RESOLUTION NO. 729-20

A Resolution of the Commission of the Port of Port Townsend

ADOPTING THE PORT OF PORT TOWNSEND CAFETERIA PLAN

WHEREAS, Section 125 of the Internal Revenue Code of the 1986 authorizes employer-sponsored benefits plans whereby employees pay for certain qualified medical expenses (e.g., health insurance premiums) on a pre-tax basis; and

WHEREAS, such plans are commonly referred to as "cafeteria plans" because employees are permitted to choose the types of healthcare options they want, and decline those they do not, analogous to choosing food options in a cafeteria; and

WHEREAS, the form of Cafeteria Plan, as authorized under Section 125 of the Internal Revenue Code of 1986, allows certain employee benefits to be provided pre-tax to employees; and

WHEREAS, the Port shall contribute to the Plan amounts sufficient to meet its obligation under the Cafeteria Plan, in accordance with the terms of the Plan Document and shall notify the Plan Administrator to which periods said contributions shall be applied; and

WHEREAS, the Plan Year shall commence, *nunc pro tunc*, September 1, 2020 until the plan is terminated; and

WHEREAS, the appropriate Port officers shall act as soon as possible to notify employees of the adoption of the Cafeteria Plan by delivering to each employee a copy of the Summary Plan Description presented at this meeting, which form is hereby approved; and

WHEREAS, the attached Exhibits A (Plan Document), B (Summary Plan Description), C (Teamsters Summary Plan Description Medical Plan B), D (Teamsters Dental Plan B) and E (Teamsters Vision Plan) are the true copies of the Plan Documents and Summary Plan Descriptions for the Port's Flexible Benefits Plan approved and adopted in the foregoing resolution; and

NOW, THEREFORE, BE IT RESOLVED that the Commission hereby authorizes and directs the proper Port officers to execute and deliver the Plan Administrator a copy of the Plan.

ADOPTED this 10th day of November, 2020 by the Commission of the Port of Port Townsend and duly authenticated in open session by the signatures of the Commissioners voting in favor thereof and the Seal of the Commission duly affixed.

ATTEST:

Pamela A. Petranek, Secretary

Peter W. Hanke, President

William W. Putney III, Vice President

APPROVED AS TO FORM:

Port Attorney

THE PORT OF PORT TOWNSEND CAFETERIA PLAN

ARTICLE I. Introductory Provisions

Port of Port Townsend ("the Employer") hereby amends and restates the Port of Port Townsend Cafeteria Plan ("the Plan") effective as of 10/23/2020 4:00:00 AM. The Plan was originally effective 9/1/2020 4:00:00 AM. Capitalized terms used in this Plan that are not otherwise defined shall have the meanings set forth in Article II.

This Plan is designed to allow an Eligible Employee to pay for his or her share of Contributions under one or more Insurance Plans on a pre-tax Salary Reduction basis.

This Plan is intended to qualify as a "cafeteria plan" under Code § 125 and the regulations issued thereunder. The terms of this document shall be interpreted to accomplish that objective.

Although reprinted within this document, the different components of this Plan shall be deemed separate plans for purposes of administration and all reporting and nondiscrimination requirements imposed on such components by the Code.

ARTICLE II. Definitions

"Accident Insurance Benefits (Also includes Accidental Death & Dismemberment (AD&D))" means the Employee's Accident/Accidental Death & Dismemberment Insurance Plan coverage for purposes of this Plan.

"Accident Plan(s) (Also includes Accidental Death & Dismemberment (AD&D)Plans)" means the plan(s) that the Employer maintains for its Employees providing benefits through a group insurance policy or policies in the event of injury or accidental death and/or dismemberment. The Employer may substitute, add, subtract, or revise at any time the menu of such plans and/or the benefits, terms, and conditions of any such plans. Any such substitution, addition, subtraction, or revision will be communicated to Participants and will automatically be incorporated by reference under this Plan.

"Benefits" means the Premium Payment Benefits.

"Benefit Package Option" means a qualified benefit under Code § 125(f) that is offered under a cafeteria plan, or an option for coverage under an underlying accident or health plan (such as an indemnity option, an HMO option, or a PPO option under an accident or health plan).

"Change in Status" has the meaning described in Section 4.6.

"COBRA" means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

"Code" means the Internal Revenue Code of 1986, as amended.

"Contributions" means the amount contributed to pay for the cost of Benefits (including self-funded Benefits as well as those that are insured), as calculated under Section 6.2 for Premium Payment Benefits.

"Committee" means the Benefits Committee (or the equivalent thereof) of Port of Port Townsend

"Compensation" means the wages or salary paid to an Employee by the Employer, determined prior to (a) any Salary Reduction election under this Plan; (b) any salary reduction election under any other cafeteria plan; and (c) any compensation reduction under any Code § 132(f)(4) plan; but determined after (d) any salary deferral elections under any Code § 401(k), 403(b), 408(k), or 457(b) plan or arrangement. Thus, "Compensation" generally means wages or salary paid to an Employee by the Employer, as reported in Box 1 of Form W-2, but adding back any wages or salary forgone by virtue of any election described in (a), (b), or (c) of the preceding sentence.

"Dental Insurance Benefits" means the Employee's Dental Insurance Plan coverage for purposes of this Plan.

"Dental Insurance Plan(s)" means the plan(s) that the Employer maintains for its Employees (and for their Spouses and Dependents that may be eligible under the terms of such plan(s)) providing dental benefits through a group insurance policy or policies. The Employer may substitute, add, subtract, or revise at any time the menu of such plans and/or the benefits, terms, and conditions of any such plans. Any such substitution, addition, subtraction, or revision will be communicated to Participants and will automatically be incorporated by reference under this Plan.

"Dependent" means any individual who is a tax dependent of the Participant as defined in Code § 152, with the following exceptions: (a) for purposes of accident or health coverage (to the extent funded under the Premium Payment Component, and for purposes of the Health FSA Component), (1) a dependent is defined as in Code § 152, determined without regard to subsections (b)(1), (b)(2), and (d)(1)(B) thereof; and (2) any child to whom IRS Rev. Proc. 2008-48 applies. Furthermore, notwithstanding anything in the foregoing that may be to the contrary, a "Dependent" shall also include for purposes of any accident or health coverage provided under this plan a child of a Participant who has not attained age 27 by the end of any given taxable year.

"Earned Income" means all income derived from wages, salaries, tips, self-employment, and other Compensation (such as

disability or wage continuation benefits), but only if such amounts are includible in gross income for the taxable year. Earned income does not include any other amounts excluded from earned income under Code § 32(c)(2), such as amounts received under a pension or annuity or pursuant to workers' compensation.

"Effective Date" of this Plan has the meaning described in Article 1.

"Election Form/Salary Reduction Agreement" means the form provided by the Administrator for the purpose of allowing an Eligible Employee to participate in this Plan by electing Salary Reductions to pay for Premium Payment Benefits. This form may be in either paper or electronic form at the Employer's discretion in accordance with the procedures detailed in Article IV.

"Eligible Employee" means an Employee eligible to participate in this Plan, as provided in Section 3.1.

"Employee" means an individual that the Employer classifies as a common-law employee and who is on the Employer's W-2 payroll, but does not include the following: (a) any leased employee (including but not limited to those individuals defined as leased employees in Code § 414(n)) or an individual classified by the Employer as a contract worker, independent contractor, temporary employee, or casual employee for the period during which such individual is so classified, whether or not any such individual is on the Employer's W-2 payroll or is determined by the IRS or others to be a common-law employee of the Employer; (b) any individual who performs services for the Employer but who is paid by a temporary or other employment or staffing agency for the period during which such individual is paid by such agency, whether or not such individual is determined by the IRS or others to be a common-law employee of the Employer; (c) **reserved;** (d) any self-employed individual; (e) any partner in a partnership; (f) any more-than-2% shareholder in a Subchapter S corporation. The term "Employee" does include "former Employees" for the limited purpose of allowing continued eligibility for benefits under the Plan for the remainder of the Plan Year in which an Employee ceases to be employed by the Employer, but only to the extent specifically provided elsewhere under this Plan.

"Employer" means Port of Port Townsend, and any Related Employer that adopts this Plan with the approval of Port of Port Townsend. Related Employers that have adopted this Plan, if any, are listed in Appendix A of this Plan. However, for purposes of Articles XI and XIV and Section 15.3, "Employer" means only Port of Port Townsend.

"Employment Commencement Date" means the first regularly scheduled working day on which the Employee first performs an hour of service for the Employer for Compensation.

"ERISA" means the Employee Retirement Income Security Act of 1974, as amended.

"FMLA" means the Family and Medical Leave Act of 1993, as amended.

"Health Insurance Benefits" means any insurance benefits providing medical or other health insurance coverage through a group insurance policy or policies.

"HIPAA" means the Health Insurance Portability and Accountability Act of 1996, as amended.

"HMO" means the health maintenance organization Benefit Package Option under the Medical Insurance Plan.

"Hospital Indemnity Benefits" means the Employee's Hospital Indemnity Plan coverage for purposes of this Plan.

"Hospital Indemnity Plan(s)" means the plan(s) that the Employer maintains for its Employees (and for their Spouses and Dependents that may be eligible under the terms of such plan(s)) providing certain indemnity benefits in the event of hospitalization or other similar medical event through a group insurance policy or policies. The Employer may substitute, add, subtract, or revise at any time the menu of such plans and/or the benefits, terms, and conditions of any such plans. Any such substitution, addition, subtraction, or revision will be communicated to Participants and will automatically be incorporated by reference under this Plan.

"HRA" means a health reimbursement arrangement as defined in IRS Notice 2002-45.

"Insurance Benefits" means benefits offered through the Insurance Plans.

"Insurance Plan(s)" means a plan or plans offering benefits through a group insurance policy or policies.

"Medical Insurance Benefits" means the Employee's Medical Insurance Plan coverage for purposes of this Plan.

"Medical Insurance Plan(s)" means the plan(s) that the Employer maintains for its Employees (and for their Spouses and Dependents that may be eligible under the terms of such plan), providing major medical type benefits through a group insurance policy or policies (with HMO and PPO options). The Employer may substitute, add, subtract, or revise at any time the menu of such plans and/or the benefits, terms, and conditions of any such plans. Any such substitution, addition, subtraction, or revision will be communicated to Participants and will automatically be incorporated by reference under this Plan.

"Open Enrollment Period" with respect to a Plan Year means any period before the beginning of the Plan Year that may be

prescribed by the Administrator as the period of time in which Employees who will be Eligible Employees at the beginning of the Plan Year may elect benefits.

"Participant" means a person who is an Eligible Employee and who is participating in this Plan in accordance with the provisions of Article III. Participants include (a) those who elect one or more of the Medical Insurance Benefits and (b) those who elect instead to receive their full salary in cash and to pay for their share of their Contributions under the Medical Insurance Plan.

"Period of Coverage" means the Plan Year, with the following exceptions: (a) for Employees who first become eligible to participate, it shall mean the portion of the Plan Year following the date on which participation commences, as described in Section 3.1; and (b) for Employees who terminate participation, it shall mean the portion of the Plan Year prior to the date on which participation terminates, as described in Section 3.2.

"Plan" means the Port of Port Townsend Cafeteria Plan as set forth herein and as amended from time to time.

"Plan Administrator" means the Port of Port Townsend Human Resources Manager or the equivalent thereof for Port of Port Townsend, who has the full authority to act on behalf of the Plan Administrator, except with respect to appeals, for which the Committee has the full authority to act on behalf of the Plan Administrator, as described in Section 13.1.

"Plan Year" means the 12-month period commencing 9/1/2020 and ending on 12/31/2020, except in the case of a short plan year representing the initial Plan Year or where the Plan Year is being changed, in which case the Plan Year shall be the entire short plan year.

"PPO" means the preferred provider organization Benefit Package Option under the Medical Insurance Plan.

"Premium Payment Benefits" means the Premium Payment Benefits that are paid for on a pre-tax Salary Reduction basis as described in Section 6.1.

"Premium Payment Component" means the Component of this Plan described in Article VI.

"QMCSO" means a qualified medical child support order, as defined in ERISA § 609(a).

"Related Employer" means any employer affiliated with Port of Port Townsend that, under Code § 414(b), § 414(c), or § 414(m), is treated as a single employer with Port of Port Townsend for purposes of Code § 125(g)(4).

"Salary Reduction" means the amount by which the Participant's Compensation is reduced and applied by the Employer under this Plan to pay for one or more of the Benefits, as permitted for the applicable Component, before any applicable state and/or federal taxes have been deducted from the Participant's Compensation (i.e., on a pre-tax basis).

"Spouse" means an individual who is legally married to a Participant as determined under applicable state law (and who is treated as a spouse under the Code).

"Vision Insurance Benefits" means the Employee's Vision Insurance Plan coverage for purposes of this Plan.

"Vision Insurance Plan(s)" means the plan(s) that the Employer maintains for its Employees (and for their Spouses and Dependents that may be eligible under the terms of such plan(s)) providing vision benefits through a group insurance policy or policies. The Employer may substitute, add, subtract, or revise at any time the menu of such plans and/or the benefits, terms, and conditions of any such plans. Any such substitution, addition, subtraction, or revision will be communicated to Participants and will automatically be incorporated by reference under this Plan.

ARTICLE III. Eligibility and Participation

3.1 Eligibility to Participate

An individual is eligible to participate in this Plan if the individual: (a) is an Employee; (b) is working 17 hours or more per week; and (c) has been employed by the Employer for a consecutive period of 30 days, counting his or her Employment Commencement Date as the first such day. Eligibility for Premium Payment Benefits may also be subject to the additional requirements, if any, specified in the Medical Insurance Plan. Once an Employee has met the Plan's eligibility requirements, the Employee may elect coverage effective the first day of the next calendar month, in accordance with the procedures described in Article IV.

3.2 Termination of Participation

A Participant will cease to be a Participant in this Plan upon the earlier of:

- the termination of this Plan; or
- the date on which the Employee ceases (because of retirement, termination of employment, layoff, reduction of hours, or any other reason) to be an Eligible Employee. Notwithstanding the foregoing, for purposes of pre-taxing COBRA coverage

certain Employees may continue eligibility for certain periods on the terms and subject to the restrictions described in Section 6.4 for Insurance Benefits.

Termination of participation in this Plan will automatically revoke the Participant's elections. The Medical Insurance Benefits will terminate as of the date specified in the Medical Insurance Plan.

3.3 Participation Following Termination of Employment or Loss of Eligibility

If a Participant terminates his or her employment for any reason, including (but not limited to) disability, retirement, layoff, or voluntary resignation, and then is rehired within 30 days or less after the date of a termination of employment, then the Employee will be reinstated with the same elections that such individual had before termination. If a former Participant is rehired more than 30 days following termination of employment and is otherwise eligible to participate in the Plan, then the individual may make new elections as a new hire as described in Section 3.1. Notwithstanding the above, an election to participate in the Premium Payment Component will be reinstated only to the extent that coverage under the Medical Insurance Plan (here, major medical insurance) is reinstated. If an Employee (whether or not a Participant) ceases to be an Eligible Employee for any reason (other than for termination of employment), including (but not limited to) a reduction of hours, and then becomes an Eligible Employee again, the Employee must complete the waiting period described in Section 3.1 before again becoming eligible to participate in the Plan.

3.4 FMLA Leaves of Absence

(a) Health Benefits. Notwithstanding any provision to the contrary in this Plan, if a Participant goes on a qualifying leave under the FMLA, then to the extent required by the FMLA, the Employer will continue to maintain the Participant's Health Insurance Benefits on the same terms and conditions as if the Participant were still an active Employee. That is, if the Participant elects to continue his or her coverage while on leave, the Employer will continue to pay its share of the Contributions.

An Employer may require participants to continue all Health Insurance Benefits coverage for Participants while they are on paid leave (provided that Participants on non-FMLA paid leave are required to continue coverage). If so, the Participant's share of the Contributions shall be paid by the method normally used during any paid leave (for instance, on a pre-tax Salary Reduction basis).

In the event of unpaid FMLA leave (or paid FMLA leave where coverage is not required to be continued), a Participant may elect to continue his or her Health Insurance Benefits during the leave. If the Participant elects to continue coverage while on FMLA leave, then the Participant may pay his or her share of the Contributions in one of the following ways:

- with after-tax dollars, by sending monthly payments to the Employer by the due date established by the Employer;
- with pre-tax dollars, by having such amounts withheld from the Participant's ongoing Compensation (if any), including unused sick days and vacation days, or pre-paying all or a portion of the Contributions for the expected duration of the leave on a pre-tax Salary Reduction basis out of pre-leave Compensation. To pre-pay the Contributions, the Participant must make a special election to that effect prior to the date that such Compensation would normally be made available (pre-tax dollars may not be used to fund coverage during the next Plan Year); or
- under another arrangement agreed upon between the Participant and the Plan Administrator (e.g., the Plan Administrator may fund coverage during the leave and withhold "catch-up" amounts from the Participant's Compensation on a pre-tax or after-tax basis) upon the Participant's return.

If the Employer requires all Participants to continue Health Insurance Benefits during an unpaid FMLA leave, then the Participant may elect to discontinue payment of the Participant's required Contributions until the Participant returns from leave. Upon returning from leave, the Participant will be required to repay the Contributions not paid by the Participant during the leave. Payment shall be withheld from the Participant's Compensation either on a pre-tax or after-tax basis, as agreed to by the Plan Administrator and the Participant.

If a Participant's Health Insurance Benefits coverage ceases while on FMLA leave (e.g., for non-payment of required contributions), then the Participant is permitted to re-enter the Medical Insurance Benefits upon return from such leave on the same basis as when the Participant was participating in the Plan prior to the leave, or as otherwise required by the FMLA. In addition, the Plan may require Participants whose Health Insurance Benefits coverage terminated during the leave to be reinstated in such coverage upon return from a period of unpaid leave, provided that Participants who return from a period of unpaid, non-FMLA leave are required to be reinstated in such coverage.

(b) Non-Health Benefits. If a Participant goes on a qualifying leave under the FMLA, then entitlement to non-health benefits is to be determined by the Employer's policy for providing such Benefits when the Participant is on non-FMLA leave, as described in Section 3.5. If such policy permits a Participant to discontinue contributions while on leave, then the Participant will, upon returning from leave, be required to repay the Contributions not paid by the Participant during the leave. Payment shall be withheld from the Participant's Compensation either on a pre-tax or after-tax basis, as may be agreed upon by the Plan Administrator and the Participant or as the Plan Administrator otherwise deems appropriate.

3.5 Non-FMLA Leaves of Absence If a Participant goes on an unpaid leave of absence that does not affect eligibility, then the Participant will continue to participate and the Contributions due for the Participant will be paid by pre-payment before going on leave, by after-tax contributions while on leave, or with catch-up contributions after the leave ends, as may be

determined by the Plan Administrator. If a Participant goes on an unpaid leave that affects eligibility, then the election change rules detailed in Article IV will apply.

ARTICLE IV. Method and Timing of Elections; Irrevocability of Elections

4.1 Elections When First Eligible

An Employee who first becomes eligible to participate in the Plan mid-year may elect to commence participation in one or more Benefits on the first day of the month after the eligibility requirements have been satisfied, provided that an Election Form/Salary Reduction Agreement is submitted to the Plan Administrator before the first day of the month in which participation will commence. An Employee who does not elect benefits when first eligible may not enroll until the next Open Enrollment Period unless an event occurs that would justify a mid-year election change, as described in Article IV.

The Employer reserves the right, within its discretion, to allow or require any or all of the election procedures detailed in this Article 4.1 to be performed electronically.

Benefits shall be subject to the additional requirements, if any, specified in the Medical Insurance Plan. The provisions of this Plan are not intended to override any exclusions, eligibility requirements, or waiting periods specified in any Insurance Plans.

4.2 Rolling Elections

During each Open Enrollment Period for a following Plan Year, Participants shall be deemed to have elected the same benefits at the same levels as in the Plan Year in which the Open Enrollment Period occurs, unless a Participant informs the Employer of a different intention in writing (or in an electronic form accepted by Employer).

4.3 ***RESERVED***

4.4 Irrevocability of Elections

Unless an exception applies (as described in this Article IV), a Participant's election under the Plan is irrevocable for the duration of the Period of Coverage to which it relates.

Unless otherwise noted in this section, a Participant's election under the Plan is irrevocable for the duration of the Period of Coverage to which it relates. In other words, unless an exception applies, the Participant may not change any elections for the duration of the Period of Coverage regarding:

- Participation in this Plan;
- Salary Reduction amounts; or
- election of particular Benefit Package Options.

4.5 Procedure for Making New Election If Exception to Irrevocability Applies

(a) Timeframe for Making New Election. A Participant (or an Eligible Employee who, when first eligible under Section 3.1 or during the Open Enrollment Period, declined to be a Participant) may make a new election within 30 days of the occurrence of an event described in Section 4.6 or 4.7, as applicable, but only if the election under the new Election Form/Salary Reduction Agreement is made on account of and is consistent with the event and if the election is made within any specified time period (e.g., for Sections 4.7(d) through 4.7(j), within 30 days after the events described in such Sections unless otherwise required by law). Notwithstanding the foregoing, a Change in Status (e.g., a divorce or a dependent's losing dependent status) that results in a beneficiary becoming ineligible for coverage under the Medical Insurance Plan shall automatically result in a corresponding election change, whether or not requested by the Participant within the normal 30-day period.

(b) Effective Date of New Election. Elections made pursuant to this Section 4.5 shall be effective for the balance of the Period of Coverage following the change of election unless a subsequent event allows for a further election change. Except as provided in Section 4.7(e) for HIPAA special enrollment rights in the event of birth, adoption, or placement for adoption, all election changes shall be effective on a prospective basis only (i.e., election changes will become effective no earlier than the first day of the next calendar month following the date that the election change was filed, but, as determined by the Plan Administrator, election changes may become effective later to the extent that the coverage in the applicable Benefit Package Option commences later).

4.6 Change in Status Defined

Participant may make a new election upon the occurrence of certain events as described in Section 4.7, including a Change in Status, for the applicable Component. "Change in Status" means any of the events described below, as well as any other events included under subsequent changes to Code § 125 or regulations issued thereunder, which the Plan Administrator, in its sole discretion and on a uniform and consistent basis, determines are permitted under IRS regulations and under this Plan:

(a) Legal Marital Status. A change in a Participant's legal marital status, including marriage, death of a Spouse, divorce, legal separation, or annulment;

(b) Number of Dependents. Events that change a Participant's number of Dependents, including birth, death, adoption, and placement for adoption;

(c) Employment Status. Any of the following events that change the employment status of the Participant or his or her Spouse or Dependents: (1) a termination or commencement of employment; (2) a strike or lockout; (3) a commencement of or return from an unpaid leave of absence; (4) a change in worksite; and (5) if the eligibility conditions of this Plan or other employee benefits plan of the Participant or his or her Spouse or Dependents depend on the employment status of that individual and there is a change in that individual's status with the consequence that the individual becomes (or ceases to be) eligible under this Plan or other employee benefits plan, such as if a plan only applies to salaried employees and an employee switches from salaried to hourly-paid, union to non-union, or full-time to part-time (or vice versa), with the consequence that the employee ceases to be eligible for the Plan;

(d) Dependent Eligibility Requirements. An event that causes a Dependent to satisfy or cease to satisfy the Dependent eligibility requirements for a particular benefit, such as attaining a specified age, or any similar circumstance; and

(e) Change in Residence. A change in the place of residence of the Participant or his or her Spouse or Dependents.

4.7 Events Permitting Exception to Irrevocability Rule

A Participant may change an election as described below upon the occurrence of the stated events for the applicable Component of this Plan:

(a) Open Enrollment Period. A Participant may change an election during the Open Enrollment Period.

(b) Termination of Employment. A Participant's election will terminate under the Plan upon termination of employment in accordance with Sections 3.2 and 3.3, as applicable.

(c) Leaves of Absence. A Participant may change an election under the Plan upon FMLA leave in accordance with Section 3.4 and upon non-FMLA leave in accordance with Section 3.5.

(d) Change in Status. A Participant may change his or her actual or deemed election under the Plan upon the occurrence of a Change in Status (as defined in Section 4.6), but only if such election change is made on account of and corresponds with a Change in Status that affects eligibility for coverage under a plan of the Employer or a plan of the Spouse's or Dependent's employer (referred to as the general consistency requirement). A Change in Status that affects eligibility for coverage under a plan of the Employer or a plan of the Spouse's or Dependent's employer includes a Change in Status that results in an increase or decrease in the number of an Employee's family members (i.e., a Spouse and/or Dependents) who may benefit from the coverage.

(1) Loss of Spouse or Dependent Eligibility; Special COBRA Rules. For a Change in Status involving a Participant's divorce, annulment or legal separation from a Spouse, the death of a Spouse or a Dependent, or a Dependent's ceasing to satisfy the eligibility requirements for coverage, a Participant may only elect to cancel accident or health insurance coverage for (a) the Spouse involved in the divorce, annulment, or legal separation; (b) the deceased Spouse or Dependent; or (c) the Dependent that ceased to satisfy the eligibility requirements. Canceling coverage for any other individual under these circumstances would fail to correspond with that Change in Status. Notwithstanding the foregoing, if the Participant or his or her Spouse or Dependent becomes eligible for COBRA (or similar health plan continuation coverage under state law) under the Employer's plan (and the Participant remains a Participant under this Plan in accordance with Section 3.2), then the Participant may increase his or her election to pay for such coverage (this rule does not apply to a Participant's Spouse who becomes eligible for COBRA or similar coverage as a result of divorce, annulment, or legal separation).

(2) Gain of Coverage Eligibility Under Another Employer's Plan. For a Change in Status in which a Participant or his or her Spouse or Dependent gains eligibility for coverage under a cafeteria plan or qualified benefit plan of the employer of the Participant's Spouse or Dependent as a result of a change in marital status or a change in employment status, a Participant may elect to cease or decrease coverage for that individual only if coverage for that individual becomes effective or is increased under the Spouse's or Dependent's employer's plan. The Plan Administrator may rely on a Participant's certification that the Participant has obtained or will obtain coverage under the Spouse's or Dependent's employer's plan, unless the Plan Administrator has reason to believe that the Participant's certification is incorrect.

(e) HIPAA Special Enrollment Rights. If a Participant or his or her Spouse or Dependent is entitled to special enrollment rights under a group health plan (other than an excepted benefit), as required by HIPAA under Code § 9801(f), then a Participant may revoke a prior election for group health plan coverage and make a new election (including, when required by HIPAA, an election to enroll in another benefit package under a group health plan), provided that the election change corresponds with such HIPAA special enrollment right. As required by HIPAA, a special enrollment right will arise in the following circumstances:

- a Participant or his or her Spouse or Dependent declined to enroll in group health plan coverage because he or she had

coverage, and eligibility for such coverage is subsequently lost because: (1) the coverage was provided under COBRA and the COBRA coverage was exhausted; or (2) the coverage was non-COBRA coverage and the coverage terminated due to loss of eligibility for coverage or the employer contributions for the coverage were terminated; or

- a new Dependent is acquired as a result of marriage, birth, adoption, or placement for adoption.

An election to add previously eligible Dependents as a result of the acquisition of a new Spouse or Dependent child shall be considered to be consistent with the special enrollment right. An election change on account of a HIPAA special enrollment attributable to the birth, adoption, or placement for adoption of a new Dependent child may, subject to the provisions of the underlying group health plan, be effective retroactively (up to 30 days).

For purposes of this Section 4.7(e), the term "loss of eligibility" includes (but is not limited to) loss of eligibility due to legal separation, divorce, cessation of dependent status, death of an employee, termination of employment, reduction of hours, or any loss of eligibility for coverage that is measured with reference to any of the foregoing; loss of coverage offered through an HMO that does not provide benefits to individuals who do not reside, live, or work in the service area because an individual no longer resides, lives, or works in the service area (whether or not within the choice of the individual), and in the case of HMO coverage in the group market, no other benefit package is available to the individual; a situation in which an individual incurs a claim that would meet or exceed a lifetime limit on all benefits; and a situation in which a plan no longer offers any benefits to the class of similarly situated individuals that includes the individual.

(f) Certain Judgments, Decrees and Orders. If a judgment, decree, or order (collectively, an "Order") resulting from a divorce, legal separation, annulment, or change in legal custody (including a QMCSO) requires accident or health coverage (including an election for Health FSA Benefits) for a Participant's child (including a foster child who is a Dependent of the Participant), then a Participant may (1) change his or her election to provide coverage for the child (provided that the Order requires the Participant to provide coverage); or (2) change his or her election to revoke coverage for the child if the Order requires that another individual (including the Participant's Spouse or former Spouse) provide coverage under that individual's plan and such coverage is actually provided.

(g) Medicare and Medicaid. If a Participant or his or her Spouse or Dependent who is enrolled in a health or accident plan under this Plan becomes entitled to (i.e., becomes enrolled in) Medicare or Medicaid (other than coverage consisting solely of benefits under Section 1928 of the Social Security Act providing for pediatric vaccines), then the Participant may prospectively reduce or cancel the health or accident coverage of the person becoming entitled to Medicare or Medicaid. Furthermore, if a Participant or his or her Spouse or Dependent who has been entitled to Medicare or Medicaid loses eligibility for such coverage, then the Participant may prospectively elect to commence or increase the accident or health coverage of the individual who loses Medicare or Medicaid eligibility.

(h) Change in Cost. For purposes of this Section 4.7(h), "similar coverage" means coverage for the same category of benefits for the same individuals (e.g., family to family or single to single). For example, two plans that provide major medical coverage are considered to be similar coverage.

(1) Increase or Decrease for Insignificant Cost Changes. Participants are required to increase their elective contributions (by increasing Salary Reductions) to reflect insignificant increases in their required contribution for their Benefit Package Option(s), and to decrease their elective contributions to reflect insignificant decreases in their required contribution.The Plan Administrator, in its sole discretion and on a uniform and consistent basis, will determine whether an increase or decrease is insignificant based upon all the surrounding facts and circumstances, including but not limited to the dollar amount or percentage of the cost change. The Plan Administrator, on a reasonable and consistent basis, will automatically effectuate this increase or decrease in affected employees' elective contributions on a prospective basis.

(2) Significant Cost Increases. If the Plan Administrator determines that the cost charged to an Employee of a Participant's Benefit Package Option(s) significantly increases during a Period of Coverage, then the Participant may (a) make a corresponding prospective increase in his or her elective contributions (by increasing Salary Reductions); (b) revoke his or her election for that coverage, and in lieu thereof, receive on a prospective basis coverage under another Benefit Package Option that provides similar coverage; or (c) drop coverage prospectively if there is no other Benefit Package Option available that provides similar coverage. The Plan Administrator, in its sole discretion and on a uniform and consistent basis, will decide whether a cost increase is significant in accordance with prevailing IRS guidance.

(3) Significant Cost Decreases. If the Plan Administrator determines that the cost of any Benefit Package Option significantly decreases during a Period of Coverage, then the Plan Administrator may permit the following election changes: (a) Participants enrolled in that Benefit Package Option may make a corresponding prospective decrease in their elective contributions (by decreasing Salary Reductions); (b) Participants who are enrolled in another Benefit Package Option may change their election on a prospective basis to elect the Benefit Package Option that has decreased in cost Medical Insurance Plan); or (c) Employees who are otherwise eligible under Section 3.1 may elect the Benefit Package Option that has decreased in cost on a prospective basis, subject to the terms and limitations of the Benefit Package Option. The Plan Administrator, in its sole discretion and on a uniform and consistent basis, will decide whether a cost decrease is significant in accordance with prevailing IRS guidance.

(i) Change in Coverage. The definition of "similar coverage" under Section 12.4(h) applies also to this Section 12.4(i).

(1) Significant Curtailment. If coverage is "significantly curtailed" (as defined below), Participants may elect coverage under another Benefit Package Option that provides similar coverage. In addition, as set forth below, if the coverage curtailment results in a "Loss of Coverage" (as defined below), then Participants may drop coverage if no similar coverage is offered by the Employer. The Plan Administrator in its sole discretion, on a uniform and consistent basis, will decide, in accordance with prevailing IRS guidance, whether a curtailment is "significant," and whether a Loss of Coverage has occurred.

(a) Significant Curtailment Without Loss of Coverage. If the Plan Administrator determines that a Participant's coverage under a Benefit Package Option under this Plan (or the Participant's Spouse's or Dependent's coverage under his or her employer's plan) is significantly curtailed without a Loss of Coverage (for example, when there is a significant increase in the deductible, the co-pay, or the out-of-pocket cost-sharing limit under an accident or health plan during a Period of Coverage, the Participant may revoke his or her election for the affected coverage, and in lieu thereof, prospectively elect coverage under another Benefit Package Option that provides similar coverage. Coverage under a plan is deemed to be "significantly curtailed" only if there is an overall reduction in coverage provided under the plan so as to constitute reduced coverage generally.

(b) Significant Curtailment With a Loss of Coverage. If the Plan Administrator determines that a Participant's Benefit Package Option coverage under this Plan (or the Participant's Spouse's or Dependent's coverage under his or her employer's plan) is significantly curtailed, and if such curtailment results in a Loss of Coverage during a Period of Coverage, then the Participant may revoke his or her election for the affected coverage and may either prospectively elect coverage under another Benefit Package Option that provides similar coverage or drop coverage if no other Benefit Package Option providing similar coverage is offered by the Employer.

(c) Definition of Loss of Coverage. For purposes of this Section 4.7(i)(1), a "Loss of Coverage" means a complete loss of coverage (including the elimination of a Benefit Package Option, an HMO ceasing to be available where the Participant or his or her Spouse or Dependent resides, or a Participant or his or her Spouse or Dependent losing all coverage under the Benefit Package Option by reason of an overall lifetime or annual limitation). In addition, the Plan Administrator, in its sole discretion, on a uniform and consistent basis, may treat the following as a Loss of Coverage:

- a substantial decrease in the medical care providers available under the Benefit Package Option (such as a major hospital ceasing to be a member of a preferred provider network or a substantial decrease in the number of physicians participating in the PPO for the Medical Insurance Plan or in an HMO);

- a reduction in benefits for a specific type of medical condition or treatment with respect to which the Participant or his or her Spouse or Dependent is currently in a course of treatment; or

- any other similar fundamental loss of coverage.

(2) Addition or Significant Improvement of a Benefit Package Option. If during a Period of Coverage the Plan adds a new Benefit Package Option or significantly improves an existing Benefit Package Option, the Plan Administrator may permit the following election changes: (a) Participants who are enrolled in a Benefit Package Option other than the newly added or significantly improved Benefit Package Option may change their elections on a prospective basis to elect the newly added or significantly improved Benefit Package Option; and (b) Employees who are otherwise eligible under Section 3.1 may elect the newly added or significantly improved Benefit Package Option on a prospective basis, subject to the terms and limitations of the Benefit Package Option. The Plan Administrator, in its sole discretion and on a uniform and consistent basis, will decide whether there has been an addition of, or a significant improvement in, a Benefit Package Option in accordance with prevailing IRS guidance.

(3) Loss of Coverage Under Other Group Health Coverage. A Participant may prospectively change his or her election to add group health coverage for the Participant or his or her Spouse or Dependent, if such individual(s) loses coverage under any group health coverage sponsored by a governmental or educational institution, including (but not limited to) the following: a state children's health insurance program (SCHIP) under Title XXI of the Social Security Act; a medical care program of an Indian Tribal government (as defined in Code § 7701(a)(40)), the Indian Health Service, or a tribal organization; a state health benefits risk pool; or a foreign government group health plan, subject to the terms and limitations of the applicable Benefit Package Option(s).

(4) Change in Coverage Under Another Employer Plan. A Participant may make a prospective election change that is on account of and corresponds with a change made under an employer plan (including a plan of the Employer or a plan of the Spouse's or Dependent's employer), so long as (a) the other cafeteria plan or qualified benefits plan permits its participants to make an election change that would be permitted under applicable IRS regulations; or (b) the Plan permits Participants to make an election for a Period of Coverage that is different from the plan year under the other cafeteria plan or qualified benefits plan. For example, if an election is made by the Participant's Spouse during his or her employer's open enrollment to drop coverage, the Participant may add coverage to replace the dropped coverage. The Plan Administrator, in its sole discretion and on a uniform and consistent basis, will decide whether a requested change is on account of and corresponds with a change made under the other employer plan, in accordance with prevailing IRS guidance. A Participant entitled to change an election as described in this Section 4.7 must do so in accordance with the procedures described in Section 4.5.

(j) Revocation Due to Reduction in Hours

A Participant may revoke his or her Major Medical coverage, along with that of any related individuals, if the Participant experiences a reduction of hours such that he or she will be reasonably expected to work fewer than 30 hours a week on a regular basis and the Participant intends to enroll, along with any such related individuals, in another plan no later than the first day of the second full month following the revocation.

(k) Revocation of Coverage for Purposes of Enrolling in Marketplace Coverage

A Participant may revoke his or her Major Medical coverage if he or she is seeking to enroll, along with any related individuals who cease coverage due to such revocation, in Marketplace coverage (either during the Marketplace's annual open enrollment period or during a special enrollment period) immediately after the revoked coverage ends.

(l) CHIP Special Enrollment Rights

Notwithstanding anything else in this document to the contrary, special enrollment rights shall be made available as a result of a loss of eligibility for Medicaid or for coverage under a state children's health insurance program (SCHIP) or as a result of eligibility for a state premium assistance subsidy under the plan from Medicaid or SCHIP.

4.8 ***Reserved***

4.9 Election Modifications Required by Plan Administrator

The Plan Administrator may, at any time, require any Participant or class of Participants to amend the amount of their Salary Reductions for a Period of Coverage if the Plan Administrator determines that such action is necessary or advisable in order to (a) satisfy any of the Code's nondiscrimination requirements applicable to this Plan or other cafeteria plan; (b) prevent any Employee or class of Employees from having to recognize more income for federal income tax purposes from the receipt of benefits hereunder than would otherwise be recognized; (c) maintain the qualified status of benefits received under this Plan; or (d) satisfy Code nondiscrimination requirements or other limitations applicable to the Employer's qualified plans. In the event that contributions need to be reduced for a class of Participants, the Plan Administrator will reduce the Salary Reduction amounts for each affected Participant, beginning with the Participant in the class who had elected the highest Salary Reduction amount and continuing with the Participant in the class who had elected the next-highest Salary Reduction amount, and so forth, until the defect is corrected.

ARTICLE V. Benefits Offered and Method of Funding

5.1 Benefits Offered

When first eligible or during the Open Enrollment Period as described under Article IV, Participants will be given the opportunity to elect Premium Payment Benefits, as described in Article VI.

5.2 Employer and Participant Contributions

(a) Employer Contributions. For Participants who elect Insurance Benefits described in Article VI, the Employer may contribute a portion of the Contributions as provided in the open enrollment materials furnished to Employees and/or on the Election Form/Salary Reduction Agreement.

(b) Participant Contributions. Participants who elect any of the Medical Insurance Benefits described in Article VI may pay for the cost of that coverage on a pre-tax Salary Reduction basis, or with after-tax deductions, by completing an Election Form/Salary Reduction Agreement.

5.3 Using Salary Reductions to Make Contributions

(a) Salary Reductions per Pay Period. The Salary Reduction for a pay period for a Participant is, for the Benefits elected, (1) an amount equal to the annual Contributions for such Benefits (as described in Section 6.2 for Premium Payment Benefits; (2) an amount otherwise agreed upon between the Employer and the Participant; or (3) an amount deemed appropriate by the Plan Administrator (i.e., in the event of shortage in reducible Compensation, amounts withheld and the Benefits to which Salary Reductions are applied may fluctuate).

(b) Considered Employer Contributions for Certain Purposes. Salary Reductions are applied by the Employer to pay for the Participant's share of the Contributions for the Premium Payment Benefits are considered to be Employer contributions.

(c) Salary Reduction Balance Upon Termination of Coverage. If, as of the date that any elected coverage under this Plan terminates, a Participant's year-to-date Salary Reductions exceed or are less than the Participant's required Contributions for the coverage, then the Employer will, as applicable, either return the excess to the Participant as additional taxable wages or recoup the due Salary Reduction amounts from any remaining Compensation.

(d) After-Tax Contributions for Premium Payment Benefits. For those Participants who elect to pay their share of the Contributions for any of the Medical Insurance Benefits with after-tax deductions, both the Employee and Employer portions of such Contributions will be paid outside of this Plan.

5.4 Funding This Plan

All of the amounts payable under this Plan shall be paid from the general assets of the Employer, but Premium Payment Benefits are paid as provided in the applicable insurance policy. Nothing herein will be construed to require the Employer or the Plan Administrator to maintain any fund or to segregate any amount for the benefit of any Participant, and no Participant or other person shall have any claim against, right to, or security or other interest in any fund, account, or asset of the Employer from which any payment under this Plan may be made. There is no trust or other fund from which Benefits are paid. While the Employer has complete responsibility for the payment of Benefits out of its general assets (except for Premium Payment Benefits paid as provided in the applicable insurance policy), it may hire an unrelated third-party paying agent to make Benefit payments on its behalf. The maximum contribution that may be made under this Plan for a Participant is the total of the maximums that may be elected as Employer and Participant Contributions for Premium Payment Benefits, as described in Section 6.2.

ARTICLE VI. Premium Payment Component

6.1 Benefits

The only Insurance Benefits that are offered under the Premium Payment Component are benefits under the Medical, Dental, Vision, Accident, Bridge, Hospital Indemnity, Other - Cancer Insurance Plan(s). Notwithstanding any other provision in these Plan(s), these benefits are subject to the terms and conditions of the Insurance Plan(s), and no changes can be made with respect to such Insurance Benefits under this Plan (such as mid-year changes in election) if such changes are not permitted under the applicable Insurance Plan. An Eligible Employee can (a) elect benefits under the Premium Payment Component by electing to pay for his or her share of the Contributions for Medical Insurance Benefits on a pretax Salary Reduction basis (Premium Payment Benefits); or (b) elect no benefits under the Premium Payment Component and to pay for his or her share of the Contributions, if any, for Medical Insurance Benefits with after-tax deductions outside of this Plan. Unless an exception applies (as described in Article IV), such election is irrevocable for the duration of the Period of Coverage to which it relates.

The Employer may at its discretion offer cash in lieu of benefits for Participants who do not choose Insurance Benefits.

6.2 Contributions for Cost of Coverage

The annual Contribution for a Participant's Premium Payment Benefits is equal to the amount as set by the Employer, which may or may not be the same amount charged by the insurance carrier.

6.3 Insurance Benefits Provided Under Insurance Plans

Insurance Benefits will be provided by the Insurance Plans, not this Plan. The types and amounts of Insurance Benefits, the requirements for participating in the Insurance Plans, and the other terms and conditions of coverage and benefits of the Insurance Plans are set forth in the Insurance Plans. All claims to receive benefits under the Insurance Plans shall be subject to and governed by the terms and conditions of the Insurance Plans and the rules, regulations, policies, and procedures adopted in accordance therewith, as may be amended from time to time.

6.4 Health Insurance Benefits; COBRA

Notwithstanding any provision to the contrary in this Plan, to the extent required by COBRA, a Participant and his or her Spouse and Dependents,as applicable, whose coverage terminates under the Health Insurance Benefits because of a COBRA qualifying event (and who is a qualified beneficiary as defined under COBRA), shall be given the opportunity to continue on a self-pay basis the same coverage that he or she had under the Health Insurance Plan(s) the day before the qualifying event for the periods prescribed by COBRA.

Such continuation coverage shall be subject to all conditions and limitations under COBRA. Contributions for COBRA coverage for Health Insurance Benefits may be paid on a pre-tax basis for current Employees receiving taxable compensation (as may be permitted by the Plan Administrator on a uniform and consistent basis, but may not be prepaid from contributions in one Plan Year to provide coverage that extends into a subsequent Plan Year) where COBRA coverage arises either (a) because the Employee ceases to be eligible because of a reduction in hours; or (b) because the Employee's Dependent ceases to satisfy the eligibility requirements for coverage. For all other individuals (e.g., Employees who cease to be eligible because of retirement, termination of employment, or layoff), Contributions for COBRA coverage for Health Insurance Benefits shall be paid on an after-tax basis (unless may be otherwise permitted by the Plan Administrator on a uniform and consistent basis, but may not be prepaid from contributions in one Plan Year to provide coverage that extends into a subsequent Plan Year).

ARTICLES VII. - XII. ***RESERVED***

ARTICLE XIII. Appeals Procedure

13.1 Procedure If Benefits Are Denied Under This Plan

If a claim for reimbursement under this Plan is wholly or partially denied, then claims shall be administered in accordance with

the claims procedure set forth in the summary plan description for this Plan. The Committee acts on behalf of the Plan Administrator with respect to appeals.

13.2 Claims Procedures for Insurance Benefits

Claims and reimbursement for Insurance Benefits shall be administered in accordance with the claims procedures for the Insurance Benefits, as set forth in the plan documents and/or summary plan description(s) for the Insurance Plan(s).

ARTICLE XIV. Recordkeeping and Administration

14.1 Plan Administrator

The administration of this Plan shall be under the supervision of the Plan Administrator. It is the principal duty of the Plan Administrator to see that this Plan is carried out, in accordance with its terms, for the exclusive benefit of persons entitled to participate in this Plan without discrimination among them.

14.2 Powers of the Plan Administrator

The Plan Administrator shall have such duties and powers as it considers necessary or appropriate to discharge its duties. It shall have the exclusive right to interpret the Plan and to decide all matters thereunder, and all determinations of the Plan Administrator with respect to any matter hereunder shall be conclusive and binding on all persons. Without limiting the generality of the foregoing, the Plan Administrator shall have the following discretionary authority:

(a) to construe and interpret this Plan, including all possible ambiguities, inconsistencies, and omissions in the Plan and related documents, and to decide all questions of fact, questions relating to eligibility and participation, and questions of benefits under this Plan (provided that, notwithstanding the first paragraph in this Section 14.2, the Committee shall exercise such exclusive power with respect to an appeal of a claim under Section 13.1);

(b) to prescribe procedures to be followed and the forms to be used by Employees and Participants to make elections pursuant to this Plan;

(c) to prepare and distribute information explaining this Plan and the benefits under this Plan in such manner as the Plan Administrator determines to be appropriate;

(d) to request and receive from all Employees and Participants such information as the Plan Administrator shall from time to time determine to be necessary for the proper administration of this Plan;

(e) to furnish each Employee and Participant with such reports with respect to the administration of this Plan as the Plan Administrator determines to be reasonable and appropriate, including appropriate statements setting forth the amounts by which a Participant's Compensation has been reduced in order to provide benefits under this Plan;

(f) to receive, review, and keep on file such reports and information regarding the benefits covered by this Plan as the Plan Administrator determines from time to time to be necessary and proper;

(g) to appoint and employ such individuals or entities to assist in the administration of this Plan as it determines to be necessary or advisable, including legal counsel and benefit consultants;

(h) to sign documents for the purposes of administering this Plan, or to designate an individual or individuals to sign documents for the purposes of administering this Plan;

(i) to secure independent medical or other advice and require such evidence as it deems necessary to decide any claim or appeal; and

(j) to maintain the books of accounts, records, and other data in the manner necessary for proper administration of this Plan and to meet any applicable disclosure and reporting requirements.

14.3 Reliance on Participant, Tables, etc.

The Plan Administrator may rely upon the direction, information, or election of a Participant as being proper under the Plan and shall not be responsible for any act or failure to act because of a direction or lack of direction by a Participant. The Plan Administrator will also be entitled, to the extent permitted by law, to rely conclusively on all tables, valuations, certificates, opinions, and reports that are furnished by accountants, attorneys, or other experts employed or engaged by the Plan Administrator.

14.4 ***Reserved***

14.5 Fiduciary Liability

To the extent permitted by law, the Plan Administrator shall not incur any liability for any acts or for failure to act except for their own willful misconduct or willful breach of this Plan.

14.6 Compensation of Plan Administrator

Unless otherwise determined by the Employer and permitted by law, any Plan Administrator that is also an Employee of the Employer shall serve without compensation for services rendered in such capacity, but all reasonable expenses incurred in the performance of their duties shall be paid by the Employer.

14.7 Bonding

The Plan Administrator shall be bonded to the extent required by ERISA.

14.8 Insurance Contracts

The Employer shall have the right (a) to enter into a contract with one or more insurance companies for the purposes of providing any benefits under the Plan; and (b) to replace any of such insurance companies or contracts at its discretion. Any dividends, retroactive rate adjustments, or other refunds of any type that may become payable under any such insurance contract shall not be assets of the Plan but shall be the property of and be retained by the Employer, to the extent that such amounts are less than aggregate Employer contributions toward such insurance.

14.9 Inability to Locate Payee

If the Plan Administrator is unable to make payment to any Participant or other person to whom a payment is due under the Plan because it cannot ascertain the identity or whereabouts of such Participant or other person after reasonable efforts have been made to identify or locate such person, then such payment and all subsequent payments otherwise due to such Participant or other person shall be forfeited following a reasonable time after the date any such payment first became due.

14.10 Effect of Mistake

In the event of a mistake as to the eligibility or participation of an Employee, the allocations made to the account of any Participant, or the amount of benefits paid or to be paid to a Participant or other person, the Plan Administrator shall, to the extent that it deems administratively possible and otherwise permissible under Code § 125 or the regulations issued thereunder, cause to be allocated or cause to be withheld or accelerated, or otherwise make adjustment of, such amounts as it will in its judgment accord to such Participant or other person the credits to the account or distributions to which he or she is properly entitled under the Plan. Such action by the Plan Administrator may include withholding of any amounts due to the Plan or the Employer from Compensation paid by the Employer.

ARTICLE XV. General Provisions

15.1 ***Reserved***

15.2 No Contract of Employment

Nothing herein contained is intended to be or shall be construed as constituting a contract or other arrangement between any Employee and the Employer to the effect that such Employee will be employed for any specific period of time. All Employees are considered to be employed at the will of the Employer.

15.3 Amendment and Termination

This Plan has been established with the intent of being maintained for an indefinite period of time. Nonetheless, the Employer may amend or terminate all or any part of this Plan at any time for any reason and any such amendment or termination will automatically apply to the Related Employers that are participating in this Plan.

15.4 Governing Law

This Plan shall be construed, administered, and enforced according to the laws of WA, to the extent not superseded by the Code, ERISA, or any other federal law.

15.5 Code and ERISA Compliance

It is intended that this Plan meet all applicable requirements of the Code , ERISA (if ERISA is applicable) and of all regulations issued thereunder. This Plan shall be construed, operated, and administered accordingly, and in the event of any conflict between any part, clause, or provision of this Plan and the Code and/or ERISA (if ERISA is applicable), the provisions of the Code and ERISA (if ERISA is applicable) shall be deemed controlling, and any conflicting part, clause, or provision of this Plan shall be deemed superseded to the extent of the conflict.

15.6 No Guarantee of Tax Consequences

Neither the Plan Administrator nor the Employer makes any commitment or guarantee that any amounts paid to or for the benefit of a Participant under this Plan will be excludable from the Participant's gross income for federal, state, or local income tax purposes. It shall be the obligation of each Participant to determine whether each payment under this Plan is excludable from the Participant's gross income for federal, state, and local income tax purposes and to notify the Plan Administrator if the Participant has any reason to believe that such payment is not so excludable.

15.7 Indemnification of Employer

If any Participant receives one or more payments or reimbursements under this Plan on a tax-free basis and if such payments do not qualify for such treatment under the Code, then such Participant shall indemnify and reimburse the Employer for any liability that it may incur for failure to withhold federal income taxes, Social Security taxes, or other taxes from such payments or reimbursements.

15.8 Non-Assignability of Rights

The right of any Participant to receive any reimbursement under this Plan shall not be alienable by the Participant by assignment or any other method and shall not be subject to claims by the Participant's creditors by any process whatsoever. Any attempt to cause such right to be so subjected will not be recognized, except to the extent required by law.

15.9 Headings

The headings of the various Articles and Sections are inserted for convenience of reference and are not to be regarded as part of this Plan or as indicating or controlling the meaning or construction of any provision.

15.10 Plan Provisions Controlling

In the event that the terms or provisions of any summary or description of this Plan are in any construction interpreted as being in conflict with the provisions of this Plan as set forth in this document, the provisions of this Plan shall be controlling.

15.11 Severability

Should any part of this Plan subsequently be invalidated by a court of competent jurisdiction, the remainder of the Plan shall be given effect to the maximum extent possible.

IN WITNESS WHEREOF, and as conclusive evidence of the adoption of the foregoing instrument comprising the Port of Port Townsend Salary Reduction Plan, Port of Port Townsend has caused this Plan to be executed in its name and on its behalf, on this ____ day of _____, 20___.

Port of Port Townsend

By: _____
Its: _____

THE PORT OF PORT TOWNSEND CAFETERIA PLAN

SUMMARY PLAN DESCRIPTION

Introduction

Port of Port Townsend sponsors the Port of Port Townsend Cafeteria Plan (the "Cafeteria Plan") that allows eligible Employees to choose from a menu of different benefits paid for with pre-tax dollars. (Such plans are also commonly known as "salary reduction plans" or "Section 125 plans").

This Summary Plan Description ("SPD") describes the basic features of the Cafeteria Plan, how it generally operates and how Employees can gain the maximum advantage from it.

PLEASE NOTE: This SPD is for general informational purposes only. It does not describe every detail of the Cafeteria Plan. If there is a conflict between the Cafeteria Plan documents and this SPD, then the Cafeteria Plan documents will control.

Cafeteria Plan

CAF Q-1. How do I pay for Port of Port Townsend benefits on a pre-tax basis?

When you first become eligible for the Plan, you may elect to pay for benefits on a pre-tax basis by entering an election with the Employer. At the Employer's option, this may be done with a traditional "paper" salary reduction agreement or it may be done in electronic form. Whatever medium is used, it shall be referred to as a Salary Reduction Agreement for purposes of this SPD.

BE ADVISED: Your Employer uses a rolling or "evergreen" election procedure for this Plan. This means you will automatically maintain the same benefits at the same level from Plan Year to Plan Year unless you indicate that you wish to do something differently during the Open Enrollment Period. Please be sure to review your benefits during the Open Enrollment Period to ensure that they meet your anticipated needs.

When you pay for benefits on a pre-tax basis, you reduce your salary to pay for your share of the cost of coverage with pretax funds instead of receiving a corresponding amount of your regular pay that would otherwise be subject to taxes.");

Example CAF Q-1(a): Sally is paid an annual salary of $30,000. Sally elects to pay for $2,000 worth of benefits for the Plan Year on a pre-tax basis. By doing so, she is electing to reduce her salary, and therefore also her taxable income, by $2,000 for the year to $28,000.

From then on, you must pay contributions for such coverage by having that portion deducted from each paycheck on a pre-tax basis (generally an equal portion from each paycheck, or an amount otherwise agreed to or as deemed appropriate by the Plan Administrator).

Example CAF Q-1(b): Using the same facts from Example Q-1(a), suppose Sally is paid 26 times a year (bi-weekly). Because she has elected $2,000 in benefits, she will have $76.92 deducted from each paycheck for the year ($2,000 divided by 26 paychecks equals $76.92).

