation filed by you or in other limited situations.

Your written authorization will be required for any disclosure of your health information that involves marketing, the sale of your health information, or any disclosure involving direct or indirect remuneration to the Trust.

YOUR RIGHTS WITH RESPECT TO YOUR HEALTH INFORMATION

You have the following rights regarding your health information that the Trust maintains:

Right to Request Restrictions. You may request restrictions on certain uses and disclosures of your health information. You have the right to request a limit on the Trust's disclosure of your health information to someone involved in payment for your care. The Trust is not required to agree to your request unless the protected health information pertains solely to a health care item or service for which you, or a person on your behalf, has paid the provider or Plan in full, and the disclosure at issue is for the purpose of carrying out payment or health care operations.

Right to Inspect and Copy Your Health Information. You have the right to inspect and copy your health information. This right, however, does not extend to psychotherapy notes or information compiled for civil, criminal or administrative proceeding. The Trust may deny your request in certain situations subject to your right to request review of the denial. A request to inspect and copy records containing your health information must be made in writing to the Privacy Contact Person listed below. If you request a copy of your health information, the Trust may charge a reasonable fee for copying, assembling costs and postage, if applicable, associated with your request. Notwithstanding the foregoing, the fee for a copy of your health information in electronic form shall not be greater than the labor costs in responding to the request.

Right to Receive Confidential Communications. You have the right to request that the Trust communicate with you in a certain way if you feel the disclosure of your health information through regular procedures could endanger you. For example, you may ask that the Trust only communicate with you at a certain telephone number or by e-mail. If you wish to receive confidential communications, please make your request in writing to the Privacy Contact Person listed below. The Trust will attempt to honor reasonable requests for confidential communications.

Right to Amend Your Health Information. If you believe that your health information records are inaccurate or incomplete, you may request that the Trust amend the records. That request may be made as long as the information is maintained by the Trust. A request for an amendment of records must be made in writing to the Trust's Privacy Contact Person listed above. The Trust may deny the request if it does not include a reasonable reason to support the amendment. The request also may be denied if your health information records were not created by the Trust, if the health information you are requesting to amend is not part of the Trust's records, if the health information you wish to amend falls within an exception to the health information you are permitted to inspect and copy, or if the Trust determines the records containing your health information are accurate and complete.

Right to an Accounting. You have the right to request a list of disclosures of your health information made by the Trust. The request must be made in writing to the Privacy Contact Person. The request should specify the time period for which you are requesting the information. No accounting will be given of disclosures made: to you; for Treatment, Payment or Health Care Operations; disclosures made before April 14, 2003; disclosures for periods of time going back more than six years; pursuant to an authorization; or in other limited situations. The Trust will provide the first accounting you request during any 12-month period without charge. Subsequent accounting requests may be subject to a reasonable cost-based fee. The Trust will inform you in advance of the fee, if applicable.

Right to Opt Out of Fundraising Communications. In the event that the Trust engages in a fundraising activity, you have the right to opt out of any fundraising communications.

Right to a Paper Copy of this Notice. You have a right to request and receive a paper copy of this Notice at any time, even if you have received this Notice previously or agreed to receive the Notice electronically. To obtain a paper copy, please contact the individual listed below. If this Notice is modified, you will be mailed a new copy.

Privacy Contact Person/Privacy Official: To exercise any of these rights related to your health information you should contact the Privacy Contact Person listed below. The Trust has also designated a Privacy Official to oversee its compliance with the Privacy Rules who is also listed below.

Privacy Official:

Claims Manager
Welfare & Pension Administration Service, Inc.
7525 SE 24th St, Suite 200
Mercer Island, WA 98040 – 2341

Mailing Address:
P.O. Box 34203
Seattle, WA 98124-1203
(800) 331-6158

Privacy Contact Person:

Assistant Claims Manager
Welfare & Pension Administration Service, Inc.
7525 SE 24th St, Suite 200
Mercer Island, WA 98040 – 2341

Mailing Address:
P.O. Box 34203
Seattle, WA 98124-1203
(800) 331-6158

DUTIES OF THE TRUST

The Trust is required by law to maintain the privacy of your health information as set forth in this Notice, to provide to you this Notice summarizing its privacy practices and duties, and to notify you following a breach of unsecured protected health information. The Trust is required to abide by the terms of this Notice, which may be amended from time to time. The Trust reserves the right to change the terms of this Notice and to make the new Notice provisions effective for all health information that it maintains. If the Trust changes its policies and procedures, the Trust will revise the Notice and will provide you a copy of the revised Notice within 60 days of the change. You have the right to request a written copy of the Notice at any time.