CAF Q-2. What benefits may be elected under the Cafeteria Plan?

The Cafeteria Plan includes the following benefit plans:

The Premium Payment Component permits an Employee to pay for his or her share of contributions for insurance plans with pretax dollars. Under the Port of Port Townsend Cafeteria Plan, these benefits may include:

* Accident
* Bridge
* Dental
* Hospital Indemnity
* Medical
* Vision
* Other - Cancer

If you select any or all of these benefits, you will likely pay all or some of the contributions; the Employer may contribute some or no portion of them. The applicable amounts will be described in documents furnished separately to you as necessary from time to time.

The Employer may at its own discretion offer cash in lieu of benefits for participants who do not choose benefits. If the Employer does choose this option, participants will be informed through other communications.

CAF Q-3. Who can participate in the Cafeteria Plan?

Employees who are working 17 hours per week or more are eligible to participate in the Cafeteria Plan following 30 days of employment with the Employer, provided that the election procedures in CAF Q-5 are followed.

An "Employee" is any individual who the Employer classifies as a common-law employee and who is on the Employer's W-2 payroll.

Please note: "Employee" does not include the following:

(a) any leased employee (including but not limited to those individuals defined as leased employees in Code § 414(n)) or an individual classified by the Employer as a contract worker, independent contractor, temporary employee, or casual employee for the period during which such individual is so classified, whether or not any such individual is on the Employer's W-2 payroll or is determined by the IRS or others to be a common-law employee of the Employer;

(b) any individual who performs services for the Employer but who is paid by a temporary or other employment or staffing agency for the period during which such individual is paid by such agency, whether or not such individual is determined by the IRS or others to be a common-law employee of the Employer;

(c) any employee covered under a collective bargaining agreement;

(d) any individual considered "self-employed" by the IRS because of an ownership interest in Port of Port Townsend;

CAF Q-4. What tax savings are possible under the Cafeteria Plan?

You may save both federal income tax and FICA (Social Security/Medicare) taxes by participating in the Port of Port Townsend Cafeteria Plan.

Example CAF Q4(a): Suppose Sally pays 15% in federal income taxes for the year. With an annual salary of $30,000, that could mean as much as $4,500 in federal income taxes, plus $2,295 in FICA taxes (calculated at 7.65% of income). But by electing $2,000 of cafeteria plan benefits for the year, Sally lowers her income by $2,000, meaning she is only taxed on $28,000. This comes out to $4,200 in income tax plus $2,142 in FICA tax. That's a $453 tax savings for the year.

(**Caution**: This example is intended to illustrate the general effect of "pre-taxing" benefits through a cafeteria plan. It does not take into account the effects of filing status, tax exemptions, tax deductions and other factors affecting tax liability. Furthermore, the amount of the contributions used in this example is not meant to reflect your actual contributions. It is also not intended to reflect specifically upon your particular tax situation. You are encouraged to consult with your accountant or other professional tax advisor with regard to your particular tax situation, especially with regard to state and local taxes.)

CAF Q-5. When does participation begin and end in the Cafeteria Plan?

After you satisfy the eligibility requirements, you can become a Participant on the first day of the next calendar month by electing benefits in a manner such as described in CAF Q-1. An eligible Employee who does not elect benefits will not be able to elect any benefits under the Cafeteria Plan until the next Open Enrollment Period (unless a "Change in Election Event" occurs, as explained in CAF Q-7).

An Employee continues to participate in the Cafeteria Plan until (a) termination of the Cafeteria Plan; or (b) the date on which the Participant ceases to be an eligible Employee (because of retirement, termination of employment, layoff, reduction of hours, or any other reason). However, for purposes of pre-taxing COBRA coverage for Health Insurance Benefits, certain Employees may be able to continue eligibility in the Cafeteria Plan for certain periods. See CAF Q-8 and CAF Q-12 for more information about this as information about how termination of participation affects your Benefits.

CAF Q-6. What is meant by "Open Enrollment Period" and "Plan Year"?

The "Open Enrollment Period" is the period during which you have an opportunity to participate under the Cafeteria Plan by electing to do so. (See Q-5.) You will be notified of the timing and duration of the Open Enrollment Period, which for any new Plan Year generally will occur during the quarter preceding the new Plan Year.

The Plan Year for the Port of Port Townsend Cafeteria Plan is the period beginning on 9/1/2020 and ending on 12/31/2020.

CAF Q-7. Can I change my elections under the Cafeteria Plan during the Plan Year?

Except in the case of HSA elections, you generally cannot change your election to participate in the Cafeteria Plan or vary the salary reduction amounts that you have selected during the Plan Year (this is known as the "irrevocability rule"). Of course, you can change your elections for benefits and salary reductions during the Open Enrollment Period, but those election changes will apply only for the following Plan Year.

However, there are several important exceptions to the irrevocability rule, many of which have to do with events in your personal or professional life that may occur during the Plan Year.

Here are the exceptions to the irrevocability rule:

1. Leaves of Absence

You may change an election under the Cafeteria Plan upon FMLA and non-FMLA leave only as described in CAF Q-14.

2. Change in Status.

If one or more of the following Changes in Status occur, you may revoke your old election and make a new election, provided that both the revocation and new election are on account of and correspond with the Change in Status (as described in item 3 below). Those occurrences that qualify as a Change in Status include the events described below, as well as any other events that the Plan Administrator, in its sole discretion and on a uniform and consistent basis, determines are permitted under IRS regulations:

- a change in your legal marital status (such as marriage, death of a Spouse, divorce, legal separation, or annulment);
- a change in the number of your Dependents (such as the birth of a child, adoption or placement for adoption of a Dependent, or death of a Dependent);
- any of the following events that change the employment status of you, your Spouse, or your Dependent and that affect benefits eligibility under a cafeteria plan (including this Cafeteria Plan) or other employee benefit plan of you, your Spouse, or your Dependents. Such events include any of the following changes in employment status: termination or commencement of employment; a strike or lockout; a commencement of or return from an unpaid leave of absence; a change in worksite; switching from salaried to hourly-paid, union to non-union, or full-time to part-time (or vice versa); incurring a reduction or increase in hours of employment; or any other similar change that makes the individual become (or cease to be) eligible for a particular employee benefit;
- an event that causes your Dependent to satisfy or cease to satisfy an eligibility requirement for a particular benefit (such as an employee's child covered as a dependent by an accident or health plan who turns 27 during the taxable year); or
- a change in your, your Spouse's, or your Dependent's place of residence.

3. Change in Status - Other Requirements.

If you wish to change your election based on a Change in Status, you must establish that the revocation is on account of and corresponds with the Change in Status. The Plan Administrator, in its sole discretion and on a uniform and consistent basis, shall determine whether a requested change is on account of and corresponds with a Change in Status. As a general rule, a desired election change will be found to be consistent with a Change in Status event if the event affects coverage eligibility.

In addition, you must satisfy the following specific requirements in order to alter your election based on that Change in Status:

- *Loss of Spouse or Dependent Eligibility; Special COBRA Rules.* For Health Insurance Benefits, a special rule governs which type of election changes are consistent with the Change in Status. For a Change in Status involving your divorce, annulment, or legal separation from your Spouse, the death of your Spouse or your Dependent, or your Dependent's ceasing to satisfy the eligibility requirements for coverage, you may elect only to cancel the accident or health benefits for the affected Spouse or Dependent. A change in election for any individual other than your Spouse involved in the divorce, annulment, or legal separation, your deceased Spouse or Dependent, or your Dependent that ceased to satisfy the eligibility requirements would fail to correspond with that Change in Status.

  However, if you, your Spouse, or your Dependent elects COBRA continuation coverage under the Employer's plan because you ceased to be eligible because of a reduction of hours or because your Dependent ceases to satisfy eligibility requirements for coverage, and if you remain a Participant under the terms of this Cafeteria Plan, then you may in certain circumstances be able to increase your contributions to pay for such coverage. See CAF Q-12.

- *Gain of Coverage Eligibility Under Another Employer's Plan.* For a Change in Status in which you, your Spouse, or your Dependent gains eligibility for coverage under another Employer's cafeteria plan (or qualified benefit plan) as a result of a change in your marital status or a change in your, your Spouse's, or your Dependent's employment status, your election to cease or decrease coverage for that individual under the Cafeteria Plan would correspond with that Change in Status only if coverage for that individual becomes effective or is increased under the other Employer's plan.

4. Special Enrollment Rights. In certain circumstances, enrollment for Health Insurance Benefits may occur outside the Open Enrollment Period, as explained in materials provided to you separately describing the Health Insurance Benefits. When a special enrollment right explained in those separate documents applies to your Medical Insurance Benefits, you may

change your election under the Cafeteria Plan to correspond with the special enrollment right. Special enrollments may also be available as a result of a loss of eligibility for Medicaid or for coverage under a state children's health insurance program (SCHIP) or as a result of eligibility for a state premium assistance subsidy under the plan from Medicaid or SCHIP.

5. Certain Judgments, Decrees, and Orders. If a judgment, decree, or order from a divorce, separation, annulment, or custody change requires your child (including a foster child who is your Dependent) to be covered under the Health Insurance Benefits, you may change your election to provide coverage for the child. If the order requires that another individual (such as your former Spouse) cover the child, then you may change your election to revoke coverage for the child, provided that such coverage is, in fact, provided for the child.

6. Medicare or Medicaid. If you, your Spouse, or your Dependent becomes entitled to (i.e., becomes enrolled in) Medicare or Medicaid, then you may reduce or cancel that person's accident or health coverage under the Medical Insurance Plan. Similarly, if you, your Spouse, or your Dependent who has been entitled to Medicare or Medicaid loses eligibility for such coverage, then you may elect to commence or increase that person's accident or health coverage.

7. Change in Cost. If the cost charged to you for your Health Insurance Benefits significantly increases during the Plan Year, then you may choose to do any of the following: (a) make a corresponding increase in your contributions; (b) revoke your election and receive coverage under another benefit package option (if any) that provides similar coverage, or elect similar coverage under the plan of your Spouse's employer; or (c) drop your coverage, but only if no other benefit package option provides similar coverage. Coverage under another employer plan, such as the plan of a Spouse's or Dependent's employer, may be treated as similar coverage if it otherwise meets the requirements of similar coverage.) If the cost of Health Insurance significantly decreases during the Plan Year, then the Plan Administrator may permit the following election changes: (a) if you are enrolled in the benefit package option that has decreased in cost, you may make a corresponding decrease in your contributions; (b) if you are enrolled in another benefit package option (such as the HMO option under the Medical Insurance Plan), you may change your election on a prospective basis to elect the benefit package option that has decreased in cost (such as the PPO option under the Medical Insurance Plan); or (c) if you are otherwise eligible, you may elect the benefit package option that has decreased in cost on a prospective basis, subject to the terms and limitations of the benefit package option.

For insignificant increases or decreases in the cost of benefits, however, the Plan Administrator will automatically adjust your election contributions to reflect the minor change in cost.

The Plan Administrator generally will notify you of increases or decreases in the cost of Health Insurance benefits.

8. Change in Coverage. You may also change your election if one of the following events occurs:

- *Significant Curtailment of Coverage.* If your Health Insurance Benefits coverage is significantly curtailed without a loss of coverage (for example, when there is an increase in the deductible under the Medical Insurance Benefits), then you may revoke your election for that coverage and elect coverage under another benefit package option that provides similar coverage. (Coverage under a plan is significantly curtailed only if there is an overall reduction of coverage under the plan generally loss of one particular physician in a network does not constitute significant curtailment.) If your Health Insurance Benefits coverage is significantly curtailed with a loss of coverage (for example, if you lose all coverage under the option by reason of an overall lifetime or annual limitation), then you may either revoke your election and elect coverage under another benefit package option that provides similar coverage, elect similar coverage under the plan of your Spouse's employer, or drop coverage, but only if there is no option available under the plan that provides similar coverage. (The Plan Administrator generally will notify you of significant curtailments in Medical Insurance Benefits coverage.
- *Addition or Significant Improvement of Cafeteria Plan Option.* If the Cafeteria Plan adds a new option or significantly improves an existing option, then the Plan Administrator may permit Participants who are enrolled in an option other than the new or improved option to elect the new or improved option. Also, the Plan Administrator may permit eligible Employees to elect the new or improved option on a prospective basis, subject to limitations imposed by the applicable option.
- *Loss of Other Group Health Coverage.* You may change your election to add group health coverage for you, your Spouse, or your Dependent, if any of you loses coverage under any group health coverage sponsored by a governmental or educational institution (for example, a state children's health insurance program or certain Indian tribal programs).
- *Change in Election Under Another Employer Plan.* You may make an election change that is on account of and corresponds with a change made under another employer plan (including a plan of the Employer or a plan of your Spouse's or Dependent's employer), so long as (a) the other cafeteria plan or qualified benefits plan permits its participants to make an election change permitted under the IRS regulations; or (b) the Cafeteria Plan permits you to

make an election for a period of coverage (for example, the Plan Year) that is different from the period of coverage under the other cafeteria plan or qualified benefits plan, which it does.

For example, if an election to drop coverage is made by your Spouse during his or her Employer's open enrollment, you may add coverage under the Cafeteria Plan to replace the dropped coverage.

9. Intention or Need to Obtain Coverage though a Marketplace Established under the Affordable Care Act.

You may revoke your Health Insurance Benefits coverage mid-Plan Year if either one of the following applies:

- You are seeking to enroll yourself and any other related individuals in coverage to be obtained through a Marketplace.
- You have experienced a reduction of hours and reasonably expect to be working less than 30 hours for the foreseeable future and will seek coverage to be obtained through a Marketplace.

CAF Q-8. What happens if my employment ends during the Plan Year or I lose eligibility for other reasons?

If your employment with the Employer is terminated during the Plan Year, then your active participation in the Cafeteria Plan will cease and you will not be able to make any more contributions to the Cafeteria Plan for Insurance Benefits.

See CAF Q-12 for information on your right to continued or converted group health coverage after termination of your employment.

For purposes of pre-taxing COBRA coverage for Health Insurance Benefits, certain Employees may be able to continue eligibility in the Cafeteria Plan for certain periods. See CAF Q-12.

If you are rehired within the same Plan Year and are eligible for the Cafeteria Plan, then you may make new elections, provided that you are rehired more than 30 days after you terminated employment. If you are rehired within 30 days or less during the same Plan Year, then your prior elections will be reinstated.

If you cease to be an eligible Employee for reasons other than termination of employment, such as a reduction of hours, then you must complete the waiting period described in CAF Q-3 before again becoming eligible to participate in the Plan.

CAF Q-9. ***RESERVED***

CAF Q-10. How long will the Cafeteria Plan remain in effect?

Although the Employer expects to maintain the Cafeteria Plan indefinitely, it has the right to amend or terminate all or any part of the Cafeteria Plan at any time for any reason. It is also possible that future changes in state or federal tax laws may require that the Cafeteria Plan be amended accordingly.

CAF Q-11. What happens if my claim for benefits is denied?

Insurance Benefits

The applicable insurance company will decide your claim in accordance with its claims procedures. If your claim is denied, you may appeal to the insurance company for a review of the denied claim. If you don't appeal on time, you will lose your right to file suit in a state or federal court, as you will not have exhausted your internal administrative appeal rights (which generally is a prerequisite to bringing a suit in state or federal court). For more information about how to file a claim and for details regarding the medical insurance company's claims procedures, consult the claims procedure applicable under that plan or policy, as described in the plan document or summary plan description for the Insurance Plan.

Appeals.

If your claim is denied in whole or part, then you (or your authorized representative) may request review upon written application to the "Committee" (the Benefits Committee that acts on behalf of the Plan Administrator with respect to appeals). Your appeal must be made in writing within 180 days after your receipt of the notice that the claim was denied. If you do not appeal on time, you will lose the right to appeal the denial and the right to file suit in court. Your written appeal should state the reasons that you feel your claim should not have been denied. It should include any additional facts and/or documents that you feel support your claim. You will have the opportunity to ask additional questions and make written comments, and you may review (upon request and at no charge) documents and other information relevant to your appeal.

Decision on Review.

Your appeal will be reviewed and decided by the Committee or other entity designated in the Plan in a reasonable time not later than 60 days after the Committee receives your request for review. The Committee may, in its discretion, hold a hearing on the denied claim. Any medical expert consulted in connection with your appeal will be different from and not subordinate to

any expert consulted in connection with the initial claim denial. The identity of a medical expert consulted in connection with your appeal will be provided. If the decision on review affirms the initial denial of your claim, you will be furnished with a notice of adverse benefit determination on review setting forth:

- the specific reason(s) for the decision on review;
- the specific Plan provision(s) on which the decision is based;
- a statement of your right to review (upon request and at no charge) relevant documents and other information;
- if an internal rule, guideline, protocol, or other similar criterion is relied on in making the decision on review, then a description of the specific rule, guideline, protocol, or other similar criterion or a statement that such a rule, guideline, protocol, or other similar criterion was relied on and that a copy of such rule, guideline, protocol, or other criterion will beprovided free of charge to you upon request;

CAF Q-12. What is "Continuation Coverage" and how does it work?

COBRA

If you have elect Health Insurance Benefits under this Plan, you may have certain rights to the continuation of such benefits after a "Qualifying Event" (e.g., a termination of employment). See Appendix B of this SPD for a detailed description of your rights to "continuation coverage" under COBRA.

USERRA

Continuation and reinstatement rights may also be available if you are absent from employment due to service in the uniformed services pursuant to the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA). More information about coverage under USERRA is available from the Plan Administrator.

CAF Q-13. How will participating in the Cafeteria Plan affect my Social Security and other benefits?

Participating in the Cafeteria Plan will reduce the amount of your taxable income, which may result in a decrease in your Social Security benefits and/or other benefits which are based on taxable income. However, the tax savings that you realize through Cafeteria Plan participation will often more than offset any reduction in other benefits. If you are still unsure, you are encouraged to consult with your accountant or other tax advisor.

CAF Q-14. How do leaves of absence (such as under FMLA) affect my benefits?

FMLA Leaves of Absence.

If the Employer is subject to the federal Family and Medical Leave Act of 1993 and you go on a qualifying leave under the FMLA, then to the extent required by the FMLA your Employer will continue to maintain your Health Insurance Benefits on the same terms and conditions as if you were still active (that is, your Employer will continue to pay its share of the contributions to the extent that you opt to continue coverage). Your Employer may require you to continue all Medical Insurance Benefits coverage while you are on paid leave (so long as Participants on non-FMLA paid leave are required to continue coverage). If so, you will pay your share of the contributions by the method normally used during any paid leave (for example, on a pre-tax salary-reduction basis).

If you are going on unpaid FMLA leave (or paid FMLA leave where coverage is not required to be continued) and you opt to continue your Insurance Benefits, then you may pay your share of the contributions in one of three ways: (a) with after-tax dollars while on leave; (b) with pretax dollars to the extent that you receive compensation during the leave, or by pre-paying all or a portion of your share of the contributions for the expected duration of the leave on a pre-tax salary reduction basis out of your pre-leave compensation, including unused sick days and vacation days (to pre-pay in advance, you must make a special election before such compensation normally would be available to you (but note that prepayments with pre-tax dollars may not be used to pay for coverage during the next Plan Year); or (c) by other arrangements agreed upon by you and the Plan Administrator (for example, the Plan Administrator may pay for coverage during the leave and withhold amounts from your compensation upon your return from leave).

If your Employer requires all Participants to continue Insurance Benefits during the unpaid FMLA leave, then you may discontinue paying your share of the required contributions until you return from leave. Upon returning from leave, you must pay your share of any required contributions that you did not pay during the leave. Payment for your share will be withheld from your compensation either on a pre-tax or after-tax basis, depending on what you and the Plan Administrator agree to.

If your Health Insurance coverage ceases while you are on FMLA leave (e.g., for non-payment of required contributions), you will be permitted to re-enter such Benefits, as applicable, upon return from such leave on the same basis as when you were participating in the Plan before the leave or as otherwise required by the FMLA. You may be required to have coverage for such Benefits reinstated so long as coverage for Employees on non-FMLA leave is required to be reinstated upon return from leave.

If you are commencing or returning from FMLA leave, then your election for non-health benefits provided under this Plan, if any, will be treated in the same way as under your Employer's policy for providing such Benefits for Participants on a non-FMLA leave (see below). If that policy permits you to discontinue contributions while on leave, then upon returning from leave you will be required to repay the contributions not paid by you during leave. Payment will be withheld from your compensation either on a pre-tax or after-tax basis, as agreed to by the Plan Administrator and you or as the Plan Administrator otherwise deems appropriate.

Non-FMLA Leaves of Absence.

If you go on an unpaid leave of absence that does not affect eligibility, then you will continue to participate and the contribution due from you (if not otherwise paid by your regular salary reductions) will be paid by pre-payment before going on leave, with after-tax contributions while on leave, or with catch-up contributions after the leave ends, as determined by the Plan Administrator. If you go on an unpaid leave that does affect eligibility, then the Change in Status rules will apply.

Premium Payment Benefits

PREM Q-1. What are "Premium Payment Benefits"?

As described in CAF Q-1, if you elect Premium Payment Benefits you will be able to pay for your share of contributions for Insurance Benefits with pre-tax dollars by electing to do so. Because the share of the contributions that you pay will be with pre-tax funds, you may save both federal income taxes and FICA (Social Security) taxes. See Q-4.

PREM Q-2. How are my Premium Payment Benefits paid?

As described in CAF Q-1 and in PREM Q-1, if you select an Insurance Plan described in CAF Q-2, then you may be required to pay a portion of the contributions. When you complete the Election Form/Salary Reduction Agreement, if you elect to pay for benefits on a pre-tax basis you agree to a salary reduction to pay for your share of the cost of coverage (also known as contributions) with pre-tax funds instead of receiving a corresponding amount of your regular pay that would otherwise be subject to taxes. From then on, you must pay a contribution for such coverage by having that portion deducted from each paycheck on a pre-tax basis (generally an equal portion from each paycheck, or an amount otherwise agreed to or as deemed appropriate by the Plan Administrator).

The Employer may contribute all, some, or no portion of the Premium Payment Benefits that you have selected, as described in documents furnished separately to you from time to time.

Miscellaneous

MISC Q-1

What are my ERISA Rights?

The Cafeteria Plan is not an ERISA welfare benefit plan under the Employee Retirement Income Security Act of 1974 (ERISA). The SPDs of the various benefits components of the Plan will describe your rights under ERISA, if applicable, under that component.

Regardless, a participant in the Cafeteria Plan, you are entitled to certain rights and protections under ERISA. ERISA provides that all participants shall be entitled to:

- Examine, without charge, at the Plan Administrator's office and at other specified locations (such as worksites) all documents governing the Plan, including insurance contracts, and a copy of the latest annual report (Form 5500 Series), if any, filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration;
- Obtain, upon written request to the Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Plan Administrator may make a reasonable charge for the copies); and
- Receive a summary of the Plan's annual financial report, if any. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

COBRA and HIPAA Rights. You have a right to continue your Health Insurance Plan coverage for yourself if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this SPD and the documents governing the plan on the rules governing your COBRA continuation coverage rights.

HIPAA Privacy Rights. Under another provision of HIPAA, group health plans are required to take steps to ensure that certain "protected health information" (PHI) is kept confidential. You may receive a separate notice from the Employer (or medical insurers) that outlines its health privacy policies.

Fiduciary Obligations. In addition to creating rights for participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefits 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 participants.

No Discrimination. No one, including your employer or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a plan benefit or exercising your rights under ERISA.

Right to Review. If your claim for a 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.

Enforcing Your Rights. Under ERISA, there are steps that you can take to enforce these rights. For instance, if you request a copy of plan documents or the latest annual report (if any) from the plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive them, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits that is denied or ignored in whole or in part, then you may file suit in a state or federal court (but only if you have first filed your claim under the Plan's claims procedures and, if applicable, filed a timely appeal of any denial of your claim).

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

MISC Q-2. What other general information should I know?

This MISC Q-2 contains certain general information that you may need to know about the Plan.

Plan Information

Official Name of the Plan: Port of Port Townsend Cafeteria Plan

Plan Number: 501

Effective Date: 9/1/2020.

Plan Year: 9/1/2020 to 12/31/2020. Your Plan's records are maintained on this period of time

Type of Plan: Welfare plan providing various insurance benefits

Employer/Plan Sponsor Information

Name and Address:

Port of Port Townsend

2701 jefferson st P.O. Box 1180
Port Townsend, WA 98368
Federal employee tax identification number (EIN): 916001024

Plan Administrator Information

Name, Address, and business telephone number:

Port of Port Townsend

2701 jefferson st P.O. Box 1180
Port Townsend, WA 98368
Attention: Human Resources Manager
Telephone: 3603850656

Agent for Service of Legal Process

The name and address of the Plan's agent for service of legal process is:

Port of Port Townsend

2701 jefferson st P.O. Box 1180
Port Townsend, WA 98368
Attention: Benefits Committee

Qualified Medical Child Support Order

The Health Insurance Plans will provide benefits as required by any qualified medical child support order (QMCSO), as defined in ERISA § 609(a). The Plan has detailed procedures for determining whether an order qualifies as a QMCSO. Participants and beneficiaries can obtain, without charge, a copy of such procedures from the Plan Administrator.

Newborns' and Mothers' Health Protection Act of 1996

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

Appendix A

*****Affiliated Employers*****

Appendix B

COBRA CONTINUATION COVERAGE RIGHTS under the Port of Port Townsend Cafeteria Plan (the "Plan")

The following paragraphs generally explain COBRA coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it. **PLEASE READ THE FOLLOWING CAREFULLY.**

The Port of Port Townsend Cafeteria Plan has group health insurance components and you may be enrolled in one or more of these components. COBRA (and the description of COBRA coverage contained in this SPD) applies only to the group health plan benefits offered under the Plan and not to any other benefits offered under the Plan or by Port of Port Townsend. The Plan provides no greater COBRA rights than what COBRA requires - nothing in this SPD is intended to expand your rights beyond COBRA's requirements.

What Is COBRA Coverage?

COBRA coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed below in the section entitled "Who Is Entitled to Elect COBRA?"

COBRA coverage may become available to "qualified beneficiaries"

After a qualifying event occurs and any required notice of that event is properly provided to Port of Port Townsend, COBRA coverage must be offered to each person losing Plan coverage who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries and would be entitled to elect COBRA if coverage under the Plan is lost because of the qualifying event. (Certain newborns, newly adopted children, and alternate recipients under QMCSOs may also be qualified beneficiaries. This is discussed in more detail in separate paragraphs below.)

Who Is Entitled to Elect COBRA?

We use the pronoun "you" in the following paragraphs regarding COBRA to refer to each person covered under the Plan who is or may become a qualified beneficiary.

Qualifying events for the covered employee

If you are an employee, you will be entitled to elect COBRA if you lose your group health coverage under the Plan because either one of the following qualifying events happens:

- your hours of employment are reduced; or
- your employment ends for any reason other than your gross misconduct.

Qualifying events for the covered spouse

If you are the spouse of an employee, you will be entitled to elect COBRA if you lose your group health coverage under the Plan because any of the following qualifying events happens:

- your spouse dies;
- your spouse's hours of employment are reduced;
- your spouse's employment ends for any reason other than his or her gross misconduct;
- you become divorced or legally separated from your spouse. Also, if your spouse (the employee) reduces or eliminates your group health coverage in anticipation of a divorce or legal separation, and a divorce or legal separation later occurs, then the divorce or legal separation may be considered a qualifying event for you even though your coverage was reduced or eliminated before the divorce or separation.

Qualifying events for dependent children

If you are the dependent child of an employee, you will be entitled to elect COBRA if you lose your group health coverage under the Plan because any of the following qualifying events happens:

- your parent-employee dies;
- your parent-employee's hours of employment are reduced;
- your parent-employee's employment ends for any reason other than his or her gross misconduct;

- you stop being eligible for coverage under the Plan as a "dependent child."

Electing COBRA after leave under the Family and Medical Leave Act (FMLA)

Under special rules that apply if an employee does not return to work at the end of an FMLA leave, some individuals may be entitled to elect COBRA even if they were not covered under the Plan during the leave. Contact Port of Port Townsend for more information about these special rules.

Special second election period for certain eligible employees who did not elect COBRA

Certain employees and former employees who are eligible for federal trade adjustment assistance (TAA) or alternative trade adjustment assistance (ATAA) are entitled to a second opportunity to elect COBRA for themselves and certain family members (if they did not already elect COBRA) during a special second election period of 60 days or less (but only if the election is made within six months after Plan coverage is lost).

When Is COBRA Coverage Available?

When the qualifying event is the end of employment, reduction of hours of employment, or death of the employee, the Plan will offer COBRA coverage to qualified beneficiaries. You need not notify Port of Port Townsend of any of these qualifying events.

Caution:

You stop being eligible for coverage as dependent child whenever you fail to satisfy any part of the plan's definition of dependent child.

You must notify the plan administrator of certain qualifying events by this deadline

For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), a COBRA election will be available to you only if you notify Port of Port Townsend in writing within 60 days after the later of (1) the date of the qualifying event; or (2) the date on which the qualified beneficiary loses (or would lose) coverage under the terms of the Plan as a result of the qualifying event.

No COBRA election will be available unless you follow the Plan's notice procedures and meet the notice deadline

In providing this notice, you must use the Plan's form entitled "Notice of Qualifying Event Form" and you must follow the notice procedures specified in the section below entitled "Notice Procedures." If these procedures are not followed or if the notice is not provided to Port of Port Townsend during the 60-day notice period, YOU WILL LOSE YOUR RIGHT TO ELECT COBRA.

How to elect COBRA

To elect COBRA, you must complete the Election Form that is part of the Plan's COBRA election notice and mail or hand-deliver it to Port of Port Townsend. An election notice will be provided to qualified beneficiaries at the time of a qualifying event. You may also obtain a copy of the Election Form from Port of Port Townsend.

Deadline for COBRA election

If mailed, your election must be postmarked (or if hand-delivered, your election must be received by the individual at the address specified on the Election Form) no later than 60 days after the date of the COBRA election notice provided to you at the time of your qualifying event (or, if later, 60 days after the date that Plan coverage is lost). IF YOU DO NOT SUBMIT A COMPLETED ELECTION FORM BY THIS DUE DATE, YOU WILL LOSE YOUR RIGHT TO ELECT COBRA.

Independent election rights

Each qualified beneficiary will have an independent right to elect COBRA.

Any qualified beneficiary for whom COBRA is not elected within the 60-day election period specified in the Plan's COBRA election notice WILL LOSE HIS OR HER RIGHT TO ELECT COBRA COVERAGE.

Special Considerations in Deciding Whether to Elect COBRA

In considering whether to elect COBRA, you should take into account that a failure to elect COBRA will affect your future rights under federal law. You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse's employer) within 30 days after your group health coverage under the Plan ends because of one of the qualifying events listed above. You will also have the same special enrollment

right at the end of COBRA coverage if you get COBRA coverage for the maximum time available to you.

Length of COBRA Coverage

COBRA coverage is a temporary continuation of coverage. The COBRA coverage periods described below are maximum coverage periods.

COBRA coverage can end before the end of the maximum coverage period for several reasons, which are described in the section below entitled "Termination of COBRA Coverage Before the End of the Maximum Coverage Period."

Death, divorce, legal separation, or child's loss of dependent status

When Plan coverage is lost due to the death of the employee, the covered employee's divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA coverage under the Plan's Medical and Dental components can last for up to a total of 36 months.

If the covered employee becomes entitled to Medicare within 18 months before his or her termination of employment or reduction of hours.

When Plan coverage is lost due to the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA coverage under the Plan's Medical and Dental components for qualified beneficiaries (other than the employee) who lose coverage as a result of the qualifying event can last until up to 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare eight months before the date on which his employment terminates, COBRA coverage for his spouse and children who lost coverage as a result of his termination can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus eight months). This COBRA coverage period is available only if the covered employee becomes entitled to Medicare within 18 months BEFORE the termination or reduction of hours.

Termination of employment or reduction of hours

Otherwise, when Plan coverage is lost due to the end of employment or reduction of the employee's hours of employment, COBRA coverage under the Plan's Medical and Dental components generally can last for only up to a total of 18 months.

Extension of Maximum Coverage Period

If the qualifying event that resulted in your COBRA election was the covered employee's termination of employment or reduction of hours, an extension of the maximum period of coverage may be available if a qualified beneficiary is disabled or a second qualifying event occurs. You must notify Port of Port Townsend of a disability or a second qualifying event in order to extend the period of COBRA coverage. Failure to provide notice of a disability or second qualifying event will eliminate the right to extend the period of COBRA coverage.

Disability extension of COBRA coverage

If a qualified beneficiary is determined by the Social Security Administration to be disabled and you notify Port of Port Townsend in a timely fashion, all of the qualified beneficiaries in your family may be entitled to receive up to an additional 11 months of COBRA coverage, for a total maximum of 29 months. This extension is available only for qualified beneficiaries who are receiving COBRA coverage because of a qualifying event that was the covered employee's termination of employment or reduction of hours. The disability must have started at some time before the 61st day after the covered employee's termination of employment or reduction of hours and must last at least until the end of the period of COBRA coverage that would be available without the disability extension (generally 18 months, as described above). Each qualified beneficiary will be entitled to the disability extension if one of them qualifies.

You must notify Port of Port Townsend of a qualified beneficiary's disability by this deadline

The disability extension is available only if you notify Port of Port Townsend in writing of the Social Security Administration's determination of disability within 60 days after the latest of:

- the date of the Social Security Administration's disability determination;
- the date of the covered employee's termination of employment or reduction of hours; and
- the date on which the qualified beneficiary loses (or would lose) coverage under the terms of the Plan as a result of the covered employee's termination of employment or reduction of hours.

You must also provide this notice within 18 months after the covered employee's termination of employment or reduction of hours in order to be entitled to a disability extension.

No disability extension will be available unless you follow the Plan's notice procedures and meet the notice deadline

In providing this notice, you must use the Plan's form entitled "Notice of Disability Form" and you must follow the notice procedures specified in the section below entitled "Notice Procedures."

If these procedures are not followed or if the notice is not provided to Port of Port Townsend during the 60-day notice period and within 18 months after the covered employee's termination of employment or reduction of hours, then there will be no disability extension of COBRA coverage.

Second qualifying event extension of COBRA coverage

An extension of coverage will be available to spouses and dependent children who are receiving COBRA coverage if a second qualifying event occurs during the 18 months (or, in the case of a disability extension, the 29 months) following the covered employee's termination of employment or reduction of hours. The maximum amount of COBRA coverage available when a second qualifying event occurs is 36 months. Such second qualifying events may include the death of a covered employee, divorce or legal separation from the covered employee, or a dependent child's ceasing to be eligible for coverage as a dependent under the Plan. These events can be a second qualifying event only if they would have caused the qualified beneficiary to lose coverage under the Plan if the first qualifying event had not occurred. (This extension is not available under the Plan when a covered employee becomes entitled to Medicare after his or her termination of employment or reduction of hours.)

You must notify Port of Port Townsend of a second qualifying event by this deadline

This extension due to a second qualifying event is available only if you notify Port of Port Townsend in writing of the second qualifying event within 60 days after the date of the second qualifying event.

No extension will be available unless you follow the Plan's notice procedures and meet the notice deadline

In providing this notice, you must use the Plan's form entitled "Notice of Second Qualifying Event Form" (you may obtain a copy of this form from Port of Port Townsend at no charge), and you must follow the notice procedures specified in the section below entitled "Notice Procedures." If these procedures are not followed or if the notice is not provided to Port of Port Townsend during the 60-day notice period, then there will be no extension of COBRA coverage due to a second qualifying event.

Termination of COBRA Coverage Before the End of the Maximum Coverage Period

COBRA coverage will automatically terminate before the end of the maximum period if:

- any required premium is not paid in full on time;
- a qualified beneficiary becomes entitled to Medicare benefits (under Part A, Part B, or both) after electing COBRA;
- the employer ceases to provide any group health plan for its employees; or
- during a disability extension period, the disabled qualified beneficiary is determined by the Social Security Administration to be no longer disabled (COBRA coverage for all qualified beneficiaries, not just the disabled qualified beneficiary, will terminate).

COBRA coverage may also be terminated for any reason the Plan would terminate coverage of a participant or beneficiary not receiving COBRA coverage (such as fraud).

You must notify Port of Port Townsend if a qualified beneficiary becomes entitled to Medicare or obtains other group health plan coverage

You must notify Port of Port Townsend in writing within 30 days if, after electing COBRA, a qualified beneficiary becomes entitled to Medicare (Part A, Part B, or both) or becomes covered under other group health plan coverage. In addition, if you were already entitled to Medicare before electing COBRA, notify Employer of the date of your Medicare entitlement at the address shown in the section below entitled "Notice Procedures."

You must notify Port of Port Townsend if a qualified beneficiary ceases to be disabled

If a disabled qualified beneficiary is determined by the Social Security Administration to no longer be disabled, you must notify Port of Port Townsend of that fact within 30 days after the Social Security Administration's determination.

Cost of COBRA Coverage

Each qualified beneficiary is required to pay the entire cost of COBRA coverage. The amount a qualified beneficiary may be required to pay may not exceed 102% (or, in the case of an extension of COBRA coverage due to a disability, 150%) of the

cost to the group health plan (including both employer and employee contributions) for coverage of a similarly situated plan participant or beneficiary who is not receiving COBRA coverage. The amount of your COBRA premiums may change from time to time during your period of COBRA coverage and will most likely increase over time. You will be notified of COBRA premium changes.

Payment for COBRA Coverage

How premium payments must be made

All COBRA premiums must be paid by check. Your first payment and all monthly payments for COBRA coverage must be mailed or hand-delivered to the individual at the payment address specified in the election notice provided to you at the time of your qualifying event. However, if the Plan notifies you of a new address for payment, you must mail or hand-deliver all payments for COBRA coverage to the individual at the address specified in that notice of a new address.

When premium payments are considered to be made

If mailed, your payment is considered to have been made on the date that it is postmarked. If hand-delivered, your payment is considered to have been made when it is received by the individual at the address specified above. You will not be considered to have made any payment by mailing or hand-delivering a check if your check is returned due to insufficient funds or otherwise.

First payment for COBRA coverage

If you elect COBRA, you do not have to send any payment with the Election Form. However, you must make your first payment for COBRA coverage not later than 45 days after the date of your election. (This is the date your Election Form is postmarked, if mailed, or the date your Election Form is received by the individual at the address specified for delivery of the Election Form, if hand-delivered.) See the section above entitled "Electing COBRA Coverage."

Your first payment must cover the cost of COBRA coverage from the time your coverage under the Plan would have otherwise terminated up through the end of the month before the month in which you make your first payment. (For example, Sue's employment terminates on September 30, and she loses coverage on September 30. Sue elects COBRA on November 15. Her initial premium payment equals the premiums for October and November and is due on or before December 30, the 45th day after the date of her COBRA election.)

You are responsible for making sure that the amount of your first payment is correct. You may contact Port of Port Townsend using the contact information provided below to confirm the correct amount of your first payment. Claims for reimbursement will not be processed and paid until you have elected COBRA and made the first payment for it.

<u>If you do not make your first payment for COBRA coverage in full within 45 days after the date of your election, you will lose all COBRA rights under the Plan.</u>

Monthly payments for COBRA coverage

After you make your first payment for COBRA coverage, you will be required to make monthly payments for each subsequent month of COBRA coverage. The amount due for each month for each qualified beneficiary will be disclosed in the election notice provided to you at the time of your qualifying event. Under the Plan, each of these monthly payments for COBRA coverage is due on the first day of the month for that month's COBRA coverage. If you make a monthly payment on or before the first day of the month to which it applies, your COBRA coverage under the Plan will continue for that month without any break. Port of Port Townsend will not send periodic notices of payments due for these coverage periods (that is, <u>we will not send a bill to you for your COBRA coverage - it is your responsibility to pay your COBRA premiums on time</u>).

Grace periods for monthly COBRA premium payments

Although monthly payments are due on the first day of each month of COBRA coverage, you will be given a grace period of 30 days after the first day of the month to make each monthly payment. Your COBRA coverage will be provided for each month as long as payment for that month is made before the end of the grace period for that payment. However, if you pay a monthly payment later than the first day of the month to which it applies, but before the end of the grace period for the month, your coverage under the Plan will be suspended as of the first day of the month and then retroactively reinstated (going back to the first day of the month) when the monthly payment is received. This means that any claim you submit for benefits while your coverage is suspended may be denied and may have to be resubmitted once your coverage is reinstated.

<u>If you fail to make a monthly payment before the end of the grace period for that month, you will lose all rights to COBRA coverage under the Plan.</u>

More Information About Individuals Who May Be Qualified Beneficiaries

Children born to or placed for adoption with the covered employee during a period of COBRA coverage

A child born to, adopted by, or placed for adoption with a covered employee during a period of COBRA coverage is considered to be a qualified beneficiary provided that, if the covered employee is a qualified beneficiary, the covered employee has elected COBRA coverage for himself or herself. The child's COBRA coverage begins when the child is enrolled in the Plan, whether through special enrollment or open enrollment, and it lasts for as long as COBRA coverage lasts for other family members of the employee. To be enrolled in the Plan, the child must satisfy the otherwise applicable Plan eligibility requirements (for example, regarding age).

Alternate recipients under QMCSOs

A child of the covered employee who is receiving benefits under the Plan pursuant to a qualified medical child support order (QMCSO) received by Port of Port Townsend during the covered employee's period of employment with Port of Port Townsend is entitled to the same rights to elect COBRA as an eligible dependent child of the covered employee.

NOTICE PROCEDURES Port of Port Townsend Welfare Benefits Plan (the Plan)

WARNING: If your notice is late or if you do not follow these notice procedures, you and all related qualified beneficiaries will lose the right to elect COBRA (or will lose the right to an extension of COBRA coverage, as applicable).

Notices Must Be Written and Submitted on Plan Forms

Any notice that you provide must be in writing and must be submitted on the Plan's required form (the Plan's required forms are described above in this SPD, and you may obtain copies from Port of Port Townsend without charge). Oral notice, including notice by telephone, is not acceptable. Electronic (including e-mailed or faxed) notices are not acceptable.

How, When, and Where to Send Notices

You must mail or hand-deliver your notice to:

Human Resources Manager

Port of Port Townsend
2701 jefferson st P.O. Box 1180
Port Townsend WA 98368
However, if a different address for notices to the Plan appears in the Plan's most recent summary plan description, you must mail or hand-deliver your notice to that address (if you do not have a copy of the Plan's most recent summary plan description, you may request one from Port of Port Townsend).

If mailed, your notice must be postmarked no later than the last day of the applicable notice period. If hand-delivered, your notice must be received by the individual at the address specified above no later than the last day of the applicable notice period. (The applicable notice periods are described in the paragraphs above entitled "You must notify the plan administrator of certain qualifying events by this deadline," "You must notify Port of Port Townsend of a qualified beneficiary's disability by this deadline", and "You must notify Port of Port Townsend of a second qualifying event by this deadline.")

Information Required for All Notices

Any notice you provide must include (1) the name of the Plan (Port of Port Townsend Welfare Benefits Plan); (2) the name and address of the employee who is (or was) covered under the Plan; (3) the name(s) and address(es) of all qualified beneficiary(ies) who lost coverage as a result of the qualifying event; (4) the qualifying event and the date it happened; and (5) the certification, signature, name, address, and telephone number of the person providing the notice.

Additional Information Required for Notice of Qualifying Event

If the qualifying event is a divorce or legal separation, your notice must include a copy of the decree of divorce or legal separation. If your coverage is reduced or eliminated and later a divorce or legal separation occurs, and if you are notifying Port of Port Townsend that your Plan coverage was reduced or eliminated in anticipation of the divorce or legal separation, your notice must include evidence satisfactory to Port of Port Townsend that your coverage was reduced or eliminated in anticipation of the divorce or legal separation.

Additional Information Required for Notice of Disability

Any notice of disability that you provide must include (1) the name and address of the disabled qualified beneficiary; (2) the date that the qualified beneficiary became disabled; (3) the names and addresses of all qualified beneficiaries who are still receiving COBRA coverage; (4) the date that the Social Security Administration made its determination; (5) a copy of the Social Security Administration's determination; and (6) a statement whether the Social Security Administration has subsequently determined that the disabled qualified beneficiary is no longer disabled.

Additional Information Required for Notice of Second Qualifying Event

Any notice of a second qualifying event that you provide must include (1) the names and addresses of all qualified beneficiaries who are still receiving COBRA coverage; (2) the second qualifying event and the date that it happened; and (3) if the second qualifying event is a divorce or legal separation, a copy of the decree of divorce or legal separation.

Who May Provide Notices

The covered employee, a qualified beneficiary who lost coverage due to the qualifying event described in the notice, or a representative acting on behalf of either may provide notices. A notice provided by any of these individuals will satisfy any responsibility to provide notice on behalf of all qualified beneficiaries who lost coverage due to the qualifying event described in the notice.

THIS CONCLUDES THE SUMMARY OF YOUR CONTINUATION COVERAGE RIGHTS UNDER COBRA. PLEASE CONTACT THE HUMAN RESOURCES OFFICE (OR THE EQUIVALENT THEREOF) OF PORT OF PORT TOWNSEND IF YOU HAVE ANY QUESTIONS OR NEED MORE INFORMATION.

RESOLUTION 729-20 EXHIBIT C

WASHINGTON TEAMSTERS WELFARE TRUST

SUMMARY PLAN DESCRIPTION
MEDICAL PLAN B

STAND STRONG
TOOLS TO GO THE DISTANCE
BE SMART > BE SAFE > BE WELL

JOINT COUNCIL OF TEAMSTERS No. 28 • WASHINGTON, ALASKA & N. IDAHO • INTERNATIONAL BROTHERHOOD OF TEAMSTERS

March 2013

WASHINGTON TEAMSTERS WELFARE TRUST
MAY 2014

SUMMARY OF MATERIAL MODIFICATIONS

This is a "summary of material modifications" (SMM) to the Washington Teamsters Welfare Trust's Summary Plan Descriptions (plan books) **effective July 1, 2014**. Some plan modifications (changes) only apply to certain plans as noted. The information in this SMM updates and/or replaces the applicable sections of each book until new books become available. Please read it carefully and keep it with your benefit plan booklet(s). If you have questions about the information presented here, feel free to contact the Trust Administrative Office at 800-458-3053.

IN-NETWORK CALENDAR YEAR OUT-OF-POCKET MAXIMUM - MEDICAL PLANS A, B, C, AND Z

Medical Plans A, B, C, and Z each currently have an annual maximum, which applies to the combined amount of in-network and out-of-network coinsurance you have to pay during a calendar year. The plans will continue to have those maximums on coinsurance. However, pursuant to mandates in the Affordable Care Act, all the plans will now also have a separate in-network annual maximum of $6,350 per person (up to $12,700 per family), which will apply to the combined amount of coinsurance, deductible, emergency room (ER) copays, and office visit copays you have to pay during a calendar year. The new maximum applies to in-network charges only incurred on or after July 1, 2014.

The current coinsurance maximums and the new in-network maximum will operate independently to help limit your out-of-pocket expenses during a calendar year. If an individual or family reaches the coinsurance annual maximum during a calendar year, there will be no further out-of-pocket expenses for the individual or family respectively during the remainder of the year as relates to the coinsurance. If an individual or family reaches the new in-network annual maximum during a calendar year, there will be no further out-of-pocket expenses for the individual or family respectively during the remainder of the year as relates to the coinsurance, deductible, ER copays, or office visit copays for eligible in-network services.

Effective July 1, 2015, the in-network calendar year out-of-pocket maximum will also include and apply to in-network prescription drug copays, in-network pediatric dental charges (unless excepted), and in-network pediatric vision charges (unless excepted)

PRESCRIPTION DRUG PROGRAM - MEDICAL PLANS A, B, C, AND JC28XL

The following provisions are being added to the prescription drug program under Medical Plans A, B, C and JC28XL on **new prescriptions only**. These provisions are currently in effect under Medical Plan Z.

Quantity Limits
For certain medications, the Plans have established a maximum quantity of medication allowed per fill or re-fill. This means there is a limit on the amount of medication that will be covered during a period of time such as during the 34-day supply limit on retail or 100-day supply limit on mail order. The Plans' Pharmacy Benefit Manager (PBM) is MedImpact Healthcare Systems, Inc. MedImpact uses information from the U.S. Food and Drug Administration (FDA) and from scientific research to establish these maximum quantities.

When you or your enrolled dependent takes a prescription to a participating pharmacy, and you present your ID card, the pharmacy will let you know if a quantity limit applies to your prescribed medication.

Any quantity over the established maximum is not covered, unless the amount is determined by MedImpact to be medically necessary. If you believe that the quantity limit should not apply in your case, you may have the physician who prescribed the medication contact MedImpact for a Prior Authorization (see section on Prior Authorization below). Your pharmacy may also be able to submit a Prior Authorization form to MedImpact. MedImpact may require medical information explaining the necessity for the larger quantity. If a waiver of the quantity limit is allowed by MedImpact after review with your physician, additional quantities will be allowed.

Step Therapy
Certain prescription medications are subject to step therapy protocols established and administered by MedImpact HealthCare Systems, Inc.

What is Step Therapy?
Step Therapy is designed to help you get the prescription drugs you need, with safety, cost and—most importantly—your health in mind.

In Step Therapy, certain covered drugs for specific conditions are organized in a series of "steps".

- Generally, if you are prescribed a drug for a condition covered by Step Therapy, a lower cost, clinically appropriate medication (often a generic drug) may be recommended to replace the prescribed drug. This first "step" of therapy will typically result in the anticipated clinical result, at lower cost to you and the Plan. These generics—rigorously tested and approved by the U.S. Food & Drug Administration (FDA)—allow you to begin or continue treatment with safe, effective drugs that are also affordable: your copayment is usually the lowest with a first-step drug.
- If, the first step agents (generic or brand) have not been effective in treating your medical condition (see the section below under "I've already tried the first-step drugs on the list. What happens now?"), you will progress to the next "step" medications. These are often more expensive brand name drugs. You then will need to consult your doctor to write you a prescription for the higher step agent based on the list of Step Therapy drugs covered by the formulary.

What should I do when my doctor is writing me a prescription?
Tell your doctor that your Plan has a Step Therapy program, and confirm whether the prescription your doctor is writing is covered by the Step Therapy program. If it is covered, ask the doctor to either write the prescription for the appropriate first step covered medication, or have them request Prior Authorization for higher level (later step) medication (see Prior Authorization instructions below).

How do I know what "first-step" drug my doctor should prescribe?
You can call MedImpact using the number on the back of your prescription card. A representative can give you some examples of possible prescription drugs for you to discuss with your doctor.

How are the drugs chosen for Step Therapy?
Step Therapy is developed under the guidance and direction of independent, licensed doctors, pharmacists and other medical experts. Together with MedImpact they review the most current research on thousands of drugs tested and approved by the FDA for safety and effectiveness. Then they recommend appropriate prescription drugs for the Step Therapy program, and MedImpact determines whether to approve the drugs recommended for coverage.

What conditions are treated under Step Therapy?
A complete list of all the conditions treated by Step Therapy and a list of all the medications included in the program may be obtained by contacting MedImpact at 800-788-2949 or by going to the MedImpact website at medimpact.com.

How does the step-therapy program work when I go to the pharmacy to fill a prescription?
When you submit a prescription that isn't for a first-step drug, your pharmacist will tell you there's a note on the computer system indicating that your plan uses Step Therapy. This simply means that if you'd rather not pay full price for the drug prescribed, your doctor needs to write you a new prescription for a first-step drug.

To receive a first-step drug:

- *Ask your pharmacist to call your doctor and request a new prescription. or*
- *Contact your doctor to get a new prescription.*

Only your doctor can change your current prescription to a first-step drug.

I need a prescription filled immediately. What can I do?
At the pharmacy, you may be informed that your drug isn't covered if you've just started taking a prescription drug regularly or if you're a new member. If this occurs and you need your medication right away, you can:

- Talk with your pharmacist about filling a small supply of your prescription. You may have to pay full price for this drug.
- Then, ask your doctor to write you a new prescription for an approved first-step drug, so that your medication will be covered.

Remember: Only your doctor can approve and change your prescription to a first-step drug.

I've already tried the first-step drugs on the list. What happens now?
With Step Therapy, more expensive brand-name drugs are usually covered in a later step in the program if:

- You've tried the "first-step," generic drugs covered in the program, and it was not effective in treating your medical condition;
- You are unable to take the "first-step" drug due to intolerance; or
- Your doctor decides that you medically need a higher step drug, and can medically substantiate why your condition requires this agent.

If any one of these applies to you, your doctor can submit a "Prior Authorization" for you to take a second-step prescription drug (see section on Prior Authorization below). If the Prior Authorization is approved, you pay the appropriate copayment for this formulary-approved drug. If the Prior Authorization is not approved, and you want to take this higher step agent, you will need to pay the full price for the drug. You will still have access to the first-step agent at a lower copayment.

Prior Authorization
Your prescription drug program covers most medications when prescribed by your physician, but not all are automatically covered. Your prescription drug program includes a formulary or a preferred drug list which contains medications that are safe and effective therapies. The Prior Authorization process is in place to allow your physician to request coverage for the use of certain medications in situations where other medications may not be appropriate for you.

Your prescription drug program determines when Prior Authorization is required. If you go to your pharmacy and the pharmacist cannot fill your prescription because he/she received a computer message saying "Prior Authorization Required," then Prior Authorization must be requested to confirm appropriateness. Prior Authorization may also be available in other situations such as when you require a larger quantity of medication than your benefit allows each month. Prior Authorization is generally not available for medications used for cosmetic purposes, nor for medications which are excluded from your prescription drug program coverage. To request Prior Authorization for a particular drug have the physician prescribing the medication contact MedImpact at 800-788-2949.

To find out in advance if any of these restrictions apply to your medications, contact Customer Service (number on the back of your ID card) or check the MedImpact HealthCare Systems, Inc. website at www.MedImpact.com. If you are a first time visitor to the site, please take a moment to register (have your member ID available).

JAW TREATMENT (INCLUDING TMJ AND MPD) - MEDICAL PLANS A, B, C, Z, AND JC28XL

The lifetime maximum benefit of $6,000 per person for jaw disorders (including temporomandibular jaw disorder (TMJ) and myofascial pain disorder (MPD)) is eliminated.

MENTAL HEALTH AND CHEMICAL DEPENDENCY - MEDICAL PLANS A, B, C, Z, AND JC28XL

The Mental Health Parity and Addiction Equity Act (MHPAEA) requires financial requirements (such as co-pays, deductibles) and treatment limitations (such as number of visits or days of coverage) applicable to mental health and chemical dependency (MHCD) treatment to be no more restrictive than the predominant requirements or limitations applied to substantially all medical benefits. The Trust is required to be in compliance with MHPAEA by July 1, 2014.

Changes to the financial requirements and some limitations were made previously. In order to complete compliance by July 1, 2014, the benefits for MHCD services will be moved from the Mental Health and Chemical Dependency Program section of the Summary Plan Description to the Medical Plan Provisions section. As a result, benefits for MHCD services will be subject to the same financial requirements and limitations that apply to substantially all medical benefits. Note: however, that change will not affect the lower outpatient copays that have been in effect for MHCD services under plans A, B, C, and Z.

DIETARY AND NUTRITIONAL COUNSELING - MEDICAL PLANS A, B, C, AND Z

In addition to dietary and nutritional counseling provided in a hospital setting, the plans will cover dietary and nutritional counseling provided by a Registered Dietician or comparably credentialed professional (e.g., Commission on Dietetic Registration) outside of a hospital setting when ordered by the participant's treating physician as part of a comprehensive treatment plan for patients with a known history of diabetes, renal failure, hepatic insufficiency, genetic metabolic disorder, hyperlipidemia, or other known risk factors for cardiovascular and diet-related chronic disease. Dietary and nutritional counseling will be covered under the preventive care benefit provisions of the plans and limited to four visits per person per calendar year. Nutritional counseling for morbid obesity is only covered when provided as part of a Trust-approved weight management program.

CLINICAL TRIALS - MEDICAL PLANS A, B, C, Z, AND JC28XL

The plans will not exclude routine patient costs for items and services furnished in connection with an approved clinical trial that would otherwise be covered by the Plan. However, the plans will not cover:

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

An approved clinical trial is a phase I, II, III, or IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life threatening disease or condition.

FILING OUT-OF-NETWORK (NON-PPO) CLAIMS - MEDICAL PLANS A, B, C, Z, AND JC28XL

If you receive healthcare services from an out-of-network provider who will not file a claim on your behalf, obtain a medical claim form from the Trust Administrative Office. The claim form may also be obtained on-line at www.nwadmin.com if you are registered on the website. Follow the instructions on the claim form and mail the form with required documentation to Cigna Healthcare – PO Box 188004 – Chattanooga TN 37422.

DEPENDENT COVERAGE – ALL PLANS

Participants may elect not to cover their spouse if: (a) they are legally separated and provide documentation of this fact to the Trust Administrative Office; or (b) their spouse consents to not being covered. Participants may elect to later reenroll their spouse or their spouse may revoke consent and reenroll.

Under federal law, a Participant's child has a right to be enrolled in coverage under the Participants' plan through the age of 25. If a Participant would like to elect not to cover a child age 18 or older, he or she must first provide the Trust Administrative Office with the child's address in order for the child to be notified that coverage is being terminated. The child will be given the right to reenroll. Participants may elect later to reenroll a child provided the child is under age 26 at the time.

Termination of coverage or coverage upon reenrollment of a spouse or child will be effective the first of the month following receipt of written notification by the Trust.

WASHINGTON TEAMSTERS WELFARE TRUST
SUMMARY OF MATERIAL MODIFICATIONS

JANUARY 2014

Dear Plan Participant:

This is a "summary of material modifications" (SMM) to the Washington Teamsters Welfare Trust's medical Summary Plan Descriptions (plan books) for Plans A, B, C, and Z. The information in this SMM updates and/or replaces the applicable sections of each book until a new book becomes available. Please read it carefully and keep it with your benefit plan booklet. If you have questions about the information presented here, feel free to contact the Trust Administrative Office at 800-458-3053.

MENTAL HEALTH AND CHEMICAL DEPENDENCY BENEFITS - MEDICAL PLANS A, B, C, AND Z EFFECTIVE JANUARY 1, 2014

Mental health and chemical dependency services will be subject to the same copay, coinsurance, annual deductible, and inpatient pre-certification requirements as other medical services except that the outpatient office visit copays will be as follows:

	Individual Sessions	Group Sessions
1-20 Sessions	$10.00 copay	$5.00 copay
21 Sessions or more	$15.00 copay	$7.50 copay

Pre-authorization of outpatient mental health and chemical dependency services will no longer be required.

Introduction

This booklet describes Washington Teamsters Welfare Trust benefits and provisions for employees of employers who negotiate a collective bargaining agreement requiring Plan contributions, and who participate in Medical Plan B as of March 1, 2013, or later.

This Plan is designed to assist you and your family in staying well and to help you pay for the cost of treatment when needed. The Plan has several features to increase your purchasing power while helping the Trust manage healthcare quality and cost, including:

- A preferred network of hospitals and physicians, with incentives to use them
- *Recommended* and *Regular* network retail pharmacies plus a mail order prescription option
- Pre-certification of hospital admissions to determine medical necessity
- Care management programs
- Hospital utilization review
- STAND STRONG wellness tools and resources to help you and your family improve your health
- Mental Health and Chemical Dependency Benefits program.

We encourage you to become familiar with your benefits and the valuable protection they offer. If you have questions about your coverage or eligibility, please contact the Trust Administrative Office.

Unincorporated owners and partners are not eligible to participate in the Plan.

IMPORTANT NOTICE

Payment of benefits as specified in this booklet depends on your employer making contributions for you to the Washington Teamsters Welfare Trust sufficient to maintain these benefits. The amount of necessary employer contributions may increase from time to time. If your employer doesn't pay the required contributions, your coverage may be transferred to a lower-cost plan. If you are ineligible for Plan coverage, the fact that contributions were made on your behalf will not entitle you to benefits.

Only the Trust Administrative Office, Northwest Administrators, Inc., 2323 Eastlake Avenue East, Seattle, Washington represents the Trustees in administering the Plan and giving information about the amount of benefits, eligibility and other Plan provisions. No union employee, union officer, business agent, employer or employer representative or representative of any other organization except the Trust Administrative Office is authorized to give Plan information, interpret the Plan or commit the Trustees on any matter. In all cases, the terms of the Plan govern.

While no change in the Plan is anticipated, the Trustees reserve the right to terminate, amend or eliminate benefits as deemed necessary. The Trustees have no obligation to furnish benefits beyond those that can be supported by the Trust fund.

Si necesita ayuda para entender este panfleto, comuniquese con la oficina administrativa al 800-458-3053.

Important Contacts

For Questions About	Contact
Eligibility Medical benefits and claims Vision benefits and claims Time Loss benefits and claims Life and Accidental Death and Dismemberment Insurance benefits and claims COBRA ID/Information cards	Trust Administrative Office Northwest Administrators, Inc. 800-458-3053 **www.nwadmin.com**
Prescription drug benefits	Pharmacy Helpdesk MedImpact 800-788-2949 **www.medimpact.com**
Mail order prescriptions Specialty prescription drugs	Union Center Pharmacy 800-441-9174 **www.unioncenterpharmacy.com**
Weight management programs	Sound Health Connects 866-779-4730 **www.soundhealthconnects.com**
Assistance Program Mental health benefits and claims Chemical dependency benefits and claims	Cigna 855-402-0272 **www.cignasharedadministration.com**
Health symptoms, drug interactions, or if you're not sure whether to see a doctor, go to the ER or treat at home	Nurse Line 855-402-0272
Chronic Condition Support Program Personal Health Assessment (PHA) Health coaching Tobacco cessation program	StayWell HelpLine 888-388-8259 **www.wateamsters.online.staywell.com**
Hospital inpatient precertification	Cigna 855-402-0272
Finding a PPO network doctor, hospital or other healthcare provider	Cigna 855-402-0272 **www.cignasharedadministration.com**
Dental benefits and claims	Washington Dental Service (WDS) 800-554-1907 **www.deltadentalwa.com**

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General Information

Trust Administrative Office

Washington Teamsters Welfare Trust
Northwest Administrators, Inc.
2323 Eastlake Avenue E.
Seattle, WA 98102

Telephone: **800-458-3053**
Online: **www.nwadmin.com**

Enrollment

Participant Data Form

To receive benefits under this Plan and avoid delays in claim administration, you must complete and submit a Participant Data Form to the Trust Administrative Office when you first become eligible. Participant Data Forms can be obtained from the Trust Administrative Office or your local union.

Updating Your Personal Data

Accurate and efficient claim processing depends, in part, on the Trust Administrative Office having current data for you and your covered dependents. Changes in address, marital status, number of dependents and information about other insurance are critical. As a result, the Trust Administrative Office requires that enrollment information be verified annually. **It is your or your dependent's responsibility to notify the Trust Administrative Office within 60 days of a qualifying event that causes coverage to end for a covered dependent.** Divorce or a dependent child losing eligibility due to age are both examples of qualifying events that end coverage under the Plan. You may update your information by submitting a revised Participant Data Form or you may update your information online at **www.nwadmin.com**.

Your employer is responsible for notifying the Trust Administrative Office only when an employee's coverage ends.

ID/Information Card

Your ID/Information card contains important information for you and your healthcare providers, such as who can answer questions and where to send claims. It also lets providers know that you're a Trust participant.

Carry your ID card at all times and present it every time you seek medical care or prescription drugs. PPO providers are required to accept PPO discounts only if you present your card at the time of service.

Guide to Claim Filing

Medical Claims

General claim filing information for Preferred and Non-Preferred providers is summarized below. See page 97 for detailed claim filing procedure.

Preferred (PPO) Providers (In-network)

See page 32 for information on the Preferred Provider Organization (PPO).

When using a PPO provider:

- Be sure to present your ID card when receiving treatment. This card identifies you as a Washington Teamsters Welfare Trust participant and tells the provider where to send the bill for payment.
- You do not need to fill out a claim form if you use a preferred provider. The provider or hospital will submit the bill for you.
- If another benefit plan is primary, the Trust Administrative Office may request an Explanation of Benefits (EOB) from you showing what the other plan paid before processing your claim.
- The Trust Administrative Office will determine the amount of benefits and reimburse the provider directly, in accordance with your Plan provisions.
- You will receive an EOB specifying what was paid under this Plan.
- If you receive a bill from the provider, remember to verify with the physician or hospital that they have billed the Trust.

Non-Preferred (non-PPO) Providers (Out-of-network)

If you receive services from a provider that is not PPO, follow these steps:

- Obtain itemized hospital and physician bills listing all services and treatments you received, confirm that the participant's correct Social Security number or subscriber ID number is on all bills, and send them to the Trust Administrative Office.
- If another benefit plan is primary, submit an EOB from the other plan with your claim.
- Claims must be submitted for payment within 90 days after the expense is incurred. (Not submitting the claim within 90 days will not necessarily invalidate or reduce your claim if you can show it was done as soon as reasonably possible.)
- The Trust Administrative Office will determine the amount of benefits and reimburse you or your provider, in accordance with your Plan provisions.
- You will receive an EOB specifying what was paid under the Plan.

Prescription Drugs

See page 70 for information on filing prescription drug benefit claims.

Time Loss Benefits

If you are unable to work due to an accident or sickness, follow these steps:

- Obtain a claim form from the Trust Administrative Office or your local union.
- Complete Part I, have your employer complete Part II and have your physician complete Part III of the form.
- Submit the completed claim form to the address at the top of the form.

Life and AD&D Insurance

Claims must be submitted within one year of the date of death or accident. Claim forms are available from the Trust Administrative Office. Submit the completed claim form to the address at the top of the form.

STAND STRONG

STAND STRONG is a series of wellness tools and resources designed to help you and your family maintain your good health, manage chronic conditions, get access to healthcare information resources and generally live a healthier, stronger life. For more information, including a complete description of your Trust-sponsored wellness tools, see the STAND STRONG section beginning on page 39.

If You Have Questions

For information on who can answer claim inquiries and questions about the benefits described in this booklet, refer to Important Contacts for phone numbers and other contact information on page 3 of this booklet.

If you would like to request an ID/Information card or if you lose your card, contact the Trust Administrative Office.

Claim Reviews and Appeals

For information about the claim review and appeal process, see the Claim Review and Appeal Procedures on page 96.

Eligibility and Coverage Effective Dates

Who's Eligible

To become eligible for contributions to be made to the Trust on your behalf, you must first meet the requirements in your employer's collective bargaining agreement, consistent with Trust guidelines. You also must be an active employee with the minimum number of compensable hours or hours worked (usually 80) during a month for any one employer who makes Plan contributions.

Coverage Effective Dates

Lag Month Rule

To help ensure timely eligibility information is provided to your healthcare providers, the Trust uses a lag month system — the Trust advances eligibility for one month while you continue working enough hours each month for a contribution to be made on your behalf. For example, if you work enough hours in January and your employer makes a contribution in February (the lag month), your coverage is effective in March (rather than February). This continues until you have a break in contributions (see Breaks in Contributions below).

Any month the Trust waives contributions for you due to a disability will be considered a month in which contributions were made for the purpose of determining if you had a break in contributions.

When Coverage Begins

Coverage and benefits for new hires begin after one month's contribution is made on your behalf under the lag month system. For example, if you are a new hire who has satisfied the requirements of your collective bargaining agreement, you work enough hours in June and your employer makes a contribution in July (the lag month), your coverage begins August 1. *Please note, you **may** need at least two consecutive months of contributions to avoid a loss of the first month of coverage. See Breaks in Contributions below for more information.*

Breaks in Contributions

The lag month eligibility system continues while you continue working enough hours each consecutive month for a contribution to be made on your behalf. For example, if you work enough hours in July, and your employer makes a contribution in August (the lag month), coverage and benefits will be provided in September.

When you have a break in contributions due to layoffs, a reduction in your work hours, termination of employment, disability, or for any reason *other than* retirement or resignation, or your employer's cessation of participation in the plan, your coverage will continue until the end of the *second* month following the month in which you last had the minimum number of hours requiring contributions as stated in your collective bargaining agreement. For example, if you are laid off in April after working enough hours to receive a contribution, and the final contribution to the Plan is made in May, your coverage will end on June 30. If you are laid off in April without enough hours to receive a contribution, and the final contribution from your employer is made in April (for your March hours), your coverage will end on May 31.

When you retire or resign, or if your employer ceases to participate in the Plan, your coverage will stop at the end of the *first* month following the month in which you last had the minimum

number of hours requiring contributions as stated in your collective bargaining agreement. For example, if you retire in April after working enough hours to receive a contribution, and the final contribution to the Plan is made in May, your coverage will end on May 31. If you retire in April without enough hours, and the final contribution from your employer is made in April (for your March hours), your coverage will end on April 30.

If you return to work after 1) you had a break in contributions, or 2) you resigned or retired, or 3) your employer ceased making contributions, and contributions are again made on your behalf, coverage will resume under the lag month eligibility system the same as for a new hire. Trust eligibility for new hires begins after one month's contribution is made on your behalf under the lag month system. For example, if contributions are first made on your behalf in October based on your employment in September, your coverage begins November 1.

Note: Some collective bargaining agreements may have a waiting period before contributions become payable to the Trust. An agreement may also require a minimum number of hours be worked in order for contributions to be made. Refer to your collective bargaining agreement or contact your local union or employer about any waiting periods or hour requirements.

If you are a new hire or an employee reestablishing eligibility, you must have at least two consecutive months of employer contributions in order to preserve lag month coverage for the first contribution if you subsequently lose coverage due to *resignation, retirement, or if your employer ceases to participate in the Plan.* For example, if you have only one contribution on your behalf and you resign or retire, you will not qualify for coverage. However, if you have only one contribution on your behalf and your employment is terminated, you are laid off, disabled, or do not work enough hours, you will receive one month of coverage.

When Coverage Ends

Coverage for you and your dependents will end if this Plan terminates or if your employer ceases to make required contributions or stops participating in the Plan. A dependent's coverage also will end when he or she no longer meets the Plan's eligibility requirements (for instance, when your child turns age 26).

When you have a break in contributions, as explained in the preceding section, coverage stops at the end of the first or second month following the month in which you last have the minimum number of hours requiring contributions as stated in the collective bargaining agreement. Whether coverage stops at the end of the first month or second month depends on the reason for the break in contributions (see previous section).

Any employee in full-time military service will not be covered except as described in Military Service under USERRA on page 17 and COBRA Self-Pay Option on page 20.

Construction Industry Dollar Bank and Shipyard Industry Hour Bank Programs

For participants in the Construction Industry or Shipyard Industry whose employers make hourly contributions to a dollar bank or hour bank program, please refer to the insert in the back of this book for information on eligibility and coverage effective dates.

Eligible Dependents

Eligible dependents are:

- Your spouse
- Your domestic partner ***if*** your local union and your employer negotiated domestic partner benefits for your group (see Domestic Partner Benefits)
- Your children under age 26 who are your:
    - Natural children
    - Adopted children
    - Step children
    - Children placed with you for adoption

  These children do not have to depend on you for support, do not have to attend school full time, can be married, and can have access to other health coverage through their own employment.
- Your eligible dependent children also include your unmarried children up to age 19 who live with you, are dependent on you for support, and are:
    - Children for whom you are the court-appointed guardian
    - Grandchildren
    - Children of your domestic partner ***if*** your local union and employer negotiated domestic partner benefits (see Domestic Partner Benefits below).

  These dependent children who would otherwise qualify as eligible dependents but are 19 years or older will be eligible until age 26 (through 25th year) if they are unmarried, depend on you for support/maintenance, and are full-time students in an accredited educational institution. School vacation and total disability periods that interrupt but do not terminate what would have been a continuous course of study are considered part of full-time attendance. A dependent who takes a Physician certified medically necessary leave of absence from a postsecondary school (college, university, or trade school) due to a serious illness or injury, which causes the Dependent to lose student status and the student was an eligible dependent immediately before the first day of the medical leave, will continue to have coverage through the Applicable Period. Applicable Period is defined as the earlier of one year from the first day of the medical leave of absence or the date on which Dependent coverage under the Plan would otherwise terminate. Proof of a medically necessary leave of absence must be certified in writing to the Fund by the student's treating physician. If the student recovers from the serious illness or injury, he or she must notify the Fund immediately and begin classes again at (or enroll again in) a postsecondary school if within the Applicable Period in order to resume Dependent student status under the Plan. If the medical leave of absence exceeds the Applicable Period, a Dependent cannot resume student status but will be eligible for COBRA coverage. COBRA coverage will run consecutive with any student disability coverage.

Except as noted below, all children who qualify as eligible dependents are eligible for medical and prescription benefits from the later of the effective date of your coverage or date the child meets the requirements above except for children of domestic partners, who are covered prospectively from the date they are enrolled. Children who lost coverage prior to July 1, 2011 and are eligible to be enrolled under the Patient Protection and Affordable Care Act on July 1,

2011 will be covered as of July 1, 2011 if they are enrolled no later than 31 days after that date, otherwise they will be covered prospectively from the date they are re-enrolled.

For dependent life benefits, unmarried children are covered only until age 19.

An unmarried eligible dependent child who is physically or mentally incapable of self-support is eligible under the Plan while incapacitated, if your own coverage is in effect. To cover a child under this provision, file a Proof of Incapacity Form with the Trust Administrative Office within 31 days after coverage would otherwise end or within 31 days of the date you become covered by the Plan if a child is 19 or older at that time. Additional proof will be required from time to time; unless you provide additional proof as requested, the child's coverage will end.

In accordance with federal law, the Plan also provides medical coverage (including dental and vision coverage if these coverages are being provided through a Trust plan) to certain dependent children (called alternate recipients) if directed to do so by a Qualified Medical Child Support Order (QMCSO) issued by a court or state agency of competent jurisdiction and your own healthcare coverage is in effect. Contact the Trust Administrative Office for details.

No dependent coverage is available for Time Loss benefits, Long-Term disability benefits, or AD&D insurance, which cover only you, the eligible active employee.

Domestic Partner Benefits

If your local union and employer have negotiated to add domestic partner benefits, you may enroll your same or opposite sex domestic partner for benefits if:

- You (the covered participant) and your domestic partner have registered as domestic partners or entered into a civil union in the state or municipality where registered, or
- You and your domestic partner meet all of the following requirements:
  - You are both at least age 18
  - Neither of you is legally married to another person of the opposite sex or in a domestic partnership with another person
  - You are not related by blood to a degree of closeness that would prohibit marriage
  - You are in an exclusive, committed relationship that is intended to be permanent
  - You share a mutual obligation of support and responsibility for each other's welfare
  - You currently share a principal residence and have done so for at least 6 months, and intend to do so permanently, or
  - You are married adults of the same sex and your marriage is recognized by the state where you live.

Coverage of a domestic partner is effective upon the Trust's receipt of the required enrollment form and documentation.

Documentation Required

If your local union and employer negotiate domestic partner benefits and you want to enroll your domestic partner, you and your partner will be required to complete a notarized Affidavit of Domestic Partnership and submit a birth certificate or driver's license as proof of your domestic partner's age, plus additional documentation to verify your domestic partner's eligibility including that you have shared a principal residence for at least six months. This additional documentation must include any three of the following:

- Declaration, Affidavit, or Certification of Civil Union from a state or municipality that issues such

- Marriage certificate from a state or municipality that recognizes same sex marriages
- Legal documents indicating that, as domestic partners, they are responsible for each other's welfare
- Home title or other documents showing joint ownership of significant property
- Rental agreement documenting joint tenancy
- Canceled checks showing rent or utility payments from both partners at the same address, or bills proving same
- Evidence of joint banking accounts (savings, checking, etc.)
- Power of Attorney (durable property or healthcare)
- Wills, life insurance policies, or retirement annuities naming each other as primary beneficiary
- Co-parenting or adoption agreement.

Children of Domestic Partners

If your local union and employer negotiate domestic partner benefits and you want to enroll children of your domestic partner, the child(ren) may be enrolled subject to the plan's preceding dependent children eligibility requirements including that the child(ren) are:

- Dependent upon you for support and maintenance, and
- Unmarried, and
- Under 19 years old and residing with you and your domestic partner ***or*** at least 19 but under 26 and enrolled full-time in an accredited educational institution ***or*** disabled and physically or mentally incapable of self-support.

Other Important Information about Domestic Partner Benefits

It's important to note that domestic partner benefits are subject to different federal and state tax rules. Income taxes may be payable as a result of the Trust providing benefits to your domestic partner and his or her children. If your bargaining unit has bargained domestic partner benefits and you are covering a domestic partner, you may wish to consult a tax professional for advice on your personal situation. Domestic partners are not eligible for COBRA self-pay benefits when coverage ends and in most cases; their children will not be eligible for COBRA continuation benefits either.

Continuation of Coverage

This section describes various options for continuing coverage under specific circumstances.

Quick Guide to Continuing Your Coverage

The Trust offers a number of options for continuing your coverage after it would normally end, depending on your situation. The chart below provides an overview of these options, which are described in more detail in the following pages. Dental, Vision, Life, and AD&D coverages are listed here but only apply if you have these coverages through a Trust plan.

Continuing Your Coverage Overview				
Continuation option	**What coverages may be continued***	**How long coverage can be continued**	**Who can be covered**	**For details**
Continuing coverage lost due to delinquency of employer contributions	Medical/prescription, dental, vision, mental health and chemical dependency, life, AD&D	Up to three months	You and your eligible dependents	See page 16
Continuing coverage lost due to a strike, lockout or labor dispute	Medical/prescription, dental, vision, mental health and chemical dependency, life, AD&D	Up to six months	You and your eligible dependents	See page 16
Continuing coverage during a military leave	Medical/prescription, dental, vision, mental health and chemical dependency	During your military leave (maximum of 24 months)	You and your eligible dependents	See page 17
Continuing coverage during a Family or Medical Leave (FMLA)	Medical/prescription, dental, vision, mental health and chemical dependency	During your FMLA leave (maximum of 12 weeks)	You and your eligible dependents	See page 18
Total Disability Waiver of Contributions	First three months: medical/prescription, dental, vision, mental health and chemical dependency, life and AD&D Months four through 12 (if applicable): medical/prescription, mental health and chemical dependency, life and AD&D	Up to three months Some groups have bargained an additional 9 months (12 months total)	You and your eligible dependents	See page 18
Extension of Medical Benefits for Total Disability (may be available after you have exhausted other options such as the Disability Waiver of Contributions, COBRA, or the Six-Month Self-Pay Option)	Provides continued medical/prescription coverage for the disabling condition only if you do not have access to other group insurance.	Up to one year	The disabled participant (you or your covered dependent) only	See page 19

Continuing Your Coverage Overview				
Continuation option	**What coverages may be continued***	**How long coverage can be continued**	**Who can be covered**	**For details**
COBRA (self-pay option)	Medical/prescription dental, vision, mental health and chemical dependency	Normally up to 18 months Up to 29 months if disabled Up to 36 months for dependents in certain circumstances	You and/or your eligible dependents	See page 20
Six-Month Self-Pay Option (in lieu of COBRA if eligible for COBRA)	Plan C medical/prescription and mental health and chemical dependency coverage	Up to six months	You and/or your eligible dependents	See page 22

**You may generally only continue coverage you already had through the Trust. For instance, you may continue dental coverage only if you had dental coverage through the Trust and it is allowed under the continuation option.*

Please note, this chart is only a brief summary and does not describe many details of the continuation options. Please refer to the pages shown in the chart for more detailed descriptions, or call the Trust Administrative Office.

Continuing Coverage Lost Due to Delinquency of Employer Contributions

Coverage for you and your eligible dependents, except Time Loss benefits, may be continued for up to three months if your employer is delinquent in Plan contributions and the employer account has been referred for collection. To be eligible for continued coverage, you must provide proof of employment that would have created eligibility if the required employer contribution had been made. This continued coverage is for a maximum of three months after employer contributions stop and is available only once for an employer or successor. (This provision does not relieve an employer of any obligation to contribute to the Plan.)

Continuation of Life and Medical Coverage in the Event of a Strike, Lockout or Other Labor Dispute

If your coverage terminates because active work ends as a result of strike, lockout or other labor dispute, your coverage (other than Time Loss benefits) may continue during the dispute while the Plan is in effect if you self-pay the required contributions. You may choose between COBRA coverage and the Six-Month Self-Pay Option described on pages 20 to 23.

In no event may you continue your benefits beyond *the earliest* of these dates:

- Six months after you stop active work
- Your request that coverage be terminated
- Your failure to make the required self-payment on time

- Your eligibility for similar coverage under another group plan
- Termination of the Plan.

You will not have the group life conversion privilege described on pages 26 and 27 if your continued coverage under this provision terminates because:

- You did not make the required self-payment on time
- You were eligible for similar coverage under another group plan
- This Plan terminates.

If your continued life insurance terminates due to policy termination, you will be entitled to convert your life insurance if you have been insured for at least five years. See pages 26 and 27 for the amount of life insurance you can convert.

Military Service Under USERRA

If you leave covered employment to perform certain United States military service, you and your covered dependents may have the right to continue your group health benefits — including medical, dental, vision and prescription drug coverage. If you're military service lasts less than 31 days (for example, active duty for training), the Plan will continue to cover you and your dependents. If your military service lasts at least 31 days, you and your dependents will be eligible to continue coverage through self-payment for up to 24 months. When you return to covered employment, your regular coverage will begin immediately, if you meet the requirements summarized below.

Under the Uniformed Services Employment and Reemployment Rights Act (USERRA), you must notify your employer before taking leave (unless precluded by military necessity or other reasonable cause). You should also tell your employer how long you expect to be gone. Upon release from military duty, you must apply for reemployment as follows:

- Less than 31 days military service — apply immediately, taking into account safe transportation plus an eight-hour rest period
- 31-180 days military service — apply within 14 days
- More than 180 days military service — apply within 90 days.

If you're hospitalized or convalescing, these reemployment deadlines are extended while you recover (but not longer than two years).

The rules above also apply to uniformed service in the commissioned corps of the Public Health Service.

To ensure proper crediting of service under USERRA, have your employer notify the Trust Administrative Office when you go on leave and again when you are reemployed following your return from leave.

Trade Act of 2002

The Trade Act of 2002 created a tax credit for certain individuals who become eligible for trade adjustment assistance and for certain retired employees who are receiving pension payments from the Pension Benefit Guaranty Corporation (PBGC) (eligible individuals). Eligible individuals

can take a tax credit for qualified health insurance, including continuation coverage. If you have questions about these tax provisions, you may call the Health Coverage Tax Credit Customer Contact Center toll-free at 866-628-4282. TTD/TTY callers may call toll-free at 866-626-4282. More information about the Trade Act is also available at http://www.doleta.gov/tradeact/.

If You Take a Family or Medical Leave

To be eligible under the federal Family and Medical Leave Act (FMLA), you must have worked for your current employer for at least 12 months and for at least 1,250 hours in the 12 months before your leave. If you meet these requirements and work for an employer with 50 or more employees within a 75-mile radius, the law requires your employer to continue contributions for your (and your dependents') medical (and if covered under the Trust, dental and vision) coverage for up to 12 weeks during a 12-month period if you're on leave due to:

- Birth of a child, or placement for adoption or foster care
- Serious health condition of a child, spouse or parent
- Your own serious health condition.

Contact your employer as soon as you think you're eligible for a family or medical leave since the law requires you to give 30 days notice, or tell your employer immediately if your leave is caused by a sudden, unexpected event. Your employer can tell you of your other rights under FMLA.

If you haven't returned to work when your coverage under FMLA ends, you and your dependents may elect COBRA self-pay coverage, as described on pages 20 to 22.

If you qualify for a Disability Waiver of Contributions as described in the following section, and under FMLA because of your own serious health condition, employer contributions are not required by the Trust while you remain qualified for the Disability Waiver of Contributions.

Waiver of Contributions for Total Disability

If you fail to work the specified minimum monthly hours for eligibility because you're totally disabled, and you've submitted proof of the disability from your physician and employer, you may receive a waiver of contributions for up to *three* months if you remain totally disabled. The waiver period will begin on the first of the month following the month your employer's paid coverage ends. This waiver allows continuation of:

- Medical/prescription
- Vision — if covered by this Trust
- Dental — if covered by this Trust
- Life/AD&D — if covered by this Trust.

Certain employer groups have negotiated an additional nine months of waivers (12 months total). For these groups, the waiver of contributions for months four through twelve apply to medical and prescription coverage only (and if covered by the Trust, life and AD&D coverage) and do not include vision, dental or Time Loss coverage. Consult the Trust Administrative Office for details.

At the conclusion of the waiver period, you may elect COBRA and begin making COBRA self-payments, but your combined continuation coverage under the waiver period and COBRA may not exceed 18 months (29 months if you are disabled and qualify for the COBRA Disability extension). The combined continuation coverage maximums will be 21 and 32 months respectively, if you are on medical leave under FMLA while also eligible for waivers of contributions for total disability and your employer's contributions under FMLA are waived. As an alternative to COBRA, you may obtain coverage for six months as described under Six-Month Self-Pay Option on page 22.

To determine eligibility for waiver of contributions, you must become disabled in a month for which you have eligibility based on an employer contribution, or, if you have returned to covered work, for which you have eligibility based on a disability waiver of contributions due to a prior disability. You must also be:

- Totally disabled due to a covered accident or illness (including pregnancy and its complications)
- Unable to perform the normal duties of your occupation, and
- Not engaged in any occupation for wage or profit (except light-duty work that may be allowed under your collective bargaining agreement), and
- Under a physician's regular care for that injury or sickness.

A subsequent disability separated by less than two weeks of full-time work is considered the same disability unless it is due to a different cause and begins after you return to full-time work.

Extension of Medical Benefits for Total Disability

Medical benefits after coverage ends (or after an extension of medical benefits under the Disability Waiver of Contributions or self-payments under the Six-Month Self-Pay Option or COBRA end) may continue for a totally disabled employee or dependent. These benefits include covered charges incurred, for the disabling condition only, within one year from the date eligibility ended.

To qualify for extension of benefits you must not have access to other group insurance and:

- The total disability must not be work-related and must be continuous from the date coverage or self-payments end to the treatment or service date, and
- Covered charges must be a result of the injury or sickness causing the disability that existed on the date coverage or self-payments end.

To determine eligibility for this extension of benefits, you must be totally disabled, meaning you are:

- Unable to work because of an accidental injury or sickness that prevents you from performing the normal duties of your occupation (or, for a dependent, prevents the normal activities of a person of the same age and gender), and
- Not engaged in any occupation for wage or profit, and
- Under a physician's regular care for the disabling injury or sickness and have submitted certification of continuous care in a form acceptable to the Trust.

Please contact the Trust Administrative Office for a Time Loss/Waiver Application or to inquire about the medical benefit extension.

Self-Pay Options for Continuing Healthcare Coverage

The Plan provides two self-pay options when your healthcare coverage would otherwise end:

- If you're eligible for COBRA, you may choose between the COBRA self-pay option and the Six-Month Self-Pay Option
- If you're not eligible for COBRA, you may continue your coverage under the Six-Month Self-Pay Option.

These continuation options are described below. Please contact the Trust Administrative Office for more details.

COBRA Self-Pay Option

You may be eligible to continue medical coverage after it would otherwise terminate based on a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). If you are an employee covered by the Plan, you and your covered dependents may choose COBRA self-pay coverage for up to 18 months if your coverage terminates due to one of these qualifying events:

- A reduction in your hours of employment
- Termination of your employment other than for gross misconduct.

A dependent spouse covered by the Plan may choose COBRA self-pay coverage for up to 36 months if coverage terminates due to one of these qualifying events:

- Death of the employee
- Divorce from the employee
- Spouse elects Medicare as primary coverage.

A dependent child covered by the Plan may choose COBRA self-pay coverage for up to 36 months if coverage terminates due to one of these qualifying events:

- Death of the employee
- Parents' divorce
- Parent elects Medicare as primary coverage
- Dependent no longer eligible under the Plan.

A spouse or dependent child who elects COBRA self-pay coverage for 18 months due to the employee's termination or reduction in hours may be eligible to continue coverage for up to 36 months due to a second qualifying event:

- Death of the employee
- Employee's divorce
- Employee elects Medicare as primary coverage

- Dependent no longer eligible under the Plan.

You or your dependent is responsible for informing the Trust Administrative Office of a divorce or loss of dependent status no later than 60 days after the qualifying event that causes coverage to end. *The employer is responsible for notifying the Trust Administrative Office when the employee's coverage ceases.*

While self-paying under this option, you or your dependent could receive a Social Security determination confirming disability at the time of the COBRA qualifying event (or within the first 60 days of continuation coverage due to the event). If this happens, the disabled person and all COBRA-eligible family participants may be eligible for up to 29 months of continuation coverage. The Trust Administrative Office must receive a copy of the disability determination within *60 days* of the determination date and *within the original 18-month coverage period.* If the disabled individual is later determined no longer to be disabled by the Social Security Administration, *you must notify the Trust Administrative Office within 30 days of the determination.*

When the Trust Administrative Office is notified that a qualifying event has occurred, it will supply details including:

- Application for COBRA self-pay coverage
- Cost information and payment procedures
- Requirements for continuation of coverage.

Timing Is Important

Your application and self-payments must be timely. You will be eligible for COBRA self-pay coverage only within the following time frames:

- You must return the COBRA application within *60 days*, starting as of the date you are notified or the date your coverage ends, whichever is later. You won't be eligible for COBRA self-pay coverage after this 60-day election period ends.
- The first self-payment is due within *45 days* after your first bill is mailed (the exact date will be determined when you are billed). Subsequent self-payments will be due the last day of the month for which payment is being made. Your COBRA coverage will terminate automatically unless you make timely payments.

Employees who qualify for a total disability extension and waiver of contributions, described on page 18, may not have to make COBRA-payments during the waiver period. However, the combined period under COBRA self-pay coverage and the waiver may not exceed 18 months (29 months if you are disabled and qualify for the COBRA Disability extension). The combined continuation coverage maximums will be 21 and 32 months respectively, if you are on medical leave under FMLA while also eligible for waivers of contributions for total disability and your employer's contributions under FMLA are waived. To qualify for the additional 11-month COBRA disability period, you must qualify for and be receiving Social Security disability benefits. Consult the Trust Administrative Office for details.

COBRA self-pay coverage will be similar to that provided under the Plan to similarly situated employees or dependents. However, continuation coverage does not include Time Loss, AD&D or Life Insurance benefits.

If you or a dependent is eligible for Medicare coverage and you are no longer actively at work, Medicare becomes the primary payer of claims over any coverage you have under COBRA, the Six-Month Self-Pay Option or the disability extension.

COBRA self-pay coverage will terminate before the COBRA eligibility period ends for any of the following reasons:

- Payment for continuation of coverage is not received by the last day of the month for which payment is being made.
- You, your spouse and/or eligible dependents obtain coverage under any other group health plan after the last date to elect COBRA self-pay coverage (unless the other plan excludes or limits your benefits because of a preexisting condition).
- You became entitled to Medicare benefits (Part A or Part B) after the last date to elect COBRA self-pay coverage; however, your dependents may be entitled to further continuation of coverage. (If your spouse or dependent becomes eligible for Medicare for any reason, coverage for that individual will end.)
- The Plan terminates.
- Social Security determines you are no longer disabled during an 11-month disability extension period.

Six-Month Self-Pay Option

If your employee coverage terminates, you have the choice to continue reduced medical coverage for up to six months. You must make the necessary self-payments by the tenth of each month to maintain coverage.

This medical coverage will be provided under Medical Plan C rather than Medical Plan B. During the six months of self-pay coverage, no Time Loss, AD&D or Life Insurance is provided.

If you have the option to continue coverage under the COBRA self-pay option and you choose this Six-Month Self-Pay Option instead, you waive your COBRA rights. After the end of your COBRA election period, COBRA coverage will not be available to you later. However, if a qualifying event occurs, your covered family members may be entitled to continue under COBRA as described above.

Payments and medical benefits for the Six-Month Self-Pay Option under Plan C are less than for COBRA self-pay coverage under Plan B.

If you qualify for a waiver of contributions due to total disability, described on page 25, you may begin the six months of self-payments at the end of the waiver period. You may not receive more than one waiver period or make more than six months of self-payments regardless of the number of disabilities that may occur during a waiver or self-payment period.

If a qualified beneficiary rejects COBRA coverage in favor of the Six-Month Self-Pay Option, this option then becomes like a different group health plan — it's not treated like COBRA coverage. The individual's status as a qualified beneficiary will cease after the initial COBRA election period. When Six-Month Self-Pay Option coverage expires, the individual will not be offered a COBRA election.

If you choose the Six-Month Self-Pay Option and your spouse or dependent child would lose this coverage as the result of a subsequent qualifying event (see below), they may continue COBRA coverage. The maximum coverage period would be 36 months, measured from the qualifying event.

For a dependent spouse, qualifying events for this COBRA coverage are:

- Death of the employee

- Divorce from the employee
- Spouse elects Medicare as the primary coverage.

For a dependent child, qualifying events for this COBRA coverage are:

- Death of the employee
- Parents' divorce
- Parent elects Medicare as primary coverage, or
- Dependent is no longer eligible under the Plan.

If coverage is lost as the result of termination or reduction in hours, the employee's death or Medicare entitlement, the Trust Administrative Office will notify you and/or your family members of COBRA continuation options. If a family member loses coverage (because of divorce or a child no longer being eligible, for example), the Trust Administrative Office must be notified within 60 days.

Life and Accidental Death & Dismemberment (AD&D) Insurance

This booklet is your Certificate of Insurance for Life and AD&D coverage. In all instances, group policy terms and conditions will determine your insured benefits.

There are three Life and AD&D plans through the Trust that can be part of your collective bargaining agreement: Life and AD&D Plan A, Plan B, or Plan C. These plans are separate from Medical Plans A, B, C, and Z. Therefore, it is possible for you to have Medical Plan B but Life and AD&D Plan A or C. Alternatively, your collective bargaining agreement may not provide Life and AD&D insurance through a Trust Plan. Refer to your collective bargaining agreement to determine which Life and AD&D Plan may apply to you.

Each Life and AD&D Plan includes employee life insurance, dependent life insurance, and employee AD&D insurance.

Life and AD&D Coverage			
	Plan A	**Plan B**	**Plan C**
Employee Life	$30,000	$15,000	$5,000
Dependent Life	$3,000	$1,500	$500
Employee AD&D	$30,000	$15,000	$5,000

The different types of insurance under these plans are described on the following pages.

Employee Life Insurance

Death Benefit

If you die, your beneficiary will receive the scheduled benefit for you under the plan specified in your employer's collective bargaining agreement:

- Plan A — $30,000 death benefit
- Plan B — $15,000 death benefit
- Plan C — $5,000 death benefit
- No coverage.

The collective bargaining agreement will specify which level applies to you.

If you die while covered by this employee life insurance, Principal Mutual Life Insurance Company will pay your beneficiary the scheduled benefit in force on the date of your death. If your beneficiary does not survive you, or if you haven't designated a beneficiary, Principal will pay:

- First, to your spouse if living, then
- To your surviving natural or adopted children in equal shares, then
- To your surviving parents in equal shares, then

- To your brother(s) and sister(s) in equal shares, then
- To your estate.

Contact the Trust Administrative Office for information about any of the settlement options available to your beneficiary at your death.

Beneficiary

You may change your beneficiary by filing a Beneficiary Form with the Trust. Contact the Trust Administrative Office or your local union for forms. A change in your beneficiary will not be effective until the Trust Administrative Office records the change.

Life Insurance Premium Waiver During Total Disability

If you stop active work for any reason, your employee life insurance will normally terminate. However, if you stop active work because you're totally disabled, you may qualify to continue this coverage, without having to pay a premium.

You are considered totally disabled when, because of sickness or injury, you are not able to perform the duties of any occupation that reasonably fits your background or training, as determined by the Trust and Principal Financial Group.

To be qualified for insurance during total disability, you must also:

- Become totally disabled while insured for employee life insurance
- Remain totally disabled continuously
- Be under the regular care of a physician
- Agree to exams by a physician when required by Principal (Principal will pay for these exams and choose the physician)
- Send proof of disability to Principal within one year of the date the disability starts and each year thereafter
- Return, without claim, any individual life insurance policy that may have been issued to you under your individual purchase rights (see page 26).

If you qualify, life insurance coverage continuation due to your total disability generally begins nine months after the date your total disability begins. However, if you die during this nine-month waiting period but you would have otherwise qualified for continuation life insurance coverage, your beneficiary will receive your life insurance benefit.

If you die while insurance is extended by this total disability provision, the Plan will pay your beneficiary the scheduled benefit that would have been paid had you remained insured under this Plan. The amount will be determined by the scheduled benefit in force on the date your disability began.

When Premium Waiver Coverage Ends

Insurance under this premium waiver provision ends when:

- The group policy terminates,
- You are no longer totally disabled,

- You fail to send required proof of Total Disability to Principal or refuse to undergo a required physician's examination, or
- You cease to be under the care of a physician.

Individual Purchase Rights

You will have the right to buy an individual life insurance policy without submitting proof of your good health if:

- Your total employee life insurance terminates because you end active work or become ineligible. In either instance, the maximum you may buy will be your employee life insurance amount on the termination date minus any individual amount purchased earlier under these rights.
- The group policy terminates or is amended to exclude your insurance class after you've been insured for at least five years. In either instance, the maximum you may buy will be the smaller of $2,000 or your employee life insurance amount on the termination date, minus any amount you become eligible for under any group policy within 31 days.

To purchase an individual life insurance policy, you must apply and pay the first premium within 31 days after your group life insurance ends. Contact the Trust Administrative Office for the proper forms. Any individual policy issued will be effective on the thirty-second day.

The individual policy will be for life insurance only; no disability or other benefits will be included. The premium you pay will be at Principal's normal rate for your age and risk class on the individual policy's date of issue.

If you die within the 31-day purchase period, your beneficiary will receive any life insurance amount you had the right to buy. This payment will be made whether or not you applied for an individual policy.

Dependent Life Insurance

Death Benefit

Dependent life insurance pays you a benefit if your eligible dependent dies. The benefit amount you will receive depends on the plan specified in your employer's collective bargaining agreement:

- Plan A — $3,000 death benefit
- Plan B — $1,500 death benefit
- Plan C — $500 death benefit
- No coverage.

You cannot be covered as both a dependent and an employee under the life insurance plans.

Payment is made to you if you survive the dependent. Otherwise, Principal will pay the beneficiary you named for employee life insurance.

Individual Purchase Rights

Your spouse may buy an individual life insurance policy without submitting proof of good health if:

- Dependent life insurance for your spouse ends because you're divorced or separated or because you die, end active work or become ineligible. In these instances, the maximum your spouse may buy will be the amount of dependent life insurance in force on the termination date minus any individual amount purchased earlier under these rights.

- The group policy terminates or is amended to eliminate dependent life insurance or your insurance class after your spouse has been insured for at least five years. In these instances, the maximum your spouse may buy will be the smaller of $2,000 or the spouse's dependent life insurance amount on the termination date, minus any amount your spouse becomes eligible for under any group policy within 31 days.

To purchase an individual life insurance policy, your spouse must apply and pay the first premium within 31 days after the group insurance ends. Contact the Trust Administrative Office for the proper forms. Any individual policy issued will be effective on the thirty-second day.

The individual policy will be for life insurance only; no disability or other benefits will be included. The premium to be paid will be at Principal's normal rate for your spouse's age and risk class on the individual policy's date of issue.

If your spouse dies within the 31-day purchase period, Principal will pay to you any life insurance amount your spouse had the right to buy. This payment will be made whether or not your spouse applied for an individual policy.

Employee AD&D Insurance

AD&D insurance covers you if you die or suffer certain injuries as the result of an accident. The Plan specified under your employer's collective bargaining agreement determines your AD&D benefit:

- Plan A — $30,000 death benefit
- Plan B — $15,000 death benefit
- Plan C — $5,000 death benefit
- No coverage.

A percentage of the death benefit is paid if you suffer certain non-fatal injuries as a result of an accident.

Benefit Qualification

To qualify for AD&D benefit payment, all of the following must occur:

- You must be injured while covered by AD&D insurance
- Your injury must be through external, violent and accidental means
- Your injury must be the direct and sole cause of a loss listed as follows, and
- Your loss must occur within 365 days of your injury.

Benefit Payable

If all of the previous qualifications are met, Principal will pay the following percentages of your scheduled benefit:

- 50% if one hand is severed at or above the wrist
- 50% if one foot is severed at or above the ankle
- 50% if the sight of one eye is permanently lost
- 100% if more than one of the listed losses occurs, or
- 100% if you lose your life.

Total payment for all losses that result from the same accident will not exceed 100% of your scheduled benefit.

Payment for loss of life will be to the beneficiary you named for employee life insurance. Payment for all other losses will be to you.

Limitations

Payment will not be made for any loss with one of these contributing causes:

- Willful self-injury or self-destruction, while sane or insane
- Disease or the treatment of disease
- Voluntary participation in a riot, assault, felony or insurrection
- War or act of war, including terrorism.

Time Loss Benefits — Employee Only

Time Loss benefits provide weekly income when you are disabled and cannot work due to a non-work related injury or illness. This benefit is sometimes referred to in collective bargaining agreements as weekly income benefits, short-term disability benefits or accident and sickness benefits. The Time Loss plans are separate from your Medical Plan. For example, you may have Medical Plan B, but Time Loss Plan A. Your weekly benefit is determined under the Plan specified in your employer's collective bargaining agreement:

- Time Loss Plan E — $500 per week
- Time Loss Plan A — $400 per week
- Time Loss Plan B — $300 per week
- Time Loss Plan C — $200 per week
- Time Loss Plan D — $100 per week
- No coverage.

If the benefit specified in the collective bargaining agreement increases or decreases while you're on Time Loss benefits, your benefit will change to the new rate if a contribution at the new rate is required and made on your behalf. The change will be effective with the month of coverage for which the contribution is made.

To qualify for Time Loss payments you must:

- Become disabled in a month for which you have eligibility based on an employer contribution for this coverage or, if you have returned to covered work, for which you have eligibility based on a disability waiver of contributions due to a prior disability, and
- Be unable to perform the normal duties of your occupation because of a disability due to a covered accidental injury or sickness (including pregnancy and its complications), and
- Be under a physician's regular care for the covered accidental injury or sickness, and
- Not engage in any occupation for wage or profit (except any light-duty work allowed under your collective bargaining agreement).

Your benefit is payable starting the first day for disabilities resulting from an accidental injury (see page 31) or medically necessary surgery or the eighth day for disabilities due to an illness, but will not begin before your first physician's visit. Written certification of your disability and beginning date is required.

Unless you're under a physician's care, you will not be considered disabled; your first day of disability for purposes of the accidental injury or sickness disability qualification period will not be before the date you first visit the physician.

The payment will continue for as long as you're disabled and under a physician's regular care — up to a maximum dollar amount for each disability equal to 26 times the weekly benefit specified in your employer's collective bargaining agreement. For example, if the collective bargaining agreement provided a benefit of $200 per week, the maximum benefits payable are $5,200 (26 x $200). During partial weeks of total disability, you will be paid at the daily rate of one-seventh of the Time Loss payment.

If you are receiving Time Loss benefits and are able to return to light-duty work, or to your normal job less than full-time with the same employer, your Time Loss benefits **will be limited**

to not more than the difference between your normal weekly straight-time pay before your disability and the combined amount for light-duty work and any holiday or sick leave pay. No Time Loss benefits will be paid if your combined wages and sick leave and holiday pay equal or exceed your straight-time pay prior to the disability.

A subsequent disability separated by less than two weeks of full-time work is considered the same disability unless it's due to a different cause and the disability period begins after you return to full-time work. After your return to work from a disability, you can qualify for Time Loss benefits or a disability waiver of contributions for a new disability, only if the new disability occurs during a month in which you have either eligibility due to a disability waiver of contributions for the prior disability or as the result of an employer contribution.

Contact the Trust Administrative Office to find out when your benefits begin, determine the amount of your Time Loss payment and obtain a Weekly Income/Disability Waiver application. All sections of the form must be completed before your claim can be processed.

Exclusions

1. Time Loss benefits will not begin before the time specified in the collective bargaining agreement

2. You will not be considered disabled and eligible for these benefits unless you are under a physician's regular care and provide certification of continuous treatment in a form acceptable to the Trust

3. These benefits do not cover disability due to an accident or sickness when coverage is available under any Workers Compensation Act or similar law (including LEOFF Act), whether or not you elect that coverage or meet the claim filing deadline

4. Disabilities resulting from war or act of war (declared or not) including terrorism are not covered

5. Disabilities that begin in a month for which you do not have eligibility based on an employer contribution or, if you have returned to covered work, for which you do not have eligibility based on a employer contribution or disability waiver of contributions due to a prior disability, are not covered by these benefits.

Social Security (FICA) Tax

The liability for FICA taxes is divided between you and your employer. The Plan is required by federal law to withhold your share of the tax from each Time Loss benefit payment made during the six months after you stop working.

Income Tax

Time Loss payments are subject to federal income tax. Upon written request, you may have income tax withheld by the Trust Administrative Office. Please contact the Trust Administrative Office for a withholding application and other details. Income tax will be withheld from Time Loss payments payable eight or more days after the Trust Administrative Office receives your written request. This withholding will end with the Time Loss payments payable eight or more days after the Trust Administrative Office receives your written notice to terminate withholding.

Time Loss Definitions

The following definitions apply to Time Loss benefits only:

Accidental Injury — Physical harm from a sudden, traumatic, unforeseen event caused by the intervention of an external force, at a specific time and place. This is independent of sickness except for infection of a cut or wound.

Disabled — Unable to perform the normal duties of your job, as determined by a physician, because of an accidental injury or sickness. In determining whether you are disabled for the purpose of receiving Time Loss benefits, the Trust has the right, at our sole discretion, to require you to undergo an independent medical evaluation by a physician of the Trust's choice, at the Trust's expense.

Light Duty — Returning to work for the same employer and performing normal job duties less than full-time or other light-duty work while under a physician's regular care.

Sickness — An illness recognized by authoritative medical or scientific literature and diagnosed by a physician.

Care Management Programs

Care management programs help you get the most appropriate healthcare in the most appropriate setting. They also help the Trust fulfill its obligation to control costs and ensure appropriate use of Trust resources. The Trust uses the services of several care management program partners who help you by:

- Advising on care and setting options
- Informing you of available health service alternatives to avoid unnecessary surgery and the corresponding risks
- Saving you out-of-pocket costs when you use providers who have agreed to discounts.

To receive maximum benefits, use the following for medical care coordination and healthcare cost containment programs:

- Hospital and physician Preferred Provider Organization (PPO)
- Mandatory hospital utilization review
- Case management programs.

These services are provided in conjunction with other cost management services such as the Prescription Drug program, the Mental Health and Chemical Dependency Program and the Stand Strong Program. Together, these services are part of the Trust's overall program designed to ensure that you receive effective healthcare at the appropriate time and in the most appropriate setting for all medically necessary treatment. Of course the final decision about your medical treatment is between you and your physician.

The Preferred Provider Organization (PPO)

The Trust has a PPO arrangement with Cigna for medical services. This network of Physicians, Hospitals and other health care professionals provide access to services and supplies at discounted rates. Using PPO providers will result in lower cost to the Trust and less out of pocket cost for you.

Using the PPO Network Can Save You Money

The PPO helps us offer healthcare at a lower cost. Of course, as a covered Washington Teamster participant, you can use any covered provider you wish. But when you use a PPO (in-network) provider, there are financial advantages.

The PPO credentials and contracts with preferred providers to offer a network of primary care physicians, specialists, hospitals, clinics, and other health care providers. The PPO also negotiates fees with these providers and facilities and passes the savings on to you, so that you can obtain medical services from these providers at a favorable rate.

When you choose from the PPO's diverse network of qualified providers, they will handle your claim paperwork. You also have the option to use any preferred physician or specialist without first obtaining a referral for most services.

When you use a PPO provider, your out-of-pocket expenses will be less than if you were treated at a non-PPO provider since your benefits are based on discounted rates. When you use a PPO provider for services that are subject to coinsurance, you will also pay at a 20%

lower coinsurance level after your annual deductible until you meet your annual maximum for coinsurance.

If you elect to use a non-PPO provider, the Plan's coverage will not include charges which exceed the usual, customary and reasonable (UCR) amount for the services provided. So, in addition to the higher coinsurance, you'll be responsible for any amount charged by a non-PPO provider which exceeds the UCR amount.

The following non-PPO providers will be covered at the PPO coinsurance rate until you reach your annual maximum for coinsurance **if** a PPO facility (hospital, ambulatory surgery center) is used for treatment:

Anesthesiologist

Radiologist

Laboratory

Pathologist

Emergency Room Physician

Ambulance

Attending Physician (staff and on-call) treating the patient in an emergent situation

The following non-PPO providers will be covered at the PPO coinsurance rate until you reach your annual maximum for coinsurance when services are coordinated through a PPO physician:

Co-Surgeon

Assistant Surgeon

Anesthesiologist

Radiologist

Laboratory

Pathologist

The PPO coinsurance level will also be applied to any claim where case management has negotiated a discount at a non-PPO provider for services on a single claim basis, for example where the case manager has negotiated a discount for durable medical equipment.

Despite the fact that the in-network PPO coinsurance level will be paid by the Plan for services performed by non-PPO providers in the above situations, the covered charges will still be limited to the UCR amount. You will be responsible for any amount charged by a non-PPO provider that is in excess of the UCR amount.

Finding a PPO Provider

The Washington Teamsters Welfare Trust contracts with **Cigna** to provide a **PPO** (preferred provider organization) — a network of preferred hospitals, physicians, and other providers who agree to offer services at discounted rates — to help control plan costs and save you money. .

You may use non-preferred (out-of-network) providers any time; however, you'll generally **save money** and keep the cost of your plan down when you see PPO (in-network) providers.

To locate a PPO provider in your area, you may refer to a hard copy of the directory. However, as providers may be added or deleted from time to time, it is also strongly recommended that you should:

- Call Cigna toll-free at **855-402-0272** to confirm the provider's status before services are performed. This is the most current source of provider information.