You have the right to express complaints to the Trust and to the Secretary of the Department of Health and Human Services if you believe that your privacy rights have been violated. Any complaints to the Trust should be made in writing to the Privacy Official identified above. The Trust encourages you to express any concerns you may have regarding the privacy of your health information. You will not be retaliated against in any way for inquiring about or filing a complaint about privacy matters.

DEFINITIONS

The following are definitions of specific terms and words used in this document or that would be helpful in understanding covered or excluded health care services. These definitions do not, and should not be interpreted to, extend coverage under the Plan.

Allowed Amount/Allowed Charge/ Allowable Expense: means the amount this Plan allows as payment for eligible Medically Necessary services or supplies. The Allowed Amount is determined by the Plan Administrator or its designee to be the lowest of:

1. **With respect to an In-Network provider** (PPO network Health Care or Dental Care provider/facility), provider's discounted charge which it has contractually agreed to in its contract with the Plan's PPO network: If there is no direct contract, the Allowed Amount is the provider's discounted charge agreed to in a contract with any third party network provider. For these providers, the Allowed Amount is the amount the preferred provider has agreed to accept as full payment for covered health care services or supplies; **or**
2. **With respect to an Out-of-Network provider**, the Allowed Amount is the Usual, Customary and Reasonable (UCR) charge determined by the Plan.

   You may be responsible for all amounts above the Allowed Amount. The Allowable Amount may be less than the provider's full charge. In all cases, the Allowed Amount is determined based on the Geographic Area where you receive the service or supply.

   Except as otherwise specified below, the Allowed Amount for each service or supply is the lesser of what the provider bills and:

   - For professional services and for other services or supplies not mentioned below - the UCR rate;
   - For services of hospitals and other facilities - the UCR rate for prescription drugs - 110% of the Average wholesale price (AWP).
3. For an In-Network Health Care Provider/facility whose network contract stipulates that they do not have to accept the network negotiated fee/rate for claims involving a third party payer, including but not limited to auto insurance, workers' compensation or other individual insurance, or where this Plan may be a secondary payer, the Allowed Amount under this Plan is the negotiated fee/rate that would have been payable by the Plan had the claim been processed as an In-Network claim; **or**
4. The Health Care or Dental Care Provider's/facility's actual billed charge when less than or equal to the PPO scheduled allowance or out-of-network allowance.

The Plan will not always pay benefits equal to or based on the Health Care or Dental Care Provider's actual charge for health care services or supplies, even after you have paid the applicable Deductible, Copay and/or Coinsurance. This is because the Plan covers only the "Allowed Amount" amount for health care services or supplies.

Any amount in excess of the Allowed Amount does not count toward the Plan's annual Coinsurance Maximums. Participants are responsible for amounts that exceed the Allowed Amounts by this Plan.

Ambulance, Professional Ambulance Service: means a ground motor vehicle, helicopter (rotorcraft), airplane (fixed wing) or boat that is: licensed or certified for emergency patient transportation by the jurisdiction in which it operates; and is specifically designed, constructed, modified and equipped with the intention to provide basic life support, intermediate life support, advanced life support, or mobile intensive care unit services by appropriately licensed and certified medical professionals.

Balance Billing: A bill from a Health Care Provider to a patient for the difference (or balance) between this Plan's Allowed Amount and what the provider actually charged (the billed charges). Amounts associated with balance billing **are not covered** by this Plan, even if the Plan's Out-of-Pocket Maximum limits are reached. Amounts exceeding the Allowed Amount do not count toward your Out-of-Pocket Maximum and may result in balance billing to you. **Out-of-Network Health Care Providers commonly**

engage in balance billing. This means a plan participant may be billed for any balance that may be due in addition to the amount payable by the Plan. Generally, you can avoid balance billing by using In-Network providers. Typically, In-Network providers do not balance bill except in situations of third-party liability claims. **Generally, you can avoid balance billing by using In-Network providers.**

Birthing Center. A freestanding facility that meets all of the following requirements:

- Meets licensing standards.
- Is set up, equipped and run to provide prenatal care, delivery and immediate postpartum care.
- Is equipped and has trained staff to handle emergency medical conditions and provide immediate support measures to sustain life if:
- Complications arise during labor; or
- A child is born with an abnormality which impairs function or threatens life.
- Provides an ongoing quality assurance program. This includes reviews by physicians who do not own or direct the facility.
- Keeps a medical record on each patient and child.