You may also find provider information by visiting **www.cignasharedadministration.com**. Click the link, "Find a Doctor," to begin your search. Although online information is updated monthly, you should call Cigna for the most current information.

- IMPORTANT — Because PPO providers change, be certain to verify your provider's participation before obtaining services; being listed in the PPO directory does not guarantee the provider continues to participate in the PPO. Contact Cigna to confirm the status of your provider or hospital before services are received.

Not all the providers in the Cigna PPO are covered by the Washington Teamsters Welfare Trust. Certain types of providers may be in the PPO but are not covered by your plan. To avoid having your claims denied, it's important to review the section, "What Types of PPO Providers Are Not Covered." If you have questions about services or types of providers covered by your plan, it's also a good idea to call the Trust Administrative Office at 800-458-3053 *before* you receive care.

What If My Provider Isn't In the Network?

It's your choice. You can switch to a preferred provider or go to the non-preferred provider — but you're likely to have higher out-of-pocket costs with the non-preferred provider. You may also nominate your provider for the PPO network, as described below.

Can My Doctor Join the PPO Network?

If your provider isn't currently in the Cigna PPO Network, you can ask your provider if he or she is interested in joining. Contact Cigna or the Trust Administrative Office to request a provider nomination form or ask your provider to contact Cigna at 800-882-4462. Nomination forms may also be found on the website at **www.cignasharedadministration.com**. Nomination doesn't guarantee your provider will be added to the PPO network. Your provider must meet the selection criteria of Cigna in order to join the network.

What Types of PPO Providers Are Not Covered

Not all providers in the Cigna PPO Network are covered by the Washington Teamsters Welfare Trust — even if they are in the PPO network and even if a PPO doctor refers you. Contact the Trust Administrative Office to verify that treatment you receive will be covered by the Trust.

- **Non-preferred providers are not covered as PPO providers, even if you are referred by a PPO provider.** When a referral is necessary, always ask your PPO provider if he or she can refer you to a PPO provider.

- **Only acupuncturists and naturopaths in the PPO network are covered by the plan.** Contact Cigna for a list of preferred acupuncturists or naturopaths.

- **Ophthalmologists and optometrists in the PPO can be used for injuries and diseases of the eye, not routine eye care.** Call NBN Vision at 800-732-1123 for the vision plan provider network and routine eye care; i.e., refractions (routine eye exam), lenses, and frames.

- **For prescription benefits, the Trust uses the MedImpact network, not Cigna.** Call MedImpact at 800-788-2949 to find a participating pharmacy.

Retaining Your Freedom of Choice

Using the PPO is voluntary — you're free to go to any covered provider, even if that physician or facility is not a PPO member. However, no PPO benefits will be allowed for services from a non-PPO provider (even in a case of non-availability or travel).

Getting the Most from Your PPO

Here are a few helpful hints on using the PPO network:

- Always present your ID/Information card when you receive medical care
- Be familiar with your Plan, including what services and types of providers are — and are not — covered under the Plan or PPO
- Remind your physicians to send lab work to a preferred lab and to refer you to PPO hospitals, clinics or specialists
- Remind your doctor that you have a pre-certification requirement for all inpatient hospital stays before you're admitted
- Claims will be submitted for you by your PPO provider.

Mandatory Hospital Utilization Review

The Trust provides utilization review (UR) to ensure you are hospitalized only when medically necessary, and for the appropriate length of stay. Pre-certification is required for all admissions, whether PPO or non-PPO. UR nurses will discuss the proposed hospitalization with your physician, then evaluate the necessity of admission and anticipated length of stay compared with locally accepted standards of care. In certain circumstances, actively practicing physician advisors may also review your hospitalization and consult with your physician. You, your physician, the Trust and the hospital will be notified in writing of the outcome from this review. *Pre-certification does not guarantee coverage — all services must be covered expenses under the Plan to be eligible for benefits.*

The UR manager also reviews outpatient procedures, such as hysterectomies and spinal surgeries, that are usually performed on an inpatient basis to determine whether the outpatient procedure could be considered medically necessary.

Your benefits will be reduced $200 for each hospitalization if you don't follow the pre-certification procedures described below. This applies to all scheduled inpatient, maternity and emergency admissions. Any days or hospitalizations that are not pre-certified as medically necessary will not be covered.

Pre-Certification Procedures

If Medicare is a patient's primary coverage, pre-certification of a hospital stay is not required.

Non-Emergency Hospital Admissions

All non-emergency admissions must be pre-certified before you or a covered dependent enters the hospital. You, a family member or your physician must call the UR manager to discuss the proposed hospitalization, medical necessity of the proposed procedure and anticipated length

of stay. UR nurses and doctors will review your physician's treatment plan to determine medical necessity and the appropriate length of stay; they may be able to suggest safe, more cost-effective treatment alternatives.

Emergency or Maternity Admissions

If the admission is an emergency or maternity related, you, a family member, your physician or hospital must call the UR manager to pre-certify the hospital stay within 48 hours after admission or on the first business day following a weekend or holiday admission.

Inpatient hospital stays for childbirth are allowed for up to 48 hours following a vaginal delivery or 96 hours following a cesarean section. The discharge may be earlier as long as the patient and provider agree.

Concurrent Review

After admission, UR nurses and doctors will continue to evaluate your length of stay through concurrent review. If the recommended length of continued confinement is found to be longer than the generally accepted standards of care — as determined by the UR manager — you, the Trust and your physician will be notified. (An explanation of your right to appeal will be included with the notice when a non-certification is issued by the UR manager.)

Maximizing Your Benefits

You and your physician always have the final decision regarding hospital confinement and medical treatment, but the coverage of related charges will be subject to Plan terms and conditions. Hospital charges for days not certified as medically necessary by the UR manager will not be covered.

With Pre-Certification

Covered admissions and hospital days that are medically necessary and approved by the UR manager will receive regular plan benefits. After reviewing your medical information and consulting with your physician, when it is determined the hospital stay is no longer medically necessary, the hospital will receive verbal notification immediately. In addition, you, your physician and the hospital will be notified by letter.

Without Pre-Certification

Failure to pre-certify non-emergency admissions, or to report emergency and maternity admissions within the stated time limits, will result in a benefit reduction of $200 even if the stay is later found medically necessary. *Claims for any days not certified as medically necessary will be denied.*

Second Surgical Opinion

A second opinion is occasionally required by the UR manager when the reasons for a requested surgical procedure are not clear from the information provided by your physician.

In addition to the surgeries listed below, the plan reserves the right to request a second opinion for any surgery. Surgical procedures may be added or deleted as medical standards dictate.

- Breast surgery (excluding needle biopsy), including breast cyst removal, mammoplasty and mastectomy.
- Hysterectomy (removal of the uterus).

- Knee surgery by either surgical incision or arthroscope.
- Nasal surgery, including submucous resection and septoplasty.
- Spinal surgery, including laminectomy and spinal fusion.
- Orthognathic surgery.

Please contact the UR manager to determine if the proposed procedure is medically necessary and if a second surgical opinion is recommended. In that case, a UR nurse will refer you to an appropriate provider for a second opinion.

Case Management Programs

Medical Case Management Services

Under special circumstances, UR nurses act as patient advocates to help meet the needs of patients with catastrophic or chronic medical problems. They work with you, your family and your physician to help you assess, plan and coordinate all of your healthcare options and find the most appropriate care for your condition. This is a voluntary program available at no cost to you.

Hospital Discharge Planning

Discharge planning helps in situations when you require continued medical care, but not necessarily care that's as intensive as in an acute (hospital) setting. Case management nurses will work with you, your physician and the hospital staff to develop a plan that provides for safe discharge from the hospital. Working with your physician and the hospital staff, the case management nurses can also arrange home healthcare, skilled nursing facilities and hospice care.

Catastrophic/Chronic Illness

The case management program can help patients with long-term, high-cost illnesses and injuries to obtain needed care. Case management nurses work with other medical professionals to identify patients who might benefit from case management — often during the UR process. A patient who chooses to participate is assigned a case manager to help coordinate care. Many times case managers identify hospital alternatives, such as home healthcare or skilled nursing facilities.

Alternative Care and Treatment

Hospital confinement is not always the best environment for treating an illness. For a patient who needs significant long-term medical supervision, case management may recommend alternative care and treatment or facilities that are:

- Not normally covered by this Plan
- Covered by this Plan, but payable on a different basis from the care and treatment they replace
- Payable on the same basis as the care and treatment they replace, once approved.

In these situations, the Trust may approve coverage for alternative care and treatment that would otherwise not be covered, when medically necessary treatment can be delivered more cost-effectively.

Contact the Trust Administrative Office when you need details about how any case management service applies to you.

STAND STRONG

STAND STRONG is a series of wellness tools and resources designed to help you and your family maintain your good health, manage chronic conditions, get access to healthcare information resources and generally live a healthier, stronger life. By leading a healthier lifestyle, you can improve your health and help keep healthcare affordable for all Trust participants.

Personal Health Assessment (PHA)

The STAND STRONG Personal Health Assessment or PHA is a series of questions about your health and lifestyle habits. Your personalized results will identify your health risks and help you find ways to improve or maintain your health. The PHA is designed for you to take every year so you'll be able to compare your results each year.

The health information you share is completely confidential. StayWell Health Management, an independent provider of health promotion programs and services, analyzes your results and provides personalized feedback. No one at your employer, your union or the Trust will ever see your information. Your privacy is assured.

Health Coaching

If your STAND STRONG Personal Health Assessment shows that you have a certain health risk, such as high blood pressure, you may be invited to participate in the STAND STRONG StayWell NextSteps Program, a personal Health Coaching program provided at no cost to you. Health Coaches work one-on-one with participants to help them make healthy changes in a variety of areas including:

- Back care
- Blood pressure
- Cholesterol
- Nutrition
- Physical activity
- Stress management
- Tobacco use
- Weight

Chronic Condition Support Program

If your medical or pharmacy claims data shows that you have one of the chronic conditions covered by the program—asthma, diabetes or coronary artery disease, then you may be invited to participate in the STAND STRONG Chronic Condition Support Program. If you choose to participate (you don't have to), the program is provided at no additional cost to you. The Chronic Condition Support Program supports your doctor's treatment plan to help you stay as healthy as possible, but does not replace the advice and treatment of your doctor. With the program, you'll receive education and support through regularly scheduled one-on-one calls with health care professionals including advice on how to follow your doctor's instructions, information about your medications and access to online tools and resources.

Quit Tobacco

If you're thinking about quitting tobacco, the Trust provides two ways to help you kick your habit for good.

Through the STAND STRONG StayWell NextSteps Health Coaching Program**, Nicotine replacement therapy** is covered 100% for you and your eligible spouse (or domestic partner if domestic partners benefits have been negotiated under your collective bargaining agreement). Nicotine replacement therapy combines nicotine replacement products (nicotine gum and patches) with the support of a personal Health Coach. Nicotine gum or patches are covered only when you enroll in the StayWell NextSteps Tobacco Cessation program and complete at least one call with a Health Coach. Call the StayWell HelpLine at **888-388-8259** anytime throughout the year to enroll.

Tobacco cessation prescription medications to help you quit tobacco, such as Zyban or Chantix, are also covered — subject to copays — up to $500 each year with a lifetime maximum benefit of $1,000 per person. In order to have a prescription refill covered by the Plan, you will need to enroll in StayWell NextSteps Tobacco Cessation program and complete one call with a Health Coach. Therefore, it is recommended you enroll in the Health Coaching program prior to, or at the time you first get a prescription for tobacco cessation drugs. Call the StayWell HelpLine at **888-388-8259** anytime throughout the year to enroll.

Nurse Line

Nurse Line is a resource that you can call for advice 24 hour a day, 7 days a week; and it's toll-free to participants and covered dependents.

Nurse Line: call toll-free at 855-402-0272.

The Nurse Line is staffed with trained, registered nurses who can answer many of your health questions and advise you about self-care steps. This service can be especially helpful when you're not sure whether or not you need to see a doctor right away. Your calls are always held in the strictest confidence. Contact the Nurse Line anytime you have a **medical question** or **you're not sure what to do** about a healthcare symptom or diagnosis.

The 24-hour health line is not a substitute for regular, scheduled care from your physician or other healthcare provider. **In an emergency, call 9-1-1, not the Nurse Line.**

Mental Wellness

Assistance Program connects you and your family to professionals who can help with personal and work-related issues such as managing stress, coping with grief and loss, family relationships, work-life balance and more. Up to three telephone or face-to-face clinical consultations per person per incident are covered each calendar year. Call Cigna at **855-402-0272** 24 hours a day, seven days a week.

Behavioral Healthcare Services provide help for more serious emotional or mental health challenges and chemical dependency treatment.

See Mental Health and Chemical Dependency Benefits Program starting on page 77 for program details.

Weight Management Programs

The Trust sponsors the following weight management programs for participants struggling with obesity or weight-related illnesses.

If your personal health assessment shows you have a weight-related health risk, you might receive a call to participate in the **StayWell NextSteps Program**, a personal health coaching program provided at no cost to you. The NextSteps weight program offers telephone based coaching to help you set and meet goals to improve your health.

Sound Health Connects (SHC) offers clinically supervised weight-management programs that include both a non-surgical and surgical option. For participants who meet certain eligibility and pre-surgical criteria, the Trust will also consider weight-loss surgery as an option. The selection criteria for weight-loss surgery are in place to help ensure participants are prepared for surgery and have a more successful outcome.

Non-Surgical Weight-Loss Program

The 24-week **non-surgical** weight-loss program is intended for eligible participants who are struggling with obesity or who are overweight with certain health risks. It is clinically supervised by Sound Health Connects (SHC).

Criteria for Participation

To qualify to participate in the program, you must meet these three criteria:

- Be at least 18 years old, and
- Be eligible for a Trust-sponsored medical plan (other than a Group Health Options plan), and
- Meet the medical definition of obesity as measured by Body Mass Index (BMI). You must have a BMI of 30 or over, or a BMI of at least 27 with two or more of the following risk factors: arthritis, asthma, congestive heart failure, coronary artery disease, depression/anxiety, diabetes Type II, GERD (heartburn), high blood pressure, high cholesterol, low back pain, polycystic ovary syndrome, sleep apnea.

Pre-Certification Procedures

Pre-certification is required before you or a covered family member can participate in the non-surgical weight-loss programs and receive benefits. You or your family member must call Sound Health Connects (SHC) at 1-866-779-4730 to obtain the pre-certification form and then schedule an appointment with your primary care provider to complete the form and return it to SHC. SHC will then determine if you qualify for the non-surgical weight-loss program.

If you qualify, the program will consist of the following:

Non-Surgical Weight-Loss Program (24 Weeks)

Weeks 1 - 12	Weeks 13-24
Nutrition Counseling (by webcam or phone with a Certified Nutritionist at SHC) • 1 one-hour assessment • 2 half-hour sessions • Half-hour webinar every two weeks • Unlimited email support	Nutrition Counseling (by webcam or phone with a Certified Nutritionist at SHC) • 2 half-hour sessions • Half-hour webinar every two weeks • Unlimited email support
Change Counseling (by webcam or phone with a Licensed Counselor at SHC) • 1 one-hour session • 3 half-hour sessions • Half-hour tele-seminar every two weeks • Unlimited email support	Change Counseling (by webcam or phone with a Licensed Counselor at SHC) • 6 half-hour sessions • Half-hour tele-seminar every two weeks • Unlimited email support
Health Counseling (by phone with a Health Coach at SHC) • Weekly 10-minute consultation calls with a SHC Health Coach	Health Counseling (by phone with a Health Coach at SHC) • Weekly 10-minute consultation calls with a SHC Health Coach
Personal Training (at location of your choice) • 3 sessions per week with your own personal fitness trainer	Personal Training (at location of your choice) • 1 session per week with your own personal fitness trainer
Benefits and Cost • The Trust will pay 80% of the SHC fee, you will pay 20%. • The Trust will pay 80% of your personal fitness trainer's fee up to maximums of $41.67 per session and $1,500 total for all sessions. You will pay the balance of your trainer's fee.	Benefits and Cost • The Trust will pay 80% of the SHC fee, you will pay 20%. • The Trust will pay 80% of your personal fitness trainer's fee up to maximums of $41.67 per session and $500 total for all sessions. You will pay the balance of your trainer's fee.

Non-Surgical Weight-Loss Program (12 Weeks)

This 12-week program is designed to serve participants who have completed the 24-week program and are seeking additional support. To qualify for participation a participant must have had 90% attendance in the 24-week program. If significant time has elapsed since completing the 24-week program, a new physician consent form must be signed by the participant's primary care physician.

Weeks 1 - 4	Weeks 5-12
Nutrition Counseling (by webcam or phone with a Certified Nutritionist at SHC) • 2 half-hour consultations • Half-hour webinar every two weeks	Nutrition Counseling (by webcam or phone with a Certified Nutritionist at SHC) • 1 half-hour consultation • Half-hour webinar every two weeks
Change Counseling (by webcam or phone with a Licensed Counselor at SHC) • 1 fifty-minute session	Change Counseling (by webcam or phone with a Licensed Counselor at SHC) • 1 fifty-minute session
Health Counseling (by webcam with a Health Coach at SHC) • 3 sessions per week	Health Counseling (by webcam with a Health Coach at SHC) • 2 sessions per week
Benefits and Cost • The Trust will pay 80% of the SHC fee, you will pay 20%.	Benefits and Cost • The Trust will pay 80% of the SHC fee, you will pay 20%.

Surgical Weight-Loss Programs

The **surgical** weight-loss programs are intended for eligible participants who are struggling with obesity or who are overweight with certain health risks and whose physician(s) are prescribing surgical intervention. It is clinically supervised by Sound Health Connects (SHC).

Criteria for Participation

To be considered as a candidate for weight-loss surgery, participants must meet all the following criteria:

- Presence of severe obesity that has persisted for at least 5 years, defined as any of the following:
  - Body mass index (BMI) exceeding 40; or
  - BMI greater than 35 in conjunction with one of the following severe co-morbidities:
    - Coronary heart disease; or
    - Clinically significant obstructive sleep apnea; or
    - Medically refractory hypertension (blood pressure greater than 140 mmHg systolic and/or 90 mmHg diastolic despite optimal medical management).
- Participant must be 18 to 60 years of age (participants over age 60 are reviewed on a case-by-case basis).
- Participant has had a medical evaluation and documented work-up to rule out underlying "treatable causes" of morbid obesity within the past year.
- Successful completion of the Plan's Weight-Loss Pre-Surgical Program through Sound Health Connects (SHC). Successful completion is defined as:
  - Participant attends more than 90% of the program
  - 5% or greater weight loss
  - Participant is a non-drinker and non-smoker
  - Participant has passed a psychological screening for surgical readiness.

In addition to the 24-week Pre-Surgical Program, participants will be required to complete a 52-week Post-Surgical Program after surgery has been performed.

You will not qualify for weight-loss surgery if you have any of these conditions: pregnancy, lactation, active substance abuse, end-stage cardiovascular disease, severe or uncontrolled psychiatric disorders or anorexia.

You may not qualify for surgery if you have any of these conditions: bulimia nervosa or active binge eating disorder, an unstable medical condition or kidney disease.

Pre-Certification Procedures

Pre-certification is required before you or a covered family member can participate in the surgical weight-loss programs and receive benefits. You or your family member must call Sound Health Connects (SHC) at 1-866-779-4730 to obtain the pre-certification form and then schedule an appointment with your primary care provider to complete the form and return it to SHC. SHC will then determine if you qualify for the surgical weight-loss programs.

At the conclusion of the Pre-Surgical Program, you will be required to follow up with your primary care provider. A SHC clinician will review your progress with your provider and

determine final eligibility for surgery. If you are determined eligible by SHC, surgery will be covered according to the specific plan benefits for bariatric surgery.

After your bariatric surgery, you must be cleared by your surgeon to resume activity in order to re-engage with the staff at Sound Health Connects in the 52-week post-surgery program.

Weight-Loss Pre-Surgical Program (24 Weeks)	
Weeks 1 - 12	**Weeks 13 - 24**
Nutrition Counseling (by webcam or telephone with a Certified Nutritionist at SHC) • 1 one-hour assessment • 2 half-hour sessions • Half-hour webinar every two weeks	Nutrition Counseling (by webcam or telephone with a Certified Nutritionist at SHC) • 2 half-hour sessions • Half-hour webinar every two weeks
Change Counseling (by webcam or telephone with a Licensed Counselor at SHC) • 1 one-hour session • 3 half-hour sessions • Half-hour tele-seminar every two weeks	Change Counseling (by webcam or telephone with a Licensed Counselor at SHC) • 6 half-hour sessions • Half-hour tele-seminar every two weeks
Personal Training • 2 sessions per week with your own personal fitness trainer	Personal Training • 1 session per week with your own personal fitness trainer
Benefits and Cost • The Trust will pay 80% of the SHC fee, you will pay 20%. • The Trust will pay 80% of your personal fitness trainer's fee up to maximums of $55.55 per session and $1,333 total for all sessions. You will pay the balance of your trainer's fee.	Benefits and Cost • The Trust will pay 80% of the SHC fee, you will pay 20%. • The Trust will pay 80% of your personal fitness trainer's fee up to maximums $55.55 per session and $667 total for all sessions. You will pay the balance of your trainer's fee.

Weight-Loss Post-Surgical Program (52 Weeks)	
Weeks 1 - 12	**Weeks 13 - 52**
Nutrition Counseling (by webcam or telephone with a Certified Nutritionist at SHC) • 2 one-hour consultations • 2 half-hour sessions	Nutrition Counseling (by webcam or telephone with a Certified Nutritionist at SHC) • 3 half-hour session .
Change Counseling (by webcam or telephone with a Licensed Counselor at SHC) • 1 fifty-minute session • 4 half-hour sessions	
Personal Training • 1 training session per week with your own personal fitness trainer	Personal Training • 1 training session every two weeks with your own personal fitness trainer
Benefits and Cost • The Trust will pay 80% of the SHC fee, you will pay 20%. • The Trust will pay 80% of your personal fitness trainer's fee up to maximums of $31.25 per session and $375 total for all sessions. You will pay the balance of your trainer's fee.	Benefits and Cost • The Trust will pay 80% of the SHC fee, you will pay 20%. • The Trust will pay 80% of your personal fitness trainer's fee up to maximums of $31.25 per session and $625 total for all sessions. You will pay the balance of your trainer's fee.

Weight-Loss Surgery Aftercare and Follow-up

After successful completion of the Post-Surgical Program, participants are required to return to their doctor to obtain ending metric data such as blood pressure, weight, waist measurement and lipid blood panel. Participants will continue to be monitored via webcam with SHC's certified exercise specialist at 6 months, one year, and every year thereafter for an additional four years. The exercise specialist will review your exercise program and suggest changes, if necessary. Additionally, SHC may request certain blood tests at regular intervals during the follow-ups.

Benefits

As well as meeting the weight-loss program requirements, you must be eligible for benefits during the month in which services are provided in order for those services to be covered by the Plan. If you are eligible during the month in which services are provided, benefits will be provided by the Trust for that month at a straight 80% up to any specified limits. Trust participants pay 20% plus all amounts in excess of any limits. These rates apply to the non-surgical, pre-surgical and post-surgical services provided by SHC and your fitness trainer. Benefits for fitness training provided by your own personal trainer are limited to $2,000 for the non-surgical program, $2,000 for the pre-surgery program, and $1,000 for the post-surgery program.

If you are approved for surgery by SHC, benefits for covered surgical services are paid at a straight 80% if using a PPO provider and 60% if using a non-PPO provider. Charges by non-PPO providers are limited to usual, customary, and reasonable (UCR) charges. You pay 20% if using a PPO provider and 40% plus any amounts in excess of UCR charges if using a non-PPO provider.

The benefits for these program services and surgery are not subject to the deductible or copays and your share of the costs do not count toward the Plan's coinsurance annual out-of-pocket maximum. The Plan's coinsurance annual out-of-pocket maximum also does not apply to these

benefits, the maximum coinsurance rate paid by the plan is 80% (PPO) or 60% (non-PPO) even if you have met your coinsurance annual out-of-pocket maximum for the year.

If You Have Questions

Contact Sound Health Connects at 1-866-779-4730 or **www.soundhealthconnects.com** for more information about the clinically supervised weight-loss program or the pre- and post-surgical programs including SHC costs and participation criteria.

Contact the Trust Administrative Office for more information about your eligibility for benefits and the benefits that will be paid by the Plan if you qualify.

Medical Plan Provisions

Medical Plan B Summary

Please note, this is a summary and many details are not included in this chart, but are covered in the rest of this section. The **calendar year deductible, out-of-pocket maximum** and **coinsurance** shown below **DO NOT** apply to the:

- Prescription Drug Program,
- Weight Management Programs, or
- Mental Health and Chemical Dependency Benefits Program.

Expenses for Mental Health and Chemical Dependency treatment, Weight Management, Bariatric Surgery, prescription drugs and professional office visits will not be paid at 100% once the out-of-pocket maximum is met, except to the extent that mental health and chemical dependency services might already be covered at 100%.

Plan Features	
Calendar Year Deductible (excluding copays)	**$200** per person; **$600** per family if you were eligible and took the Trust's Personal Health Assessment in the prior calendar year[1] **$400** per person; **$1,200** per family if you were eligible and did not take the Trust's Personal Health Assessment in the prior calendar year[1] **$300** per person; **$900** per family if you become eligible during the calendar year[1]
Coinsurance (applies to most benefits) Coinsurance percentages listed in this summary refer to: • Percentage paid of discounted charges for an in-network (PPO) provider • Percentage paid of UCR (usual, customary, and reasonable) charges for an out-of-network (non-PPO) provider	**80%** In-network (PPO)[2] **60%** Out-of-network (non-PPO)[2]
Calendar Year Out-of-Pocket Maximum for Coinsurance (excluding all plan deductibles and copays)	**$2,500** per person; **$5,000** per family[2]
Plan Year Annual Maximum (July 1-June 30) through June 30, 2014	**$2,000,000** per person. No maximum effective July 1, 2014
PPO Network	Cigna

1. The deductible does not include copays and does not apply to office visits that are subject to copays, prescription drug program, mental health and chemical dependency program, or weight loss program. To qualify for the $200 per person/$600 per family deductible both the participant and spouse, if married, or domestic partner, if covered, must complete Personal Health Assessment(s) during the prior calendar year when it is available for completion.

2. Once an individual reaches the out-of-pocket maximum for coinsurance during a calendar year, the Plan pays most eligible expenses at 100% for the rest of that calendar year. Costs for mental health treatment, chemical dependency treatment, weight management, bariatric surgery, outpatient professional copays, deductible, prescription drug expenses, non-covered expenses, charges over UCR amounts, and penalties for not pre-certifying hospitalizations do not apply to the out-of-pocket maximum for coinsurance. Hospital emergency room services at an out-of-network (non-PPO) hospital will be paid at 80%

Plan Features	
Hospital and Emergency Room Benefits	
Hospital Emergency Room Care	$75 copay per visit (waived if admitted), then 80% after the deductible
Hospital Pre-Certification/Utilization Review	Hospital pre-certification required; $200 penalty when admission not pre-certified; no coverage for days not certified by Cigna as medically necessary
Inpatient Hospital (room and board)	Applicable coinsurance after the deductible
Second Surgical Opinion	100% (not subject to deductible) if required by Cigna
Surgery (inpatient and outpatient)	Applicable coinsurance after the deductible
Physician Services	
Office Visits	100% after $25 copay per visit (not subject to deductible)
Preventive Care	In-network (PPO) - 100% Out-of Network (Non-PPO) - 60% after $25 copay per visit and deductible.
Inpatient Care and Surgery	Applicable coinsurance after the deductible
Diagnostic X-Ray/Lab	Applicable coinsurance after the deductible
Other Plan Benefits	
Acupuncture Treatment	100% after $25 copay per visit (not subject to deductible), up to 15 visits per calendar year; acupuncturist (LAC) covered only if a PPO provider is used
Alternative Treatment Settings, instead of Hospitalization:	Applicable coinsurance after the deductible
• Alternate Housing Facility	Up to $60 per day and 70 days for each period of confinement
• Home Healthcare	Up to 130 visits per calendar year[3]
• Hospice Care	Up to 60 visits per lifetime[3]
• Skilled Nursing Facility	Up to 180 days per same or related condition[3]
Durable Medical Equipment	Applicable coinsurance after the deductible; pre-certification for items over $2,000 purchase price or $500 per month rental fee
Hearing Aids	Applicable coinsurance after the deductible up to $1,000 per person per ear every 36 months (maximum waived for children with a congenital defect)
Inpatient Rehabilitation	Applicable coinsurance after the deductible
Jaw Treatment (including TMJ and MPD)	Applicable coinsurance after the deductible up to $6,000 per lifetime (maximum waived if for a congenital defect in children)
Massage Therapy	100% after $25 copay per visit (not subject to deductible), up to 12 visits per calendar year per person. Prescription required
Naturopathic Services	100% after $25 copay per visit (not subject to deductible), up to two visits per person per calendar year. Covered only if a PPO provider is used. Does not include naturopathic supplies
Organ Transplants	Special rules and limits apply
Outpatient Physical or Occupational Therapy	100% after $25 copay per visit (not subject to deductible), up to 24 visits for physical therapy and 24 visits for occupational therapy per calendar year; up to 48 visits for physical therapy and 48 visits for occupational therapy per calendar year following an accident, surgery, or stroke

Plan Features	
Speech Therapy	100% after $25 copay per visit (not subject to deductible), up to 60 visits per lifetime
Spinal Treatment	100% after $25 copay per visit (not subject to deductible), up to 15 visits per calendar year; diagnostic X-rays at the applicable coinsurance after the deductible up to one set of x-rays per calendar year
Vision Therapy	Applicable coinsurance after the deductible, up to 60 visits per lifetime; special rules apply[3]

3. *Benefit limits on number of visits or days apply whether or not the visits or days are subject to the deductible*.

Prescription Drug Program – See page 70 for program details

Program Description	Generic Drugs	Formulary (Preferred) Brand-Name Drugs	Non-Formulary (Non-Preferred Brand-Name Drugs
Recommended Network Retail Pharmacy (up to 34-day supply)	100% after 10% copay	100% after 30% copay	100% after 40% copay
Regular Network Retail Pharmacy (up to 34-day supply)	100% after 15% copay	100% after 35% copay	100% after 45% copay
Non-Network Retail Pharmacy (covered for medical emergencies only)	100% after $9 handling fee *plus* your normal copay or cost share		
Mail Order Pharmacy (up to a 100-day supply)	100% after lesser of 10% or $15 copay per prescription	100% after lesser of 30% or $90 copay per prescription	100% after lesser of 40% or $130 copay per prescription
Contraceptives	Covered, retail or mail order		

Weight Management Programs – See page 41 for program details

Non-Surgical Program, Surgery, and Pre- and Post-Surgery Programs	80% for the Plan's non-surgical and pre- and post-surgery programs; 80% for in-network and 60% for out-of-network surgery if surgery is approved upon completion of the Plan's pre-surgery program; Preauthorization is required. Deductible does not apply. Calendar year out-of-pocket maximum for coinsurance does not apply.

Mental Health and Chemical Dependency Program – See page 77 for program details

Benefit	Network Provider/Facility	Non-Network Provider/Facility
Assistance Program		
Assessment Visits	**Call 855-402-0272 24 hours a day, 7 days a week** Program pays 100% for up to 3 face-to-face counseling sessions per incident per person per calendar year and unlimited telephone-based counseling. Must be authorized by Cigna	None

Mental Health and Chemical Dependency Program – See page 77 for program details			
Benefit	**Network Provider/Facility**		**Non-Network Provider/Facility**
Mental Health Treatment Program			
Ambulance or Emergency Room	100% (not subject to Medical Plan deductible) if admitted for mental health treatment		Program pays 50% of UCR (not subject to Medical Plan deductible) if admitted for mental health treatment; 100% for hospital emergency room services
Outpatient	Program pays 100% after applicable copay if you preauthorize with Cigna Program pays 50% after applicable copay if you **do not** preauthorize treatment with Cigna		Program pays 50% of UCR Cigna preauthorization is not required
	Individual Sessions 1-20 sessions: $10 copay 21-50 sessions: $15 copay	**Group Sessions** 1-20 sessions: $5 copay 21-50 sessions: $7.50 copay	
	Up to 50 individual/group sessions per person per calendar year, combined network and non-network.		
Inpatient/ Alternate Care and Residential/ Partial Treatment	Program pays 100% if you preauthorize with Cigna Program pays 50% if you **do not** preauthorize treatment with Cigna The following alternate care levels equal 1 day of inpatient treatment: • 2 days of partial hospitalization • 1 day of residential treatment at a licensed residential treatment center • 4 sessions of in-home or outpatient (office) treatment by a licensed therapist • 4 home nursing visits for psychiatric or detox 23 hours of 1 to 1 observation		Program pays 50% of UCR if you preauthorize with Cigna No benefits are payable if you **do not preauthorize** treatment with Cigna
	Up to 45 days of authorized residential/inpatient/alternate/partial care treatment per person per calendar year combined network and non-network. Ninety days lifetime maximum per eligible participant. Two days of residential and/or partial treatment equal one day of inpatient treatment. Emergency admissions require Cigna authorization within 48 hours of the admission.		

Mental Health and Chemical Dependency Program – See page 77 for program details		
Benefit	**Network Provider/Facility**	**Non-Network Provider/Facility**
Chemical Dependency Treatment Program		
Ambulance or Emergency Room	100% (not subject to Medical Plan deductible) if admitted for chemical dependency treatment	Program pays 50% of UCR (not subject to Medical Plan deductible) if admitted for chemical dependency treatment; 100% for hospital emergency room services
Outpatient/ Inpatient	Program pays 100% if you preauthorize with Cigna	Program pays 50% of UCR if you preauthorize with Cigna
Alternate Care and Residential/ Partial Treatment	Program pays 50% if you **do not** preauthorize treatment with Cigna	No benefits are payable if you **do not preauthorize** treatment with Cigna
	Program pays 100% of authorized Substance Abuse Professional (SAP) services for eligible active employees who fail a DOT alcohol or drug test	Non-network SAP services are not covered
	Emergency admissions require Cigna authorization within 48 hours of the admission.	

Deductibles

You must generally pay a deductible each calendar year before the Plan pays any benefits.

The combined deductible for PPO and non-PPO physician services, outpatient care and other covered services is $300 per person per calendar year, with a maximum of $900 per family per calendar year if you first become eligible and covered during the calendar year. See page 47 for the deductible amounts if you were eligible and covered prior to the calendar year. The deductible does not apply to:

- In-network (PPO) preventive or routine care, office visits and office visit copays
- Second surgical opinions, when required by the UR manager
- The out-of-pocket maximum for coinsurance.

Since weight management, mental health, chemical dependency and prescription benefits are covered under separate programs charges for those services do not apply to the medical deductible.

Deductible Carry-Over Provision

The calendar year deductible must be satisfied by eligible expenses incurred in that calendar year. Any eligible expenses incurred during the last three months of the previous calendar year and applied to that year's deductible will be carried over and also applied to the next year's deductible. This carry-over provision does not apply to out-of-pocket expenses.

Copays

Office visit: $25 per visit (waived for preventive care obtained at a PPO provider)

Emergency Room: $75 per visit (waived if admitted)

Coinsurance

Plan B pays 80% of covered in-network (PPO) and 60% of covered out-of-network (non-PPO) hospital, physician, outpatient care, X-ray, lab, home healthcare, skilled nursing facility and hospice charges after the deductible and before your out-of-pocket maximum for coinsurance is reached. Once you reach the out-of-pocket maximum for coinsurance during a calendar year, eligible charges will be paid at 100% until the calendar year ends. Emergency room services at an out-of-network (non-PPO) hospital will be paid at 80%.

The Plan pays 100% after a $25 copay per visit for professional office visits, including related X-ray and lab for preventive or routine care (copay waived for preventive care obtained at a PPO provider).

Covered charges for non-PPO providers are subject to UCR limits.

Since weight management, mental health, chemical dependency and prescription benefits are covered under separate programs, charges for those services are subject to different coinsurance or copay levels.

Out-of-Pocket Maximum for Coinsurance

The out-of-pocket maximum for coinsurance limits your portion of covered coinsurance charges to a certain dollar amount each calendar year.

After the deductible has been met, the Plan pays 80% in-network (PPO) and 60% out-of-network (non-PPO) for most services until your out-of-pocket expenses for covered coinsurance adds up to $2,500 per person or $5,000 per family during a calendar year. Then the Plan pays 100% of most eligible charges for the rest of that calendar year.

The out-of-pocket maximum for coinsurance **does not** apply to:

- Copays for outpatient professional visits (and copays are not applied toward the out-of-pocket maximum)
- Charges applied to the deductible or in excess of UCR
- Charges not covered by the Plan
- Hospital pre-certification penalty or hospital days not certified as medically necessary.

Since weight-loss, mental health and chemical dependency benefits and prescription benefits are covered under separate programs, charges for those services do not apply to the out-of-pocket maximum for coinsurance.

Maximum Annual Benefit

In order to comply with the Patient Protection and Affordable Care Act, the Trust's maximum annual payment per Plan Year (July 1 – June 30) is $2,000,000 per person through June 30, 2014. No maximum will apply effective July 1, 2014.

Since weight-loss, mental health and chemical dependency benefits and prescription benefits are covered under separate programs, charges for those services do not apply to the annual maximum.

Covered Charges

The following charges are covered by the Plan and paid according to the Summary starting on page 47. For more information on what isn't covered and benefit limits, see Medical Plan Exclusions starting on page 66.

Benefit limits on number of visits or days apply whether or not the visits or days are subject to the deductible.

Inpatient Hospital Charges

Charges for Room and Board

Hospital room and board charges for admissions that have been certified as medically necessary.

Other Hospital Charges

Medically Necessary services and supplies furnished by the hospital for drugs, medicines, X-rays, lab tests, anesthesia, operating room facilities and other non-physician services and supplies used during a hospital stay. Take-home drugs or prescription drugs obtained at discharge that are used on an outpatient basis, and not during an inpatient stay, are covered only if obtained through the Prescription Drug program. See page 70.

Other Covered Charges In or Out of the Hospital

Acupuncture

Services by an MD, DO, or PPO acupuncturist for chronic pain or anesthesia up to the limits in the Summary on page 48. Acupuncture is not covered if you see a non-PPO acupuncturist.

Ambulance

Local professional licensed ambulance service, when medically necessary, to or from the nearest accredited hospital qualified to treat the condition. Air ambulance services are covered when medically necessary and only when other ambulance or transportation would endanger life or safety.

Anesthesia

Anesthetics and their administration.

Blood Transfusions

Including cost of blood and blood derivatives used by a covered patient and not replaced by a donor.

Contraceptive Devices

Charges for contraceptive devices and/or injections for the purpose of birth control when administered or prescribed by a physician. See Prescription Drug Program starting on page 70 for other contraceptive medical coverage.

Dental Coverage

Charges for treatment by a physician, dentist or dental surgeon for removal of a tumor or treatment of accidental injuries to natural teeth within 12 months after the accident. Emergency room care is not covered unless emergency care to treat dental pain is not available from a dentist under the dental plan. Except as noted, this medical plan does not cover treatment involving the teeth, surrounding tissue or structure.

Durable Medical Equipment and Supplies

Covered for items that are:

- Able to stand repeated use (except certain consumable medical supplies)
- Primarily and customarily used to serve a medical purpose, but generally not useful to a person in the absence of illness or injury
- Ordered and/or prescribed by a physician for the patient's exclusive use such as oxygen and rental equipment for its administration, surgical dressings, casts, splints, braces, trusses and crutches, pacemakers, blood glucose monitors and (up to the purchase price) hospital beds, wheelchairs or respirators.

Durable medical equipment does not include modifications to vehicles or residences, exercise equipment, ergonomic chairs or hot tubs.

Pre-certification is required for items over a $2,000 purchase price or $500/month rental fee or as otherwise deemed necessary by the Plan.

Education and Training Expenses

Medically necessary education and training provided in a hospital setting, inpatient or outpatient, as treatment for an illness. Examples include diet and nutrition counseling for diabetic patients, instructions for self-injections, wound care, ostomy care, and instruction for self-catheterization of kidney patients. Other types of education and training expenses are not covered.

Inpatient Well-Baby Care

Physician and approved nursery room charges for well newborns while hospitalized for routine care received within 72 hours of birth. No other physician or hospital charges are covered unless the infant is ill or injured.

Massage Therapy

When prescribed by a physician as part of a rehabilitation program for a diagnosed medical condition, up to the limit in the Summary on page 48.

Naturopathic Services

Services by a naturopath in the PPO network, up to the limits in the Summary on page 48. Naturopathic services are not covered if you see a non-PPO provider. Naturopathic supplies are not covered.

Occupational and Physical Therapy

By a licensed or registered physical or occupational therapist, up to the limits in the Summary on page 48.

Orthotics

Impression casting, corrective shoes or appliances. Must be prescribed by a physician for therapeutic purposes for an injury or covered medical condition under the Plan, and not primarily for use during participation in sports, recreational or similar activities. See Medical Plan Exclusions starting on page 66.

Outpatient Services

Emergency room care and other hospital-based outpatient care. Emergency room care will be paid at the applicable coinsurance percentage of the allowed charge after the deductible. The $75 copay per visit will be waived if you or a family member is admitted to the hospital and the charge is billed as an inpatient stay by the hospital.

Outpatient Surgery Center

Surgical treatment.

Physician Services

Covered surgery or assistant surgery, home, office or hospital visits and other medical care.

Preventive Care

Routine physical exams and screenings, outpatient well-baby care and immunizations recommended by the United States Preventive Services Task Force, Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention and the Health Resources and Services Administration (HRSA) and consistent with the Patient Protection and Affordable Care Act (PPACA) are covered at 100% if provided by an in-network (PPO) provider. If provided by an out-of-network (non-PPO) provider, standard out-of-network deductible, copays, or coinsurance and out-of-pocket limits apply.

The following table provides examples of the preventive care and immunizations covered. For a complete list of the covered preventive services pursuant to the PPACA, please contact the Trust office, or refer to the following website:
http://www.healthcare.gov/law/resources/regulations/prevention/recommendations.html

Preventive Care Guidelines	
Routine Physicals/Wellness Exam (Age 19+)	One physical exam every 3 to 5 years – age 19 to 65 One physical exam every 1 to 2 years – age 65+
Total Cholesterol/HDL Screenings	Men beginning at age 35, test every 5 years, shorter or longer intervals depending on lipid levels Women beginning at age 45, test every 5 years, shorter or longer intervals depending on lipid levels
Blood Pressure Screenings	Every 1 to 2 years
Other Screenings	Based on risk factors
Adult Immunizations (Age 19+)	Influenza – every year for adults at risk or age 50 and older Pneumonia – once for adults at risk and booster after 5 years for adults at highest risk and those most likely to lose their immunity Tetanus/Diphtheria – booster every 10 years Chicken Pox – test for immunity if under age 50; for adults at risk for exposure and blood test does not confirm immunity, administer two doses 4 to 8 weeks apart Measles, Mumps, Rubella – one dose if born 1957 or later unless vaccinated prior or immune; second dose if at risk Hepatitis A – two doses at least six months apart if at risk Hepatitis B – three doses if at risk Meningitis – one dose if at risk and additional dose for those that remain at high risk Tuberculin Skin Test – annual test if at high risk Human Papillomavirus (HPV) – at physician's discretion, three-dose series approved for all women 19 to 26 years.
Well Child Exams	Exams within first two weeks after birth and at 2, 4, 6-9, 12 and 15 months of age 2 to 3 years – exam at age 2 4 to 18 years – 4 to 7 exams
Child Immunizations	Immunizations per HHS/CDC schedule (includes Papillomavirus (HPV) three-dose series approved for all females 11 to 12 years; at physician's discretion, approved for females 9 to 10 years, and 13 to 18 years if not previously vaccinated)
Breast Cancer Screening	Beginning at age 40, every one to two years; earlier if at increased risk
Colon and Rectal Cancer Screening	Beginning at age 50, or earlier if at high risk, both men and women should follow one of these four testing schedules: Yearly fecal occult blood test (FOBT) Flexible sigmoidoscopy every 5 years Yearly fecal occult blood test plus flexible sigmoidoscopy every 5 years Colonoscopy every 10 years
Cervical Cancer Screening	Beginning three years after onset of sexual activity, but no later than age 21, women should be screened annually until 2 to 3 consecutive normal pap smears, then every three years At risk women should continue with annual screenings
Prostate Cancer Screening	Beginning at age 50, or age 40 if at increased risk, men should be offered the prostate-specific antigen (PSA) blood test and digital rectal exam (DRE) annually

Prostheses

Artificial limbs, eyes and larynx to replace natural body parts. Cosmetic or elective prostheses are not covered. Prostheses replacements are covered only if the original cannot be made functional.

Radiation Therapy and Chemotherapy

Radiation Therapy and Chemotherapy are covered when medically necessary.

Speech Therapy

If part of a prescribed treatment program, medically necessary speech therapy by a covered provider to restore or improve function that was normal but lost due to injury or sickness or to treat a congenital anomaly is covered up to the limits in the Summary on page 49 if part of a treatment program prescribed by a physician. Pre-certification by the Trust Administrative Office is recommended.

Spinal Treatment

Non-surgical treatment of the spine and its supporting structures, up to the limits described in the Summary on page 49. Diagnostic tests and X-rays in conjunction with the spinal treatments are covered up to one set of x-rays per calendar year.

Vision Therapy

Treatment by a covered provider such as an OD when medically necessary. Care must be part of a treatment program prescribed by a physician up to a 60-treatment lifetime maximum. Pre-certification by the Trust Administrative Office is recommended.

X-ray and Laboratory

Tests and analysis.

Special Treatment Benefits

Hearing Aids

Charges for hearing evaluation examinations and hearing aid devices. Benefits will be paid at the applicable coinsurance percentage of allowed charges after the deductible up to a maximum of $1,000 per ear per person every 36 months.

The $1,000 maximum will be waived for hearing aids purchased for dependent children whose hearing loss was the result of a congenital anomaly. The child must still be in his or her physical growth years. The maximum will apply once the child has reached growth maturity.

You must be examined by a physician before obtaining a hearing aid. The physician must certify that your hearing loss may be lessened by the use of the hearing aid.

In conjunction with the purchase of a hearing aid, benefits will be provided for:

- An otologic examination by a physician and surgeon
- An audiologic examination and hearing examination by a certified or licensed audiologist (including a follow-up consultation)

- A hearing aid (monaural or binaural) prescribed as a result of such examination (including ear molds, the hearing aid instrument, the initial batteries, cords and other necessary ancillary equipment, a warranty, and follow-up consultation within 30 days following delivery of the hearing aid).

Hearing aid benefits will not be provided for:

- More than one examination during a period of three consecutive years without a hearing aid being obtained
- Replacement of a hearing aid for any reason more than once in any three consecutive years
- Batteries or other ancillary equipment other than that obtained on purchase of the hearing aid
- Repairs, servicing or alteration of hearing aid equipment
- A hearing aid exceeding specifications prescribed for correction of hearing loss
- Expenses incurred after termination of coverage under the Plan except expenses for a hearing aid ordered prior to termination and delivered within 30 days after the date of termination.

Cochlear Implants

Cochlear implants are covered only when medically necessary and pre-approved by the UR manager. When approved, the plan will pay the applicable coinsurance percentage of allowed expenses after the deductible. The $1,000 hearing aid maximum benefit does not apply to pre-approved cochlear implants.

Jaw Treatment Benefits

Diagnosis and treatment, surgical and non-surgical, by a physician or dentist for Temporomandibular Joint (TMJ)/Myofascial Pain Dysfunction (MPD) and conditions which the Trust, upon medical review, determines are related to such jaw conditions, will be covered up to a $6,000 lifetime maximum. Orthodontia is not covered. Regular plan benefits apply to other jaw conditions, including treatment related to congenital skeletal deformities, tumors, or malignancies.

Jaw treatment maximums do not apply to jaw surgery or repair if the required treatment is for accidental injury. Regular plan benefits apply and require treatment to be started within the 12 months immediately following the accident unless you can show it was not reasonably possible to begin treatment within the 12 months and the treatment began as soon as reasonably possible. Orthodontia is not covered.

Organ, Tissue, and Bone Marrow Transplant Benefits

Human organ transplants considered medically necessary, appropriate and effective using prevailing standards of community medical practice. Experimental transplants are not covered.

These and other criteria are used to evaluate transplants:

- The patient is faced with a high risk of death
- All conventional therapies must have been attempted and proven unsuccessful
- The patient must not have a concurrent terminal disease

- The procedure must be to sustain life in a normal functioning state.

The transplant recipient becomes eligible for organ and bone marrow transplant benefits on the first day of the seventh month of continuous coverage under this Plan — whether or not the condition is pre-existing or an emergency. An infant (less than six months old) must have been continuously covered by the Plan since birth to be eligible for transplant benefits.

For breaks in coverage of more than 12 consecutive months, a new six-month waiting period for transplants is required.

The Plan pays covered charges for all related medically necessary services or supplies for these transplants subject to the conditions and limits described above:

- Heart
- Heart/Lung (combined)
- Kidney
- Kidney/Pancreas (combined)
- Liver
- Cornea
- Bone marrow
- Lungs (single/bilateral)

Benefits for all transplants are subject to pre-certification by the Utilization Review manager.

If a transplant is not successful, one re-transplant will be covered, except for medically necessary corneal transplants; additional corneal transplants will be covered if medically necessary.

The donor's medical expenses are covered in the absence of other group insurance, including tests for potential donors as well as selecting and procuring the organ. If donor expenses are eligible under another plan, this Plan's Coordination of Benefits (COB) provision applies (see pages 91 to 94). No transplant benefits are paid for:

- Non-human, artificial or mechanical transplants
- Recipients not covered under this Plan
- Experimental or investigational procedures as determined by the Plan
- Donor and procurement costs incurred outside the United States unless approved by the Plan.

Hospital Alternative Treatment

The Plan covers skilled nursing facility care, home healthcare, hospice care and alternative housing facility care in place of hospitalization. The Plan pays for covered charges incurred in the most appropriate treatment setting. The care must be recommended by the attending physician in a written treatment plan.

After your deductible is met and before your out-of-pocket maximum is reached, covered charges are paid at the applicable coinsurance percentage. Once you meet the out-of-pocket maximum, covered charges are paid at 100% until the beginning of the next calendar year or until the benefit maximum is reached (whichever occurs first). Plan payments for these alternatives are subject to the conditions and limits described below.

Skilled Nursing Facility Expenses

- The Plan pays for confinement in a skilled nursing facility ordered by a physician for up to 180 days for the same or related condition. The confinement must be for medically necessary treatment of a covered illness or injury. To ensure coverage, call Cigna at 855-402-0272 for preauthorization of your stay.

- Excluded from coverage are charges for any confinement deemed not medically necessary for the treatment of a covered illness or injury, primarily for rehabilitation or care that can be provided on an outpatient basis, custodial care, residential treatment , personal comfort items or private duty nursing.

Home Healthcare Expenses

- The Plan pays for medically necessary care by registered nurses, licensed practical nurses, home health aides, physical, occupational, speech or respiratory therapists and professional ambulance services

- Rental of durable medical equipment (such as wheelchairs, hospital beds and crutches), lab services, drugs, medicines and other supplies prescribed by the attending physician are covered if they're medically necessary and would have been covered in a hospital

- Services and supplies for infusion therapy by an infusion therapy provider are covered (the infusion therapy provider must submit a written treatment plan to the Trust Administrative Office that specifically describes the infusion therapy services to be provided)

- The Plan excludes services by any person who normally lives in your home or by volunteer agencies, custodial care (such as meals and personal grooming), transportation services, nutritional guidance, supportive environmental materials (such as handrails, ramps and air conditioners) or any services/supplies not included in the treatment plan

- The Plan pays for up to 130 home healthcare visits in any calendar year; each visit counts toward the maximum whether or not any of the visits apply to the deductible

- A visit of any duration to provide home healthcare constitutes one visit.

Hospice Care Expenses

- The Plan pays for hospice care when, in the opinion of the attending physician, the patient is terminally ill

- Services may be provided by a hospice care team, a hospital, home healthcare agency or skilled nursing facility, but must be under the terms of a hospice care program and billed through the hospice that manages the program

- Hospice services may include inpatient and outpatient care, home healthcare, nursing care, counseling and other supportive services and supplies

- Professional ambulance services certified as medically necessary by a physician as well as drugs, medicines and other supplies prescribed by a physician are covered

- Respite care is covered in the most appropriate setting up to five continuous days per three months of hospice care

- The Plan excludes hospice care services not approved by the attending physician, transportation except as provided by professional ambulance service and custodial care (such as meals or personal grooming)

- Home care services of an approved hospice agency are covered up to 60 visits per person per lifetime. All visits by any person representing the hospice agency will count toward the 60 visit maximum. If the life expectancy of the patient is extended, or benefits are otherwise exhausted, the patient's family should contact the Trust Office to request an extension. Limited extensions will be granted if it is determined the care is medically necessary.

Alternative Housing Facility Expenses

- The Plan pays covered charges for alternative housing while receiving special treatment unavailable at a local facility if the patient's medical condition prohibits traveling between the home and the site of treatment
- A physician must certify that the medical condition requires hospitalization and that the alternative housing is instead of hospitalization
- The alternative housing facility must be an approved facility
- The Plan pays the lesser of the single occupancy rate or $60 per day up to 70 days for each period of confinement. The level of payment is constant and will not change when your out-of-pocket maximum for coinsurance is reached (charges above $60 per day do not apply to the annual out-of-pocket maximum for coinsurance).

Medical Plan Definitions

Accidental Injury — Physical harm from a sudden, traumatic, unforeseen event caused by the intervention of an external force, at a specific time and place.

Acupuncture — A therapy used for relieving chronic pain or anesthesia, covered only if performed by a covered PPO acupuncturist, MD or DO.

Calendar Year — Period of one year beginning January 1 and ending December 31.

Coinsurance — The percentage of the allowed charge you're responsible for paying (for example, after you meet your deductible you pay 20% coinsurance and the Plan pays 80% for covered services obtained from an in-network (PPO) provider, or you pay 40% coinsurance and the Plan pays 60% for covered services obtained from an out-of-network (non-PPO) provider.

Copays — A flat dollar amount you generally pay at the time you receive a specified healthcare service or supply. Copays are not applied toward deductibles or out-of-pocket maximums.

Cosmetic Surgery — Surgery performed to alter the texture or configuration of the skin or any bodily feature's configuration or relationship with adjoining structures. It is performed primarily for psychological purposes and does not correct or materially improve a bodily function.

Covered Charges — Medically necessary expenses for care provided according to the Plan's conditions and limits that do not exceed UCR charges (defined on page 66). Covered charges means the same as covered expenses or covered services.

Custodial Care — Any portion of a service, procedure or supply that, in the Trust's judgment, is provided primarily:

- For ongoing maintenance of health and not for its therapeutic value in treating an accidental injury or sickness

- To assist the patient in meeting the activities of daily living such as help in walking, bathing, dressing, eating, preparing special diets and supervising self-administration of medicines
- To sustain a patient without attempting to treat an illness or injury.

Deductible — The amount of eligible medical expenses you must pay each calendar year before the Plan pays benefits. Eligible expenses applied to the deductible in the last three months of the calendar year apply to the next calendar year deductible. Does not apply to office visits, preventive care, or to second surgical opinions required by the UR manager.

Durable Medical Equipment — Items that are able to stand repeated use (except certain consumable medical supplies)

- Primarily and customarily used to serve a medical purpose, but generally not useful to a person in the absence of illness or injury
- Ordered and/or prescribed by a physician for the patient's exclusive use such as oxygen and rental equipment for its administration, surgical dressings, casts, splints, braces, trusses and crutches, pacemakers, blood glucose monitors and (up to the purchase price) hospital beds, wheelchairs or respirators.

Durable medical equipment does not include modifications to vehicles or residences, exercise equipment, ergonomic chairs or hot tubs.

Experimental/Investigational — Any service (treatment, procedure, facility, equipment, drug, drug usage, medical device or supply) that meets one or more of the following criteria as determined by the Trust:

- A drug or device that cannot be lawfully marketed without United States Food and Drug Administration (FDA) approval and has not been granted that approval on the date it is furnished
- A facility or provider that has not demonstrated proficiency in the service, based on experience, outcome or volume of cases
- Reliable evidence shows the service is the subject of ongoing clinical trials to determine maximum toxicity, safety, efficacy or tolerated dose
- Reliable evidence shows the service is not safe or effective for a particular medical condition compared to other generally available services, or
- Poses a significant risk to the patient's health or safety

Reliable evidence means published reports and articles in authoritative medical and scientific literature, scientific results of your provider's written protocols or scientific data from another provider studying the same service.

Home Health Aide — A person, other than a registered nurse, who provides medical or therapeutic care under the supervision of a home healthcare agency.

Home Healthcare Agency — A hospital, agency or other service certified to provide home healthcare by the proper authority of the state where it's located.

Home Healthcare Treatment Plan — A program of home care that is:

- Required as the result of sickness or injury
- Established and reviewed at least every 60 days by the attending physician

- Certified by the attending physician as a replacement for hospital confinement or confinement in a skilled nursing facility that would otherwise be necessary.

The treatment plan must also describe the services and supplies to be provided by the home healthcare agency. Treatment plans are subject to periodic review by any designated agent of the Trust or Trust Administrative Office.

Hospice — A facility, agency or service that:

- Is licensed, accredited or approved by the proper regulatory authority to establish and manage hospice care programs
- Arranges, coordinates and/or provides hospice care services for dying individuals and their families
- Maintains records of hospice care services provided and bills for those services on a consolidated basis.

Hospice Care Program — A program to meet the special physical, psychological and spiritual needs of dying individuals and their families that are:

- Managed by a hospice
- Established jointly by a hospice, a hospice care team and an attending physician.

Hospital — A legally-operated institution providing inpatient care and treatment through medical, diagnostic and major surgical facilities on its premises, under supervision of a staff of physicians, and with 24-hour nursing service or one accredited as a hospital by the Joint Commission on Accreditation of Healthcare Organizations. The term also includes:

- An approved Christian Science Sanatorium or other institution approved by the Committee on Christian Science Nursing Homes by the Mother Church of the First Church of Christ Scientist in Boston, Massachusetts (confinement for spiritual guidance or rest in any such institution is not covered)
- Transitional care facility for rehabilitation (subject to pre-certification)
- A state-licensed birthing clinic.

The term hospital does not include a nursing home or institution (or part of one) used mainly as a facility for convalescence, nursing, rest, the aged, treatment of chemical dependency or domiciliary or custodial care.

Massage Therapist — A licensed massage therapist.

Medically Necessary/Medical Necessity — Treatments, services or supplies that must be ordered through a physician or other covered, qualified provider and commonly and customarily recognized by the physician's profession as appropriate to treat the patient's diagnosed injury or sickness (as specified by authoritative medical or scientific literature). This also must be the least costly of alternative treatments, settings, services or supplies that can safely be provided. It does not include maintenance or supportive treatments or services or those that are educational, experimental or primarily for medical or other research. The fact that any treatments, services or supplies are furnished, prescribed or approved by a physician or other qualified provider does not in itself mean it is medically necessary. A medical treatment, service, supply or setting may be medically necessary in part only.

Network or Preferred Provider — A provider who has contracted with the Trust's PPO; also referred to as an in-network provider or PPO provider.

Non-Network or Non-Preferred Provider — A provider who has not contracted with the Trust's PPO; also referred to as an out-of-network or non-PPO provider.

Nurse — Includes Licensed Registered Nurses (RNs), Licensed Practical Nurses (LPNs) and Certified Registered Nurse Practitioners (CRNPs).

Occupational Therapy — Rehabilitative treatment for an illness, injury or condition when performed by a certified occupational therapist and prescribed by a physician.

Out-of-Pocket Maximum for Coinsurance — Refers to the calendar year limit on your coinsurance portion of covered charges. Does not include:

- Emergency room or office visit copays
- Charges applied to the deductible
- Mental health or chemical dependency treatment charges
- Excluded charges
- Amounts in excess of UCR
- Any portion of the benefit reduction due to failure to obtain pre-certification or for hospital stays not considered medically necessary
- Prescription drug charges
- Weight-loss treatment charges

Outpatient Care — Treatment in a non-hospital facility or by a hospital for outpatient treatment.

Outpatient Surgical Center — A physician's office, medical clinic or legally-operated institution engaged primarily in providing outpatient surgical care that meets all established standards for this kind of facility.

Physical Therapy — Treatment of an illness, injury or condition by physical means (such as hydrotherapy, heat or similar treatments) when performed by a licensed or registered physical therapist and prescribed by your physician.

Physician — A physician licensed to practice medicine and perform surgery. For Plan purposes, the term includes these health professionals only:

- A licensed medical doctor (MD), osteopathic doctor (DO), dentist, podiatrist, chiropractor or optometrist who:
  - Is legally licensed or certified by the state
  - Is legally licensed to perform services for which benefits are provided under the Plan
  - Acts within the scope of that license in performing services (benefits for certified registered nurse charges are payable only if in place of physician charges).
- A Christian Science Practitioner authorized by the Mother Church of the First Church of Christ Scientist in Boston, Massachusetts
- A certified registered nurse who:

  - Is legally licensed or certified by the state
  - Is legally licensed to perform services covered under the Plan
  - Acts within the scope of that license in performing services (benefits for certified registered nurse charges are payable only if in place of physician charges).
- A midwife who:
  - Is legally licensed to perform services covered under the Plan
  - Acts within the scope of that license in performing services (benefits for midwife charges are payable only if in place of physician charges).
- Licensed acupuncturist (only if a PPO provider).
- Licensed naturopath (only if a PPO provider).

Physician or Office Visit — A personal interview where the physician sees the patient. Telephone consultations are not considered visits.

Plan Year — Period of one year beginning July 1 and ending June 30.

PPO Allowed Amount — A discounted or set negotiated rate for PPO services. The PPO provider cannot charge the patient more than the PPO allowed amount for any service.

Preferred Provider Organization (PPO) — A network of doctors, hospitals, specialists, clinics and other healthcare providers who are members of the contracted PPO. These providers furnish medical services to Trust participants at negotiated rates.

Prescription Drug — Any medical substance with a label required (by the federal Food, Drug and Cosmetic Act) to say: “Caution: federal law prohibits dispensing without a prescription.”

Respite Care — Care for a homebound participant requiring continuous attendance to relieve from their duties all persons caring for and residing with the patient.

Skilled Nursing Facility/Home — A licensed facility having seven or more beds, accredited by the Joint Commission on Accreditation of Healthcare Organizations and primarily for convalescent care. It must be under the supervision of a physician and surgeon and not a home for the care of mental health/chemical dependency patients or the aged, or a rest home or place for custodial care. This includes a facility that would be classified as a skilled nursing care facility under Medicare if the facility actively sought Medicare approval.

Subrogation (third-party reimbursement) — If you receive benefits for any condition or injury caused by another party, this Plan has the right of recovery. Also, if you sue the person who may have been responsible for your condition, benefits paid or payable by the Plan must be included in your suit. When the suit is settled, the Plan must be reimbursed for the amount of benefits provided.

Temporomandibular Joint (TMJ) Disorder and Myofascial Pain Disorder (MPD) — A disorder of the temporomandibular joint (the joint that connects the mandible or jawbone to the temporal bone), generally characterized by:

- Pain, tenderness or muscle spasms in one or more of the following areas: face, jaw, neck, head, ears, throat, shoulders or the preauricular, temporal, occiput or masticatory muscles
- Popping or clicking of the jaw or TMJ
- Abnormal range of motion, or locking of the jaw or TMJ

- Malocclusion, overbite or underbite and/or mastication (chewing) difficulties.

Terminally Ill Person — A person whose life expectancy is six months or less, as certified by the primary attending doctor.

Totally Disabled — A person is considered totally disabled when, because of a covered accident or illness (including pregnancy and its complications) they are:

- Not able to perform the normal duties of their occupation
- Not engaged in any occupation for wage or profit (except for light-duty work with the same employer)
- Under a physician's regular care for that injury or sickness. A dependent is considered totally disabled when, because of a disability, they're unable to engage in the normal activities of a person of the same age.

Trust Administrative Office — The Administrative Office retained by the Trust to provide administrative services. (See page 106 for the address and telephone number.)

Usual, Customary and Reasonable (UCR) charges — Charges that do not exceed the fee usually charged by the individual or institution and are similar to charges by other providers with similar training and experience in the same geographic area for comparable services and supplies as determined by the Trust.

Medical Plan Exclusions

Medical benefits are not payable for any of the following listed items. This applies to all medical benefits as described on pages 53 to 61.

1. Services or supplies received while not eligible under the Plan.
2. Expenses in excess of the usual, customary and reasonable (UCR) charges.
3. Services or supplies that are:
    a. Not recommended by a licensed physician or surgeon
    b. Not medically necessary
    c. Considered experimental or investigational
    d. Provided by or paid for by the United States Government or any of its agencies, except as otherwise required by law
    e. Not considered by the Trust to be durable medical equipment such as air purifiers, hot tubs, waterbeds, exercise equipment, modifications to vehicles or residences, ergonomic chairs, etc. (whether or not prescribed by a physician)
    f. Prescribed or provided by non-covered providers
    g. For your convenience or that of your family, or personal services such as meals for guests, phone charges, TV charges or barber/beautician charges
    h. Furnished to you by yourself or by a provider who lives in your home or is related to you by blood, marriage or adoption.
4. Services, supplies or Time Loss for a claim not submitted within one year of the date the services or supplies were provided or the disability took place.

5. Injury or sickness for which you have received, or are entitled to receive, compensation under any workers compensation, occupational disease law or other similar legislation, whether or not you elect that coverage or meet the claim filing deadline (not applicable to LEOFF 1 participants).

6. Loss incurred while serving the armed forces or as the result of an act of war, including terrorism.

7. Custodial care.

8. Expenses an eligible person does not have to pay.

9. Physical exams or immunizations required as a condition of employment.

10. Diagnosis and treatment to restore fertility or promote conception, such as:

    a. Artificial insemination
    b. In vitro fertilization
    c. Embryo transplant
    d. Microinjections
    e. Zona drilling or other artificial means of conception
    f. Consecutive follicular ultrasounds
    g. Cycle therapy
    h. Reversal of sterilization procedures
    i. Tuboplasty
    j. Fertility drugs
    k. Corresponding lab tests associated with artificial means of conception (for a covered person or surrogate as a donor or recipient)

    Any expenses in connection with conception, pregnancy, or delivery with a surrogacy arrangement are also not covered.

11. Sex transformations or sexual dysfunction treatment except for conditions of organic origin where the cause is documented by the attending physician.

12. Sexual problems (including counseling).

13. Maternity expenses for covered dependent children, including delivery, abortion or miscarriage.

14. Education or training other than the covered expenses described on page 54 or covered under Preventive Care on page 55. Examples of education and training exclusions include:

    a. Lifestyle, fitness or tobacco cessation programs, except as provided under the Stand Strong wellness programs beginning on page 39. See Prescription Drug Program for covered smoking cessation medications and limits.
    b. Rehabilitation or job training or outreach
    c. Vocational assistance or counseling.

15. Learning disabilities (unless medically necessary).

16. Marital or family problems (including counseling).

17. Sleeping or eating disorders.

18. Over-the-counter drugs or medications, vitamins or nutritional or dietary supplements (whether or not prescribed by a physician).

19. Vision exams, glasses or the fitting of glasses or contact lenses, or any type of surgery to correct visual acuity (such as radial keratotomy or LASIK surgery).

20. Periodontal or dental disease or any condition involving the teeth, surrounding tissue or structure (except as described under Covered Charges beginning on page 53).

21. Jaw surgery, orthodontic treatment for malocclusion or TMJ (except as described on page 58).

22. Cosmetic or reconstructive surgery, except for:

    a. Accidental injuries occurring while you or a covered dependent is eligible under the Plan, so long as treatment occurs within 12 months of the injury
    b. Repair of defects resulting from a covered surgery for which benefits are paid under the Plan
    c. Reconstruction of a breast after mastectomy, including all stages of any reconstructive breast reduction performed on the non-diseased breast to make it equal in size with the reconstructed diseased breast
    d. Prostheses and treatment of physical complications of mastectomies including lymphedemas.

23. Hygienic or routine foot care, such as treatment of:

    a. Weak, strained, flat, pronated, unstable or unbalanced feet
    b. Metatarsalgia
    c. Bunions (except open cutting operations)
    d. Corns, calluses or trimming of nails.

24. Orthopedic appliances, shoes or orthotics for non-covered injuries or medical conditions or prescribed primarily for use during participation in sports, recreational or similar activities.

25. Obesity, including surgery and its complications, as well as services or supplies connected with weight loss/weight control, except as provided in Weight Management Programs beginning on page 41. (This exclusion applies even if you also have an accidental injury or sickness that might be helped by weight loss.)

26. Long-term storage of blood other than charges in connection with bone marrow transplants associated with a diagnosed medical condition.

27. Surgery or other services required to repair or treat a condition resulting from an excluded medical treatment or procedure.

28. Milieu therapy (treatment designed primarily to provide a change in environment or a controlled environment).

29. Dyslexia, attention deficit disorder or delays/disorders in the development of a child's language, cognitive, motor or social skills except for physician services for the management of prescribed medications.

30. Claims incurred while legally confined for participation in criminal activities.

31. Prescription drugs obtained from a retail pharmacy, except for oral vaccines. See pages 70 to 76 for a description of your prescription drug benefit.

32. Acupuncture except as described on page 53.

33. Charges for any covered services in excess of the maximum benefits specified under this Plan.

34. Hearing aids or cochlear implants except as described on page 57.

35. Naturopathy services and supplies except as described on page 55.

Prescription Drug Program

MedImpact administers your prescription drug program and provides a **nationwide network** of *Recommended* and *Regular* network pharmacies and a Mail Order pharmacy. The *Recommended* network, *Regular* network and Mail Order pharmacy have an agreement to provide discounted prices. However, the Mail Order and the *Recommended* pharmacies offer better discounts; they are also unionized employers or pharmacies that do business with unionized employers.

A list of the network pharmacies (*Recommended* and *Regular*) including the Mail Order pharmacy is available through MedImpact. All network pharmacies are linked to a computer system that identifies Trust participants by plan and provides your pharmacy immediate pricing and other information based on plan provisions (see Quality Control on page 76 for details).

Prescription drug benefits are not subject to the medical plan deductible, and the reimbursement level doesn't change when your medical plan coinsurance out-of-pocket maximum is satisfied.

The Trust is the primary payer for prescription drug benefits, and therefore doesn't coordinate these benefits with other plans outside the Trust. Contact the Trust Administrative Office for details.

Retail Prescription Benefits

Except in medical emergencies, only prescriptions purchased at a MedImpact *Recommended* or *Regular* network pharmacy are covered by the Plan.

When you use a retail network pharmacy you pay only your share of the cost to the pharmacy, as listed below. The pharmacy then submits the claim to the Plan, and the Plan pays the balance of the cost directly to the pharmacy. A maximum 34-day supply is allowed for retail.

Prescription Drugs — Retail Pharmacy			
Type of Drug	***Recommended* Network Pharmacy – you pay:**	***Regular* Network Pharmacy – you pay:**	**Non-Network Pharmacy (medical emergency only) – you pay:**
Generic	10% of the drug cost	15% of the drug cost	$9 handling fee in addition to your normal cost share
Formulary Brand (preferred)	30% of the drug cost	35% of the drug cost	$9 handling fee in addition to your normal cost share
Non-formulary Brand (non-preferred)	40% of the drug cost	45% of the drug cost	$9 handling fee in addition to your normal cost share

Your retail pharmacy benefit depends on whether the prescription drug is generic or Formulary or non Formulary brand and whether you buy your prescription drugs at a *Recommended* or *Regular* MedImpact network pharmacy. You pay only your share of the cost to the pharmacy when you purchase your prescription. The Plan then pays the balance of the cost directly to the pharmacy.

Non-Network Pharmacy

Prescriptions purchased from a non-network pharmacy are **not covered** except in a medical emergency where using a network pharmacy is not reasonable. See Medical Emergency Non-Network Benefits, below.

Mail Order Prescription Benefits

You can save time and money in many cases and get a larger supply of your medication (up to 100 days) using the Mail Order prescription program.

Prescription Drugs – Mail Order Pharmacy	
When you use the network mail order pharmacy you pay only the copay amount. The pharmacy then submits the claim to the Plan, and the Plan pays the balance of the cost directly to the mail order pharmacy as listed below. A maximum 100-day supply is allowed for mail order.	
Type of Drug	**You pay the lesser of:**
Generic	10% of the drug cost or $15 copay per prescription
Formulary Brand (preferred)	30% of the drug cost or $90 copay per prescription
Non-formulary Brand (non-preferred)	40% of the drug cost or $130 copay per prescription

Specialty Prescription Drug Program

The Plan offers a specialty prescription drug program that covers medications used to treat the following health conditions:

- Crohn's disease
- Growth hormone deficiency
- Hepatitis C
- HIV/AIDS
- Multiple sclerosis
- Psoriasis
- Rheumatoid arthritis

Prescription medications covered under the specialty prescription drug program may change from time-to-time.

You can order many specialty prescription drugs through the Plan's Mail Order pharmacy which can save you money. You can get a 100-day supply for the lesser of a $15 or 10% copay on generic drugs, or the lesser of a $90 or 30% copay for brand-name drugs. Ancillary supplies, such as syringes and alcohol swabs are included with your order at no charge. Your medication will be delivered to your home or doctor's office at no cost to you.

If you have questions about the specialty prescription drug program or to refill a prescription, call the Union Center Pharmacy at 800-441-9174.

Medical Emergency Non-Network Benefits

Prescriptions purchased at non-network pharmacies are covered under certain circumstances by Trust medical plans for medical emergencies where using a network pharmacy is not feasible.

Here's how the prescription drug program works ***in a medical emergency.*** If you are:

- Traveling outside the United States or traveling within the United States in an area with no network pharmacy — At the *Recommended* pharmacy benefit level using the full price of

the prescription less a $9 handling fee. The $9 is in addition to your normal Recommended network pharmacy cost share.

- In a city with a network pharmacy, but due to unusual circumstances or circumstances beyond your control, you cannot use a network pharmacy — At the *Regular* pharmacy benefit level using the *discounted price* of the prescription less a $9 handling fee. The $9 is in addition to your normal Regular network pharmacy coinsurance or cost share. The *discounted price* is the price the Trust would have received if you had used a *Regular* network pharmacy.

To receive benefits, you must file an *Emergency non-network prescription drug claim form*, including proof of purchase and an explanation of the medical emergency that made it unreasonable to use a network pharmacy. *Emergency non-network prescription drug claim forms* are available from MedImpact or the Trust Administrative Office. If approved, you will be reimbursed according to the description above.

Generic Drugs

The generic name of a drug is simply its chemical name. Generic drugs meet strict requirements under the FDA and are considered to be as safe, efficient and effective as brand-name drugs, but are usually much less expensive. Unless otherwise specified by your doctor, your prescriptions will be filled with generic drugs. You may override this policy and request the brand-name prescription if you don't want to accept a generic drug, but the Plan will require you to pay the difference in cost between the brand-name and generic drug in addition to the brand-name copay or cost share.

Trial Doses

Certain new and/or high-cost prescriptions may be limited to a trial dose (instead of the usual 34- or 100-day supply) on the first and possibly second order of a new prescription to determine patient tolerance and drug effectiveness.

Using the Retail Pharmacy

- You must use a MedImpact *Recommended* or *Regular* network pharmacy
- You will receive a higher level of benefits if you use a *Recommended* MedImpact network pharmacy
- Give the pharmacist your Trust ID card or identify yourself as a participant in the Washington Teamsters Welfare Trust
- The pharmacist will ask for identifying information (such as employee Social Security number or Trust ID # and patient date of birth) to enter into the computer system
- The pharmacist may recommend alternative medications after consulting with your physician The pharmacist will fill your prescription up to a 34-day supply
- You pay the pharmacy only your share of the cost of the prescription
- Network pharmacies will substitute generic drugs when permitted by the prescribing physician; you may override this policy and request the brand-name prescription if you don't want to accept a generic drug, but the Plan will require you to pay the difference in cost between the brand-name and generic drug in addition to the brand-name copay or cost share
- The pharmacy will electronically submit your prescription data to MedImpact to verify eligibility and payment of the remaining balance.

When Refills Are Available

The Plan will only cover prescriptions that are refilled after a certain amount of time has passed. Have your prescription refilled when at least 75% of the medication has been used. If you refill your prescription when more than 25% of the total days supply remains, the Plan will not cover the cost of the refill.

Using the Mail Order Pharmacy

The Mail Order program is designed for individuals using maintenance medications (for 30 days or longer) to treat chronic or long-term conditions such as diabetes, arthritis, heart conditions, high cholesterol, digestive, asthma and high blood pressure. Mail order is not intended for medications needed immediately.

Prescription drugs supplied by the Mail Order pharmacy meet the highest pharmaceutical standards of quality, safety and effectiveness. Each prescription is filled and checked by a registered pharmacist to assure the quantity and strength is accurate. A patient profile is maintained to help avoid undesirable drug interaction.

To use the Mail Order program, request a mail order form from Union Center Pharmacy or your local union and follow the instructions. Refills can generally be ordered over the phone or online. Again, follow the instructions enclosed with your original prescription. Allow about 10 days to receive your medication by mail.

The Plan cannot reimburse prescriptions that are refilled too soon. Have your prescription refilled when at least 75% of the medication has been used. If you refill your prescription when more than 25% of the total days supply remains, your reimbursement cannot be processed.

For questions about using the network Mail Order program or your benefits, contact the Trust Administrative Office.

Talk to Your Doctor About Your Medication

- Bring a copy of the Plan's formulary (preferred drug list) to your next doctor's visit; using formulary drugs can result in lower overall costs for you — and the Trust. The formulary is available on the MedImpact website at **www.medimpact.com** or from the Trust Administrative Office.

- Ask about lower cost alternatives such as generic medications and preferred medications listed on the formulary

- Check the prescription to make sure the dosage, your doctor's signature, your name and your address are included and are clear

- If the medication is for a long-term condition or is considered a maintenance drug, think about using the Mail Order program. After you and your doctor have confirmed the drug is effective for your condition, ask your doctor to write your prescription for up to a 100-day supply with up to three refills. If you need medication immediately, ask your doctor to write two prescriptions — one for an immediate supply to be taken to your retail pharmacy, and the second for an extended supply to be sent to the mail order pharmacy.

Covered Prescriptions

The following drugs, medicines and supplies are covered when prescribed in writing by a physician:

- Antacids containing aluminum hydroxide, aluminum hydroxide with magnesium trisilicate, aluminum and magnesium hydroxide gel, calcium carbonate, magnesium carbonate suspension and dihydroxy-aluminum amino acetate
- Compounded dermatological preparations including ointments and lotions prepared by a pharmacist under doctor's prescription. You will be charged the brand-name drug copay and/or coinsurance.
- Contraceptives or contraceptive devices requiring a prescription
- Diabetic supplies (excluding appliances) including insulin, syringes, needles, test tape or strips, acetone test tablets, Benedict's solution or equivalent, lancets and similar test supplies
- Eye or ear medications requiring a prescription
- Legend drugs requiring a prescription from a physician or dentist (that is, any medicine labeled "Caution: federal law prohibits dispensing without a prescription")
- Miscellaneous items such as bee sting kits, ephedrine sulfate and ferrous sulfate (only the sulfate)
- Smoking cessation prescriptions (limited to $500 in benefits per calendar year to a $1,000 lifetime maximum per person). You must enroll in the StayWell Nextsteps Tobacco Cessation program and complete one call with a Health Coach in order to have a prescription refill covered by the Plan.

Prescription Drug Program Exclusions

1. Any prescription or refill that individually, or cumulatively over time, creates dosages exceeding the FDA or manufacturer recommendations.
2. Claims not electronically filed by a network pharmacy (unless it was not reasonably possible to file the claim and the claim is submitted within one year with proper documentation).
3. Contraceptives or contraceptive devices that do not require a prescription.
4. Cosmetic purpose drugs such as Minoxidil or Retin A.
5. Devices used to administer drugs.
6. Dietary supplements and vitamins including fluorides or any medication containing fluorides.
7. Drugs dispensed in a hospital, nursing home, clinic, ambulatory surgical center, doctor's office or other institution.
8. Drugs dispensed to a dependent child because of pregnancy.
9. Drugs labeled "Caution — limited by federal law to investigational use," or experimental drugs.
10. Drugs prescribed or purchased while in service in the armed forces or as a result of war or act of war, including terrorism.
11. Drugs to treat conditions that are not within uses approved by the FDA or manufacturer (including experimental uses).

12. Drugs used to restore fertility or promote conception.
13. Drugs purchased at non-MedImpact network pharmacies, including take-home drugs or drugs purchased at discharge from an inpatient facility for outpatient use, if those drugs are not obtained from a MedImpact network pharmacy.
14. Immunization agents, biological sera or non-drug items.
15. Medications, drugs or supplies that are compensated or furnished by the United States government or any of its agencies.
16. Medicines or drugs procured or procurable without a prescription from a physician or dentist, including all over-the-counter drugs (except as may be allowed by the Trust or described in Covered Prescriptions on page 74).
17. More than a 34-day supply at a retail pharmacy or a 100-day supply from the mail order pharmacy.
18. Smoking cessation products that do not require a prescription.
19. Reimbursement of drugs when the Trust is paying as the secondary insurer (or when another insurance plan has made a primary payment).
20. Prescriptions for illness or injuries as a result of service in the armed forces or as a result of an act of war, including terrorism.

Drug Utilization Review (DUR)

The Trust has authorized a structured system to analyze and improve drug prescribing and use patterns. This Drug Utilization Review committee consists of professors, pharmacists and physicians with experience in drug benefit management, clinical pharmacy and drug interactions. The committee confidentially reviews prescription profiles using predetermined medical and pharmaceutical standards; these reviews may include:

- Possibility of clinically significant drug interactions
- Profiles with an unusual number of prescriptions in a given period
- Numerous prescribing physicians and dispensing pharmacies
- Profiles with a high number of controlled substances
- Physician prescribing patterns or pharmacy dispensing patterns that result in excessive drug costs.

If the reviews disclose possible inappropriate use of prescription drugs or drug interactions, the DUR committee is authorized to contact the prescribing physicians or dispensing pharmacies to resolve the matter. Unresolved cases may be referred to the Trust Administrative Office with a recommendation for benefit denial.

Formulary

Your prescription benefit uses a list of preferred drugs called a formulary. These drugs have been selected by a panel of physicians and pharmacists based on therapeutic effectiveness and favorable pricing arrangements, including volume rebates. The formulary is available on the MedImpact website at **www.medimpact.com** or from the Trust Administrative Office. Compliance with the formulary is voluntary but will affect the amount of your copay or

reimbursement. Please share this list with your physician during your visit; use of formulary drugs can result in lower overall costs to the Trust — and to you.

Medicare and Prescription Drug Coverage

The prescription drug benefits you have under the Washington Teamsters Welfare Trust medical plan are expected to pay out, on average, at least as much as the standard Medicare Part D prescription drug coverage. (This is known as “creditable coverage.”) The reason this is important is that if you or a covered dependent are or become eligible for Medicare and you decide to enroll in a Medicare prescription drug plan during a subsequent annual enrollment period, you will not be subject to a late enrollment penalty as long as you had creditable coverage within 63 days of your Medicare prescription drug plan enrollment. The Trust will review the benefits annually to determine if they continue to qualify as creditable coverage and issue an annual notice to participants.

Quality Control

All MedImpact retail and mail order pharmacies are electronically linked to a central computer system containing certain information on Plan participants. This system is updated frequently based on current eligibility status. Occasionally you may attempt to purchase a prescription from a MedImpact network pharmacy that cannot confirm your eligibility because pertinent data isn’t in the system. This may happen because:

- You are a new participant and have not been entered into the Trust data files
- You have not been eligible under the Plan for an extended period (usually two or more months)
- You have an inconsistent pattern of eligibility
- Your dependent child reaches an age that makes him/her ineligible
- Your newly acquired dependents (due to marriage or remarriage, newborn children, stepchildren, etc.) have not been entered into the Trust data files
- Your employer’s contributions have not been received.

On other occasions, a new network pharmacy not yet familiar with the MedImpact program may have difficulty confirming your eligibility.

If you experience any of these issues with a MedImpact network pharmacy, ask the pharmacist to call MedImpact at **800-788-2949**.

Mental Health and Chemical Dependency Benefits Program

The Mental Health and Chemical Dependency Benefits program is designed to provide you and your family with counseling for personal problems and mental health or chemical dependency treatment options. Your benefits include 24-hour assistance, assessment, referral, outpatient counseling, inpatient and alternate care programs, utilization management, and case management.

You can call Cigna 24 hours a day, 7 days a week, 365 days a year at **855-402-0272**. Cigna staff is available to assist you in obtaining referrals, answering questions about your benefits or can connect you immediately to a staff clinician for a clinical emergency.

Assistance Program & Behavioral Healthcare Services: Two Components Working Together

Component One: Assistance Program

The Assistance Program provides referral, legal and identity theft recovery services along with financial planning and short-term counseling with Cigna network practitioners who identify, discuss, and develop a plan of action to help resolve your problem. For longer-term care, your network practitioner works with Cigna to facilitate continued treatment based on your coverage and your clinical needs.

You can access the Assistance Program by calling Cigna 24 hours a day, 7 days a week, 365 days a year at 855-402-0272. Referral and authorization are always required for Assistance Program services. Cigna only provides Assistance Program referrals to its network practitioners.

The Assistance Program provides up to three 50-minute face-to-face sessions per incident per person each year and unlimited telephone-based counseling for you and your eligible dependents with an Cigna network practitioner. The Assistance Program service is covered at 100% if preauthorized by Cigna. There are no copays, coinsurance, or deductible payments.

The Program also provides Substance Abuse Professional (SAP) services for eligible employees who are subject to Department of Transportation (DOT) alcohol and drug testing rules. Employees referred to Cigna due to a positive alcohol or drug test will be provided with a SAP evaluation that satisfies DOT requirements along with SAP recommended clinically appropriate treatment/education under their managed mental health and chemical dependency benefits program.

The Assistance Program benefit does not provide coverage for:

- Inpatient treatment or outpatient treatment for any medically treated illness
- Prescription drugs
- Treatment/services for mental retardation or autism
- Counseling services beyond the number of sessions covered by the Program
- Services by non-network practitioners
- Counseling required by law, a court, or paid for by Workers' Compensation, or

- Formal psychological evaluations and fitness-for-duty opinions.

If you use Cigna's services, your treatment's confidentiality is protected by state and federal law. Exceptions to confidentiality include, but are not limited to, mandatory reporting of child and elder abuse, threat of homicide or suicide, subpoena or court order and certain disclosures made by persons dangerous to themselves or others. See Notice of Privacy Practices on page 91 for more information.

You acknowledge that healthcare providers may disclose health information about you or your dependents, including information about substance abuse or mental/emotional conditions, to Cigna. Cigna uses and discloses this information for purposes of treatment, payment and health plan operations, including but not limited to utilization management, quality improvement or disease or case management programs.

Component Two: Behavioral Healthcare Services

You or your eligible dependents may need services to deal with mental health disorders and chemical dependency problems. These problems can include, but are not limited to:

- Alcohol and drugs
- Anxiety
- Depression
- Family (marital and parenting issues)
- Gambling
- Stress

Mental health and chemical dependency covered services consist of outpatient counseling (both individual and group sessions), inpatient acute hospitalization (includes detoxification) and alternate care programs. Alternate care programs include day treatment, intensive outpatient services, chemical dependency rehabilitation programs and partial hospitalization. Services are provided by licensed mental health professionals including psychiatrists, psychologists, licensed clinical social workers, marriage and family therapists, and licensed/certified chemical dependency professionals. Services received must be medically necessary and clinically appropriate for your condition. Cigna counselors monitor treatment for mental disorders and chemical dependency conditions to determine medical necessity and clinically appropriate level of care.

About Providers

Covered Providers

The following types of licensed providers are covered by this program:

- Psychiatrists
- Psychologists
- Clinical social workers
- Marriage and family therapists
- Masters level counselors
- Chemical dependency, rehabilitation and mental health facilities.

Network and Non-Network Providers

Network Outpatient Providers

To maximize your benefits, mental healthcare or chemical dependency treatment must be preauthorized by Cigna and provided by an Cigna network provider. To access benefits call Cigna at 855-402-0272 24 hours a day, 7 days a week. A specially trained Cigna staff member will be there to take your call. Calls can also be made to Cigna on your behalf by your physician or family member with your permission.

For a list of Cigna network providers located within your geographic area, call **855-402-0272** or visit *www.cignasharedadministration.com*. Cigna's roster of network providers is subject to change. Although the website is updated each week to include only currently available providers, Cigna cannot guarantee the initial or continued availability of any particular network provider. If you locate a network provider using the *cignasharedadministration.com* website, you still must call Cigna for precertification.

You do not need to submit a claim for preauthorized treatment by an Cigna network provider. You are responsible only for any copay.

Non-Network Outpatient Providers

You may receive outpatient mental health services from a non-network provider, or a Cigna network provider whose treatment has not been authorized by Cigna, but you will receive a lower level of benefits except for hospital emergency room services. Outpatient chemical dependency benefits must be preauthorized by Cigna or no benefits will be paid under the Program. See the Schedule of Benefits on page 81. You will also need to submit a claim form. See Filing Claims for more details.

Inpatient or Alternate Care Treatment

The Program provides benefits for inpatient hospitalization and alternate care treatment. You will receive the maximum benefits if your treatment has been authorized by Cigna and provided by an Cigna network facility. However, you may elect to receive inpatient hospitalization or alternate care treatment from a non-network facility, but at a lower level of benefits.

Preauthorization from Cigna is required for all **non-emergency** inpatient or alternate care treatment, provided by a Cigna network facility or a non-network facility. If you do not receive preauthorization prior to entering a hospital or alternate care facility, your benefits will be paid as follows:

- Cigna network providers – Program pays 50%
- Non-network providers – No benefits are payable.

Only medically necessary and clinically appropriate services will be authorized.

To preauthorize mental health and chemical dependency inpatient or alternate care program admissions call Cigna at 855-402-0272.

For emergency admissions, see Emergency Care on page 80.

Special Provision Where an Cigna Network Provider or Facility Is Not Available

The Cigna nationwide network of providers and facilities can be expanded as the need for services in a particular location arises. Should you or a dependent need care, and Cigna is unable to refer you to an Cigna network provider or facility located in your area (within a 30-minute driving distance or 30-mile radius from your home), you may use the services of a non-

network provider or facility and benefits will be paid as if a network provider or facility has been used. This provision applies only if you call Cigna first and give Cigna an opportunity to refer you to a network provider/facility in your area, or a provider/facility who is willing to become a network member for the services that you or your dependent may require. Special situations must be reviewed and approved in advance by Cigna. Exceptions to this rule are cases of an emergency, if authorization is provided in writing by Cigna's Medical Director or his/her designee, or as otherwise permitted under this Program.

How to Obtain Behavioral Healthcare Services

Emergency Care

An emergency is any situation in which you experience a sudden onset of severe symptoms that would lead a prudent layperson acting reasonably to believe the failure to provide immediate behavioral healthcare services could result in serious impairment to your health or others. If you need immediate assistance, call 911 or go to the nearest emergency room. Emergencies do not require preauthorization for treatment. However, you, your provider, or a family member must call Cigna at **855-402-0272** within 48 hours of an admission for authorization of continued care following the emergency.

Coverage after an emergency admission is based on Cigna's determination of medically appropriate care. If Cigna determines transferring your care to a network provider is medically appropriate, your consent and cooperation with the transfer is a condition of receiving network coverage. If you refuse to transfer to a network provider, Cigna may apply non-network benefit limits (except for hospital emergency room services) or coverage for treatment may be denied from the date Cigna determines such treatment does not meet the medical necessity criteria for that level of care.

Non-Emergency Care

For network coverage, call Cigna at **855-402-0272** for a referral to a network provider and authorization of services. Cigna will review your treatment with your provider, monitor the treatment for medical necessity and appropriate level of care. Cigna must authorize all network services in advance, including transfers to different levels of care and additional services, except in emergency situations. For information about non-network coverage, see Network and Non-Network Providers on page 79 and the Schedule of Benefits on page 81.

All inpatient, residential or alternate treatment programs must be authorized by Cigna in advance, whether network or non-network, except in an emergency as described in Emergency Care above. Cigna's referral and authorization is based on your eligibility for coverage at the time covered services are received. If you become ineligible for coverage after authorization is generated, Cigna will deny coverage accordingly.

Schedule of Benefits

<table>
<tr><th>Benefit</th><th colspan="2">Network Provider/Facility</th><th>Non-Network Provider/Facility</th></tr>
<tr><td colspan="4">Assistance Program</td></tr>
<tr><td>Assessment Visits</td><td colspan="2">Call 855-402-0272 24 hours a day, 7 days a week

Program pays 100% for up to 3 face-to-face counseling sessions per incident per person each calendar year and unlimited telephone-based counseling. Must be authorized by Cigna</td><td>None</td></tr>
<tr><td colspan="4">Mental Health Treatment Program</td></tr>
<tr><td>Ambulance or Emergency Room</td><td colspan="2">100% (not subject to Medical Plan deductible) if admitted for mental health treatment</td><td>Program pays 50% of UCR (not subject to Medical Plan deductible) if admitted for mental health treatment; 100% for hospital emergency room services</td></tr>
<tr><td rowspan="2">Outpatient</td><td colspan="2">Program pays 100% after applicable copay if you preauthorize with Cigna

Program pays 50% after applicable copay if you do not preauthorize treatment with Cigna</td><td rowspan="2">Program pays 50% of UCR

Cigna preauthorization is not required</td></tr>
<tr><td>Individual Sessions
1-20 sessions:
$10 copay
21-50 sessions:
$15 copay</td><td>Group Sessions
1-20 sessions:
$5 copay
21-50 sessions:
$7.50 copay</td></tr>
<tr><td></td><td colspan="3">Up to 50 individual/group sessions per person per calendar year, combined network and non-network.</td></tr>
<tr><td rowspan="2">Inpatient/ Alternate Care and Residential/ Partial Treatment</td><td colspan="2">Program pays 100% if you preauthorize with Cigna.

Program pays 50% if you do not preauthorize treatment with Cigna.

The following alternate care levels equal 1 day of inpatient treatment:
• 2 days of partial hospitalization
• 1 day of residential treatment at a licensed residential treatment center
• 4 sessions of in-home or outpatient (office) treatment by a licensed therapist
• 4 home nursing visits for psychiatric or detox
• 23 hours of 1 to 1 observation</td><td>Program pays 50% of UCR if you preauthorize with Cigna.

No benefits are payable if you do not preauthorize treatment with Cigna.</td></tr>
<tr><td colspan="3">Up to 45 days of authorized residential/inpatient/alternate/partial care treatment per person per calendar year combined network and non-network. Ninety days lifetime maximum per eligible participant. Two days of residential and/or partial treatment equal one day of inpatient treatment.

Emergency admissions require Cigna authorization within 48 hours of the admission.</td></tr>
</table>

Benefit	Network Provider/Facility	Non-Network Provider/Facility
Chemical Dependency Treatment Program		
Ambulance or Emergency Room	100% (not subject to Medical Plan deductible) if admitted for chemical dependency treatment	Program pays 50% of UCR (not subject to Medical Plan deductible) if admitted for chemical dependency treatment; 100% for hospital emergency room services
Outpatient/ Inpatient/ alternate Care and Residential/Partial Treatment	Program pays 100% if you preauthorize with Cigna Program pays 50% if you **do not** preauthorize treatment with Cigna Program pays 100% of authorized SAP services for eligible active employees who fail a DOT alcohol or drug test	Program pays 50% of UCR if you preauthorize with Cigna No benefits are payable if you **do not preauthorize** treatment with Cigna Non-network SAP services are not covered
	Emergency admissions require Cigna authorization within 48 hours of the admission.	

Changing Providers

When you call Cigna, every attempt is made to help you select a network provider who will best meet your needs. If you are dissatisfied with the network provider, you may request a referral to another network provider. There may be times when you require care that your initial network provider is unable to administer. In this case, you or your provider can call Cigna for a referral to another network provider.

Continuity of Care

New Participants

If you became newly eligible for Trust benefits while you were receiving services from a non-network provider for a current episode of an acute, chronic or serious mental health condition, Cigna may authorize continuing services from your non-network provider. This decision is determined by Cigna, after consulting with you and the non-network provider, consistent with current professional practices. If authorized, Cigna will allow you to continue your treatment with the non-network provider for 90 days prior to transferring to a network provider.

Continuity of care services, where Cigna allows you to continue seeing your non-network provider, will not apply in the following situations:

- You were offered a non-network option by the Trust, but refused it
- You could continue with your previous health plan or non-network provider and voluntarily chose to change health plans
- Your non-network provider does not agree to follow the terms and conditions of Cigna's standard network provider contract.

Participants Whose Provider's Contract Has Been Terminated

Under certain circumstances, a provider whose contract has terminated with the Cigna network may continue to provide medically necessary care for Trust members for a current episode of an acute, chronic or serious mental health condition for the time period necessary to complete a

course of treatment or arrange a safe transfer, subject to any benefit limits. This provision only applies when benefits are provided by a Cigna network provider.

If the terminated provider does not agree to comply or does not comply with Cigna's contractual terms and conditions, Cigna is not obligated to continue the provider's services beyond the contract termination date. If the terminated provider voluntarily terminates his or her contract, Cigna is not obligated to continue the provider's services beyond the contract termination date.

Your copays during continuation of care with a terminated provider will be the same amount that you would have paid when receiving care from a currently contracted network provider. Your provider must agree to accept Cigna reimbursement as payment in full for covered services.

Filing Claims

You do not need to submit claims for behavioral healthcare services received from network providers. Network providers will file the claim for you and they will be paid directly by the Trust Administrative Office.

Non-network provider claims must be submitted according to the terms of this Program. Written notice of a claim must be submitted to Cigna within 90 days after the occurrence or beginning of any loss covered by the Program, or as soon as is reasonably possible. Claim forms are available at **www.cignasharedadministration.com**. Submit claims to:

Cigna Healthcare
PO Box 188004
Chattanooga, TN 37422

Utilization Review

This Program includes prior, concurrent and retrospective reviews of proposed treatments to determine medical necessity and if the services are covered. An example of concurrent review is Cigna's review of whether current use of an inpatient facility is the appropriate treatment setting for the patient's symptoms as determined by medical necessity criteria. An example of retrospective review is Cigna's review of whether past use of a hospital was appropriate for the patient's symptoms and met medical necessity. If required clinical information is not supplied by the provider in support of the treatment, Cigna will deny coverage of such treatment.

The final judgment of the reviewer or professional review organization is not a substitute for the independent judgment of the treating provider about a treatment plan. Utilization review decisions that are not consistent with a treating provider's determination do not preclude treatment or hospitalization — but do determine Cigna's coverage for treatment or hospitalization.

A medically necessary service is defined as psychiatric and/or other related healthcare services proposed by a provider, which must meet all of the following conditions as determined by Cigna:

- The requested services facilitate the diagnosis and/or active treatment of a covered current *Diagnostic and Statistical Manual of Mental Disorders* (DSM)–IV Axis I mental disorder or substance-related disorder.

- The proposed treatment plan represents an active, necessary and appropriate intervention for the timely resolution of symptoms and the restoration to baseline level of functioning. The proposed services are not primarily custodial.
- The type, level and length of the proposed services and setting are consistent with Cigna's level of care criteria and guidelines provided in the least restrictive level of care in which the patient can be safely and effectively treated.
- The proposed treatment is not experimental in nature; its safety and efficacy have been clearly demonstrated and widely accepted in modern psychiatric literature.
- The proposed treatment plan has been demonstrated in peer reviewed journals to be at least equally effective in bringing about a rapid resolution of symptoms when compared to alternative treatment interventions.
- The proposed treatment plan utilizes clinical services efficiently when compared to alternative treatment interventions and contributes to effective management of your benefit.
- Treatment is provided by a mental health professional licensed to practice independently who meets Cigna's credentialing standards.

The Independent Contractor Relationship

The relationship between Cigna and network providers is that of an independent contractor. Network providers are not agents or employees of Cigna, nor is Cigna and/or its employees and agents an employee or agent of any network provider. Cigna and its network providers are not authorized to represent each other for any purposes, nor are they or their respective officers, agents or employees considered officers, agents or employees of the other. Network providers maintain the provider-patient relationship with participants and are solely responsible to participants for their services. In no event will Cigna be liable for the negligence, wrongful acts or omissions of network providers.

Cigna and the Trust are independent contractors in relation to one another and no joint venture, partnership, employment, agency or other relationship is created by the agreement. Neither Cigna nor the Trust are liable for any act, negligence or omission of the other, nor are they each other's agents or employees. Neither Cigna nor the Trust is authorized to represent the other for any purpose. None of the parties to the agreement nor any of their respective officers, agents or employees shall be construed to be the officer, agent or employee of any other party.

Non-Assignability of Benefits

You cannot transfer the coverage and benefits of this Program to another person without Cigna's prior written consent. Such a request may be denied for any reason. Cigna reserves the right to make payment of benefits, at its sole discretion, directly to the network provider or to the participant.

Mental Health and Chemical Dependency Benefits Program Definitions

Acute — The sudden onset or abrupt change of a mental health condition requiring prompt attention, but is of limited duration, as determined by the administrator.

Administrator — Cigna and/or the Trust Administrative Office depending on the program provision.

Alternate Treatment — A planned, medical therapeutic program for persons with mental disorders. This includes diagnosis, medical care, and treatment when the patient does not require full-time hospitalization, but does need more intensive care than traditional outpatient visits. Alternate treatment includes residential treatment, partial hospitalization or day treatment program and intensive outpatient programs authorized by Cigna and is considered an inpatient benefit.

Authorization — A decision, issued in writing by the Cigna medical director or his/her designee, that benefits are payable for certain services that a covered person will receive or has received.

Behavioral Healthcare Services — Chemical dependency, substance abuse and/or mental healthcare services determined by Cigna to be covered services under this plan.

Chemical Dependency and/or Substance Abuse — Psychological or physical dependence on alcohol or other mind-altering drugs that requires diagnosis, care and medically necessary treatment.

Copay — The payment to be collected directly by the network provider or non-network provider from you for covered services, excluding any deductibles.

Covered Services — Behavioral healthcare services that constitute benefits covered under the plan. The determination that a benefit is a covered service rests with the administrator.

Dependent — The eligibility provisions for the Program's benefits and services are the same as those described in the Summary Plan Description (SPD) for your medical plan. See Eligibility and Coverage Effective Dates for information detailing the rules on who is eligible for benefits.

This Program is not applicable for participants who are enrolled in a Group Health Options Plan through the Trust.

Diagnostic and Statistical Manual of Mental Disorders (DSM) — A listing of diagnostic categories and criteria that provides guidelines for diagnosing mental and substance abuse disorders. The DSM is a widely accepted basis for describing the presence and type of these disorders. A DSM diagnosis of mental or substance abuse disorder is a minimum requirement for the demonstration of medical necessity under the Policy. The diagnosis must be contained in the most recent edition of the DSM.

Eligible Participant — An individual who meets the eligibility requirements as set forth by the Trust and meets the eligibility requirements in the Eligibility and Coverage Effective Dates section of your Washington Teamsters Welfare Trust Medical Summary Plan Description.

Emergency — The sudden onset of a condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that, a prudent layperson possessing an average knowledge of medicine and health could reasonably expect in the absence of immediate behavioral healthcare services, could reasonably result in:

- Serious impairment to bodily functions
- Permanently placing the person's health, or others, in serious jeopardy, or
- Causing serious and permanent dysfunction to the person.

Facility — A hospital or a facility providing alternate treatment which furnishes covered services to you or your dependents.

Hospital — Any institution that is a duly licensed and/or accredited healthcare organization as:

- Providing behavioral healthcare services
- A chemical dependency or substance abuse treatment facility that is under the supervision of a staff of physicians, with 24 hours-a-day nursing service, and operated primarily to assist in the withdrawal from dependency on alcohol or drugs
- A psychiatric treatment facility that is under the supervision of a staff of physicians, with 24 hours-a-day nursing service, and operated primarily to provide treatment of mental disorders, or
- Any other institution designated as a hospital by the administrator.

Inpatient — You or your dependent who have been admitted to a hospital or other authorized institution for bed occupancy for purposes of receiving medically necessary behavioral healthcare services, with the reasonable expectation that you or your dependent will remain in the institution at least 24 hours.

Medical Director — A physician who is:

- Licensed to practice medicine and board certified as a psychiatrist, and
- Employed or contracted by the administrator to coordinate and monitor the quality management, utilization management, and provide services for the administrator.

Medically Necessary or Medical Necessity — Services that must meet ALL of the following conditions:

- The requested services provide for the diagnosis and/or active treatment of a covered current DSM–IV Axis I Mental Disorder or substance-related disorder.
- The proposed treatment plan represents an active, necessary and appropriate intervention for the timely resolution of the participant's symptoms and the restoration to baseline level of functioning. The proposed services are not primarily custodial in nature.
- The type, level and length of the proposed services and setting are consistent with Cigna's level of care guidelines and are rendered in the least restrictive level of care in which the participant can be safely and effectively treated.
- The proposed treatment is not experimental in nature; that is, its safety and efficacy have been clearly demonstrated and widely accepted in the modern psychiatric literature.
- The proposed treatment plan has been demonstrated in peer reviewed journals to be at least equally effective in bringing about a rapid resolution of symptoms when compared to possible alternative treatment interventions.
- The proposed treatment plan utilizes clinical services in an efficient manner when compared to alternative treatment interventions and contributes to effective management of the patient's benefit.
- Treatment is provided by a mental health/substance abuse professional licensed to practice independently who meets Cigna's credentialing standards.

Mental Disorder — A nervous or mental condition that meets **ALL** of the following conditions:

- It is a clinically significant behavioral or psychological syndrome or pattern; AND
- It is associated with a painful symptom, such as distress; AND
- It impairs a patient's ability to function in one or more major life activities; AND
- It is a condition listed in an Axis I Disorder (excluding V Codes) of the Diagnostic and Statistical Manual of Mental Disorders (Fourth Edition) by the American Psychiatric Association (DSM-IV), or successor publication.

Mental Healthcare Services — Those services determined by the administrator to be medically necessary for the treatment of a mental disorder.

Network Provider — A practitioner, facility or hospital that has contracted with Cigna to provide care and treatment to persons covered by the Policy.

Non-Network Provider — A practitioner, facility or hospital that has not contracted with Cigna to provide care and treatment to persons covered by the Policy.

Outpatient — An ambulatory person receiving covered services who has not been admitted to a hospital or facility.

Peer Reviewer — A mental health professional licensed to practice in the state in which he or she practices and who is employed by or contracted with the administrator to provide ongoing services involving peer review, utilization review and claims payment review.

Practitioner — A mental health professional who is appropriately licensed as a psychiatrist, clinical psychologist, marriage, family or child counselor, social worker or other person designated by Cigna and acting within the scope of their license.

Prepayment Fee/Premium — A pre-negotiated fixed monthly fee that is payable to the administrator by a Fund for each participant who is enrolled with the administrator pursuant to the policy.

Reasonable Charge(s) (UCR, Usual and Customary Rates) — An amount measured and determined by comparing the actual charge for the service or supply with the prevailing charges made for it. The prevailing charge is determined utilizing the 90th percentile MDR UCR Index. This takes into account all pertinent factors including:

- The complexity of the service
- The range of services provided
- The prevailing charge level in the geographic area where the practitioner, hospital or facility is located and other geographic areas having similar medical cost experience.

Mental Health and Chemical Dependency Benefits Program Exclusions

The following are specifically excluded from covered services:

1. Treatment of detoxification in newborns.
2. Treatment of congenital and/or organic disorders. This includes, without limitation, Alzheimer's disease, mental retardation (other than the initial diagnosis), organic brain

disease, delirium, dementia, amnesic disorders and other cognitive disorders as defined in the DSM.

3. Treatment for chronic pain and other pain disorders, smoking cessation, nicotine dependence, nicotine withdrawal and nicotine-related disorders.
4. Treatment of obesity and eating disorders unless otherwise required by law. This does not include the diagnosis of anorexia and bulimia nervosa as defined in DSM.
5. Court-ordered testing and treatment.
6. Private hospital rooms and/or private duty nursing, unless determined to be a medically necessary service and authorization from Cigna is obtained.
7. Ancillary services such as:
    a. Vocational rehabilitation.
    b. Behavioral training.
    c. Speech or occupational therapy.
    d. Sleep therapy and employment counseling.
    e. Training or educational therapy for reading or learning disabilities.
    f. Other education services.
8. Testing, screening or treatment for:
    a. Learning disorders, expressive language disorders, mathematics disorder, phonological disorder and communication disorder NOS.
    b. Motor skills disorders and developmental coordination disorder.
    c. All disorders of infancy and early childhood and developmental disorders including, but not limited to, communication disorders, pervasive developmental disorders, autistic disorder, Rett's disorder, Asperger's disorder (except as otherwise required by law).
    d. Disorders resulting from general medical conditions, including but not limited to: catatonic disorder due to general medical condition, personality change due to general medical disorder, narcolepsy, stuttering, stereotypic movement disorders, sleep disorders, TIC disorders, elimination disorders, sexual dysfunctions, and primary insomnia.
    e. Personality disorders.
    f. Pedophilia.
    g. Primary sleep disorders, primary hypersomnia, and dyssomnia NOS.
    h. Age-related cognitive decline.
9. Treatment of conditions which are medical in nature, even when such conditions may have been caused by a mental disorder.
10. Treatment by providers other than those within licensing categories then recognized by the administrator as providing medically necessary services in accordance with applicable medical community standards.
11. Treatment rendered for conditions not listed as an Axis I disorder (V Code diagnoses listed as an Axis I disorder are also excluded unless otherwise specified in the Plan).
12. Services in excess of those with respect to which authorization by Cigna is obtained.