Cosmetic Surgery or Treatment: Services to improve change or restore physical appearance and/or self-esteem due to deformity or abnormality without materially correcting a functional disorder, or to prevent or treat a psychological disorder through a change in bodily appearance.

Custodial Care: Treatment, services or confinement, intended primarily to help a person with daily living activities and that are not rendered mainly for their therapeutic value in the treatment of an injury or disease. Custodial care includes personal care such as help in walking, getting in and out of bed, bathing, eating (including by tube or gastrostomy), exercising, dressing, using the toilet or administration of an enema, homemaking, such as preparing meals or special diets, moving the patient, acting as a companion or sitter, and supervising medication which can usually be self-administered.

Durable Medical Equipment. Equipment, and the accessories needed to operate it, that is:

- Made to withstand prolonged use;
- Made for and mainly used in the treatment of an illness or injury;
- Suited for use in the home;
- Not normally of use to people who do not have an illness or injury;
- Not for use in altering air quality or temperature; and
- Not for exercise or training.

Durable medical and surgical equipment does not include equipment such as whirlpools, portable whirlpool pumps, sauna baths, massage devices, over bed tables, elevators, communication aids, ramps, rails, vision aids, telephone alert systems or other home improvements.

Elective Hospital Admission, Service or Procedure: Any non-emergency Hospital admission, service or procedure that can be scheduled or performed at the patient's or Physician's convenience without jeopardizing the patient's life or causing serious impairment of body function.

Eligible Medical Expenses/Eligible Charges: Expenses for medical services or supplies, but only to the extent that the expenses meet all of the following qualification as determined by the Board of Trustees or its designee: are Medically Necessary, as defined in this Definitions chapter; and the charges for them are an Allowed Amount, as defined above; and coverage for the services or supplies is not excluded; and the Limited Overall, and/or Annual Maximum Plan benefits for those services or supplies has not been reached; and are for the diagnosis or treatment of an injury or illness (except where wellness/preventive services are payable by the Plan as noted in the Covered Medical Benefits in this document).

Emergency Medical Condition means a medical condition or injury with acute symptoms of sufficient severity (including severe pain) that, lacking immediate medical attention, could reasonably be expected to result in the health of the person (including an unborn child) being placed in serious jeopardy or result in serious impairment or dysfunction of any bodily organ or part.

Experimental or Investigational Medical Care. Is a service or supply if any of the following apply:

- The drug or device cannot be lawfully marketed without approval of the FDA and approval for marketing has not been given for regular non-experimental or non-investigational purposes at the time the drug or device is furnished;
- The drug, device, medical treatment, or procedure has been determined experimental or investigational by the treating facility's institutional review board or other body serving a similar function, and the patient has signed an informed consent document acknowledging such experimental status;
- Federal law classifies the drug, device or medical treatment under an investigational program;
- Reliable evidence shows the drug, device, medical treatment or procedure is the subject of ongoing Phase I or Phase II clinical trials or is otherwise under study to determine its maximum tolerated dose, toxicity, safety, efficacy, or efficacy compared with standard means of treatment or diagnosis;
- Reliable evidence shows the prevailing opinion among experts regarding the drug, device, medical treatment or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, toxicity, safety, efficacy, or efficacy compared with standard means of treatment or diagnosis (except as provided below); or
- For this section, "reliable evidence" means only published reports and articles in peer reviewed authoritative medical and scientific literature; the written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same drug, device, medical treatment or procedure; or the written informed consent used by the treating facility or by another facility studying substantially the same drug, device, medical treatment or procedure (except as provided below).

Exceptions: A service or supply will not be considered experimental or investigational if it is part of an approved clinical trial. An approved clinical trial is one that meets the criteria in either Category 1 or 2 below:

Category 1

- The trial is a Phase III or Phase IV trial approved by the National Institutes of Health, the FDA, the Department of Veteran Affairs or an approved research center;
- The trial has been reviewed and approved by a qualified institutional review board; and
- The facility and personnel have sufficient experience or training to provide the treatment or use the supplies.