13. Psychological testing except as authorized by Cigna and conducted by a licensed psychologist for assistance in treatment planning, including medication management or diagnostic clarification and specifically excluding all educational, academic and achievement tests, psychological testing related to medical conditions or to determine surgical readiness and automated computer-based reports.

14. Missed appointments. Cigna will consider one of the participant's counseling sessions used if the participant fails to cancel with the provider at least 24 hours in advance, unless the appointment is missed because of an emergency or circumstances beyond the participant's control.

15. All prescription or non-prescription drugs and laboratory fees, except for drugs and laboratory fees prescribed by a psychiatrist in connection with inpatient treatment.

16. Medication management or other pharmacological services rendered by a non-psychiatrist provider.

17. Inpatient services, treatment, or supplies rendered without authorization, if required, except in the event of an emergency.

18. Healthcare services, treatment, or supplies rendered in a non-emergency by a non-participating provider, unless authorization by Cigna has been received or as otherwise provided by the Plan.

19. Damage to a hospital or facility caused by the participant.

20. Healthcare services, treatment or supplies determined to be experimental by administrator in accordance with accepted mental health standards, except as otherwise required by law.

21. Healthcare services, treatment or supplies:

    a. Provided as a result of any Workers' Compensation law or similar legislation.

    b. Obtained through, or required by, any governmental agency or program.

    c. Caused by the conduct or omission of a third party for which the participant has a claim for damages or relief.

22. Healthcare services, treatment, or supplies for military service disabilities for which treatment is reasonably available under governmental healthcare programs.

23. Treatment for biofeedback, acupuncture or hypnotherapy.

24. Healthcare services, treatment, or supplies rendered to the participant which are not medically necessary services. This includes, but is not limited to, services, treatment, or supplies primarily for rest or convalescence, custodial or domiciliary care as determined by administrator.

25. Services received before the participant's effective date, during an inpatient stay that began before the participant's effective date or services received after the participant's coverage ended, except as specifically stated herein.

26. Services for which:

    a. The person is not legally obligated to pay.

    b. No charge is made to the person.

    c. No charge is made to the person in the absence of insurance coverage.

    d. It is provided without cost to the person by a local, state or federal government agency.

27. Services in connection with conditions caused by an act of war.

28. Conditions caused by release of nuclear energy, whether or not the result of war.
29. Emergency room services not provided by a psychiatrist directly related to the treatment of a mental disorder in accordance with the limitations listed above.
30. Professional services received from a person who lives in the participant's home or who is related to the participant by blood or marriage.
31. Any services or supplies under Parts A or B of Medicare if either:
    a. The participant is enrolled in Part A of Medicare, whether or not the participant is enrolled in Part B of Medicare, or
    b. The participant is entitled to enroll in Medicare and has made the required number of quarterly contributions to the Social Security System, whether or not the participant has actually enrolled in Medicare or claimed Medicare benefits.
32. Services performed in any emergency room which are not directly related to the treatment of a mental disorder.
33. Services received out of the participant's primary state of residence except in the event of an emergency and as otherwise authorized by the administrator.
34. Electro-Convulsive Therapy (ECT) except authorized by the administrator according to the administrator's policies and procedures.
35. All other services, confinements, treatments or supplies not provided primarily for the treatment of specific covered benefits outlined in the Schedule of Benefits and/or specifically included as covered services elsewhere in this Plan.
36. County-based case management services.

Plan Administration

About the Privacy of Your Health

The Plan Sponsor and the Trust group healthcare plans (the medical, mental health and chemical dependency, prescription drug and care management health plans described in this booklet) are subject to HIPAA's privacy requirements beginning on April 14, 2003, and HIPAA's privacy protections apply to them.

Participants will receive a copy of the Trust's HIPAA privacy notice separately.

Federal Mandates

Newborns' and Mothers' Health Protection Act

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

Women's Health and Cancer Rights Act

Under federal law, group health plans and health insurance issuers offering group health insurance coverage that includes medical and surgical benefits with respect to a mastectomy shall include medical and surgical benefits for breast reconstructive surgery as part of a mastectomy procedure. Breast reconstructive surgery in connection with a mastectomy shall at a minimum provide for:

- Reconstruction of the breast on which the mastectomy has been performed
- Surgery and reconstruction of the other breast to produce a symmetrical appearance
- Prostheses and treatment of physical complications for all stages of mastectomy, including lymphedemas in a manner determined in consultation with the attending physician and the patient.

Coordination With Other Medical Benefits

Coordination of Benefits or COB refers to how the Trust Plan coordinates benefits payments when you or your dependents have group coverage under more than one plan. The intent of coordination with other medical and mental health benefits (but not prescription drug benefits) is to ensure the total paid under this Plan and all other group plans does not exceed the actual charge or allowed charge for a treatment or service.

If your spouse or dependent children have primary medical coverage under a group plan outside of the Trust, the Trust plan will pay benefits secondary to your dependent's primary coverage, with payments made up to 100% of covered charges rather than to only the Trust's level of benefits. If the allowed charge for a covered service is less under

the primary plan, the Trust plan will coordinate only up to the allowed charge of the primary plan.

Conventional COB

Effect on Benefits

Benefits otherwise payable under this Plan for allowable expenses during a claim determination period may be reduced if:

- Benefits are payable under any other plan for the same allowable expenses
- Under the rules listed below, benefits payable under the other plan are to be determined before benefits payable under this Plan.

The reduction will be the amount needed to ensure that the sum of payments under this Plan plus benefits under the other plan is not more than the total of allowable expenses under the primary plan or the Trust plan, whichever is less. Each benefit that would be payable without this section will be reduced proportionately. The total amount paid will be charged against any applicable benefit limit of this Plan.

For this purpose, benefits payable under other plans will include those that would have been paid if claims had been made for them. Also, for any person covered by Medicare Part A, benefits payable will include benefits provided by Medicare Part B, whether or not the person is covered under Part B.

Under conventional COB, when this Plan is secondary and its payment is reduced because of the primary plan's benefits, a record is kept of the reduction. The amount will be used to increase this Plan's payments on the patient's later claims in the same calendar year — to the extent there are allowable expenses that would not otherwise be fully paid by this Plan and other plan(s). This provision applies only to the Trust's medical benefits.

Definitions

For the purposes of COB, the following definitions apply:

Plan — Means this Plan and any medical or dental benefits provided under any of the following:

- Insured or non-insured group, service, prepayment or other program arranged through an employer, trustee, union or association
- Program required or established by state or federal law (including Medicare Parts A and B, but excluding Medicaid)
- Program sponsored by or arranged for students through a school or other educational institution.

The term Plan does not include benefits provided under a student accident policy or under a state medical assistance program where eligibility is based on financial need. Plan applies separately to parts of any program that contain COB provisions and separately to parts of any program that do not contain COB provisions.

Allowable Expense — All prevailing charges for treatments or services when at least part of those charges is covered under at least one of the plans then in force for the covered person. However, the difference between the cost of a private room and a semi-private room will be an allowable expense only when confinement in a private room is medically necessary. If a plan provides benefits in other than cash payments, the cash value of those benefits will be both an allowable expense and a benefit paid.

Claim Determination Period — The part of a calendar year when you would receive benefit payments under this Plan if this section were not in force.

Order of Benefit Determination

Except as described under Medicare Exception below, the benefits payable by a plan that doesn't have a COB provision will be determined before those of a plan that does have a COB provision. In all other instances, the order of determination will be:

1. **Employee/Dependent.** The benefits of a plan that covers the person as an employee participant are determined before those of a plan that covers the person as a dependent participant.

2. **Dependent Child — Parents Not Separated or Divorced.** When this Plan and another plan cover the same child as a dependent of parents who are not separated or divorced, benefits of the plan of the parent whose birthday falls earlier in a calendar year are determined before those of the plan of the parent whose birthday falls later in that year. If both parents have the same birthday, the benefits of the plan that covered the parent longer are determined before those of the plan that covered the other parent for a shorter time.

3. **Dependent Child — Parents Separated or Divorced.** If two or more plans cover a dependent child of divorced or separated parents, and the terms of the specific court decree state the parents have joint custody or that both parents are responsible for the child's health care expenses, benefits of the plan of the parent whose birthday falls earlier in a calendar year are determined before those of the plan of the parent whose birthday falls later in that year. If both parents have the same birthday, the benefits of the plan that covered the parent longer are determined before those of the plan that covered the other parent for a shorter time.

   If there is no specific court decree that determines responsibility for the child's health care expenses, benefits for the child are determined in this order:

   - First, the plan of the custodial parent
   - Second, the plan of the custodial parent's spouse, if applicable
   - Third, the plan of the non-custodial parent.
   - Finally, the plan of the non-custodial parent's spouse.

     However, if the specific terms of a court decree state that one of the parents is responsible for the child's healthcare expenses, and the entity obligated to pay or provide benefits for the plan of that parent has knowledge of those terms, the benefits of that plan are determined first. (This doesn't apply to any claim determination period or plan year when any benefits are actually paid or provided before the entity has that knowledge.)

     If the specific terms of a court decree state that both of the parents are responsible for the child's healthcare expenses, benefits of the plan of the parent whose birthday falls earlier in a calendar year are determined before those of the plan of the parent whose birthday falls later in that year.

4. **Active/Inactive Employee.** The benefits of a plan that covers a person as an employee who is neither laid off nor retired, or as that employee's dependent, are determined before the benefits of a plan that covers that person as a laid-off or retired employee or as that employee's dependent. If the other plan doesn't have this rule, and if, as a result, the plans disagree on the order of benefits, this rule will not apply.

5. **Longer/Shorter Length of Coverage.** If none of the above rules determines the order of benefits, the benefits of the plan that has covered a person longer are determined before those of a plan that has covered the person for a shorter time. It does not apply to prescription drug, mental health or chemical dependency benefits.

Benefit Credit Provision

When this Plan is secondary and its payment is reduced because of the primary plan's benefits, a record is kept of the reduction. The amount will be used to increase this Plan's payments on the patient's later claims in the same calendar year, to the extent there are allowable expenses that would not otherwise be fully paid by this Plan and other plan(s). This provision applies only to the Trust's medical benefits.

Medicare Exception

You are considered actively at work and this Plan is primary if you are:

- Actively working as an employee, or
- Not actively working and are receiving disability benefits from an employer for up to 6 months; or
- Not actively working but meet all of the following conditions:
    - Retain employment rights in the industry;
    - Have not had your employment terminated by the employer;
    - Are not receiving disability benefits from your employer for more than 6 months;
    - Are not receiving Social Security disability benefits; and
    - Have employment-based health coverage that is not COBRA continuation coverage.

If you or a dependent is eligible for Medicare coverage and you are no longer actively at work, Medicare becomes the primary payer of claims over any coverage you have under this Plan, including COBRA, the Six-Month Self-Pay option or Extension of Benefits.

For employees and dependents, the benefits payable under this Plan will normally be primary and Medicare will normally be secondary. However, employees have the option of electing Medicare as primary coverage. If an employee or dependent spouse age 65 or over makes this election, the Trust will pay no further medical benefits.

Importance of Enrollment in Medicare Part B

Medicare Part A (hospital charges) is generally automatic when you reach age 65, and requires only completion of a Medicare form. However, Medicare Part B (physician charges) requires enrollment and monthly premium payments. Even if you retain primary coverage under this Plan, it's still beneficial to enroll in Medicare Part B to cover certain expenses not paid by the Trust and to avoid being without coverage for physician charges if you lose coverage under the Trust. Unless you enroll for Medicare Part B when first eligible, or promptly after coverage under this Plan ends, a 10% penalty will be added to the monthly Medicare Part B premium for every 12 months you were eligible to enroll but did not.

Special rules for individuals with end stage renal disease (ESRD) – If you are eligible for Medicare due to ESRD, Medicare becomes primary over this plan after an initial 30-month coordination period and benefits under this plan will be secondary at that time even if you have coverage under this plan as an active employee. If you are eligible for Medicare, but are not

enrolled in both Medicare Parts A and B, this plan will estimate what Medicare would have paid as primary and will only pay secondary based on the estimated primary coverage. Therefore, you will need to be enrolled in both Medicare Parts A and B in order to have primary coverage after the initial 30-month coordination period.

If you are no longer covered as an active employee or the dependent of an active employee, benefits under this plan will be reduced by Medicare Parts A and B benefits. This provision is applicable even if you are not covered by Medicare Part A and B.

Subrogation (Third-Party Reimbursement)

If you or your dependents incur any medical expense resulting from injury or sickness for which there is right of recovery against a third party (including workers compensation claims), Trust benefits will be paid on the condition the Trust will be reimbursed from any amount you or your dependents receive in settlement or judgment. You or your dependents also must give the Trust the name and address of the responsible third party and, if requested, execute a Trust Subrogation Agreement agreeing to reimburse the Trust. The Trust may withhold benefit payment if you are requested to execute a Trust Subrogation Agreement and do not comply.

As security for the Trust's right to this reimbursement, the Trust will be subrogated to all rights of recovery against the third party to the extent of any benefits the Trust paid. You or your dependents must do whatever is necessary to fully secure and protect, and nothing to prejudice, the Trust's rights to this subrogation.

Recovery of Unauthorized Benefit Payments

The Trust provides benefits only under the written terms of this Plan. If the Trust has mistakenly made benefit payments to or for an ineligible person, or payments exceeding those authorized by this Plan — or if you or a dependent fails to reimburse benefits advanced under an agreement to reimburse — the individual profiting from the benefit is obligated, upon notice from the Trust, to reimburse the overpayment. Otherwise, the Trust is entitled to bring legal action to recover the overpayment. The court may award the Trust reasonable attorney fees and court costs in addition to the overpayment amount.

The Trust also has the right to deduct the overpayment amount from any future benefits to the individual or others claiming eligibility through the same individual.

Use of Medical and Dental Consultants

The Board of Trustees has authorized the Trust Administrative Office to refer claims for medical, dental, prescription drug or Time Loss benefits to outside doctors, dentists or other professionals for review and advice. In determining the issues presented, these consultants may rely on their own expertise and on professional standards, procedures and protocols.

Any claim denial that incorporates or is based on medical or dental consulting advice may, as any other claim denial, be reviewed in accordance with the Trust's appeals process (see below).

Interpretation of the Plan

Trust Fund administration is vested wholly and exclusively in the Trustees, who have sole discretion and entire authority to determine eligibility for benefits and to interpret and apply the

provisions of this Trust Agreement, the benefit plans, their own motions, resolutions, administrative rules and regulations and any contracts, instruments or writings the Trustees may have adopted or entered. Any benefit determination the Trustees make in good faith will be conclusive and binding on the unions, employers, employees and beneficiaries under the benefit plans and the Trust Fund.

Claim Review and Appeal Procedures

The Washington Teamsters Welfare Trust plans have adopted specific procedures and timeframes, required by law, to evaluate and process claims for benefits, as well as appeals of denied claims. The timeframes and rules for making decisions on claims and appeals vary, depending on the type of claim and the benefit plan involved. This section provides information about the specific timelines and information requirements that apply to your claims and appeals filings and the claim administrator's claims and appeals determinations. The claim administrator, unless otherwise specified, is the Trust Administrative Office.

If your claim for benefits is wholly or partially denied, you or your duly authorized representative may submit a written request for a review of the claim by the Washington Teamsters Welfare Trust Appeals Committee (Appeals Committee). In certain cases, you will have the right to ask that the decision of the Appeals Committee be reviewed by an external independent review organization. The request for review must be submitted to the Trust office within the timeframe applicable for that benefit plan and type of claim, as described in the following pages.

The length of time the claim administrator has to evaluate and process your claim generally begins on the date the claim is received. The claim administrator will consider the claim and notify you of an adverse decision on the claim, in writing, within the appropriate timeframes described on page 97, unless the claim administrator determines that special circumstances require an extension of time to process the claim. If such an extension is necessary under any of the plans, the claim administrator will notify you of any such extension, the reasons for it, and the date by which the claim administrator expects to render the decision, within the original decision timeframe.

The claim administrators for each plan are as follows:

Benefit	Claim Administrator
Medical Plans A, B, C, Z, JC-28XL, WT-100, Mental Health, and Chemical Dependency	Washington Teamsters Welfare Trust Trust Administrative Office
Prescription drug plan	MedImpact
Hospital Precertification and Hospital Concurrent Care, Mental Health and Chemical Dependency Pre-Authorization and Concurrent Care	Cigna
Group Health Options Medical Plans	Group Health Options
Dental Plans	Washington Dental Service (WDS)
Vision Plan	Washington Teamsters Welfare Trust Trust Administrative Office
Time Loss Plans	Washington Teamsters Welfare Trust Trust Administrative Office
Life and Accidental Death and Dismemberment Plan (AD&D)	Principal Mutual Life Insurance
Long-Term Disability (LTD) Plans	The Hartford

If you believe that you are entitled to a benefit under one of the Washington Teamsters Welfare Trust plans, or that you are entitled to a greater benefit than the amount you received, then you, your beneficiary (if applicable) or your authorized representative may file a written appeal with the appropriate claim administrator listed above. See "Note" on page 100 if you are covered under a Group Health Options Plan through the Trust.

The claim review and appeal procedures apply to these types of claims:

Urgent Healthcare Claim (before healthcare treatment)	A claim or pre-approval request for a medical, dental, or vision benefit where treatment delay could seriously jeopardize life, health, the ability to regain maximum function or, in the opinion of a physician who knows the medical condition, would subject the patient to severe pain that cannot be adequately managed without care or treatment that is the subject of the claim.
Pre-Service Healthcare Claim (before healthcare treatment)	Any claim or pre-approval request for a medical, dental or vision benefit, where receipt of benefit is conditioned, in whole or in part, based on advance approval.
Concurrent Healthcare Claim (changes in healthcare treatment)	Any claim involving the reduction or termination of an ongoing course of treatment before the end of that course of treatment if the treatment was previously authorized by the Plan, or a request to extend treatment beyond the authorized time or number of treatments.
Post-Service Healthcare Claim (after healthcare treatment)	Any claim for a medical, dental or vision benefit that is not a pre-service claim.
Disability Claim (income benefit, not a healthcare benefit)	Any claim for a Time Loss or LTD benefit.

Healthcare Claim Procedures

The following procedures do not apply to the Trust's Group Health Options medical plans. See your Group Health Options booklet for claim filing, review and appeal procedures.

Timeframe for Initial Claim Decisions

The timeframe for initial claim decisions for medical, dental and vision plans depends on the type of claim filed:

Type of Claim	Timeframe for Notice of Claim Decision	Extensions*
Urgent care	The claim administrator will provide notice of claim approval or denial as soon as possible, taking into account the seriousness of your condition, but no longer than 72 hours; notice of denial may be by phone with written or electronic confirmation to follow within three days.	If additional information is needed to complete your claim, you'll be notified within 24 hours.
Pre-service	The claim administrator will provide notice of a claim approval or denial within 15 days.	Up to 15 days, provided you are notified within the original 15-day period.

Type of Claim	Timeframe for Notice of Claim Decision	Extensions*
Concurrent care	If an ongoing course of treatment that was previously approved by the Plan will be reduced or terminated, the claim administrator will notify you sufficiently in advance to give you an opportunity to appeal and obtain a decision on appeal before the reduction or termination takes effect. For any request to extend ongoing treatment in an urgent care situation, you'll be notified within 24 hours, provided your request is made at least 24 hours before the end of the approved treatment. For any request to extend ongoing treatment in a non-urgent care situation, your request will be considered a new claim and decided according to post-service or pre-service timeframes, whichever applies.	
Post-service	The claim administrator will provide notice of a claim approval or denial within 30 days.	Up to 15 days, provided you are notified of the extension within the original 30-day period.

**If more time is needed to process claims due to circumstances beyond the claim administrator's control.*

Insufficient Healthcare Claims

Please note that the claims review and appeals procedures include rules that specify what happens if you file certain insufficient or incomplete claims.

Improperly Filed Pre-Service Claims

If your pre-service claim was filed improperly, you will be notified within five days after a pre-service claim is received (or within 24 hours in an urgent care case). Notice of an improperly filed pre-service claim may be provided by phone, or in writing upon request. The notice will identify the proper procedures to be followed in filing the claim.

To receive notice of an improperly filed pre-service claim, you or your authorized representative must have provided a communication regarding the claim to the claim administrator. This communication must include:

- Your name
- A specific medical condition or symptom
- Request for approval for a specific treatment, service or product.

Incomplete Pre- and Post-Service Claims

If more information is required to process your pre- or post-service healthcare claim, you'll be notified within the original 15-day period for pre-service claims, and within the original 30-day period for post-service claims. If you are notified of the need to provide additional information for a pre- or post-service claim, you will have at least 45 days to supply this information. If you supply the requested information within the 45 days and your claim is denied, the claim administrator will notify you of the denial within 15 days after the requested information is received. If you do not supply the requested information within 45 days, your claim may be denied.

Incomplete Urgent Care Claims

If more information is needed to process a properly filed urgent care claim, you'll be notified as soon as possible, but no later than 24 hours after your claim is received. This notice will include the specific information necessary to complete the claim. Once you are notified of the need to provide more information, you'll have a reasonable amount of time — considering the circumstances, but not less than 48 hours — to submit the requested information. You'll receive notice of the claim decision as soon as possible, but no later than 48 hours after whichever occurs earlier:

- The claim administrator receives the information, or
- The additional period given for providing the information ends.

Notice of Initial Claim Denial

If the claim administrator denies the claim, you'll receive written or electronic notice containing:

- Specific reasons for the denial
- References to specific plan provisions on which the denial is based
- List of any additional material or information necessary for you to perfect the claim and an explanation of why it's necessary
- Description of the plan's claim appeal procedure (and applicable time limits), including a statement of your right to bring a civil action under ERISA Section 502(a) if your appeal is denied
- Certain other information in accordance with applicable U.S. Department of Labor regulations.

Claim Appeal Procedures

You can use these appeal procedures, if, in response to your claim, you received:

- No reply after the initial decision period, as listed above
- Notice of an extension to the initial decision period, as listed above, then no reply before the end of an extension
- A denial from the claim administrator.

If the claim is denied, in whole or in part, or if you believe plan benefits have not been properly provided, you, your beneficiary (if applicable), or your authorized representative may appeal the denial. The claim administrator will provide details about your right to appeal, along with the appeals process, address for filing an appeal, and timeframes. If you don't appeal within the designated timeframes, you may lose your right to later file suit in court.

To appeal a claim denial, you must file a written request for appeal pursuant to the procedure provided by the claim administrator (see the chart on page 96 for a list of claim administrators) within a certain period after receiving the claim denial, as described herein. The appeal must set forth all the grounds on which it is based, all the facts in support of the request, and other matters which you deem pertinent. Plan provisions require that you pursue the claim and appeal rights described here before seeking other legal recourse.

During the appeal, you will receive, upon request and free of charge, reasonable access to and copies of all documents, records and other information relevant to your benefit claim. For this claim procedure, a document, record or other information is considered relevant to a claim if it:

- Was relied on by the claim administrator in making the initial claim decision
- Was submitted, considered or generated in the course of deciding the claim, without regard to whether the document, record or other information was relied upon by the claim administrator in reaching the claim decision
- Demonstrates compliance with the administrative processes and safeguards required under Department of Labor regulations in making the benefit determination.

You may submit any written comments, documents, records or other information relating to your claim. In making its determination, on healthcare, time loss, or LTD claim appeals, the Appeals Committee of the Washington Teamsters Welfare Trust will take into account all the comments, documents, records and other information you submitted relating to the claim, without regard to whether they were submitted or considered by the claim administrator in making the initial claim decision.

The Appeals Committee will conduct a review and make a final decision within a certain period after receiving your written request for review, as described as follows and on page 97. For certain plans, if the Appeals Committee needs more than this initial period to make a decision due to special circumstances, it will notify you in writing within the initial decision timeframe and explain why more time is required and the date the plan expects to make a decision.

The Appeals Committee will review your denied claim. You or your authorized representative has the right to present relevant information or testimony at the quarterly Appeals Committee meeting scheduled to hear your appeal. You will be notified of the meeting time and date, however a personal appearance is not required. The appeal review will not be conducted by the individual who denied the initial claim or that person's subordinate. The Appeals Committee will not give deference to the original decision on your claim; that is, they will take a fresh look and make an independent decision about the claim within the timeframes.

If your claim was denied based on a medical judgment, the Appeals Committee will consult with a healthcare professional who has appropriate training and experience in the field of medicine involved in your claim. The healthcare professional will not be the same person as the one consulted on the initial decision (or a subordinate of that person). A medical judgment includes whether a treatment, drug or other item is experimental, investigational or not medically necessary or appropriate. You also have the right to learn the identity of any medical or other experts who advised on your original claim decision, whether or not the Plan relied on their advice.

Note: If you are appealing benefits denied by one of the Trust's Group Health Options medical plans, see your Group Health booklet or the Appeal language provided by Group Health. In some cases, your appeals under the Group Health Options Plan will be reviewed by the Appeals Committee of the Washington Teamsters Welfare Trust, and in other cases, by Group Health Options.

Timeframes for Filing and Determination of Healthcare Appeals

You have 180 days from the date you receive notice of a healthcare claim denial to file your appeal. Appeal decision timeframes vary, depending on the type of healthcare claim filed:

- **Urgent care** — The claim administrator will provide notice of appeal decision as soon as possible, considering the medical situation, but no later than 72 hours after receiving your appeal, unless you do not provide sufficient information to determine whether, or to what extent, benefits are covered or payable under the plan (see page 99).

- **Pre-service** — The claim administrator will provide notice of appeal decision within 30 days of appeal.
- **Post-service** — The claim administrator will provide notice of appeal decision within five days after the next quarterly meeting of the Appeals Committee if the appeal is received at least 30 days before the meeting, otherwise the decision will be provided within five days after the second quarterly meeting that follows receipt of the appeal. If special circumstances require an extension of time for rendering a decision, the claim administrator will provide notice of the extension within the initial decision timeframe, and a decision will be rendered at the next quarterly meeting, with notice provided within five days after that meeting.

Notice of Decisions on Appeal

The decision on appeal will be in writing. If your appeal is denied, the notice will include:

- Reasons for the denial
- References to specific plan provisions on which the denial is based
- A statement of your right to access and receive copies, upon request and free of charge, of all documents and other information relevant to the claim for benefits
- A statement of your right to bring a civil action under ERISA Section 502(a)
- Certain other information in accordance with applicable U.S. Department of Labor regulations.

If the Appeals Committee does not respond within the applicable timeframe, you should generally consider the appeal denied. Contact the Trust Administrative Office if you have questions.

Request for External Review

You must complete the internal claims appeal process discussed above before requesting an external review. Once the internal claim appeal process is completed by the Appeals Committee making its decision, you will have 120 days from the date you receive that decision to file a request for an external review.

You may request external review for any denied claim except for denials based on finding that you did not satisfy the eligibility requirements for a benefit under the terms of the applicable Plan.

Requests for external reviews should be sent to:

External Review Appeals
PO Box 12267
Seattle, WA 98102

Preliminary Review of External Review Request

Within five (5) business days of receiving a request for external review, the Trust will complete a preliminary review of the request to make sure that:

- The patient is or was covered under the Trust at the time the health care item or service was requested or, in the case of a retrospective review, was covered under the Trust at the time the health care item or service was provided;

- The decision being appealed does not relate to any failure to meet the applicable eligibility requirements;

- The Trust's internal claims appeal process has been completed; and

- All the information and forms required to process an external review have been received.

- The matter appealed involves either medical judgment or rescission.

Within one business day after completion of this preliminary review, the Trust will issue notification of its decision. If the request is not eligible for external review, the Trust's notice will explain the reasons and provide any other information required, including contact information for the U. S. Department of Labor's Employee Benefits Security Administration (EBSA). If the request for external review is incomplete, the Trust 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 Trust will refer the matter to an Independent Review Organization (IRO).

Review by Independent Review Organization

After a properly filed request for external review is referred, the Trust will provide the IRO with the required documentation in the time required by applicable Federal regulations. The IRO will notify both you and the Trust of its decision within 45 days after it has received the request to review.

Expedited External Review

You may request the IRO to provide you an expedited external review if you received:

- An adverse benefit determination involving a medical condition of the patient for which the time frame for completion of the Trust's expedited internal review process would seriously jeopardize the life or health of the patient or would jeopardize the patient's ability to regain maximum function and you have filed a request for an expedited internal appeal; or

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

If the Trust receives a request for expedited external review, it will proceed immediately to determine whether the request meets the reviewability requirements for a standard external review and will notify you of its determination. If the Trust determines that the appeal is eligible for a standard external review, the Trust will assign an IRO and will provide all necessary documents and information considered in making the adverse benefit determination or final adverse benefit determination to the IRO electronically or by any other available expeditious method. The IRO will notify the Trust and you of its determination as expeditiously as the patient's medical condition or circumstances require, but in no event more than 72 hours after

the IRO receives the request for an expedited external review. If the notice from the IRO is not in writing, within 48 hours after the date of providing the notice, the IRO will provide both you and the Trust written confirmation of the decision.

Actions Following the Decision of the IRO

If the IRO directs that benefits be paid, the Trust will provide benefits under the applicable Plan in accordance with the decision. If the decision is adverse, you will have the right to pursue a suit pursuant to 29 U.S.C. 1132(a). Any legal action seeking to overturn a denial or an action that has otherwise adversely affected a claimant must be brought within 180 days of the latest of the following events: the initial denial with no appeal being made; the final adverse benefit determination by the Trust; or the IRO's denial.

Life, AD&D, Time Loss and LTD Claims

Time frames for Initial Claim Decisions

The claim administrator for the LTD plan is The Hartford. For the Life and AD&D plans, the claim administrator is Principal and for the Time Loss plan, the Trust Administrative Office.

Under the Life and AD&D plans, the claim administrator has 90 days to determine initial claims. If the claim administrator determines that an extension of time is necessary under certain circumstances, then the initial decision period may be extended for an additional 90 days.

Under the Time Loss and LTD plans, the claim administrator has 45 days to determine initial claims. If the claim administrator determines that an extension of time is necessary under certain circumstances, then the initial decision period may be extended for an additional 30 days. If necessary, this initial extension may then be extended for another 30 days. You'll be notified of any extensions within the previous time period, including information on the unresolved issues that prevent a decision on your claim. If you receive notification that additional information is needed from you to complete the claim, you'll have at least 45 days to provide the information.

Notice of Initial Claim Denial

If the claim administrator denies the claim, you'll receive written or electronic notice containing:

- Specific reasons for the denial
- References to specific plan provisions on which the denial is based
- List of any additional material or information necessary for you to perfect the claim and an explanation of why it's necessary
- Description of the plan's claim appeal procedure (and applicable time limits), including a statement of your right to bring a civil action under ERISA Section 502(a) if your appeal is denied
- Certain other information in accordance with applicable U.S. Department of Labor regulations.

AD&D, Time Loss, LTD and Life Claims Appeal Procedures

You can use these appeal procedures, if, in response to your claim, you received:

- No reply after the initial decision period, as listed above
- Notice of an extension to the initial decision period, as listed above, then no reply before the end of an extension
- A denial from the claim administrator.

If the claim is denied, in whole or in part, or if you believe plan benefits have not been properly provided, you, your beneficiary (if applicable), or your authorized representative may appeal the denial. The claim administrator will provide details about your right to appeal, along with the appeals process, address for filing an appeal, and timeframes. If you don't appeal within the designated timeframes, you may lose your right to later file suit in court.

To appeal a claim denial, you must file a written request for appeal pursuant to the procedure provided by the claim administrator (see the chart on page 96 for a list of claim administrators) within a certain period after receiving the claim denial, as described herein. The appeal must set forth all the grounds on which it is based, all the facts in support of the request, and other matters which you deem pertinent. Plan provisions require that you pursue the claim and appeal rights described here before seeking other legal recourse.

During the appeal, you will receive, upon request and free of charge, reasonable access to and copies of all documents, records and other information relevant to your benefit claim. For this claim procedure, a document, record or other information is considered relevant to a claim if it:

- Was relied on by the claim administrator in making the initial claim decision
- Was submitted, considered or generated in the course of deciding the claim, without regard to whether the document, record or other information was relied upon by the claim administrator in reaching the claim decision
- Demonstrates compliance with the administrative processes and safeguards required under Department of Labor regulations in making the benefit determination.

You may submit any written comments, documents, records or other information relating to your claim. In making its determination on healthcare, time loss, or LTD claim appeals, the Appeals Committee of the Washington Teamsters Welfare Trust will take into account all the comments, documents, records and other information you submitted relating to the claim, without regard to whether they were submitted or considered by the claim administrator in making the initial claim decision.

The Appeals Committee will conduct a review and make a final decision within a certain period after receiving your written request for review, as described below and on page 97. For certain plans, if the Appeals Committee needs more than this initial period to make a decision due to special circumstances, it will notify you in writing within the initial decision timeframe and explain why more time is required and the date the plan expects to make a decision.

The Appeals Committee will review your denied claim. You or your authorized representative has the right to present relevant information or testimony at the quarterly Appeals Committee meeting scheduled to hear your appeal. You will be notified of the meeting time and date, however a personal appearance is not required. The appeal review will not be conducted by the individual who denied the initial claim or that person's subordinate. The Appeals Committee will not give deference to the original decision on your claim; that is, they will take a fresh look and make an independent decision about the claim within the timeframes.

If your claim was denied based on a medical judgment, the Appeals Committee will consult with a healthcare professional who has appropriate training and experience in the field of medicine involved in your claim. The healthcare professional will not be the same person as the one consulted on the initial decision (or a subordinate of that person). A medical judgment includes whether a treatment, drug or other item is experimental, investigational or not medically necessary or appropriate. You also have the right to learn the identity of any medical or other experts who advised on your original claim decision, whether or not the Plan relied on their advice.

Timeframe for Filing and Determination of Life, AD&D, Time Loss and LTD Plan Appeals

For Life and AD&D claims you have 60 days from the date you receive notice of a claim denial to file an appeal. The Life and AD&D claims administrator must make a decision within 60 days after receiving your written appeal. If the Life and AD&D claims administrator determines that an extension of time is necessary under certain circumstances, then the 60-day decision period may be extended for another 60 days. If an extension is necessary, you'll be notified within the initial decision timeframe.

Under the Time Loss and LTD plans, you have 180 days from the date you receive notice of a claim denial to file an appeal. The Appeals Committee must make a decision at the next quarterly meeting of the Committee if the appeal is received at least 30 days prior to the meeting, otherwise the decision will be provided within five days after the second quarterly meeting that follows receipt of the appeal. If the Appeals Committee determines that an extension is necessary under certain circumstances, then the initial decision period may be extended to the following quarterly meeting of the Appeals Committee. If an extension isn't necessary, you'll be notified within the initial claim decision timeframe.

Notice of Decisions on Appeal

The decision on appeal will be in writing. If your appeal is denied, the notice will include:

- Reasons for the denial
- References to specific plan provisions on which the denial is based
- A statement of your right to access and receive copies, upon request and free of charge, of all documents and other information relevant to the claim for benefits
- A statement of your right to bring a civil action under ERISA Section 502(a)
- Certain other information in accordance with applicable U.S. Department of Labor regulations.

If the Appeals Committee does not respond within the applicable timeframe, you should generally consider the appeal denied. Contact the Trust Administrative Office if you have questions.

Administrative Details

The Employee Retirement Income Security Act of 1974 (ERISA) as amended, requires that certain information be furnished to Plan participants and beneficiaries:

Name of Plan

This Plan is known as the Washington Teamsters Welfare Trust — Medical Plan B.

Name, Address and Telephone Number of Board of Trustees as Plan Administrator

This Plan is sponsored and administered by a joint labor-management Board of Trustees:

Board of Trustees of the Washington Teamsters Welfare Trust
2323 Eastlake Avenue East
Seattle, Washington 98102
206-329-4900

You can obtain information on whether a particular employer or employee organization is a Plan sponsor (and, if so, their address) by writing to the Trustees. This information is also available to examine at the Trust Administrative Office. The Trustees may impose a reasonable charge for furnishing this information. You may want to inquire about the charge before requesting information.

Employer Identification Number and Plan Number

The employer identification number assigned to the Board of Trustees by the Internal Revenue Service is EIN 91-6034673.

- The Plan number is 501.

Type of Plan

This Plan is a welfare plan that provides hospital, surgical, medical, Time Loss, accidental death and dismemberment and life insurance benefits.

Type of Administration

This Plan is administered by the Board of Trustees with the assistance of this administrative organization:

Northwest Administrators, Inc.
2323 Eastlake Avenue East
Seattle, Washington 98102
206-329-4900

Name and Address of Agent for Service of Legal Process

Each member of the Board of Trustees is designated as an agent for accepting service of legal process on behalf of the Plan. The names and addresses of the Trustees are below.

Legal process can also be served on:

Northwest Administrators, Inc.
2323 Eastlake Avenue East
Seattle, Washington 98102

Names and Addresses of Board of Trustees

Employer Trustees	Employee Trustees
Randy Zeiler Allied Employers, Inc. 4020 Lake Washington Boulevard NE, Suite 205 Kirkland, Washington 98033-7870 Jerry D'Ambrosio 11019 SE 60th Street Bellevue, Washington 98006 Brian Isom United Parcel Service 13035 Gateway Drive, Suite 149 Seattle, Washington 98168 John H. Mack PO Box 80681 Seattle, Washington 98108 Yvonne Peters Allied Employers, Inc. 4020 Lake Washington Boulevard NE, Suite 205 Kirkland, Washington 98033-7870 H.L. "Buzz" Ravenscraft SAHARA, Inc. 6631 113th Place SE Bellevue, Washington 98006-6429 Doug Ruygrok Safeway Stores, Inc. 618 Michillinda Avenue Arcadia, California 91007-6300 Terry Ann Bodwin United Grocers 5200 Sheila St Commerce, California 90040	Tracey Thompson Teamsters Local Union No. 117 14675 Interurban Avenue S, Suite 307 Tukwila, Washington 98168-4614 Steve Chandler Teamsters Local Union No. 38 PO Box 1548 (98206) 2601 Everett Avenue Everett, Washington 98201 John Emrick Teamsters Local Union No. 313 220 South 27th Street Tacoma, Washington 98402 Bob Hawks Teamsters Local Union No. 839 1103 W Sylvester Street Pasco, Washington 99301-4873 Rick Hicks Teamsters Local Union No. 174 14675 Interurban Avenue S, Suite 305 Tukwila, Washington 98168-4614 Rich Ewing Teamsters Local Union 231 PO Box H (98227) 1700 North State Street Bellingham, Washington 98225 Darren O'Neil Teamsters Local Union 252 217 East Main Street Centralia, Washington 98531 Scott Sullivan Teamsters Local Union No. 763 14675 Interurban Avenue S, Suite 305 Tukwila, Washington 98168-4614 John Witte Teamsters Local Union No. 589 10049 Kitsap Mall Blvd NW, Suite 105 Silverdale, Washington 98383

Description of Collective Bargaining Agreements

This Plan is maintained under many collective bargaining agreements between various employers and labor organizations. You may obtain a copy of these collective bargaining agreements by writing to the Trust Administrative Office. This information is also available to examine at the Trust Administrative Office. The Trustees may impose a reasonable charge for furnishing the collective bargaining agreements. You may want to inquire about the charge before requesting a copy.

Eligibility and Benefits

Employees are entitled to participate in the Plan if they work under a collective bargaining agreement requiring contributions on their behalf and the employer makes those contributions to the Trust. The eligibility rules describing which employees and dependents are entitled to benefits begin on page 10. The benefits are described beginning on page **Error! Bookmark not defined.**.

Termination of Eligibility

An employee or dependent who is eligible for benefits may become ineligible as a result of one or more of the following circumstances:

- The employee's failure to work the required hours to maintain eligibility (or failure to make a self-payment, where authorized). See When Coverage Ends, COBRA Self-Pay Option and Six-Month Self-Pay Option on pages 11, 20 and 22.
- The failure of the employee's employer to report the hours and remit contributions on the employee's behalf to the Trust Fund.
- An eligible dependent is no longer being a dependent as described on page 12 or attains a disqualifying age as shown on page 11.
- Termination of the governing collective bargaining agreement or the Trust.

Future of the Plan and Trust Fund

The Board of Trustees has authority to terminate the Trust Fund. The Trust Fund will also terminate when collective bargaining agreements and special agreements requiring the payment of contributions expire. In the event of termination, the Board of Trustees will:

- Use the Trust Fund to pay expenses incurred up to the date of termination and expenses incident to the termination.
- Distribute the balance, if any, of Trust Fund assets to carry out the purpose of the Trust.
- Upon termination, the Board of Trustees may transfer remaining Trust Fund assets to the Trustees of any fund established to provide substantially the same or greater benefits than this Plan. In no event will any of the funds revert to or be recoverable by any employee, employer or union.

Source of Contributions

This Plan is funded through employer contributions; the amount is specified in the collective bargaining agreements. Also, self-payments by employees are permitted as outlined in this Plan booklet. The amount of the total plan cost is changed from time to time by the Board of Trustees, including employer contributions alone or a combination of employer contributions and employee self-payments.

Entities Used for Accumulation of Assets and Payment of Benefits

Employer contributions are received and held in trust by the Board of Trustees pending the payment of benefits or premiums. The Trustees pay benefits directly from the Trust Fund for Time Loss and medical benefits.

The Trustees pay premiums to The Principal Mutual Life Insurance Company to underwrite and provide benefits for Group Term Life and AD&D insurance:

Home Office:	Regional Office:
Des Moines, Iowa	1111 Third Avenue, Suite 620 Seattle, Washington 98101

Plan Year

This Plan is on a 12-month fiscal year basis beginning July 1 and ending the following June 30.

ERISA Rights and Protections

As a participant in the Trust, you are entitled to certain rights and protections under ERISA, which provides that all Plan participants be entitled to:

- Examine, without charge, at the Plan Administrator's office and at other specified locations, such as work sites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the Department of Labor and available at the Public Disclosure room of the Employee Benefits Security Administration.
- Obtain, upon written request to the Plan Administrator, copies of documents governing Plan operation, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Plan Administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.
- Continue healthcare coverage for yourself, spouse or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the Plan to learn the rules governing these COBRA continuation coverage rights.
- Reduce or eliminate exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan. You should receive a certificate of creditable coverage, free of charge, from your Plan or insurer when you lose coverage under the Plan, when you become entitled to elect COBRA continuation coverage and when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after enrolling.

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for operation of the Plan. The people who operate your Plan, called "fiduciaries," have a duty to do so prudently and in the interest of you and other 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.

If your claim for a welfare benefit is denied or ignored, in whole or in part, you must receive a written explanation of the reason for the denial. You have the right to have the Plan review and reconsider your claim.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of documents or the latest annual report for the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the Plan Administrator's control. If your claim for benefits is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the Plan's decision or lack of decision concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in federal court. If fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the 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.

If you have any questions about your Plan, contact the Trust Administrative Office (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 nearest office of the Employee Benefits Security Administration, Department of Labor, listed in your phone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, Department of Labor, 200 Constitution Avenue NW, Washington, DC 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.

Washington Teamsters Welfare Trust

Eligibility and Coverage Effective Dates

For participants in the Shipyard Industry whose Employers make Hourly Contributions to the Hour Bank Program

Who's Eligible

To become eligible for contributions to be made on your behalf under this section of the Plan you must be working under a collective bargaining agreement that requires hourly rate contributions to the Trust's Hour Bank program for your work hours in covered employment.

Hour Bank Program

Hourly rate employer contributions made on your behalf are credited to your hour bank. If you have enough hours credited to your bank, the minimum required for a month of coverage will be deducted from your hour bank and you will receive a month of coverage. The minimum required for a month of coverage is determined by the collective bargaining agreement.

You may accumulate a balance in your hour bank up to a maximum of the amount required to provide for two months of coverage. If you are not working the minimum required hours per month but have enough hours in your bank to continue coverage, the required amount will be deducted from your bank to continue your coverage for as long as you maintain the minimum required in your bank for a month of coverage.

Coverage Effective Dates

Lag Month Rule

To help ensure timely eligibility information is provided to your healthcare providers, the Trust uses a double lag month system — the Trust advances eligibility for two months while you continue working enough hours each month and contributions are being made on your behalf. For example, if you work enough hours in January and your employer makes a contribution in February based on the January work hours, your coverage is effective for April.

When Coverage Begins

Coverage and benefits for a newly hired employee begins after one month's contributions are made on the employee's behalf under the double lag month system, provided the employee worked enough hours in the month. For example, if you are a new hire, you work enough hours in June to qualify for coverage, and your employer makes a contribution in July based on the June hours, your coverage would begin September 1.

In order for you to work enough hours in a month to receive coverage:

Your hour bank after contributions are made on your hours of work in the month must have a balance of at least the minimum amount required for a month of coverage. As previously noted under The Hour Bank Program, if you are not working and do not have contributions made on your behalf but you have the minimum hours in your hour bank as required for a month of coverage, you will also

receive coverage. The minimum hours required for a month of coverage will be deducted from your bank and a month of coverage provided.

The double lag month eligibility system continues while you continue working enough hours each consecutive month. For example, if you work at least the minimum required hours in July, or you have the minimum required in your hour bank after contributions for your July work hours have been made in August, coverage and benefits will be provided in October.

When Coverage Ends

When you fail to work the minimum required hours in covered employment during a month, whether due to a layoff, a reduction in your work hours, termination of employment, disability, your employer ceasing contributions, your employer's cessation of participation in the plan, or other reason, your coverage and coverage for your spouse (if married) or eligible children will continue until the end of the third month following the month in which you last had the minimum hours. For example, if you are laid off in October after working the minimum hours in covered employment that month, and the final contribution to the Plan is made by your employer for you in November based on the October hours, your coverage will end on January 31; provided that, if you still have at least the minimum required hours in your hour bank for a month of coverage, you will continue to receive additional months of coverage based on the number of months your hour bank will provide.

If you return to work after you had a break in coverage, and contributions are again made on your behalf, you will need to re-qualify for coverage. To do so, you will have to again satisfy the same requirements as apply to a new hire.

Your spouse or dependent's coverage will also end when he or she no longer meets the Plan's eligibility requirements (for instance, when you divorce (in the case of a spouse), or when your child turns age 26.

Any employee in full-time military service will not be covered except as described in Military Service under the USERRA or COBRA Self-Pay Options in the Summary Plan Description.

RESOLUTION 729-20 EXHIBIT D

WASHINGTON TEAMSTERS WELFARE TRUST

Summary Plan Description
Dental Plan B

Effective January 1, 2003

WASHINGTON TEAMSTERS WELFARE TRUST
MAY 2014

SUMMARY OF MATERIAL MODIFICATIONS

This is a "summary of material modifications" (SMM) to the Washington Teamsters Welfare Trust's Summary Plan Descriptions (plan books) **effective July 1, 2014**. Some plan modifications (changes) only apply to certain plans as noted. The information in this SMM updates and/or replaces the applicable sections of each book until new books become available. Please read it carefully and keep it with your benefit plan booklet(s). If you have questions about the information presented here, feel free to contact the Trust Administrative Office at 800-458-3053.

DEPENDENT COVERAGE

Participants may elect not to cover their spouse if: (a) they are legally separated and provide documentation of this fact to the Trust Administrative Office; or (b) their spouse consents to not being covered. Participants may elect to later reenroll their spouse or their spouse may revoke consent and reenroll.

Under federal law, a Participant's child has a right to be enrolled in coverage under the Participants' plan through the age of 25. If a Participant would like to elect not to cover a child age 18 or older, he or she must first provide the Trust Administrative Office with the child's address in order for the child to be notified that coverage is being terminated. The child will be given the right to reenroll. Participants may elect later to reenroll a child provided the child is under age 26 at the time.

Termination of coverage or coverage upon reenrollment of a spouse or child will be effective the first of the month following receipt of written notification by the Trust.

WASHINGTON TEAMSTERS WELFARE TRUST

DENTAL PLAN B SUMMARY PLAN DESCRIPTION

SUMMARY OF MATERIAL MODIFICATIONS (CHANGES SINCE THE FOLLOWING BOOK WAS LAST PRINTED)

This is a "summary of material modifications" (SMM) to the Washington Teamsters Welfare Trust dental benefit plan for active employees covering the period from April 2004 through July 2011. The information in this SMM updates and replaces the applicable sections of this booklet, until a new booklet become available. Please read it carefully and keep it with your benefit plan booklet.

If you have questions about the information presented here, feel free to contact the Trust Administrative Office at 800-458-3053. If you need information on what coverage you have through the Trust, please refer to your collective bargaining agreement or contact the Trust Office, your local union, or employer.

ELIGIBILITY (LAG MONTH) RULE CHANGES

Effective April 1, 2004, your coverage will end as explained below if you cease working enough hours and your employer ceases to make contributions, or stops participating in the Plan.

The Trust's lag month eligibility system continues while you work enough hours each consecutive month for a contribution to be made on your behalf. For example, if you work enough hours in July, and your employer makes a contribution in August (the lag month), coverage and benefits will be provided in September.

When you have a break in contributions due to layoffs, a reduction in your work hours, termination of employment, or for any reason *other than* retirement or resignation, the lag month system will no longer terminate. In these instances, your coverage will continue until the end of the *second* month following the month in which you last had the minimum number of hours, as stated in your collective bargaining agreement for contributions from any one contributing employer. For example, if you are laid off in April after working enough hours to receive a contribution, and the final contribution to the Plan is made in May, your coverage will end on June 30. If you are laid off in April without enough hours to receive a contribution, and the final contribution from your employer is made in April (for your March hours), your coverage will end on May 31.

When you retire or resign, or if your employer ceases to participate in the Plan, the lag month system will terminate. In these instances, your coverage will stop at the end of the month following the month in which you last had the minimum number of hours, as stated in your collective bargaining agreement for contributions from any one contributing employer. For example, if you retire in April after working enough hours to receive a contribution, and the final contribution to the Plan is made in May, your coverage will end on May 31. If you retire in April without enough hours, and the final contribution from your employer is made in April (for your March hours) your coverage will end on April 30.

If you return to work after 1) you had a break in contributions, or 2) you resigned or retired, or 3) your employer ceased making contributions, and contributions are again made on your behalf, coverage will resume under the lag month eligibility system the same as for a new hire. Trust eligibility for new hires begins after one month's contribution is made on your behalf under the lag month system. For example, if contributions are first made on your behalf in October based on your employment in September, your coverage begins November 1.

Note: Some collective bargaining agreements may have a waiting period before contributions become payable to the Trust. An agreement may also require a minimum number of hours be

worked in order for contributions to be made. Refer to your collective bargaining agreement or contact your local union or employer about any waiting periods or hour requirements.

If you are a new hire or an employee reestablishing eligibility, the requirement of having at least two consecutive months of employer contributions in order to preserve lag month coverage for the first contribution no longer applies if you subsequently lose coverage due to termination, lay-off, or lack of hours. *As of April 1, 2004, this requirement only applies to resignations and retirements (or if an employer ceases to participate in the Plan).* For example, if you have only one contribution on your behalf and you resign or retire, you will not qualify for coverage. However, if you have only one contribution on your behalf and your employment is terminated, you are laid-off or do not work enough hours, you will receive one month of coverage.

The eligibility rule in effect September 1, 2003 that allowed your coverage to resume without the lag month if you returned to work for enough hours to receive a contribution while you were maintaining coverage under COBRA is no longer in effect as of April 1, 2004 (unless your coverage under COBRA was in effect before April 1, 2004).

RADIATION TREATMENT

Effective April 1, 2006, additional coverage of up to $10,000 has been added for treatment of teeth and gum deterioration due to radiation treatment for cancer in the head, neck, or throat.

DOMESTIC PARTNERS

Your domestic partner and children of your domestic partner may be covered **after March 2007** subject to plan rules if your collective bargaining unit has bargained this coverage.

DENTAL CROWNS

Effective November 1, 2010, the five-year limitation on replacement of a crown is waived if replacement is due to dental necessity as a result of injury to the crown.

ESSENTIAL PEDIATRIC DENTAL CARE

Effective July 1, 2011, there is no annual limit of $1,800 for essential pediatric dental care for children under age 18.

DEPENDENT CHILD ELIGIBILITY

Effective July 1, 2011, as part of the Patient Protection and Affordable Care Act (PPACA), children meeting the following criteria will be covered by the Trust:

Your eligible dependent children are your children under age 26 who are your:

- Natural children
- Adopted children
- Step Children
- Children placed with you for adoption

These children do not have to depend on you for support, do not have to attend school full time, and can be married and can have access to other health coverage through their own employment.

Your eligible dependent children also include your unmarried children up to age 19 who live with you and are dependent on you for support and are:

- Children for whom you are the court-appointed guardian
- Grandchildren
- Children of your domestic partner if your local union and employer negotiated domestic partner benefits

These dependent children who would otherwise qualify as eligible dependents but are 19 years or older will be eligible until age 26 (through 25th year) if they depend on you for

support/maintenance and are full-time students in an accredited educational institution. School vacation and total disability periods that interrupt but do not terminate what would have been a continuous course of study are considered part of full-time attendance.

Except as noted below, all children who qualify as eligible dependents are eligible for benefits from the later of the effective date of your coverage or the date child meets the requirements above, except for children of domestic partners, who are covered prospectively from the date they are enrolled. Children who lost coverage prior to July 1, 2011 and are eligible to be enrolled under the Patient Protection and Affordable Care Act on July 1, 2011 will be covered as of July 1, 2011 if they are enrolled no later than 31 days after that date, otherwise they will be covered prospectively from the date they are re-enrolled.

For dependent life benefits, unmarried children are covered only until age 19.

An unmarried eligible dependent child who is physically or mentally incapable of self-support is eligible under the Plan while incapacitated, if your own coverage is in effect. To cover a child under this provision, file a Proof of Incapacity Form with the Trust Administrative Office within 31 days after coverage would otherwise end or within 31 days of the date you become covered by the Plan if a child is 19 or older at that time. Additional proof will be required from time to time; unless you provide additional proof as requested, the child's coverage will end.

In accordance with federal law, the Plan also provides medical coverage (including dental and vision coverage if these coverages are being provided through a Trust plan) to certain dependent children (called alternate recipients) if directed to do so by a Qualified Medical Child Support Order (QMCSO) issued by a court or state agency of competent jurisdiction and your own healthcare coverage is in effect.

CLAIMS APPEAL PROCEDURES

Effective for services provided on or after July 1, 2011, the Claim Appeal Procedures are modified as described below. These modifications are required by Section 2719 of the Patient Protection and Affordable Care Act (PPACA) and the regulations thereunder.

The Trust's internal claim appeal procedures consist of a right of appeal to a Committee of Trustees for an internal review. The health care reform legislation now requires that a claimant who is dissatisfied with a decision by the Trustees' Appeals Committee has a right to request an external review. Technical Release 2010-01 issued by the U.S. Department of Labor's Employee Benefits Security Administration describes how such an external review is to be conducted pending final guidance from the regulatory agencies. These requirements are summarized below.