Category 2

- The trial is to treat a condition too rare to qualify for approval under Category 1;
- The trial has been reviewed and approved by a qualified institutional review board;
- The facility and personnel have sufficient experience or training to provide the treatment or use the supplies;
- The available clinical or preclinical data provide a reasonable expectation that the trial treatment will be at least as effective as non-investigational therapy; and
- There is no therapy that is clearly superior to the trial treatment.

The plan's administrator shall investigate each claim for benefits that might include experimental or investigational treatment. The administrator may consult with medical professionals, including its own staff, to determine whether the treatment is excluded as experimental or investigational, or whether it is covered as one of the exceptions stated above.

Health Care Practitioner: Includes the following licensed professionals acting within the scope of their license: Physician (M.D. or D.O.), Behavioral Health Practitioner, Chiropractor, Nurse (RN or ARNP), Physician's Assistant, CRNA, Podiatrist (DPM), Licensed Midwife, dentist, psychologist, clinical social worker who has a master's degree from an accredited institution of higher learning, marriage, family and child counselor, an alcoholism or chemical dependency counselor, physical therapist (only if patient is referred by a physician), speech therapist (only if patient is referred by a physician), chiropractor, podiatrist, optometrist, optician, massage therapist and a certified acupuncturist

Home Health Agency means a public or private agency or organization, certified to participate in the federal Medicare program that specializes in providing skilled nursing services and other therapeutic services, such as physical therapy, in a home type environment. An agency must:

- be licensed or certified by the appropriate regulatory authority, if such licensing or certification is required;
- have policies established by a professional group associated with the agency or organization, which includes at least one registered nurse (R.N.) to govern the services provided;
- provide for full-time supervision of such services by a physician or registered nurse (R.N.);
- maintain a complete medical record on each patient; and
- have a full-time administrator**.**

Hospice Care Agency. Is a public or private agency or organization that administers and provides hospice care and is either a Medicare certified hospice agency or certified as a hospice care agency by the Washington State Department of Social and Health Services or the equivalent department of another state.

Hospice Care Program. This is a written plan of hospice care, which:

- Is designed to provide palliative and supportive care to terminally ill persons, and supportive care to their families; and
- Includes an assessment of the person's medical and social needs; and a description of the care to be given to meet those needs.

Hospital. An institution that:

- Meets any licensing or certification standards established by the jurisdiction where it is located; or,
- Meet the requirements of the jurisdiction in which it operates for licensing as a hospital and is accredited as a hospital by the Joint Commission on the Accreditation of Healthcare Organizations.

Any portion of a Hospital used as an Ambulatory Surgical/Outpatient Surgery Facility, Birth (or Birthing) Center, Hospice, Skilled Nursing Facility, Inpatient Rehabilitation facility, or other residential treatment facility or place for rest, Custodial Care, or facility for the aged will **not** be regarded as a Hospital for any purpose related to this Plan.

Illness: Any bodily sickness or disease, including pregnancy and any congenital abnormality of a newborn child, as diagnosed by a Physician and as compared to the person's previous condition.

Injury: Any damage to a body part resulting from trauma.

Maintenance Care: Services and supplies provided primarily to maintain, support and/or preserve a level of physical or mental function rather than to improve such function.

Medically Necessary/Medical Necessity: "Medically Necessary" means (as determined by the Board of Trustees or its designee) the service or supply meets all of the following criteria and limitations:

- It is appropriate to the diagnosis and/or treatment of the patient's illness or injury and meets the generally accepted standards of medical practice.
- It is known to be effective in improving health outcomes for the patient's medical condition in accordance with generally accepted standards of medical practice.

- It represents the most economically efficient use of medical services and supplies that may be provided safely and effectively to the patient, as determined by the Plan.
- It is not primarily for the convenience of the patient or provider.
- When applied to an inpatient, it cannot safely be provided to the patient as an outpatient.

A service or supply may be medically necessary in part only. The fact a procedure, service, or supply may be furnished, prescribed, recommended or approved by a physician or other covered provider does not, of itself, make it medically necessary under the terms of the plan.

The "generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer-reviewed literature, the clinical policies adopted by the Trust's network providers or similar entities.

With regard to a provider and facility billing the term "generally accepted professional standards and/or medical practice" shall mean profession standards and practice set forth in published guidance publish by nationally recognized peer-reviewed organizations, such as the American Medical Association, American Board of Medical Specialties, American Board of Internal Medicine, American Academy of Professional Coders, as well as federal institutions, such as the Centers for Medicare & Medicare Services and the U.S. Department of Health and Human Services. Examples of published guidance include, but are not limited, to the most current versions of the Current Procedural Terminology (CPT), Healthcare Common Procedural Coding System (HCPCS), International Classification of Diseases, National Drug Codes (NDC), Code on Dental Procedures and Nomenclature, Diagnostic and Statistical Manual of Mental Disorders (DSM) and Medicare Provider Reimbursement Manual, and related interpretive materials published by the same or similar organizations.

Physician. A duly licensed member of a medical profession who:

- Has an M.D. or D.O. degree;
- Is properly licensed or certified to provide medical care under the laws of the jurisdiction where the individual practices.

Physical Therapy: Rehabilitation directed at restoring function following disease, injury, surgery or loss of body part using therapeutic properties such as active and passive exercise, cold, heat, electricity, traction, diathermy, and/or ultrasound to improve circulation, strengthen muscles, return motion, and/or train/retrain an individual to perform certain activities of daily living such as walking and getting in and out of bed.

Preferred Provider Organization (PPO): An independent group or network of Health Care Providers (*e.g.* hospitals, Physicians, laboratories) under contract with the Plan to provide health care services and supplies at agreed-upon discounted/reduced rates.

Pre-service Claim: See the Claim Filing and Appeal Information chapter for the definition.

Residential Treatment Facility. An institution that meets all of the following requirements:

- Provides a comprehensive patient assessment (preferably before admission, but at least upon admission).
- Admissions are approved by a Physician.
- Has access to necessary medical services 24 hours per day/7 days a week and 24-hours per day/7 days a week supervision by a physician with evidence of close and frequent observation.
- Provides access to at least weekly sessions with a Psychiatrist or psychologist for individual psychotherapy.
- Services are managed by a licensed Behavioral Health Provider who, while not needing to be individually contracted, needs to (1) meet the UM provider's credentialing criteria as an individual practitioner, and (2) function under the direction/supervision of a licensed psychiatrist (Medical Director).

- Has individualized active treatment plan directed toward the alleviation of the impairment that caused the admission.
- Meets any and all applicable licensing standards established by the jurisdiction in which it is located.

Semi-Private Room Rate. The room and board charge that an institution applies to the most beds in its semi-private rooms with 2 or more beds. If there are no such rooms, the Plan will figure the rate based on the rate most commonly charged by similar institutions in the same geographic area.

Skilled Nursing Facility. An institution that meets all of the following requirements:

- It is licensed to provide, and does provide, the following on an inpatient basis for persons convalescing from illness or injury:
- Professional nursing care by an R.N., or by a L.P.N. directed by a full-time R.N.; and
- Provides 24 hour a day nursing care by licensed nurses directed by a full-time R.N.
- Is supervised full-time by a physician or an R.N.
- Keeps a complete medical record on each patient.
- Is not mainly a place for rest, for the aged, for drug addicts, for alcoholics, for intellectually disabled, for custodial or educational care, or for care of psychiatric disorders.

Skilled nursing facilities also include rehabilitation hospitals (all levels of care, e.g. acute) and portions of a hospital designated for skilled or rehabilitation services.

Spinal Manipulation: The detection and correction, by manual or mechanical means, of the interference with nerve transmissions and expressions resulting from distortion, misalignment or dislocation of the spinal (vertebrae) column. Spinal Manipulation is commonly performed by Chiropractors, but it can be performed by Physicians.

Substance Abuse. This is a physical or psychological dependency, or both, on a controlled substance or alcohol agent (as defined on Axis I in the Diagnostic and Statistical Manual of Mental Disorders (DSM) published by the American Psychiatric Association which is current as of the date services are rendered to you or your covered dependents.) This term does not include conditions not attributable to a mental disorder that are a focus of attention or treatment (the V codes on Axis I of DSM); an addiction to nicotine products, food or caffeine intoxication.

Surgery Center. A freestanding ambulatory surgical facility that meets all of the following requirements:

- Meets licensing standards.
- Is set up, equipped and run to provide general surgery.
- Is directed by a staff of physicians. At least one of them must be on the premises when surgery is performed and during the recovery period.
- Has at least one certified anesthesiologist at the site when surgery requiring general or spinal anesthesia is performed and during the recovery period.