REQUEST FOR EXTERNAL REVIEW

You must complete the internal claims appeal process discussed above before requesting an external review. Once the internal claim appeal process is completed by the Appeals Committee making its decision, you will have 120 days from the date you receive that decision to file a request for an external review.

You may request external review for any denied claim except for denials based on finding that you did not satisfy the eligibility requirements for a benefit under the terms of the applicable Plan.

Requests for external reviews should be sent to:

External Review Appeals
PO Box 12267
Seattle, WA 98102

PRELIMINARY REVIEW OF EXTERNAL REVIEW REQUEST

Within five (5) business days of receiving a request for external review, the Trust will complete a preliminary review of the request to make sure that:

- The patient is or was covered under the Trust at the time the health care item or service was requested or, in the case of a retrospective review, was covered under the Trust at the time the health care item or service was provided;
- The decision being appealed does not relate to any failure to meet the applicable eligibility requirements;
- The Trust's internal claims appeal process has been completed; and
- All the information and forms required to process an external review have been received.
- The matter appealed involves either medical judgment or rescission.

Within one business day after completion of this preliminary review, the Trust will issue notification of its decision. If the request is not eligible for external review, the Trust's notice will explain the reasons and provide any other information required, including contact information for the U. S. Department of Labor's Employee Benefits Security Administration (EBSA). If the request for external review is incomplete, the Trust 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 Trust will refer the matter to an Independent Review Organization (IRO).

REVIEW BY INDEPENDENT REVIEW ORGANIZATION

After a properly filed request for external review is referred, the Trust will provide the IRO with the required documentation in the time required by applicable Federal regulations. The IRO will notify both you and the Trust of its decision within 45 days after it has received the request to review.

EXPEDITED EXTERNAL REVIEW

You may request the IRO to provide you an expedited external review if you received:

- An adverse benefit determination involving a medical condition of the patient for which the time frame for completion of the Trust's expedited internal review process would seriously jeopardize the life or health of the patient or would jeopardize the patient's ability to regain maximum function and you have filed a request for an expedited internal appeal; or
- A final adverse benefit determination, if the patient has a medical condition where the timeframe for completion of a standard external review would seriously jeopardize the life or health of the patient or would jeopardize the patient's ability to regain maximum function, or if the final adverse benefit determination concerns an admission, availability of care, continued stay, or health care item or service for which the patient received emergency services, but has not been discharged from a facility.

If the Trust receives a request for expedited external review, it will proceed immediately to determine whether the request meets the reviewability requirements for a standard external review and will notify you of its determination. If the Trust determines that the appeal is eligible for a standard external review, the Trust will assign an IRO and will provide all necessary documents and information considered in making the adverse benefit determination or final

adverse benefit determination to the IRO electronically or by any other available expeditious method. The IRO will notify the Trust and you of its determination as expeditiously as the patient's medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request for an expedited external review. If the notice from the IRO is not in writing, within 48 hours after the date of providing the notice, the IRO will provide both you and the Trust written confirmation of the decision.

ACTIONS FOLLOWING THE DECISION OF THE IRO

If the IRO directs that benefits be paid, the Trust will provide benefits under the applicable Plan in accordance with the decision. If the decision is adverse, you will have the right to pursue a suit pursuant to 29 U.S.C. 1132(a). Any legal action seeking to overturn a denial or an action that has otherwise adversely affected a claimant must be brought within 180 days of the latest of the following events: the initial denial with no appeal being made; the final adverse benefit determination by the Trust; or the IRO's denial.

INTRODUCTION

This booklet describes the benefits and provisions of the Washington Teamsters Welfare Trust Dental Plan B for employees of employers who negotiate a collective bargaining agreement requiring Plan contributions. This plan is designed to assist you and your family in paying the cost of dental care. Although the plan provides coverage for many dental services, it will generally pay only a portion of the charges, not the whole cost. We encourage you to become familiar with your dental benefits and to discuss costs with your dentist before service begins, to prevent misunderstandings. If you have any questions not answered by this booklet, please contact Washington Dental Service (WDS/Delta Dental), which administers this plan on behalf of the Washington Teamsters Welfare Trust. WDS/Delta Dental handles most of the administrative details, such as paying claims and answering your benefit questions.

WDS/Delta Dental is a member of the Delta Dental Plans Association (DDPA), the nation's largest, most experienced dental benefits organization. The DDPA is made up of local, not-for-profit Delta Dental plans that provide a range of employee dental benefit programs. DDPA is unique in that its members contract with close to 106,000 dentists nationwide who provide dental care to subscribers at previously agreed-upon fee levels.

This Plan is funded directly by the Trust, using contributions from both employers and participants. This money goes into the Trust and the Trustees, representing the participating employers and local union members, decide the level of funding and plan design. WDS/Delta Dental follows the rules set forth by the Trustees, and takes care of the plan's benefit and claims administration.

As you think about how to use your benefits, consider that your use of the plan directly affects costs. We encourage you to be a wise consumer and to evaluate all your treatment options.

IMPORTANT NOTICE

Payment of benefits as specified in this booklet depends on your employer making contributions for you to the Washington Teamsters Welfare Trust sufficient to maintain these benefits. The amount of necessary employer contributions may increase from time to time. If your employer doesn't pay the required contributions, your coverage may be transferred to a lower-cost plan. If you are ineligible for Plan coverage, the fact that contributions were made on your behalf will not entitle you to benefits.

Only Washington Dental Service (WDS/Delta Dental) is authorized by the Trustees to administer the Plan and provide information about the amount of benefits. Similarly, only the Trust Administrative Office, Northwest Administrators, Inc. is authorized to administer eligibility issues and provide eligibility information. No union employee, union officer, business agent, employer or employer representative or representative of any other organization except WDS/Delta Dental or the Trust Administrative Office is authorized to give Plan information, interpret the Plan or commit the Trustees on any matter. In all cases, the terms of the Plan govern.

While no change in the Plan is anticipated, the Trustees reserve the right to terminate, amend or eliminate benefits as deemed necessary. The Trustees have no obligation to furnish benefits beyond those that can be supported by the Trust fund.

Si necesita ayuda para entender este panfleto, comuniquese con la oficina administrativa.

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General Information

General Information

Administrator

This plan is administered by Washington Dental Service (WDS/Delta Dental). To file a dental claim or for questions about benefits covered under this Plan, whether you are eligible for a specific benefit (such as orthodontia or a cleaning), or to check on the status of a dental claim contact:

Washington Dental Service
Customer Service Department
PO Box 75688
Seattle, WA 98175-0688

Telephone: 206-522-2300 or 800-554-1907

For questions about enrollment in the Plan and whether you have eligibility for coverage, contact the Trust Administrative Office:

Washington Teamsters Welfare Trust
Northwest Administrators, Inc.
2323 Eastlake Avenue East
Seattle, WA 98102

Telephone: 800-458-3053

Enrollment

Participant Data Form

To receive benefits under this Plan and avoid delays in claim administration, you must complete and submit a Participant Data Form to the Trust Administrative Office when you first become eligible. Participant Data Forms can be obtained from the Trust Administrative Office or your local union.

Updating Enrollment Data

Accurate and efficient claim processing depends, in part, on WDS/Delta Dental having current data. Changes in address, marital status, number of dependents and information about other insurance are critical. Remember to advise the Trust Administrative Office promptly of these changes, using a revised Participant Data Form.

ID/Information Card

Your dental ID card contains important information for you and your providers, such as who can answer questions and where to send claims. It also lets providers know that you're a Trust member. Carry your ID card at all times and present it to your dental providers.

Quick Guide to Claim Filing

WDS/Delta Dental Member Dentists

You may receive services from any licensed dentist, but costs may be lower if you receive service from a WDS/Delta Dental provider. When using a member dentist:

- Be sure to present your ID card when receiving treatment. This card identifies you as a Washington Teamsters Welfare Trust participant and tells the provider where to send the bill for payment.
- You do not need to fill out a claim form if you use a WDS/Delta Dental member dentist. The dentist will submit the claim for you.
- If another plan is primary, submit an Explanation of Benefits (EOB) from the other plan with your claim.
- You will receive an EOB specifying what was paid under this Plan and your financial responsibility.
- WDS/Delta Dental is not obligated to pay for treatment performed if the claim is submitted more than 12 months after the date treatment is provided.

Nonmember Dentists

If you receive services from a dentist who is not a member of WDS/Delta Dental, follow these steps:

- Have your dentist complete and sign an American Dental Association-approved claim form and submit it to WDS/Delta Dental.
- If another plan is primary, submit an Explanation of Benefits (EOB) from the other plan with your claim.
- WDS/Delta Dental is not obligated to pay for treatment performed if the claim is submitted more than 12 months after the date treatment is provided.
- You will receive an EOB specifying what was paid under the Plan and your financial responsibility.

If You Have Questions

For claim inquiries and questions about the benefits, contact WDS/Delta Dental at (206) 522-2300 or (800) 554-1907.

For information about enrollment, contact the Trust Administrative Office at (800) 458-3053.

For information about the claim review and appeal process, see the Claim Review and Appeal Procedures on page 45.

If you would like to request an ID card or if you lose your card, contact WDS/Delta Dental at (206) 522-2300 or (800) 554-1907.

Eligibility and Coverage Effective Dates

Eligibility and Coverage Effective Dates

Who's Eligible

To become eligible for contributions to be made to the Trust on your behalf, you must first meet the requirements in your employer's collective bargaining agreement, consistent with Trust guidelines. You also must be an active employee with the minimum number of compensable hours or hours worked (usually 80) during a month for any one employer who makes Plan contributions.

Coverage Effective Dates

Lag Month Rule

To help ensure timely eligibility information is provided to your health care providers, the Trust uses a lag month system — the Trust advances eligibility for one month while you continue working enough hours each month for a contribution to be made on your behalf. For example, if you work enough hours in January and your employer makes a contribution in February (the lag month), your dental coverage is effective in March (rather than February). This continues until you have a break in contributions (see Breaks in Contributions below).

Any month the Trust waives contributions for you due to a disability will be considered a month in which contributions were made for the purpose of determining if you had a break in contributions.

When Coverage Begins

Dental coverage and benefits for new hires begin after one month's contribution is made on your behalf under the lag month system. For example, if you are a new hire who has satisfied the requirements of your collective bargaining agreement, you work enough hours in June and your employer makes a contribution in July (the lag month), your coverage begins August 1. *Please note, you generally need at least two consecutive months of contributions to avoid a loss of the first month of coverage. See Breaks in Contributions below for more information.*

Breaks in Contributions

The lag month eligibility system continues while you continue working enough hours each consecutive month for a contribution to be made on your behalf. For example, if you work enough hours in July, and your employer makes a contribution in August (the lag month), dental coverage and benefits will be provided in September, and so on. The lag month eligibility system will end, however, any time you have a break in contributions for whatever reason. When you have a break in contributions, the lag month system terminates and your coverage will end with the month following the month in which you last had enough hours, provided you had at least two consecutive contributions. For instance, if you last have adequate hours in October, and contributions are last made in November, your coverage will end November 30.

If, following a break in contributions, you return to work for sufficient hours in a month and contributions resume, your coverage will resume the same as for a new hire.

Two Consecutive Months Contributions Requirement to Prevent a Loss of the First Month of Coverage

If you are a new hire, or an employee re-establishing eligibility following a break in contributions, you must have at least two consecutive months of contributions in order to preserve lag month dental coverage for the first contribution. If you have one month of contributions followed by a break in contributions before a second consecutive monthly contribution on your behalf, you will lose eligibility for coverage for that single month of contributions.

Example

You did not work enough hours in May to receive a contribution, but you do work enough hours in June, so your employer makes one contribution in July (for August coverage). However, you do not work enough hours in July to receive a second consecutive contribution. Your coverage for August will be cancelled because the break in contributions results in a termination of the lag month system.

If your break in contributions was due to a disability, and you return to employment for sufficient hours during a disability waiver of contribution month, you will qualify for reinstatement of your lag month without having to satisfy the new hire rule again.

When Coverage Ends

Dental coverage for you and your dependents will end if this Plan terminates or if your employer ceases to make required contributions or stops participating in the Plan. A dependent's coverage also will end when he or she no longer meets the Plan's eligibility requirements (for instance, when your child who is not a full-time student turns 19).

When you have a break in contributions, coverage stops at the end of the month following the month in which you last have the minimum number of hours stated in the collective bargaining agreement for contributions from any one contributing employer, provided you had at least two consecutive contributions.

Any employee or dependent in full-time military service will not be covered except as described in Military Service Under USERRA on page 15 and COBRA Self-Pay Option on page 18.

Please note, slightly different lag month eligibility rules applied to new hires and active participants from January 1, 2003, through May 31, 2003. Details are available in the Summary of Material Modifications provided to participants in July of 2003. Please call the Trust Administrative Office if you did not receive a copy or you have questions about your eligibility.

Eligible Dependents

Eligible dependents are:

- Your wife or husband
- Your unmarried natural or adopted children younger than 19, including children under age 19 placed in your home pending adoption where you have assumed a legal obligation for support and maintenance of the child in anticipation of the adoption
- Unmarried children for whom you are the court-appointed legal guardian, or your stepchildren or grandchildren if they are unmarried and younger than 19, live with you and depend on you for support/maintenance.

All children who qualify as eligible dependents are eligible for dental benefits from birth.

For dental benefits, all children who otherwise qualify as eligible dependents but are 19 or older will be eligible until age 26 (through age 25) if they depend on you for support/maintenance and are full-time students in an accredited educational institution. School vacation and total disability periods that interrupt but do not terminate what would have been a continuous course of study are considered part of full-time attendance.

An unmarried eligible dependent child who is physically or mentally incapable of self-support is eligible under the Plan while incapacitated, if your own coverage is in effect. To cover a child under this provision, file a Proof of Incapacity Form with the Trust Administrative Office within 31 days after coverage would otherwise end or within 31 days of the date you become covered by the Plan if a child is 19 or older at that time. Additional proof will be required from time to time; unless you provide additional proof as requested, the child's coverage will end.

In accordance with federal law, the Plan also provides dental coverage to certain dependent children (called alternate recipients) if directed to do so by a Qualified Medical Child Support Order (QMCSO) issued by a court or state agency of competent jurisdiction and your own health care coverage is in effect. Contact the Trust Administrative Office for details.

Any employee or dependent in full-time military service will not be covered except as described in Military Service Under USERRA on page 15 and COBRA Self-Pay Option on page 18.

Continuation of Coverage

Continuation of Coverage

This section describes various options for continuing dental coverage under specific circumstances.

Quick Guide to Continuing Your Coverage

The Trust offers a number of options for continuing your dental coverage after it would normally end, depending on your situation. The chart below provides an overview of these options, which are described in more detail in the following pages.

Continuing Your Dental Coverage Overview

Continuation option*	How long coverage can be continued	Who can be covered	For details
Continuing coverage lost due to delinquency of employer contributions	Up to three months	You and your eligible dependents	See page 15
Continuing coverage lost due to a strike, lockout or labor dispute	Up to six months	You and your eligible dependents	See page 15
Continuing coverage during a military leave	During your military leave (maximum of 18 months)	You and your eligible dependents	See page 15
Continuing coverage during a Family or Medical Leave (FMLA)	During your FMLA leave (maximum of 12 weeks)	You and your eligible dependents	See page 16
Total Disability Waiver of Contributions	Up to three months	You and your eligible dependents	See page 17
COBRA (self-pay option)	Normally up to 18 months Up to 29 months if disabled Up to 36 months for dependents in certain circumstances	You and/or your eligible dependents	See page 18

* *You may generally only continue coverage you already had through the Trust. For instance, you may continue dental coverage only if you had dental coverage through the Trust and it is allowed under the continuation option.*

Please note, this chart is only a brief summary and does not describe many details of the continuation options. Please refer to the pages shown in the chart for more detailed descriptions, or call the Trust Administrative Office.

Continuing Coverage Lost Due to Delinquency of Employer Contributions

Dental coverage for you and your eligible dependents may be continued for up to three months if your employer is delinquent in Plan contributions and the employer account has been referred for collection. To be eligible for continued coverage, you must provide proof of employment that would have created eligibility had the required employer contribution been made. This continued coverage is for a maximum of three months after employer contributions stop and is available only once for an employer or successor. (This provision does not relieve an employer of any obligation to contribute to the Plan.)

Continuation of Dental Coverage in the Event of a Strike, Lockout or Other Labor Dispute

If your coverage terminates because active work ends as a result of strike, lockout or other labor dispute, your dental coverage may continue during the dispute while the Plan is in effect if you self-pay the required contributions. See pages 18 to 20 for information on COBRA self-pay coverage.

In no event may you continue your benefits beyond *the earliest* of these dates:

- Six months after you stop active work
- Your request that coverage be terminated
- Your failure to make the required self-payment on time
- Your eligibility for similar coverage under another group plan
- Termination of the Plan.

Military Service Under USERRA

If you leave covered employment to perform certain United States military service, you and your covered dependents may have the right to continue your group health benefits — including medical, dental, vision and prescription drug coverage. If your military service lasts less than 31 days (for example, active duty for training), the Plan will continue to cover you and your dependents. If your military service lasts over 31 days, you and your dependents will be eligible to continue coverage through self-payment for up to 18 months. When you return to covered employment, your regular coverage will begin immediately, if you meet the requirements summarized below.

Under the Uniformed Services Employment and Reemployment Rights Act (USERRA), you must notify your employer before taking leave (unless precluded by military necessity or other reasonable cause). You should also tell your employer how long you expect to be gone. Upon release from military duty, you must apply for reemployment as follows:

- Less than 31 days military service — apply immediately, taking into account safe transportation plus an eight-hour rest period
- 31-180 days military service — apply within 14 days
- More than 180 days military service — apply within 90 days.

If you're hospitalized or convalescing, these reemployment deadlines are extended while you recover (but not longer than two years).

The rules above also apply to uniformed service in the commissioned corps of the Public Health Service.

To ensure proper crediting of service under USERRA, have your employer notify the Trust Administrative Office when you go on leave and again when you are reemployed following your return from leave.

If You Take a Family or Medical Leave

To be eligible under the federal Family and Medical Leave Act (FMLA), you must have worked for your current employer for at least 12 months and for at least 1,250 hours in the 12 months before your leave. If you meet these requirements and work for an employer with 50 or more employees within a 75-mile radius, the law requires your employer to continue contributions for your (and your dependents') medical, dental, vision and coverage (if covered under the Trust) for up to 12 weeks during a 12-month period if you're on leave due to:

- Birth of a child, or placement for adoption or foster care
- Serious health condition of a child, spouse or parent
- Your own serious health condition.

Contact your employer as soon as you think you're eligible for a family or medical leave since the law requires you to give 30 days notice, or tell your employer immediately if your leave is caused by a sudden, unexpected event. Your employer can tell you of your other rights under FMLA.

If you haven't returned to work when your coverage under FMLA ends, you and your dependents will be able to elect COBRA self-pay coverage, as described on pages 18 to 20.

If you qualify for a Disability Waiver of Contributions and under FMLA because of your own serious health condition, as described in the following section, employer contributions are not required by the Trust while you remain qualified for the Disability Waiver of Contributions.

Waiver of Contributions for Total Disability

If you fail to work the specified minimum monthly hours for eligibility because you're totally disabled, and you've submitted proof of the disability from your physician and employer, you may receive a waiver of contributions for up to *three* months if you remain totally disabled. The waiver period will begin on the first of the month following the month your employer's paid coverage ends. This waiver allows continuation of:

- Dental
- Medical/prescription — if covered by this Trust
- Vision — if covered by this Trust
- Life AD&D — if covered by this Trust.

At the conclusion of the waiver period you may elect COBRA and begin making COBRA self-payments, but your combined continuation coverage under the waiver period and COBRA may not exceed 18 months (29 months if disabled).

To determine eligibility for waiver of contributions, you must become disabled in a month for which you have eligibility based on an employer contribution. You must also be:

- Totally disabled due to a covered accident or illness (including pregnancy and its complications), and
- Unable to perform the normal duties of your occupation, and
- Not engaged in any occupation for wage or profit (except light-duty work that may be allowed under your collective bargaining agreement), and
- Under a physician's regular care for that injury or sickness.

A subsequent disability separated by less than two weeks of full-time work is considered the same disability unless it is due to a different cause and begins after you return to full-time work.

Self-Pay for Continuing Health Care Coverage

COBRA Self-Pay Option

You may be eligible to continue dental coverage after it would otherwise terminate based on a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). If you are an employee covered by the Plan, you and your covered dependents may choose COBRA self-pay coverage for up to 18 months if your coverage terminates for one of these qualifying events:

- A reduction in your hours of employment
- Termination of your employment other than for gross misconduct.

A dependent spouse covered by the Plan may choose COBRA self-pay coverage for up to 36 months if coverage terminates for one of these qualifying events:

- Death of the employee
- Divorce from the employee
- Spouse elects Medicare as primary coverage.

A dependent child covered by the Plan may choose COBRA self-pay coverage for up to 36 months if coverage terminates for one of these qualifying events:

- Death of the employee
- Parents' divorce
- Parent elects Medicare as primary coverage
- Dependent no longer eligible under the Plan.

A spouse or dependent child who elects COBRA self-pay coverage for 18 months due to the employee's termination or reduction in hours may be eligible to continue coverage for up to 36 months for a second qualifying event:

- Death of the employee
- Employee's divorce
- Employee elects Medicare as primary coverage
- Dependent no longer eligible under the Plan.

You or your dependent is responsible for informing the Trust Administrative Office of a divorce or loss of dependent status no later than 60 days after the qualifying event that causes coverage to end. *The employer is responsible for notifying the Trust Administrative Office when the employee's coverage ceases.*

While self-paying under this option, you or your dependent could receive a Social Security determination confirming disability at the time of the COBRA qualifying event (or within the first 60 days of continuation coverage due to the event). If this happens, the disabled person and all COBRA-eligible family members may be eligible for up to 29 months of continuation coverage. The Trust Administrative Office must receive a copy of the disability determination within *60 days* of the determination date and *within the original 18-month coverage period*. If the disabled individual is later determined no longer to be disabled by the Social Security Administration, *you must notify the Trust Administrative Office within 30 days of the determination*.

When the Trust Administrative Office is notified that a qualifying event has occurred, it will supply details including:

- Application for COBRA self-pay coverage
- Cost information and payment procedures
- Requirements for continuation of coverage.

Timing Is Important

Your application and self-payments must be timely. You will be eligible for COBRA self-pay coverage only within the following time frames:

- You must return the COBRA application within *60 days*, starting as of the date you are notified or the date your coverage ends, whichever is later. You won't be eligible for COBRA self-pay coverage after this 60-day election period ends.
- The first self-payment is due within *45 days* after your first bill is mailed (the exact date will be determined when you are billed). Subsequent self-payments will be due the last day of the month for which payment is being made. Your COBRA coverage will terminate automatically unless you make timely payments.

Employees who qualify for a total disability extension and waiver of contributions, described on page 17, may not have to make COBRA-payments during the three-month waiver period. However, the combined period under COBRA self-pay coverage and the waiver may not exceed 18 months (29 months if disabled). To qualify for the additional 11-month COBRA disability period, you must qualify for and be receiving Social Security disability benefits. Consult the Trust Administrative Office for details.

COBRA self-pay coverage will be identical to that provided under the Plan to similarly situated employees or dependents.

You may also be required to purchase other plan benefits you are eligible for under the Trust, such as medical and vision plan benefits, in order to purchase dental plan benefits. Contact the Trust Administrative Office for further details.

COBRA self-pay coverage will terminate before the COBRA eligibility period ends for any of the following reasons:

- Payment for continuation of coverage is not received by the last day of the month for which payment is being made.
- You, your spouse and/or eligible dependents obtain coverage under any other group health plan after the last date to elect COBRA self-pay coverage (unless the other plan excludes or limits your benefits because of a preexisting condition).
- You became entitled to Medicare benefits (Part A or Part B) after the last date to elect COBRA self-pay coverage; however, your dependents may be entitled to further continuation of coverage. (If your spouse or dependent becomes eligible for Medicare for any reason, coverage for that individual will end.)
- The Plan terminates.
- Social Security determines you are no longer disabled during an 11-month disability extension period.

Dental Plan Provisions

Dental Plan Provisions

Dental Plan B Plan Features

Plan Feature	Plan pays*
Annual Deductible	None
Covered Services	Scheduled Allowance (see Covered Services on page 31)
Annual Maximum	$1,800
Orthodontia for children through the age of 18 *Only dependent children through the age of 18 are eligible. If orthodontia work began before the dependent's 19th birthday and the child is a full time student, coverage for the work already begun may continue through age 25.*	70% up to $1,800 lifetime maximum
Dental Accident	100% of the member dentists' pre-approved fee or the amount allowed by the schedule of allowance (up to the unused annual maximum)

*Certain exclusions and limitations apply. See Covered Services for specific dental benefits under this plan.

How to Use Your Program

The best way to take full advantage of your dental plan is to understand its features. You can do this most easily by reading this benefits booklet *before* you go to the dentist. The booklet is designed to give you a clear understanding of how your dental insurance works and how to make it work for you. It also answers some common questions and defines a few technical terms. If this booklet doesn't answer all of your questions, or if you don't understand something, call a WDS/Delta Dental customer service representative at (800) 554-1907. If you have questions about your enrollment under the plan, call the Trust Administrative Office at (800) 458-3053.

Choosing a Dentist

With the DeltaPremier USA program, you may select any licensed dentist. Tell your dentist you are covered by a WDS/Delta Dental plan and give him or her your Social Security number, the program name, which is Washington Teamster Welfare Trust and the group number, which is **#9086**.

WDS/Delta Dental Member Dentists

There are advantages to selecting a WDS/Delta Dental member dentist. First, you have a choice of more than 3,000 dentists in Washington State or 106,000 participating dentists nationwide. And, if you select a dentist who is a member of WDS/Delta Dental, that dentist has agreed to provide treatment for eligible persons covered by Delta Dental programs according to the provisions of his or

her member dentist contract. Member dentists complete and submit claim forms to WDS, and they receive payment directly from WDS. You will not be charged for more than the approved fee that your dentist has with the Delta Dental plan in his or her state. You are, however, responsible for copayments , the difference between the approved fee and the scheduled allowance (see Covered Services section) and for any elective care you choose to receive outside the covered benefits. To find out whether your dentist is a member, ask him or her, check your plan's Directory of Dentists or go online to the WDS/Delta Dental Web site at *www.DeltaDentalWA.com* and click on the "Find a Dentist" option. Please make sure to select the DeltaPremier network.

Nonmember Dentists

If you select a dentist who is not a member of Delta Dental, you are responsible for paying the dentist and having him or her complete and sign claim forms. WDS/Delta Dental accepts any American Dental Association-approved claim form that your dentist may provide. It is up to you to ensure that the claim is sent to WDS/Delta Dental. The payment for services performed by a nonmember dentist is based on the dentist's actual charges or amount allowed under the schedule of allowances, whichever is less. You should be aware that WDS/Delta Dental has no controls over nonmember dentists' fees. If your nonmember dentist charges more than the WDS/Delta Dental nonmember allowable fee, you may end up paying more out of pocket to make up the difference.

Non-member Dentist Allowable Fee

The maximum amount recognized by the plan will be based on the WDS/Delta Dental allowable fees for non-member dentists. You will pay any amounts above this in addition to any difference between the allowable fees and the schedule of allowance.

Certain limitations and exclusions apply, meaning that the plan does not cover every aspect of dental care. This can affect the type of procedures performed or the number of visits. These limitations are detailed in this booklet under the sections called Covered Services on page 31 and General Exclusions on page 36.

Program Maximums

The annual maximum is the maximum dollar amount the plan will pay toward the cost of dental care within a calendar year. You are personally responsible for paying any costs above the annual maximum.

For your program, the maximum annual amount payable for covered dental benefits (including dental accident benefits) per eligible person is $1,800 each calendar year. Charges for dental procedures requiring multiple treatment dates are incurred at the time the treatment is completed. Amounts paid for such procedures will be applied to the annual maximum of the calendar year in which the treatment is completed.

The lifetime maximum amount payable by WDS for orthodontic benefits is $1,800 per eligible child.

All covered employees and covered dependents are eligible for service benefits excluding orthodontia. Only covered dependent children through the age of 18 are eligibile for orthodontic benefits.

Claims Filing and Deadlines

American Dental Association-approved claim forms may be obtained from your dentist. WDS/Delta Dental is not obligated to pay for treatment performed in the event that a claim form is submitted for payment more than 12 months after the date the treatment is provided.

Predetermination of Benefits

If your dental care will be extensive, you may ask your dentist to complete and submit an American Dental Association-approved claim for an estimate. This "predetermination of benefits" will allow you to know in advance what procedures are covered, the amount the plan will pay toward the treatment and your financial responsibility.

Benefit Period

Most dental benefits are calculated within a "benefit period," which is typically for one year. For the Washington Teamsters Welfare Trust, the benefit period is January 1st through December 31st.

Class I Services

Examinations

Covered Examination Benefits

- Routine examinations
- X-rays
- Emergency examinations
- Examination by a specialist in an American Dental Association recognized specialty
- WDS/Delta Dental-approved caries susceptibility tests.

Limitations

- Examinations are covered twice in a calendar year
- Complete series (four bitewing x-rays and up to 10 periapical X-rays) or panorex X-rays are covered once in a three-year period
- Supplementary bitewing X-rays are covered twice in a calendar year.

Exclusions

- Diagnostic services and X-rays related to temporomandibular joints (TMJ or jaw joints)
- Consultations or elective second opinions
- Study models.

Refer also to general exclusions.

Preventive

Covered Preventive Benefits

- Prophylaxis (cleaning)
- Periodontal maintenance
- Fissure sealants

- Topical application of fluoride or preventive therapies
- Space maintainers when used to maintain space for eruption of permanent teeth.

Limitations

- Prophylaxis is covered twice in a calendar year
- Under certain conditions of oral health and when approved by WDS/Delta Dental, periodontal maintenance may be covered, up to a total of four combined regular and periodontal visits in a calendar year. *Please note: It is strongly recommended that you have your dentist submit a predetermination of benefits to determine if the treatment will be fully covered*
- Topical application of fluoride or preventive therapies (but not both) is covered twice in a calendar year
- Fissure sealants are available for children through age 18. Payment for application of sealants will be for permanent maxillary (upper) or mandibular (lower) molars with incipient or no caries (decay) on an intact occlusal surface. The application of fissure sealants is a covered benefit once in a three-year period per tooth.

Exclusions

- Plaque control program (oral hygiene instruction, dietary instruction and home fluoride kits)
- Cleaning of a prosthetic appliance
- Replacement of a space maintainer previously paid for by WDS/Delta Dental.

Refer also to general exclusions.

Class II Services

Restorative

Covered Restorative Benefits

- Amalgam, composite or filled resin restorations (fillings) for treatment of carious lesions (visible destruction of hard tooth structure resulting from the process of dental decay) or fracture resulting in significant loss of tooth structure (missing cusp)
- Stainless steel crowns.

Limitations

- Restorations on the same surface(s) of the same tooth are covered once in a two-year period
- Stainless steel crowns are covered once in a two-year period
- Recementing of crowns, inlays and onlays
- Repair of prosthetics appliances
- Refer to Class III Limitations if teeth are restored with crowns, inlays or onlays.

Exclusions

- Restorations necessary to correct vertical dimension or to alter the morphology (shape) or occlusion
- Overhang removal, re-contouring or polishing of restoration.

Refer also to general exclusions.

Oral Surgery

Covered Oral Surgery Benefits

- Removal of teeth and surgical extractions
- Preparation of the alveolar ridge and soft tissue of the mouth for insertion of dentures
- Treatment of pathological conditions and traumatic facial injuries
- General anesthesia/intravenous sedation
- Ridge extension for insertion of dentures (vestibuloplasty)
- General anesthesia/intravenous sedation
- Tooth transplants and reimplants.

Limitations

- General anesthesia/intravenous sedation is covered only when administered by a licensed dentist or other WDS/Delta Dental -approved licensed professional who meets the educational, credentialing and privileging guidelines established by the Dental Quality Assurance Commission of the state of Washington in conjunction with certain covered oral surgery procedures, as determined by WDS/Delta Dental
- Tooth transplants or reimplants are covered only when performed for stabilization or splinting of a tooth due to an accident.

Exclusions

- Iliac crest or rib grafts to alveolar ridges.

Refer also to general exclusions.

Periodontics

Covered Periodontic Benefits

- Surgical and nonsurgical procedures for treatment of the tissues supporting the teeth. Services covered include examinations, periodontal scaling/root planing, periodontal surgery
- Limited adjustments to occlusion (eight or fewer teeth)
- WDS/Delta Dental-approved localized delivery of chemotherapeutic agents
- General anesthesia/intravenous sedation
- Nightguards.

Limitations

- Periodontal scaling/root planing is covered once in a three-year period
- Limited occlusal adjustments are covered once in a 12-month period
- Localized delivery of chemotherapeutic agents approved by WDS/Delta Dental are a covered benefit under certain conditions of oral health. Localized delivery of chemotherapeutic agents is limited to two teeth per quadrant and up to two times (per tooth) in a calendar year
- Periodontal surgery (per site) is covered once in a three-year period
- Soft tissue grafts (per site) are covered once in a three-year period
- Periodontal surgery and localized delivery of chemotherapeutic agents must be preceded by scaling and root planing a minimum of six weeks and a maximum of six months, or the patient must have been in active supportive periodontal therapy, prior to such treatment
- General anesthesia/intravenous sedation is covered only when administered by a licensed dentist or other WDS/Delta Dental-approved licensed professional who meets the educational, credentialing and privileging guidelines established by the Dental Quality Assurance Commission of the state of Washington in conjunction with certain covered periodontal surgery procedures, as determined by WDS/Delta Dental
- Nightguards covered once in a two year period for bruxism (grinding) only.

Exclusions

- Periodontal splinting and/or crown and bridgework in conjunction with periodontal splinting, crowns as part of periodontal therapy and periodontal appliances
- Gingival curettage
- Localized delivery of chemotherapeutic agents is not covered when used for the purpose of maintaining non-covered dental procedures or implants.

Refer also to general exclusions.

Endodontics

Covered Endodontic Benefits

- Procedures for pulpal and root canal treatment
- Services covered include pulp exposure treatment, pulpotomy and apicoectomy
- General anesthesia/intravenous sedation.

Limitations

- Root canal treatment on the same tooth is covered only once in a two-year period
- General anesthesia/intravenous sedation is covered only when administered by a licensed dentist or other WDS/Delta Dental-approved licensed professional who meets the educational, credentialing and privileging

guidelines established by the Dental Quality Assurance Commission of the state of Washington in conjunction with certain covered endodontic surgery procedures, as determined by WDS/Delta Dental

- Refer to Class III Limitations if the root canals are placed in conjunction with a prosthetic appliance.

Exclusions

- Bleaching of teeth.

Refer also to general exclusions.

Covered General Anesthesia Benefits

- General anesthesia, when medically necessary, for children through age six, or a physically or developmentally disabled person, when in conjunction with Class I, II and III covered dental procedures.

Limitations

- General anesthesia is covered only when administered by a licensed dentist or other WDS/Delta Dental-approved licensed professional who meets the educational, credentialing and privileging guidelines established by the Dental Quality Assurance Commission of the state of Washington, when medically necessary, for children through age six, or for a physically or developmentally disabled person, when in conjunction with covered dental procedures.

Refer also to general exclusions.

Class III Services

Restorative

Covered Restorative Benefits

- Crowns, inlays (only when used as an abutment for a fixed bridge), onlays (whether they are gold, porcelain, WDS/Delta Dental-approved gold substitute castings [except processed resin] or combinations thereof) for treatment of carious lesions (visible destruction of hard tooth structure resulting from the process of dental decay) or fracture resulting in significant loss of tooth structure (missing cusp), when teeth cannot reasonably be restored with filling materials such as amalgam or filled resins
- Crown buildups, subject to limitations and exclusions.

Limitations

- Crowns or onlays on the same teeth are covered once in a five-year period. Inlays are a covered benefit on the same teeth once in a five-year period only when used as an abutment for a fixed bridge. If a tooth can be restored with a filling material such as amalgam or filled resin, an allowance will be made for such a procedure toward the cost of any other type of restoration that may be provided. WDS/Delta Dental will allow the appropriate amount

for an amalgam or composite restoration toward the cost of processed filled resin or processed composite restorations

- Crown buildups are a covered benefit when more than 50% of the natural tooth structure is missing or there is less than 2mm of circumferential tooth structure remaining around the gingival portion
- Crown buildups are not a covered benefit within two years of a restoration on the same tooth.

Exclusions

- A crown used as an abutment to a partial denture for purposes of re-contouring, repositioning or to provide additional retention is not covered unless the tooth is decayed to the extent that a crown would be required to restore the tooth whether or not a partial denture is required
- Crowns used to repair micro-fractures of tooth structure when the tooth is asymptomatic (displays no symptoms) or existing restorations with defective margins when no pathology exists
- Crowns and/or onlays placed because of weakened cusps or existing large restorations without overt pathology
- Crown buildups for the purpose of improving tooth form, filling in undercuts or reducing bulk in castings are considered basing materials and are not a covered benefit.

Refer also to general exclusions.

Prosthodontics

Covered Prosthodontic Benefits

- Dentures, fixed bridges, removable partial dentures and the adjustment of an existing prosthetic device
- Surgical placement or removal of implants or attachments to implants.

Limitations

- Replacement of an existing prosthetic device is covered only once every five years and only then if it is unserviceable and cannot be made serviceable
- Replacement of implants and superstructures is covered only after five years have elapsed from any prior provision of the implant
- **Full, immediate and overdentures** — WDS/Delta Dental will allow the appropriate amount for a full, immediate or overdenture toward the cost of any other procedure that may be provided, such as personalized restorations or specialized treatment (adding a special filling on a denture to make it look more like your natural tooth). You will be responsible for any amount above the preapproved fee
- **Temporary/interim dentures** — WDS/Delta Dental 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 six months

- Root canal treatment performed in conjunction with overdentures is limited to two teeth per arch and is paid at the Class III payment level
- **Partial dentures** — If a more elaborate or precision device is used to restore the case, WDS/Delta Dental will allow the cost of a cast chrome and acrylic partial denture toward the cost of any other procedure that may be provided
- **Denture adjustments and relines** — Denture adjustments and relines done more than six months after the initial placement are covered. Subsequent relines or jump rebases (but not both) will be covered once in a 12-month period.

Exclusions

- Duplicate dentures
- Personalized dentures
- Cleaning of prosthetic appliances
- Crowns and copings in conjunction with overdentures.

Accidental Injury

WDS/Delta Dental will pay 100% of covered dental benefit expenses arising as a direct result of an accidental bodily injury. However, payment for accidental injury claims will not exceed the unused program maximum. The accidental bodily injury must have occurred while the patient was eligible. A bodily injury does not include teeth broken or damaged during the act of chewing or biting on foreign objects. Coverage includes necessary procedures for dental diagnosis and treatment rendered within 180 days following the date of the accident.

Orthodontic Benefits for Eligible Children

You may choose any licensed orthodontist. There is no network of providers for orthodontic benefits.

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.

Only dependent children are eligible for orthodontic benefits and orthodontic treatment must start prior to the date they reach their 19th birthday. In addition, orthodontia services for dependent children may be continued after age 18 only if the dependent is a full-time student, and only to complete treatment begun before age 19.

The lifetime maximum amount payable by WDS/Delta Dental for orthodontic benefits for an eligible child is $1,800. WDS/Delta Dental will pay a constant 70% of the fees actually charged for orthodontic benefits up to this lifetime orthodontia maximum.

Payments of WDS's responsibility will be made on a monthly basis, if the employee is eligible and the dependent is in compliance with the age limitation. It is strongly suggested that orthodontic treatment be submitted to, and authorized by, WDS prior to commencement of treatment.

Covered Orthodontia Benefits for Children Through the Age of 18

- Treatment of malalignment of teeth and/or jaws.

Limitations

Payment is limited to:

- Completion, through age 18, or through age 25 if full-time student and treatment begun before age 19, whichever occurs first
- Termination of the treatment plan prior to completion of the case
- Termination of the contract.

Exclusions

- Charges for replacement or repair of an appliance
- Orthognathic Surgery
- No benefits will be provided for services considered inappropriate and unnecessary, as determined by WDS/Delta Dental
- Orthodontics for adults age 19 and older regardless of the reason for the treatment unless a full-time student through age 25 and treatment begun before age 19.

Refer also to general exclusions.

Covered Services

The following schedule of covered dental benefits is subject to the limitations and exclusions contained in this booklet. These benefits are available only when services are performed by a WDS/Delta Dental member dentist or a non-member dentist that is an approved licensed professional when appropriate and necessary as determined by the standards of generally accepted dental practice and WDS/Delta Dental.

The amount shown in the Schedule of Dental Allowance is the maximum amount the plan will pay when you see a WDS/Delta Dental member dentist or a non-member dentist that is an approved licensed professional. You are responsible for the difference between the member dentists' pre-approved fees and the scheduled dental allowance. ***If you see a nonmember dentist, you will pay any additional amount charged that is above the WDS pre-approved fees for the services you receive in addition to the difference between the pre-approved fees and the scheduled dental allowance.***

Please note, some of the benefits described in this section may be available only under certain conditions of oral health. To find out whether or how much a specific treatment will be covered, you are strongly encouraged to have your dentist submit a predetermination of benefits to determine what will be covered.

Abbreviated Schedule of Dental Allowance

	ADA Procedure code	Procedure	Plan pays
Class I Services	**Exams**		
	00120	Periodic oral evaluation	$33
	00140	Limited Oral Evaluation — problem focused	$54
	00180	Comprehensive Periodontal Evaluation	$55
	X-rays		
	00210	Intraoral — complete series (including bitewings)	$79
	00220	Intraoral — periapical first film	$14
	00230	Intraoral — periapical each additional film	$11
	00272	Bitewings — Two Films	$26
	00274	Bitewings — Four Films	$35
	00277	Vertical Bitewings — Seven to Eight Films	$57
	00330	Panoramic film	$64
	Cleanings, fluorides, sealants		
	01110	Prophylaxis — Adult	$65
	01120	Prophylaxis — Child	$45
	01201	Topical application of fluoride (including prophylaxis) — child	$63
	01203	Topical application of fluoride — child	$25
	01204	Topical application. of fluoride — adult	$0
	01351	Sealant — per tooth	$28
	04910	Periodontal Maintenance	$102
	Miscellaneous procedures		
	09110	Palliative (Emergency) Treatment of dental pain — minor proc	$77
	09310	Consultation (by doctor other than doctor providing treatment)	$163
	09430	Office Visit for observation — regular hours — no service performed	$0
Class II Services	**Restorations/fillings**		
	02110	Amalgam One Surface Primary	$75
	02120	Amalgam Two Surface Primary	$94
	02130	Amalgam Three Surface Primary	$114
	02131	Amalgam Four Surface Primary	$181
	02140	Amalgam — 1 surface, permanent	$83
	02150	Amalgam — 2 surfaces, permanent	$106

Class II Services

ADA Procedure code	Procedure	Plan pays
02160	Amalgam — 3 surfaces, permanent	$129
02161	Amalgam — 4 or more surfaces, permanent	$157
02330	Resin-based Composite — 1 surface anterior	$96
02331	Resin-based Composite — 2 surfaces anterior	$123
02332	Resin-based Composite — 3 surfaces anterior	$151
02335	Resin Composite — 4 or more surfaces or incisal angl	$177
02336	Resin-based Composite Crown, anterior — primary	$192
02337	Resin-based Composite Crown, anterior — permanent	$0
02380	Resin-based composite — 1 surface, post. primary	$110
02381	Resin-based composite — 2 surfaces, post. primary	$128
02382	Resin-based composite — 3 surfaces, post. primary	$156
02391	Resin One Surface Permanent	$108
02392	Resin Two Surface Permanent	$150
02393	Resin Three Surface Permanent	$185
02394	Resin Four of More Surface Permanent	$269
Other restorative procedures		
02910	Recement Inlay	$62
02920	Recement Crown	$52
02930	Prefabricated stainless steel crown — primary tooth	$142
02931	Prefabricated stainless steel crown — permanent tooth	$160
02940	Sedative Filling	$54
02950	Core buildup, including any pins	$175
02951	Pin Retention — per tooth, in add. to restoration	$29
02960	Labial Veneer (resin laminate) — chairside	$314
Endodontic procedures		
03110	Pulp Cap — Direct (excluding final restoration)	$46
03220	Therapeutic Pulpotomy (excluding final restoration)	$110
03310	Root Canal — anterior (excluding final restoration)	$464
03320	Root Canal — bicuspid (excluding final restoration)	$566
03330	Root Canal — molar (excluding final restoration)	$732
Periodontal procedures		
04210	Gingivectomy or gingivoplasty — per quad	$425
04211	Gingivectomy or gingivoplasty — per tooth	$114
04240	Gingival Flap Proc — per quad	$501
04260	Osseous Surgery — per quad	$807
04270	Pedicle Soft Tissue Graft Procedure	$598

Class II Services

ADA Procedure code	Procedure	Plan pays
04271	Free Soft Tissue Graft	$615
04341	Perio scaling/root planing — per quad	$182
Extraction and other surgical procedures		
07111	Extraction — Single Tooth	$88
07120	Extraction — Each Additional Tooth	$83
07130	Root Removal — Exposed Roots	$113
07210	Surgical Removal of Erupted Tooth	$179
07220	Removal of impacted tooth — soft tissue	$224
07230	Removal of impacted tooth — partially bony	$298
07240	Removal of impacted tooth — completely bony	$350
07241	Removal of impacted tooth — complete bony with comp	$439
07250	Surgical Removal of Residual Tooth Roots	$189
07280	Surgical access of an unerupted tooth	$421
07282	Mobilization of erupted or malpositioned tooth/aid eruption	$356
07285	Biopsy of oral tissue — hard (bone, tooth)	$745
07286	Biopsy of oral tissue — soft (all others)	$306
07310	Alveoplasty in conjunction with extractions — per quad	$208
07510	Incision/Drain of Abscess — Intraoral soft tissue	$199
07960	Frenulectomy — separate procedure	$438
Miscellaneous procedures		
06930	Recement Fixed Partial Denture	$68
09220	Deep sedation/General Anesthesia — 1st 30 minutes	$312
09221	Deep sedation/Gen Anesthesia — each additional 15 minutes	$141
09241	Intravenous Conscious Sedation/analgesia — 1st 30 minutes	$281
09242	Intravenous Conscious Sedation/analgesia — each additional 15 minutes	$118
09940	Occlusal Guard, By Report	$410
09951	Occlusal Adjustment — limited	$98

Class III Services

Onlays and crowns		
02542	Onlay — metallic — 2 surfaces	$510
02543	Onlay — metallic — 3 surfaces	$534
02544	Onlay — metallic — 4 or more surfaces	$555
02740	Crown — porcelain/ceramic substrate	$415
02750	Crown — porcelain fused to high noble metal	$409

Class III Services

ADA Procedure code	Procedure	Plan pays
02751	Crown — porcelain fused to predominant base metal	$381
02752	Crown — porcelain fused to noble metal	$390
02780	Crown — ¾ cast high noble metal	$459
02790	Crown — full cast high noble metal	$395
02791	Crown — full cast predominantly base metal	$374
02792	Crown — full cast noble metal	$381
Complete dentures		
05110	Complete denture — maxillary	$596
05120	Complete denture — mandibular	$596
05130	Immediate denture — maxillary	$649
05140	Immediate denture — mandibular	$649
Partial dentures		
05213	Maxillary partial denture-cast frame with resin base	$658
05214	Mandibular partial denture-cast frame with resin base	$658
Repair to dentures and other procedures		
05410	Adjust complete denture — maxillary	$32
05411	Adjust complete denture — mandibular	$32
05421	Adjust partial denture — maxillary	$32
05422	Adjust partial denture — mandibular	$32
05510	Repair broken complete denture base	$87
05520	Replace missing or broken tooth — complete denture	$72
05710	Rebase complete maxillary denture	$242
05730	Reline complete maxillary denture (chairside)	$137
05731	Reline complete mandibular denture (chairside)	$137
05740	Reline maxillary partial denture (chairside)	$125
05741	Reline mandibular partial denture (chairside)	$125
05750	Reline complete maxillary denture (laboratory)	$181
05751	Reline complete mandibular denture (laboratory)	$181
05760	Reline maxillary partial denture (laboratory)	$179
05761	Reline mandibular partial denture (laboratory)	$179
05850	Tissue Conditioning, maxillary	$55
05851	Tissue Conditioning, mandibular	$57
Implant procedures		
06010	Surgical placement of implant body, endosteal implant	$994
06055	Dental implant supported connecting bar	$297

Class III Services

ADA Procedure code	Procedure	Plan pays
Fixed bridge procedures		
06210	Pontic — Cast High Noble Metal	$389
06211	Pontic — Cast Predominantly Base Metal	$364
06212	Pontic — Cast Noble Metal	$379
06240	Pontic — Porcelain Fused to High Noble Metal	$384
06241	Pontic — Porcelain Fused to Predominantly Base Metal	$355
06242	Pontic — Porcelain Fused to Noble Metal	$374
06245	Pontic — Porcelain/Ceramic	$464
06750	Crown — Porcelain fused to High Noble Metal	$438
06751	Crown — Porcelain fused to Predominantly Base Metal	$409
06752	Crown — Porcelain fused to Noble Metal	$419
06780	Crown — Cast High Noble Metal	$413
06790	Crown — Full Cast High Noble Metal	$423
06791	Crown — Full Cast Predominantly Base Metal	$401
06792	Crown — Full Cast Noble Metal	$416

General Exclusions

Dental benefits are not payable for any of the following listed items. These limitations and exclusions are in addition to the exclusions listed in Class I, II and III Services on pages 24 to 31.

1. Services for injuries or conditions that are compensable under Worker's Compensation or Employers' Liability laws, and services that are provided to the eligible person by any federal or state or provincial government agency or provided without cost to the eligible person by any municipality, county, or other political subdivision, other than medical assistance in this state, under medical assistance RCW 74.09.500, or any other state, under 42 U.S.C., Section 1396a, section 1902 of the Social Security Act

2. Dentistry for cosmetic reasons

3. Treatment of temporomandibular joint dysfunction (TMJ)

4. Restorations or appliances necessary to correct vertical dimension or to restore the occlusion. Such procedures include restoration of tooth structure lost from attrition, abrasion or erosion and restorations for malalignment of teeth

5. Application of desensitizing agents

6. Experimental services or supplies. Experimental services or supplies are those whose use and acceptance as a course of dental treatment for a specific condition is still under investigation/observation. In determining whether services are experimental, WDS/Delta Dental, in conjunction with the American Dental Association, will consider if:

   (a) The services are in general use in the dental community in the state of Washington;

   (b) The services are under continued scientific testing and research;

   (c) The services show a demonstrable benefit for a particular dental condition; and

   (d) They are proven to be safe and effective. Any individual whose claim is denied due to this experimental exclusion clause will be notified of the denial within 20 working days of receipt of a fully documented request

   Any denial of benefits by WDS/Delta Dental on the grounds that a given procedure is deemed experimental, may be appealed to WDS/Delta Dental. By law, WDS/Delta Dental must respond to such appeal within 20 working days after receipt of all documentation reasonably required to make a decision. The 20-day period may be extended only with written consent of the covered individual.

   General anesthesia/intravenous (deep) sedation, except as specified by WDS/Delta Dental for certain oral, periodontal, or endodontic surgical procedures. General anesthesia except when medically necessary, for children through age six, or for a physically or developmentally disabled person, when in conjunction with covered dental procedures

7. Analgesics such as nitrous oxide, conscious sedation, euphoric drugs, injections or prescription drugs

8. In the event an eligible participant fails to obtain a required examination from a WDS/Delta Dental-appointed consultant dentist for certain treatments, no benefits will be provided for that treatment

9. Hospitalization charges and any additional fees charged by the dentist for hospital treatment

10. Broken appointments

11. Patient management problems

12. Completing insurance forms

13. Habit-breaking appliances

14. This program does not provide benefits for services or supplies to the extent that benefits are payable for them under any motor vehicle medical, motor vehicle no-fault, uninsured motorist, underinsured motorist, personal injury protection (PIP), commercial liability, homeowner's policy, or other similar type of coverage

15. All other services not specifically included in this program as covered dental benefits.

WDS/Delta Dental has the discretionary authority to determine whether services are covered benefits in accordance with the general limitations and exclusions shown in this Summary Plan Description, but it shall not exercise this authority arbitrarily or capriciously or in violation of the provisions of the contract.

Dental Plan Definitions

Alveolar — Pertaining to the ridge, crest or process of bone that projects from the upper and lower jaw and supports the roots of the teeth.

Amalgam — A mostly silver filling often used to restore decayed teeth.

Bitewing X-ray — An X-ray picture that shows, simultaneously, the portions of the upper and lower back teeth that extend above the gumline, as well as a portion of the roots and supporting structures of these teeth.

Bridge — A replacement for a missing tooth or teeth. The bridge consists of the artificial tooth (pontic) and attachments to the adjoining abutment teeth (retainers). Bridges are cemented (fixed) in place and therefore are not removable.

Caries — Decay. A disease process initiated by bacterially produced acids on the tooth surface.

Caries Susceptibility Test — A test done to determine how likely someone is to develop tooth decay. The test is usually done by measuring the concentration of certain bacteria in the mouth.

Composite — A tooth colored filling, made of a combination of materials, used to restore teeth.

Crown — A restoration that replaces the entire surface of the visible portion of tooth.

Denture — A removable prosthesis that replaces missing teeth. A complete (or "full") denture replaces all of the upper or lower teeth. A partial denture replaces one to several missing upper or lower teeth.

Endodontics — The diagnosis and treatment of dental diseases, including root canal treatment, affecting dental nerves and blood vessels.

Exclusions — Dental services not provided under a dental insurance plan.

Filed Fees — Approved fees that participating Washington Dental Service member dentists have agreed to accept as the total fees for the specific services performed.

Filled Resin — Tooth colored plastic materials that contain varying amounts of special glass-like particles that add strength and wear resistance.

Fluoride — A chemical agent used to strengthen teeth to prevent cavities.

Fluoride Varnish — A fluoride treatment contained in a varnish base that is applied to the teeth to reduce acid damage from the bacteria that causes tooth decay. It remains on the teeth longer than regular fluoride and is typically more effective than other fluoride delivery systems.

General Anesthesia — A drug or gas that produces unconsciousness and insensibility to pain.

Implant — A device specifically designed to be placed surgically within the jawbone as a means of providing an anchor for an artificial tooth or denture.

Inlay — A dental filling shaped to the form of a cavity and then inserted and secured with cement.

Intravenous (I.V.) Sedation — A form of sedation where the patient experiences a lowered level of consciousness but is still awake and can respond.

Limitations — Restricting conditions, such as age, period of time covered and waiting periods, under which a group or individual is insured.

Localized delivery of chemotherapeutic agents — treating isolated areas of advanced gum disease by placing antibiotics or other germ-killing drugs into the gum pocket. This therapy is viewed as an alternative to gum surgery when conditions are favorable.

Maximum Allowable Fees — The maximum dollar amount that will be allowed toward the reimbursement for any service provided for a covered dental benefit.