Surgery: Any operative or diagnostic procedure performed in the treatment of an injury or illness by instrument or cutting procedure through an incision or any natural body opening. When more than one surgical procedure is performed through the same incision or operative field or at the same operative session, the Plan Administrator or its designee will determine which surgical procedures will be considered to be separate procedures and which will be considered to be included as a single procedure for the purpose of determining Plan benefits. Surgery guidelines are as follows:

- If two or more surgical procedures are performed at the same time, the covered medical charges will be limited to those incurred for the major procedure plus no more than 50% of those incurred for each lesser procedure that adds significant time or complexity. No benefits are paid for incidental surgery done at the same time and under the same anesthetic as another surgery.

- The benefit for performing surgery includes the administration of any local, digital block, or topical anesthesia along with normal follow-up care.
- Reduced benefits may be paid for the administration of other anesthetics if done by the operating or assisting surgeon rather than an anesthesiologist.
- If you have a surgical procedure performed at a PPO facility with a PPO surgeon, anesthesiology charges will be paid at the PPO percentage of the Allowed Charge.

Totally Disabled: a state of incapacity due to an Injury or Illness, and:

- You are unable to work at your normal job.
- Your dependent's is unable, due solely to Illness or Injury, to engage in all of the normal activities of an individual of like age and sex who is in good health.

Transplant, Transplantation: The transfer of whole or partial organs (such as the heart, kidney, liver) or living tissue/cells (such as bone marrow, peripheral stem cells, cornea, skin, tendon or bone) from a donor to a recipient with the intent to maintain the functional integrity of the transplanted organ or tissue in the recipient.

Usual and Customary Charges (U&C). Usual, Customary and Reasonable (UCR) charge means the amount payable to a non-PPO provider as determined by the Board of Trustees or its designee for a particular service, and subject to the following:

1. Charges for services or supplies which are not provided or billed in accordance with generally accepted professional standards and/or medical practice are not considered UCR regardless of the amount billed;
2. In no event will the UCR charge exceed the amount billed or the amount for which the covered person is financially responsible;
3. UCR may not reflect the actual billed charges and does not take into account the professional service provider's training, experience or category of licensure;
4. The Trust's UCR methodology may vary between claims based on the facts and circumstance of the claim, the services provided and the expected savings;
5. The Trust may hire a third-party reviewer to determine the UCR amount consistent with this provision; and
6. Irrespective of the Trust's methodology or UCR determination, the Trustees reserve the right to negotiate an acceptable UCR amount directly with a provider.

For properly billed non-PPO professional service provider charges, the UCR amount shall be no higher than the 80th percentile identified by a commercially available database selected by the Trust. When there is, in the Trust's determination, minimal data available from the database for a covered service, the Trust will determine the UCR amount by calculating the unit cost for the applicable service category using the database, and multiplying that by the relative value of the covered service assigned by the Medicare resource based relative value scale (supplemented with a commercially available relative value scale selected by the Trust where one is not available from Medicare). In the event of an unusually complex procedure, a new procedure, or a procedure that otherwise does not have a relative value that is in the Trust's determination applicable, the Trust will assign one.

For non-PPO professional services in excess of $5,000, the Trust may attempt to establish a negotiated rate that if accepted will result in no balance billing for the Trust participant as beneficiary beyond deductible and co-insurance.

For facility charges, this means the Facility Charge Review (FCR) Rate. The FCR rate is an amount that the Trust determines is enough to cover the provider's estimated costs for the service and leave the provider with a reasonable profit. For hospitals and other facilities which report costs (or cost-to-charge ratios) to CMS, the FCR Rate is based on what the facilities report to CMS, the FCR Rate is based on statewide averages of the facilities that do report to CMS. The Trust may adjust the formulas as needed to maintain

the reasonableness of the recognized charge. For example, an adjustment may be made if it is determined that in a particular state the charges of ambulatory surgery centers (or another class of facility) are much higher than charges of facilities that report costs (or cost-to -charge ratios) to CMS.

For properly billed non-PPO facility charges, UCR may mean 200% of the Medicare reimbursements amount. For non-PPO facility services in excess of $10,000, the Trust reserves the right to attempt to establish a negotiated rate that if accepted will result in no balance billing for the Trust participant or beneficiary beyond deductible and co-insurance.

Non-PPO providers (including both professionals and facilities) seeking claim payment under the Plan shall be obligated to submit to a prompt audit of their claims by the Trust, notwithstanding any internal rules they may have to the contrary. In the event a non-PPO provider refuses or delays a reasonable audit request by the Trust, the Trust shall have the right to withhold payment to the said non-PPO provider on the claim in question and on other pending or future claims by said non-PPO provider.

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