Nightguard — A removable dental appliance — sometimes called an occlusal guard — that is designed to minimize the effects of gnashing or grinding of the teeth (bruxism). A nightguard is typically used at night.

Occlusal Adjustment — Modification of the occluding surfaces of opposing teeth to develop harmonious relationships between the teeth themselves and neuromuscular mechanism, the temporomandibular joints and the structure supporting the teeth.

Occlusal Guard — See "Nightguard."

Onlay — A restoration of the contact surface of the tooth that covers the entire surface.

Orthodontics — Diagnosis, prevention and treatment of irregularities in tooth and jaw alignment and function, frequently involving braces.

Overdenture — A removable denture constructed over existing natural teeth or implanted studs.

Panorex X-ray — An X-ray, taken from outside the mouth, that shows the upper and lower teeth and the associated structures in a single picture.

Periodontics — The diagnosis, prevention and treatment of diseases of gums and the bone that supports teeth.

Prophylaxis — Cleaning and polishing of teeth.

Prosthodontics — The replacement of missing teeth by artificial means such as bridges and dentures.

Restorative — Replacing portions of lost or diseased tooth structure with a filling or crown to restore proper dental function.

Root Planning — A procedure done to smooth roughened root surfaces.

Sealants — A material applied to teeth to seal surface irregularities and prevent tooth decay.

Temporomandibular Joints (TMJ) — The joint just ahead of the ear, upon which the lower jaw swings open and shut, and can also slide forward.

Plan Administration

Plan Administration

About the Privacy of Your Health Information

As part of the normal process of administering its health care plans, the Trust, the Plan Sponsor (which is the Board of Trustees), and its health care claims administrators may receive personal health information about you and your covered dependents. Effective April 14, 2003, the use and disclosure of certain types of health information (called protected health information) will be governed by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), a federal law that governs the privacy of individuals' protected health information.

The Plan Sponsor and the Trust group health care plans (the dental health plans described in this booklet) are subject to HIPAA's privacy requirements beginning on April 14, 2003, and HIPAA's privacy protections apply to them.

Participants will receive a copy of the Trust's HIPAA privacy notice separately.

Coordination With Other Dental Benefits

Coordination of Benefits or COB refers to how the Plan coordinates benefits when you or your dependents have dental coverage under more than one plan.

Benefits otherwise payable under this Plan for allowable expenses during a claim determination period may be reduced if:

- Benefits are payable under any other plan for the same allowable expenses
- Under the rules listed below, benefits payable under the other plan are to be determined before benefits payable under this Plan.

The reduction will be the amount needed to ensure that the sum of payments under this Plan plus benefits under the other plan is not more than the total of allowable expenses. Each benefit that would be payable without this section will be reduced proportionately. The total amount paid will be charged against any applicable benefit limit of this Plan.

For this purpose, benefits payable under other plans will include those that would have been paid if claims had been made for them.

Under this Plan's COB rules, when this Plan is secondary and its payment is reduced because of the primary plan's benefits, a record is kept of the reduction. The amount will be used to increase this Plan's payments on the patient's later claims in the same calendar year — to the extent there are allowable expenses that would not otherwise be fully paid by this Plan and other plan(s). This provision applies only to the Trust's medical benefits.

Order of Benefit Determination

The benefits payable by a plan that doesn't have a COB provision will be determined before those of a plan that does have a COB provision. In all other instances, the order of determination will be:

1. **Employee/Dependent.** The benefits of a plan that covers the person as an employee participant are determined before those of a plan that covers the person as a dependent participant.

   If you are covered under a Trust Dental Plan as both the employee and a dependent (for example, if your spouse also has Trust coverage as an employee and covers you as an eligible dependent), the Trust Plan will be both primary and secondary.

2. **Dependent Child — Parents Not Separated or Divorced.** When this Plan and another plan cover the same child as a dependent of parents who are not separated or divorced, benefits of the plan of the parent whose birthday falls earlier in a calendar year are determined before those of the plan of the parent whose birthday falls later in that year. If both parents have the same birthday, the benefits of the plan that covered the parent longer are determined before those of the plan that covered the other parent for a shorter time.

3. **Dependent Child — Parents Separated or Divorced.** If two or more plans cover a dependent child of divorced or separated parents, benefits for the child are determined in this order:

   - First, the plan of the parent with custody of the child
   - Then, the plan of the spouse of the parent with custody of the child
   - Finally, the plan of the parent not having custody of the child.

   However, if the specific terms of a court decree state that one of the parents is responsible for the child's health care expenses, and the entity obligated to pay or provide benefits for the plan of that parent has knowledge of those terms, the benefits of that plan are determined first. (This doesn't apply to any claim determination period or plan year when any benefits are actually paid or provided before the entity has that knowledge.)

4. **Active/Inactive Employee.** The benefits of a plan that covers a person as an employee who is neither laid off nor retired, or as that employee's dependent, are determined before the benefits of a plan that covers that person as a laid-off or retired employee or as that employee's dependent. If the other plan doesn't have this rule, and if, as a result, the plans disagree on the order of benefits, this rule will not apply.

5. **Longer/Shorter Length of Coverage.** If none of the above rules determines the order of benefits, the benefits of the plan that has covered a person longer are determined before those of a plan that has covered the person for a shorter time. It does not apply to prescription drug, mental health or chemical dependency benefits.

Subrogation (Third-Party Reimbursement)

If you or your dependents incur any dental expense resulting from injury or sickness for which there is right of recovery against a third party (including workers compensation claims), Trust benefits will be paid on the condition the Trust will be reimbursed from any amount you or your dependents receive in settlement or judgment. You or your dependents also must give the Trust (through its Plan Benefits Administrator) the name and address of the responsible third party and, if requested, execute a Trust Subrogation Agreement agreeing to reimburse the Trust. The Trust may withhold benefit payment if you are requested to execute a Trust Subrogation Agreement and do not comply.

As security for the Trust's right to this reimbursement, the Trust will be subrogated to all rights of recovery against the third party to the extent of any benefits the Trust paid. You or your dependents must do whatever is necessary to fully secure and protect, and nothing to prejudice, the Trust's rights to this subrogation.

Recovery of Unauthorized Benefit Payments

The Trust provides benefits only under the written terms of this Plan. If the Trust has mistakenly made benefit payments to or for an ineligible person, or payments exceeding those authorized by this Plan — or if you or a dependent fails to reimburse benefits advanced under an agreement to reimburse — the individual profiting from the benefit is obligated, upon notice from the Trust, to reimburse the overpayment. Otherwise, the Trust is entitled to bring legal action to recover the overpayment. The court may award the Trust reasonable attorney fees and court costs in addition to the overpayment amount.

The Trust also has the right to deduct the overpayment amount from any future benefits to the individual or others claiming eligibility through the same individual.

Use of Medical and Dental Consultants

The Board of Trustees has authorized the Plan Benefits Administrator to refer claims for dental benefits to outside doctors, dentists or other professionals for review and advice. In determining the issues presented, these consultants may rely on their own expertise and on professional standards, procedures and protocols.

Any claim denial that incorporates or is based on medical or dental consulting advice may, as any other claim denial, be reviewed in accordance with the Trust's appeals process (see page 45).

Interpretation of the Plan

Administration and interpretation of eligibility for coverage in this Plan is vested wholly and exclusively in the Trustees, who have sole discretion and entire authority to determine eligibility for benefits. The Trustees have contracted with WDS/Delta Dental and have delegated to WDS/Delta Dental the sole discretion and entire authority to interpret and apply the provisions of this Plan, their own motions, resolutions, administrative rules and regulations. Any benefit determination the Trustees or WDS/Delta Dental make in good faith will be conclusive and binding on the unions, employers, employees and beneficiaries under the benefit plans and the Trust Fund.

Claim Review and Appeal Procedures

The Washington Teamsters Welfare Trust plans have adopted specific procedures and timeframes, required by law, to evaluate and process claims for benefits, as well as appeals of denied claims. The timeframes and rules for making decisions on claims and appeals vary, depending on the type of claim and the benefit plan involved. This section provides information about the specific timelines and information requirements that apply to your claims and appeals filings and the claim administrator's claims and appeals determinations. The claim administrator, unless otherwise specified, is WDS/Delta Dental.

If your claim for benefits is wholly or partially denied, you or your duly authorized representative may submit a written request for a review of the claim by the Washington Teamsters Welfare Trust Appeals Committee (Appeals Committee). The request for review must be submitted to the claims administrator within the timeframe applicable for that benefit plan and type of claim, as described in the following pages.

The length of time the claim administrator has to evaluate and process your claim generally begins on the date the claim is received. The claim administrator will consider the claim and notify you of an adverse decision on the claim, in writing, within the appropriate timeframes described on page 47, unless the claim administrator determines that special circumstances require an extension of time to process the claim. If such an extension is necessary under any of the plans, the claim administrator will notify you of any such extension, the reasons for it, and the date by which the claim administrator expects to render the decision, within the original decision timeframe.

Washington Dental Service (WDS/Delta Dental) is the claim administrator for all dental plans.

If you believe that you are entitled to a benefit under one of the Washington Teamsters Welfare Trust plans, or that you are entitled to a greater benefit than the amount you received, then you, your beneficiary (if applicable) or your authorized representative may file a written claim with the appropriate Claim Administrator listed above.

The claim review and appeal procedures apply to these types of claims:

Urgent Health Care Claim (before health care treatment)	A claim or pre-approval request for a dental benefit where treatment delay could seriously jeopardize life, health, the ability to regain maximum function or, in the opinion of a physician who knows the medical condition, would subject the patient to severe pain that cannot be adequately managed without care or treatment that is the subject of the claim.
Pre-Service Health Care Claim (before health care treatment)	Any claim or pre-approval request for a dental benefit, where receipt of benefit is conditioned, in whole or in part, based on advance approval.
Concurrent Health Care Claim (changes in health care treatment)	Any claim involving the reduction or termination of an ongoing course of treatment before the end of that course of treatment if the treatment was previously authorized by the Plan, or a request to extend treatment beyond the authorized time or number of treatments.
Post-Service Health Care Claim (after health care treatment)	Any claim for a dental benefit that is not a pre-service claim.

Dental Claim Procedures

Timeframe for Initial Claim Decisions

The timeframe for initial claim decisions for dental plans depends on the type of claim filed:

Type of Claim	Timeframe for Notice of Claim Decision	Extensions*
Urgent care	The claim administrator will provide notice of claim approval or denial as soon as possible, taking into account the seriousness of your condition, but no longer than 72 hours; notice of denial may be by phone with written or electronic confirmation to follow within three days	If additional information is needed to complete your claim, you'll be notified within 24 hours
Pre-service	The claim administrator will provide notice of a claim approval or denial within 15 days	Up to 15 days, provided you are notified within the original 15-day period
Concurrent care	If an ongoing course of treatment that was previously approved by the Plan will be reduced or terminated, the claim administrator will notify you sufficiently in advance to give you an opportunity to appeal and obtain a decision on appeal before the reduction or termination takes effect. For any request to extend ongoing treatment in an urgent care situation, you'll be notified within 24 hours, provided your request is made at least 24 hours before the end of the approved treatment. For any request to extend ongoing treatment in a non-urgent care situation, your request will be considered a new claim and decided according to post-service or pre-service timeframes, whichever applies.	
Post-service	The claim administrator will provide notice of a claim approval or denial within 30 days	Up to 15 days, provided you are notified of the extension within the original 30-day period

**If more time is needed to process claims due to circumstances beyond the claim administrator's control.*

Insufficient Health Care Claims

Please note that the claims review and appeals procedures include rules that specify what happens if you file certain insufficient or incomplete claims.

Improperly Filed Pre-Service Claims

If your pre-service claim was filed improperly, you will be notified within five days after a pre-service claim is received (or within 24 hours in an urgent care case). Notice of an improperly filed pre-service claim may be provided by phone, or in writing upon request. The notice will identify the proper procedures to be followed in filing the claim.

To receive notice of an improperly filed pre-service claim, you or your authorized representative must have provided a communication regarding the claim to the claim administrator. This communication must include:

- Your name
- A specific medical condition or symptom
- Request for approval for a specific treatment, service or product.

Incomplete Pre- and Post-Service Claims

If more information is required to process your pre- or post-service health care claim, you'll be notified within the original 15-day period for pre-service claims, and within the original 30-day period for post-service claims. If you are notified of the need to provide additional information for a pre- or post-service claim, you will have at least 45 days to supply this information. If you supply the requested information within the 45 days and your claim is denied, the claim administrator will notify you of the denial within 15 days after the requested information is received. If you do not supply the requested information within 45 days, your claim may be denied.

Incomplete Urgent Care Claims

If more information is needed to process a properly filed urgent care claim, you'll be notified as soon as possible, but no later than 24 hours after your claim is received. This notice will include the specific information necessary to complete the claim. Once you are notified of the need to provide more information, you'll have a reasonable amount of time — considering the circumstances, but not less than 48 hours — to submit the requested information. You'll receive notice of the claim decision as soon as possible, but no later than 48 hours after whichever occurs earlier:

- The claim administrator receives the information, or
- The additional period given for providing the information ends.

Notice of Initial Claim Denial

If the claim administrator denies the claim, you'll receive written or electronic notice containing:

- Specific reasons for the denial
- References to specific plan provisions on which the denial is based
- List of any additional material or information necessary for you to perfect the claim and an explanation of why it's necessary
- Description of the plan's claim appeal procedure (and applicable time limits), including a statement of your right to bring a civil action under ERISA Section 502(a) if your appeal is denied
- Certain other information in accordance with applicable U.S. Department of Labor regulations.

Claim Appeal Procedures

You can use these appeal procedures, if, in response to your claim, you received:

- No reply after the initial decision period, as listed above
- Notice of an extension to the initial decision period, as listed above, then no reply before the end of an extension
- A denial from the claim administrator.

If the claim is denied, in whole or in part, or if you believe plan benefits have not been properly provided, you, your beneficiary (if applicable), or your authorized representative may appeal the denial. The claim administrator will provide details about your right to appeal, along with the appeals process, address for filing an appeal, and timeframes. If you don't appeal within the designated timeframes, you may lose your right to later file suit in court.

To appeal a claim denial, you must file a written request for appeal pursuant to the procedure provided by the claim administrator within a certain period after receiving the claim denial, as described herein. The appeal must set forth all the grounds on which it is based, all the facts in support of the request, and other matters which you deem pertinent. Plan provisions require that you pursue the claim and appeal rights described here before seeking other legal recourse.

During the appeal, you will receive, upon request and free of charge, reasonable access to and copies of all documents, records and other information relevant to your benefit claim. For this claim procedure, a document, record or other information is considered relevant to a claim if it:

- Was relied on by the claim administrator in making the initial claim decision
- Was submitted, considered or generated in the course of deciding the claim, without regard to whether the document, record or other information was relied upon by the claim administrator in reaching the claim decision

- Demonstrates compliance with the administrative processes and safeguards required under Department of Labor regulations in making the benefit determination.

You may submit any written comments, documents, records or other information relating to your claim. In making its determination on health care claim appeals, the Appeals Committee of the Washington Teamsters Welfare Trust will take into account all the comments, documents, records and other information you submitted relating to the claim, without regard to whether they were submitted or considered by the claim administrator in making the initial claim decision.

The Appeals Committee will conduct a review and make a final decision within a certain period after receiving your written request for review, as described below and on page 47. For certain plans, if the Appeals Committee needs more than this initial period to make a decision due to special circumstances, it will notify you in writing within the initial decision timeframe and explain why more time is required and the date the plan expects to make a decision.

The Appeals Committee will review your denied claim. You or your authorized representative has the right to present relevant information or testimony at the quarterly Appeals Committee meeting scheduled to hear your appeal. You will be notified of the meeting time and date, however a personal appearance is not required. The appeal review will not be conducted by the individual who denied the initial claim or that person's subordinate. The Appeals Committee will not give deference to the original decision on your claim; that is, they will take a fresh look and make an independent decision about the claim within the timeframes.

If your claim was denied based on a medical judgment, the Appeals Committee will consult with a health care professional who has appropriate training and experience in the field of medicine involved in your claim. The health care professional will not be the same person as the one consulted on the initial decision (or a subordinate of that person). A medical judgment includes whether a treatment, drug or other item is experimental, investigational or not medically necessary or appropriate. You also have the right to learn the identity of any medical or other experts who advised on your original claim decision, whether or not the Plan relied on their advice.

Timeframes for Filing and Determination of Health Care Appeals

You have 180 days from the date you receive notice of a health care claim denial to file your appeal. Appeal decision timeframes vary, depending on the type of health care claim filed:

- **Urgent care** — The Trust Administrative Office will provide notice of appeal decision as soon as possible, considering the medical situation, but no later than 72 hours after receiving your appeal, unless you do not provide sufficient information to determine whether, or to what extent, benefits are covered or payable under the plan (see page 48).

- **Pre-service** — The Trust Administrative Office will provide notice of appeal decision within 30 days of appeal.

- **Post-service** — The Trust Administrative Office will provide notice of appeal decision within five days after the next quarterly meeting of the Appeals Committee if the appeal is received at least 30 days before the meeting, otherwise the decision will be provided within five days after the second quarterly meeting that follows receipt of the appeal. If special circumstances require an extension of time for rendering a decision, the claim administrator will provide notice of the extension within the initial decision timeframe, and a decision will be rendered at the next quarterly meeting, with notice provided within five days after that meeting.

Notice of Decisions on Appeal

The decision on appeal will be in writing. If your appeal is denied, the notice will include:

- Reasons for the denial
- References to specific plan provisions on which the denial is based
- A statement of your right to access and receive copies, upon request and free of charge, of all documents and other information relevant to the claim for benefits
- A statement of your right to bring a civil action under ERISA Section 502(a)
- Certain other information in accordance with applicable U.S. Department of Labor regulations.

If the Appeals Committee does not respond within the applicable timeframe, you should generally consider the appeal denied. Contact the Trust Administrative Office if you have questions.

Administrative Details

The Employee Retirement Income Security Act of 1974 (ERISA) as amended, requires that certain information be furnished to Plan participants and beneficiaries:

Name of Plan

- This Plan is known as the Washington Teamsters Welfare Trust — Dental Plan B.

Name, Address and Telephone Number of Board of Trustees as Plan Sponsor

- This Plan is sponsored by a joint labor-management Board of Trustees:

Board of Trustees of the Washington Teamsters Welfare Trust
2323 Eastlake Avenue East
Seattle, Washington 98102
206-329-4900

You can obtain information on whether a particular employer or employee organization is a Plan sponsor (and, if so, their address) by writing to the Trustees. This information is also available to examine at the Trust Administrative Office. The Trustees may impose a reasonable charge for furnishing this information. You may want to inquire about the charge before requesting information.

Employer Identification Number and Plan Number

- The employer identification number assigned to the Board of Trustees by the Internal Revenue Service is EIN 91-6034673.
- The Plan number is 501.

Type of Plan

- This Plan is a welfare plan that provides dental benefits.

Type of Administration

This Plan's benefits are administered by the Board of Trustees with the assistance of this administrative organization:

Washington Dental Service
Customer Service Department
PO Box 75688
Seattle, Washington 98175-0688
206-522-2300
800-554-1907
www.DeltaDentalWA.com

This Plan's COBRA administration, participant enrollment, and other services are administered by the Board of Trustees with the assistance of this administrative organization:

Northwest Administrators, Inc.
2323 Eastlake Avenue East
Seattle, Washington 98102
206-329-4900

Name and Address of Agent for Service of Legal Process

Each member of the Board of Trustees is designated as an agent for accepting service of legal process on behalf of the Plan. The names and addresses of the Trustees are below.

Legal process can also be served on:

Northwest Administrators, Inc.
2323 Eastlake Avenue East
Seattle, Washington 98102

Names and Addresses of Board of Trustees

Employer Trustees	Employee Trustees
Al Baird Allied Employers, Inc. 4030 Lake Washington Boulevard NE Suite 201 Kirkland, Washington 98033-7870	Earl D. "Doug" Bush, Jr. Teamsters Local Union No. 589 632 Fifth Street, #4 Bremerton, Washington 98337
Jim Bryant United Parcel Service 4455 7th Avenue S. Seattle, Washington 98108	Al Hobart Joint Council of Teamsters No. 28 553 John Street Seattle, Washington 98109
Jerry D'Ambrosio 11019 SE 60th Street Bellevue, Washington 98006	Justin "Buck" Holliday Teamsters Local Union No. 690 1912 N. Division Spokane, Washington 99207
Frank Jorgensen Safeway Stores, Inc. PO Box 85001 Bellevue, Washington 98015-8501	Ed Jacobson Teamsters Local Union No. 252 217 E. Main Street Centralia, Washington 98531-4449
John H. Mack PO Box 80681 Seattle, Washington 98108	David Lovell Teamsters Local Union No. 117 220 S. 27th Street Tacoma, Washington 98402-2799
H.L. "Buzz" Ravenscraft 6631 113th Place SE Bellevue, Washington 98006-6429	John Parks Teamsters Local Union No. 760 1211 West Lincoln Avenue Yakima, Washington 98902
Dan White Washington Employers, Inc. 2940 Fairview Avenue E. PO Box 12068 Seattle, Washington 98102	Scott Sullivan Teamsters Local Union No. 174 553 John Street Seattle, Washington 98109
Randall Zeiler Allied Employers, Inc. 4030 Lake Washington Boulevard NE Suite 201 Kirkland, Washington 98033-7870	John A. Williams Teamsters Local Union No. 117 553 John Street Seattle, Washington 98109

Description of Collective Bargaining Agreements

This Plan is maintained under many collective bargaining agreements between various employers and labor organizations. You may obtain a copy of these collective bargaining agreements by writing to the Trust Administrative Office. This information is also available to examine at the Trust Administrative Office. The Trustees may impose a reasonable charge for furnishing the collective bargaining agreements. You may want to inquire about the charge before requesting a copy.

Eligibility and Benefits

Employees are entitled to participate in the Plan if they work under a collective bargaining agreement requiring contributions on their behalf and the employer makes those contributions to the Trust. The eligibility rules describing which employees and dependents are entitled to benefits begin on page 10. The benefits are described beginning on page 22.

Termination of Eligibility

An employee or dependent who is eligible for benefits may become ineligible as a result of one or more of the following circumstances:

- The employee's failure to work the required hours to maintain eligibility (or failure to make a self-payment, where authorized). See When Coverage Ends and COBRA Self-Pay Option on pages 11 and 18.
- The failure of the employee's employer to report the hours and remit contributions on the employee's behalf to the Trust Fund.
- An eligible dependent is no longer being a dependent as described on page 12 or attains a disqualifying age as shown on page 11.
- Termination of the governing collective bargaining agreement or the Trust.

Future of the Plan and Trust Fund

The Board of Trustees has authority to terminate the Trust Fund. The Trust Fund will also terminate when collective bargaining agreements and special agreements requiring the payment of contributions expire. In the event of termination, the Board of Trustees will:

- Use the Trust Fund to pay expenses incurred up to the date of termination and expenses incident to the termination.
- Distribute the balance, if any, of Trust Fund assets to carry out the purpose of the Trust.
- Upon termination, the Board of Trustees may transfer remaining Trust Fund assets to the Trustees of any fund established to provide substantially the same or greater benefits than this Plan. In no event will any of the funds revert to or be recoverable by any employee, employer or union.

Source of Contributions

This Plan is funded through employer contributions; the amount is specified in the collective bargaining agreements. Also, self-payments by employees are permitted as outlined in this Plan booklet. The amount of the total plan cost is changed from time to time by the Board of Trustees, including employer contributions alone or a combination of employer contributions and employee self-payments.

Entities Used for Accumulation of Assets and Payment of Benefits

Employer contributions are received and held in trust by the Board of Trustees pending the payment of benefits or premiums. The Trustees pay benefits directly from the Trust Fund.

Plan Year

This Plan is on a 12-month fiscal year basis beginning July 1 and ending the following June 30.

ERISA Rights and Protections

As a participant in the Trust, you are entitled to certain rights and protections under ERISA, which provides that all Plan participants be entitled to:

- Examine, without charge, at the Trust Administrative Office and at other specified locations, such as work sites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the Department of Labor and available at the Public Disclosure room of the Employee Benefits Security Administration.
- Obtain, upon written request to the Trust Administrative Office, copies of documents governing Plan operation, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Trust Administrative Office may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report. The Trust Administrative Office is required by law to furnish each participant with a copy of this summary annual report.
- Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the Plan to learn the rules governing these COBRA continuation coverage rights.
- Reduce or eliminate exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan. You should receive a certificate of creditable coverage, free of charge, from your Plan or insurer when you lose coverage under the Plan, when you become entitled to elect COBRA continuation coverage and when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after enrolling.

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for operation of the Plan. The people who operate your Plan, called "fiduciaries," have a duty to do so prudently and in the interest of you and other 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.

If your claim for a welfare benefit is denied or ignored, in whole or in part, you must receive a written explanation of the reason for the denial. You have the right to have the Plan review and reconsider your claim.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of documents or the latest annual report for 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 Trust 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 Trust's control. If your claim for benefits is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the Plan's decision or lack of decision concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in federal court. If fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the 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.

If you have any questions about your Plan, contact the Trust Administrative Office or WDS/Delta Dental. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Trust Administrative Office or WDS/Delta Dental, contact the nearest office of the Employee Benefits Security Administration, Department of Labor, listed in your phone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, Department of Labor 200 Constitution Avenue NW, Washington, DC 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.

RESOLUTION 729-20 EXHIBIT E

WASHINGTON TEAMSTERS WELFARE TRUST

Summary Plan Description
Vision Plan EXT

Effective January 1, 2010

WASHINGTON TEAMSTERS WELFARE TRUST
MAY 2014

SUMMARY OF MATERIAL MODIFICATIONS

This is a "summary of material modifications" (SMM) to the Washington Teamsters Welfare Trust's Summary Plan Descriptions (plan books) **effective July 1, 2014**. Some plan modifications (changes) only apply to certain plans as noted. The information in this SMM updates and/or replaces the applicable sections of each book until new books become available. Please read it carefully and keep it with your benefit plan booklet(s). If you have questions about the information presented here, feel free to contact the Trust Administrative Office at 800-458-3053.

CONTACT LENSES – VISION PLAN EXT

The NBN in-network benefit limit of $150 per 365 days for contact lenses is eliminated for covered participants (employees, spouses, and children) under age 19 and replaced with a limit of one set of contact lenses or the equivalent number of disposable lenses per 365 days, which will be covered in full. The non-network benefit limit of $90 per 365 days remains.

DEPENDENT COVERAGE – ALL PLANS

Participants may elect not to cover their spouse if: (a) they are legally separated and provide documentation of this fact to the Trust Administrative Office; or (b) their spouse consents to not being covered. Participants may elect to later reenroll their spouse or their spouse may revoke consent and reenroll.

Under federal law, a Participant's child has a right to be enrolled in coverage under the Participants' plan through the age of 25. If a Participant would like to elect not to cover a child age 18 or older, he or she must first provide the Trust Administrative Office with the child's address in order for the child to be notified that coverage is being terminated. The child will be given the right to reenroll. Participants may elect later to reenroll a child provided the child is under age 26 at the time.

Termination of coverage or coverage upon reenrollment of a spouse or child will be effective the first of the month following receipt of written notification by the Trust.

WASHINGTON TEAMSTERS WELFARE TRUST

VISION PLAN EXT SUMMARY PLAN DESCRIPTION

SUMMARY OF MATERIAL MODIFICATIONS (CHANGES SINCE THE FOLLOWING BOOK WAS LAST PRINTED)

This is a "summary of material modifications" (SMM) to the Washington Teamsters Welfare Trust Vision plan for active employees covering the period from January 2010 through July 2011. The information in this SMM updates and replaces the applicable sections of this booklet, until a new booklet become available. Please read it carefully and keep it with your benefit plan booklet.

If you have questions about the information presented here, feel free to contact the Trust Administrative Office at 800-458-3053. If you need information on what coverage you have through the Trust, please refer to your collective bargaining agreement or contact the Trust Office, your local union, or employer.

DEPENDENT CHILD ELIGIBILITY

Effective July 1, 2011, as part of the Patient Protection and Affordable Care Act (PPACA), children meeting the following criteria will be covered by the Trust:

Your eligible dependent children are your children under age 26 who are your:

- Natural children
- Adopted children
- Step Children
- Children placed with you for adoption

These children do not have to depend on you for support, do not have to attend school full time, and can be married and can have access to other health coverage through their own employment.

Your eligible dependent children also include your unmarried children up to age 19 who live with you and are dependent on you for support and are:

- Children for whom you are the court-appointed guardian
- Grandchildren
- Children of your domestic partner if your local union and employer negotiated domestic partner benefits

These dependent children who would otherwise qualify as eligible dependents but are 19 years or older will be eligible until age 26 (through 25th year) if they depend on you for support/maintenance and are full-time students in an accredited educational institution. School vacation and total disability periods that interrupt but do not terminate what would have been a continuous course of study are considered part of full-time attendance.

Except as noted below, all children who qualify as eligible dependents are eligible for benefits from the later of the effective date of your coverage or the date child meets the requirements above, except for children of domestic partners, who are covered prospectively from the date they are enrolled. Children who lost coverage prior to July 1, 2011 and are eligible to be enrolled under the Patient Protection and Affordable Care Act on July 1, 2011 will be covered as of July 1, 2011 if they are enrolled no later than 31 days after that date, otherwise they will be covered prospectively from the date they are re-enrolled.

For dependent life benefits, unmarried children are covered only until age 19.

An unmarried eligible dependent child who is physically or mentally incapable of self-support is eligible under the Plan while incapacitated, if your own coverage is in effect. To cover a child

under this provision, file a Proof of Incapacity Form with the Trust Administrative Office within 31 days after coverage would otherwise end or within 31 days of the date you become covered by the Plan if a child is 19 or older at that time. Additional proof will be required from time to time; unless you provide additional proof as requested, the child's coverage will end.

In accordance with federal law, the Plan also provides medical coverage (including dental and vision coverage if these coverages are being provided through a Trust plan) to certain dependent children (called alternate recipients) if directed to do so by a Qualified Medical Child Support Order (QMCSO) issued by a court or state agency of competent jurisdiction and your own healthcare coverage is in effect.

CLAIMS APPEAL PROCEDURES

Effective for services provided on or after July 1, 2011, the Claim Appeal Procedures are modified as described below. These modifications are required by Section 2719 of the Patient Protection and Affordable Care Act (PPACA) and the regulations thereunder.

The Trust's internal claim appeal procedures consist of a right of appeal to a Committee of Trustees for an internal review. The health care reform legislation now requires that a claimant who is dissatisfied with a decision by the Trustees' Appeals Committee has a right to request an external review. Technical Release 2010-01 issued by the U.S. Department of Labor's Employee Benefits Security Administration describes how such an external review is to be conducted pending final guidance from the regulatory agencies. These requirements are summarized below.

REQUEST FOR EXTERNAL REVIEW

You must complete the internal claims appeal process discussed above before requesting an external review. Once the internal claim appeal process is completed by the Appeals Committee making its decision, you will have 120 days from the date you receive that decision to file a request for an external review.

You may request external review for any denied claim except for denials based on finding that you did not satisfy the eligibility requirements for a benefit under the terms of the applicable Plan.

Requests for external reviews should be sent to:
External Review Appeals
PO Box 12267
Seattle, WA 98102

PRELIMINARY REVIEW OF EXTERNAL REVIEW REQUEST

Within five (5) business days of receiving a request for external review, the Trust will complete a preliminary review of the request to make sure that:

- The patient is or was covered under the Trust at the time the health care item or service was requested or, in the case of a retrospective review, was covered under the Trust at the time the health care item or service was provided;
- The decision being appealed does not relate to any failure to meet the applicable eligibility requirements;
- The Trust's internal claims appeal process has been completed; and
- All the information and forms required to process an external review have been received.
- The matter appealed involves either medical judgment or rescission.

Within one business day after completion of this preliminary review, the Trust will issue notification of its decision. If the request is not eligible for external review, the Trust's notice

will explain the reasons and provide any other information required, including contact information for the U. S. Department of Labor's Employee Benefits Security Administration (EBSA). If the request for external review is incomplete, the Trust 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 Trust will refer the matter to an Independent Review Organization (IRO).

REVIEW BY INDEPENDENT REVIEW ORGANIZATION

After a properly filed request for external review is referred, the Trust will provide the IRO with the required documentation in the time required by applicable Federal regulations. The IRO will notify both you and the Trust of its decision within 45 days after it has received the request to review.

EXPEDITED EXTERNAL REVIEW

You may request the IRO to provide you an expedited external review if you received:

- An adverse benefit determination involving a medical condition of the patient for which the time frame for completion of the Trust's expedited internal review process would seriously jeopardize the life or health of the patient or would jeopardize the patient's ability to regain maximum function and you have filed a request for an expedited internal appeal; or
- A final adverse benefit determination, if the patient has a medical condition where the timeframe for completion of a standard external review would seriously jeopardize the life or health of the patient or would jeopardize the patient's ability to regain maximum function, or if the final adverse benefit determination concerns an admission, availability of care, continued stay, or health care item or service for which the patient received emergency services, but has not been discharged from a facility.

If the Trust receives a request for expedited external review, it will proceed immediately to determine whether the request meets the reviewability requirements for a standard external review and will notify you of its determination. If the Trust determines that the appeal is eligible for a standard external review, the Trust will assign an IRO and will provide all necessary documents and information considered in making the adverse benefit determination or final adverse benefit determination to the IRO electronically or by any other available expeditious method. The IRO will notify the Trust and you of its determination as expeditiously as the patient's medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request for an expedited external review.
If the notice from the IRO is not in writing, within 48 hours after the date of providing the notice, the IRO will provide both you and the Trust written confirmation of the decision.

ACTIONS FOLLOWING THE DECISION OF THE IRO

If the IRO directs that benefits be paid, the Trust will provide benefits under the applicable Plan in accordance with the decision. If the decision is adverse, you will have the right to pursue a suit pursuant to 29 U.S.C. 1132(a). Any legal action seeking to overturn a denial or an action that has otherwise adversely affected a claimant must be brought within 180 days of the latest of the following events: the initial denial with no appeal being made; the final adverse benefit determination by the Trust; or the IRO's denial.

INTRODUCTION

This booklet describes the benefits and provisions of the Washington Teamsters Welfare Trust's Vision Plan EXT for employers who negotiate a collective bargaining agreement requiring Plan contributions on behalf of their employees.

This Plan is designed to assist you and your family in paying the cost of vision care. We encourage you to become familiar with the NBN network of vision care providers, your vision benefits, and the valuable protection they offer. If you have any questions, please contact Northwest Administrators, Inc. (NWA), which administers this plan on behalf of the Washington Teamsters Welfare Trust. This Plan is funded directly by the Trust, using contributions from both employers and participants. This money goes into the Trust and the Trustees, representing the participating employers and local union members, decide the level of funding and plan design. NWA follows the rules set forth by the Trustees, and takes care of the plan's benefit and claims administration.

As you think about how to use your benefits, consider that your use of the Plan directly affects costs. We encourage you to be a wise consumer.

IMPORTANT NOTICE

Payment of benefits as specified in this booklet depends on your employer making contributions for you to the Washington Teamsters Welfare Trust sufficient to maintain these benefits. The amount of necessary employer contributions may increase from time to time. If you are ineligible for Plan coverage, the fact that contributions were made on your behalf will not entitle you to benefits.

Only the Trust Administrative Office, Northwest Administrators, Inc., 2323 Eastlake Avenue East, Seattle, Washington represents the Trustees in administering the Plan and giving information about the amount of benefits, eligibility and other Plan provisions. No union employee, union officer, business agent, employer or employer representative or representative of any other organization except the Trust Administrative Office is authorized to give Plan information, interpret the Plan or commit the Trustees on any matter. In all cases, the terms of the Plan govern.

While no change in the Plan is anticipated, the Trustees reserve the right to terminate, amend or eliminate benefits as deemed necessary. The Trustees have no obligation to furnish benefits beyond those that can be supported by the Trust fund.

Si necesita ayuda para entender este panfleto, comuniquese con la oficina administrativa al 206-726-3278 o 1-800-732-1123.

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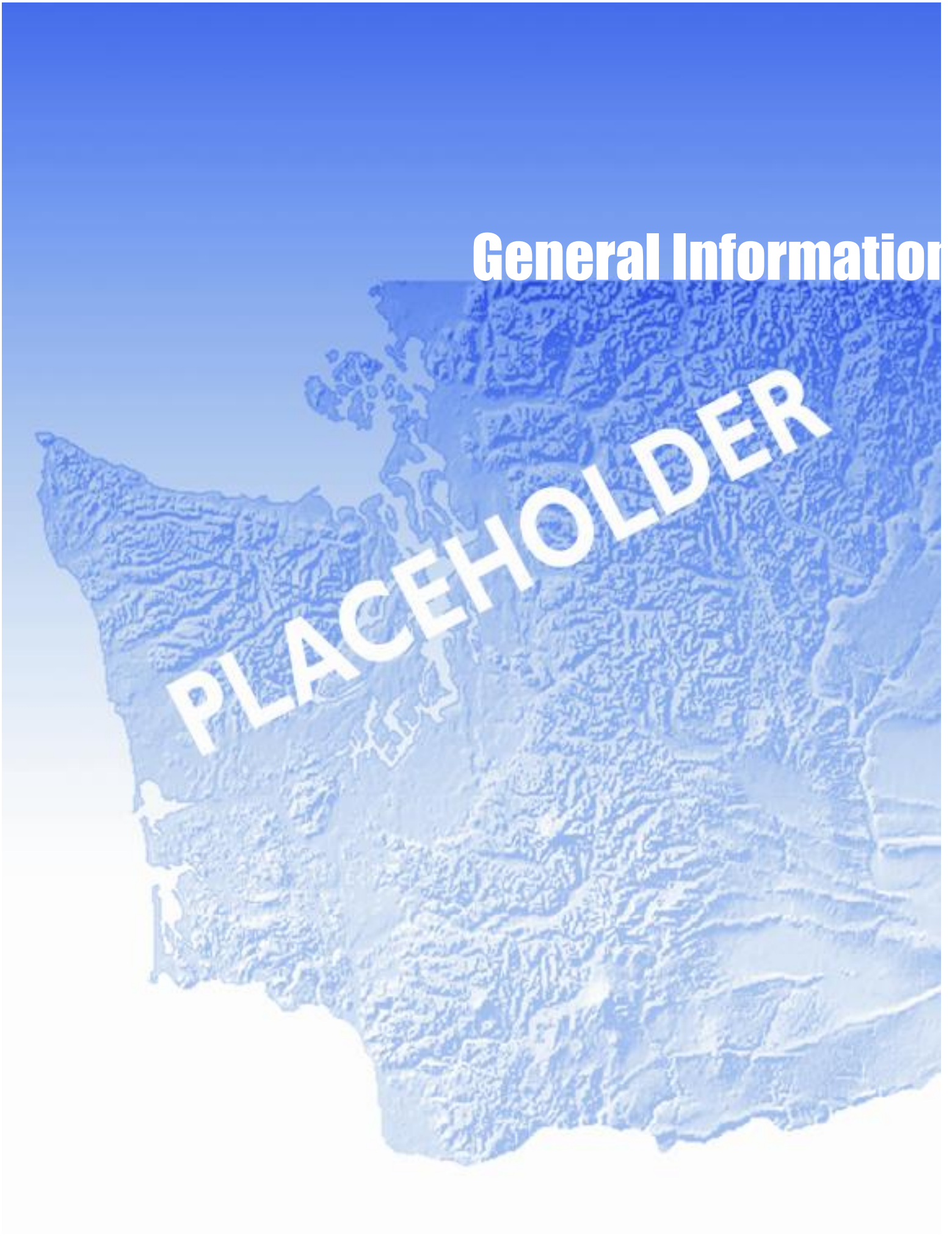
General Information



General Information

Trust Administrative Office

This Plan is administered by Northwest Administrators, Inc. (NWA). Contact the Trust Administrative Office for questions about:

- Enrollment in the Plan
- Whether you are eligible for coverage
- Filing a vision claim or checking the status of a vision claim or
- Benefits covered under this Plan.

The Trust Administrative Office can be contacted at:

Washington Teamsters Welfare Trust
Northwest Administrators, Inc.
2323 Eastlake Avenue East
Seattle, WA 98102

206-726-3278 or 800-732-1123

Northwest Benefit Network (NBN)

This Plan uses the NBN network of vision care providers to help control costs. You may choose any licensed vision care provider, but when you use an NBN network provider, you receive the highest level of coverage and reduce your out-of-pocket expenses.

NBN network providers may change from time to time. To verify that your vision care provider is in the network or to check the status of a vision care provider, call the Trust Administrative Office at the number above or check online in the *Plan Participant* section of the Northwest Administrators, Inc. website at www.nwadmin.com.

Enrollment Information

Participant Data Form

To receive benefits under this Plan and avoid delays in claim administration, you must complete and submit a Participant Data Form to the Trust Administrative Office when you first become eligible for coverage. Participant Data Forms can be obtained from the Trust Administrative Office or your local union.

If you have completed a Participant Data Form for a Trust medical or dental plan, you do not need to complete another form.

Updating Enrollment Data

Accurate and efficient claim processing depends, in part, on the Trust Administrative Office having current data. Changes in address, marital status, number of dependents and information about other insurance are critical. Remember to advise the Trust Administrative Office promptly of these changes by completing a new Participant Data Form.

Identification (ID)/Information Card

This Vision Plan does not require use of an ID/information card. Simply take a Washington Teamsters Welfare Trust NBN vision claim form with you when you see a vision care provider.

Your Trust ID/Information card does contain important Vision Plan information for you and your vision care providers, such as telephone numbers and where to send claims.

Quick Guide to Claim Filing

Following these guidelines ensures that the providers and vision claims processors have all the information needed to pay your claims. Using NBN network providers also ensures that you receive the highest level of coverage provided by the Plan.

If you are uncertain about your eligibility, you or your vision provider can call the Trust Administrative Office at 206-726-3278 or 1-800-732-1123 to verify eligibility.

NBN Network Providers

1. Contact the Trust Administrative Office to locate an NBN network provider or to verify that your provider is in the network. A list of network providers can also be found online on the home page of the Northwest Administrators, Inc. website at www.nwadmin.com; just click on *Search NBN Vision Providers* and enter information for your search.

2. Obtain an NBN claim form from your local union or the Trust Administrative Office. A separate claim form must be submitted for each pair of eyewear. The claim form must be given to the provider when you first visit the NBN provider's office. If the provider does not receive the claim form until after services have started, you will be responsible for paying the provider for all services and/or materials provided and you will be reimbursed according to the non-network benefit schedule.

3. Check to see that "Washington Teamsters Welfare Trust" appears in "Name of Group" space on the claim form(s). This information should be printed on the form; however, if it is missing, be sure to provide it. Complete the top portion of the form and the eligible employee must sign the form.

4. You should be charged only for items not covered by the Plan. The provider will bill you for the cost of any non-covered services and/or eyewear, including the cost of the materials and any additional dispensing fee. You are not required to file a claim. The provider will submit the claim to NBN for you.

Non-Network Providers

1. Obtain an NBN claim form(s) from your local union or the Trust Administrative Office. A separate claim form must be submitted for each pair of eyewear.

2. You can pay the provider directly or assign your Trust benefit to the provider. Either you or your provider should send a copy of the itemized bill along with the NBN claim form to:

   Washington Teamsters Welfare Trust
   2323 Eastlake Avenue East
   Seattle, Washington 98102-3393

3. If you paid the provider, the Trust's benefit payment will be sent directly to you. If you assigned your benefit to the provider, the Trust's payment will be sent to the provider.

Eligibility and Coverage Effective Dates

Eligibility and Coverage Effective Dates

Who's Eligible

To become eligible for contributions to be made to the Trust on your behalf, you must first meet the requirements in your employer's collective bargaining agreement, consistent with Trust guidelines. You also must be an active employee with the minimum number of compensable hours or hours worked (usually 80) during a month for any one employer who makes Plan contributions.

Coverage Effective Dates

When Coverage Begins

Coverage and benefits for new hires begin after one month's contribution is made on your behalf under the lag month eligibility system. For example, if you are a new hire who satisfies the requirements of your collective bargaining agreement, you work enough hours in June and your employer makes a contribution in July (the lag month), your coverage begins August 1. *Please note, you need at least two consecutive months of contributions before resigning or retiring to preserve the first month of coverage. See Two-Month Rule on page 11 for more information.*

The lag month eligibility system continues while you work enough hours each consecutive month for a contribution to be made on your behalf. For example, if you work enough hours in January and your employer makes a contribution in February (the lag month), coverage is provided in March (rather than February).

Break in Contributions

Coverage and benefits will end, however, any time you have a break in contributions from any one employer for whatever reason. When coverage ends depends on the reason for the break in contributions as explained below.

Resignation, Retirement or Employer Withdrawal from the Trust

When you have a break in contributions from one employer *due to resignation, retirement or as a result of your employer withdrawing from coverage under the Trust*, the lag month system terminates and your coverage will stop at the end of the month following the month in which you last had enough hours to receive a contribution (provided you had at least two consecutive months of contributions; see Two-Month Rule). For example, if you resign in April after working enough hours to receive a contribution, and the final contribution to the Plan is made in May, your coverage will end on May 31.

Layoff, Reduction in Hours, Disability, or Termination of Employment

When you have a break in contributions from one employer due to any reason other than resignation, retirement or as a result of your employer withdrawing from coverage under the Trust – *such as a layoff, a reduction in hours, disability or termination of employment* – the lag month system does not terminate and your coverage will continue until the end of the *second* month following the month in which you last had enough hours to receive a contribution. For example, if you are laid off in April after working enough hours to receive a contribution, and the final contribution to the Plan is made in May, your coverage will end on June 30.

If following a break in employer contributions from any one employer, you return to work for sufficient hours in a month and contributions are again made on your behalf, your coverage will resume the same as for a new hire.

Two-Month Rule

If you are a new hire or re-establishing eligibility following a break in contributions, you must have at least two consecutive months of contributions before a break in contributions due to resignation, retirement, or your employer withdrawing from the Trust in order to preserve coverage for the first contribution. If you do not have two consecutive months of contributions before a break in contributions due to resignation, retirement, or your employer withdrawing from the Trust, you will lose eligibility for coverage for that single month of contributions.

For example, you did not work enough hours in May to receive a contribution, but you do work enough hours in June, so your employer makes one contribution in July (for August coverage). Then, you resign in July without working enough hours to receive a second consecutive contribution. Your coverage for August will be cancelled because the break in contributions due to your resignation results in a termination of the lag month system.

This two-month rule does not apply in cases of layoff, reduction in hours, disability or termination of employment. It only applies to resignations, retirements, or employer withdrawals from the Trust

When Coverage Ends

Your coverage will end if this Plan terminates or if your employer ceases to make required contributions or stops participating in the Plan.

When you have a break in contributions, coverage stops at the end of the first or second month following the month in which you last have the minimum number of hours stated in the collective bargaining agreement for contributions from any one contributing employer, depending on the reason for your break in contributions. See Break in Contributions on page 10 for more information.

Any employee or dependent in full-time military service will not be covered except as described in Military Service Under USERRA on page 17 and COBRA Self-Pay Option on page 20.

Eligible Dependents

Eligible dependents are:

- Your spouse
- Your domestic partner ***if*** your local union and your employer negotiated domestic partner benefits for your group (see "Domestic Partner Benefits" below).
- Your unmarried natural or adopted children younger than 19, including children under age 19 placed in your home pending adoption where you have assumed a legal obligation for support and maintenance of the child in anticipation of the adoption
- Unmarried children for whom you are the court-appointed legal guardian, or your stepchildren or grandchildren if they are unmarried and younger than 19, live with you and depend on you for support/maintenance.
- Children of your domestic partner ***if*** your local union and employer negotiated domestic partner benefits (see "Domestic Partner Benefits" below):

All children who qualify as eligible dependents are eligible for vision benefits from birth.

For vision benefits, all children who otherwise qualify as eligible dependents but are 19 or older will be eligible until age 26 (through age 25) if they depend on you for support/maintenance and are full-time students in an accredited educational institution. School vacation and total disability periods that interrupt but do not terminate what would have been a continuous course of study are considered part of full-time attendance.

An unmarried eligible dependent child who is physically or mentally incapable of self-support is eligible under the Plan while incapacitated, if your own coverage is in effect. To cover a child under this provision, file a Proof of Incapacity Form with the Trust Administrative Office within 31 days after coverage would otherwise end or within 31 days of the date you become covered by the Plan if a child is 19 or older at that time. Additional proof will be required from time to time; unless you provide additional proof as requested, the child's coverage will end.

In accordance with federal law, the Plan also provides medical coverage (including dental and vision coverage if these coverages are being provided through a Trust plan) to certain dependent children (called alternate recipients) if directed to do so by a Qualified Medical Child Support Order (QMCSO) issued by a court or state agency of competent jurisdiction and your own health care coverage is in effect. Contact the Trust Administrative Office for details.

Any employee or dependent in full-time military service will not be covered except as described in Military Service Under USERRA on page 17 and COBRA Self-Pay Option on page 20.

Domestic Partner Benefits

If your group has negotiated to add domestic partner benefits, you may enroll your same or opposite sex domestic partner for benefits if:

- You (the covered member) and your domestic partner have registered as domestic partners or entered into a civil union in the state or municipality where registered; or
- You and your domestic partner meet all of the following requirements:
  - You are both at least age 18
  - Neither of you is legally married to another person of the opposite sex or in a domestic partnership with another person
  - You are not related by blood to a degree of closeness that would prohibit marriage
  - You are in an exclusive, committed relationship that is intended to be permanent
  - You share a mutual obligation of support and responsibility for each other's welfare
  - You currently share a principal residence and have done so for at least 6 months, and intend to do so permanently

  or

  - You are married adults of the same sex and your marriage is recognized by the state where you live.

Documentation Required

If your group negotiates domestic partner benefits and you want to enroll your domestic partner, you and your partner will be required to complete a notarized Affidavit of Domestic Partnership and submit a birth certificate or driver's license as proof of your domestic partner's age, plus additional documentation to verify your domestic partner's eligibility including that you have shared a principal residence for at least six months. This additional documentation must include any three of the following:

- Declaration, Affidavit, or Certification of Civil Union from a state or municipality that issues such
- Marriage certificate from a state or municipality that recognizes same sex marriages
- Legal documents indicating that, as domestic partners, they are responsible for each other's welfare
- Home title or other documents showing joint ownership of significant property
- Rental agreement documenting joint tenancy

- Canceled checks showing rent or utility payments from both partners at the same address, or bills proving same
- Evidence of joint banking accounts (savings, checking, etc.)
- Power of Attorney (durable property or health care)
- Wills, life insurance policies, or retirement annuities naming each other as primary beneficiary
- Co-parenting or adoption agreement.

Children of Domestic Partners

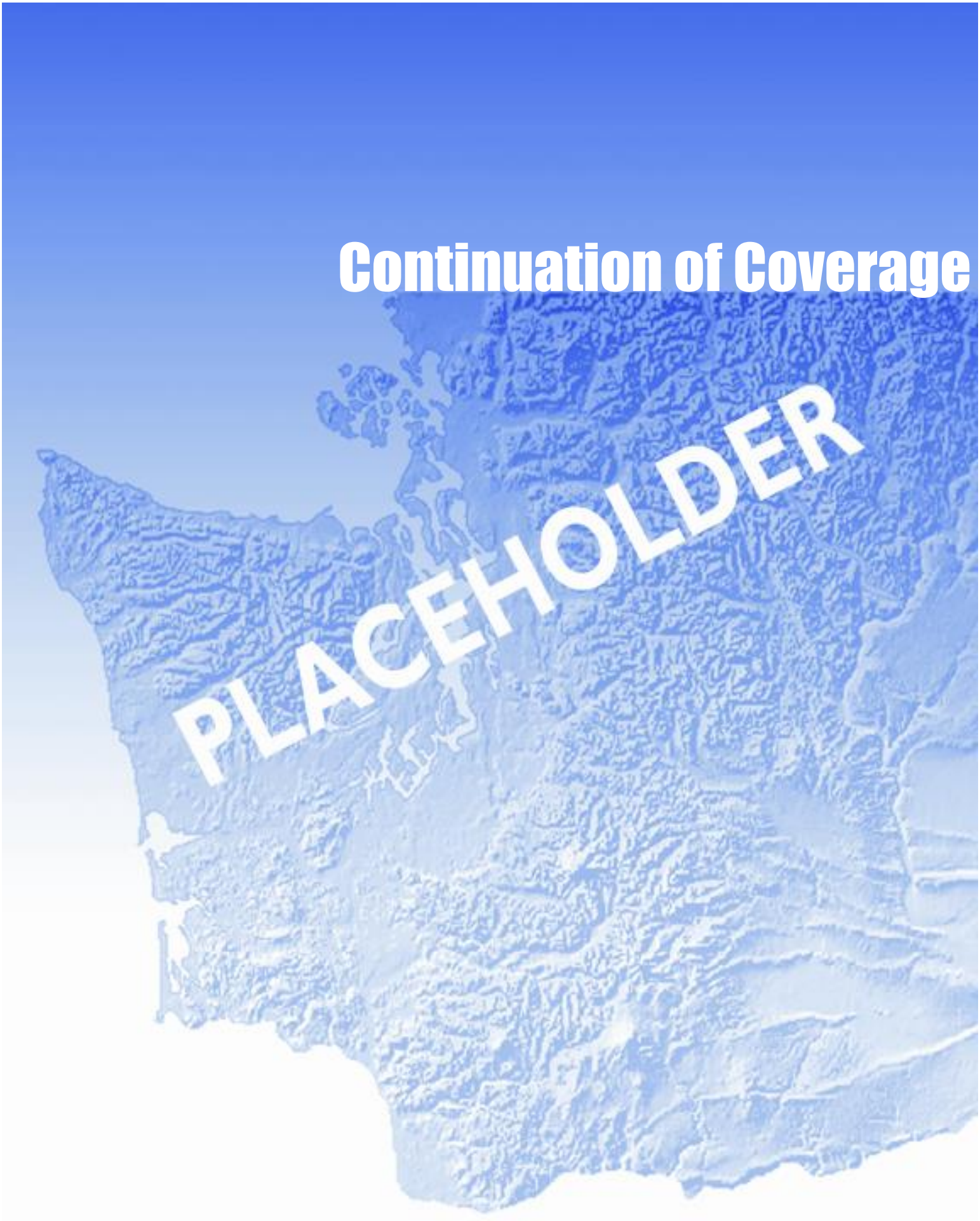
If your group negotiates domestic partner benefits and you want to enroll children of your domestic partner, the child(ren) may be enrolled subject to the plan's preceding dependent children eligibility requirements including that the child(ren) are:

- Dependent upon you for support and maintenance, and
- Unmarried, and
- Under 19 years old and residing with you and your domestic partner ***or*** at least 19 but under 26 and enrolled full-time in an accredited educational institution ***or*** disabled and physically or mentally incapable of self-support.

Other Important Information about Domestic Partner Benefits

It's important to note that domestic partner benefits are subject to different federal and state tax rules. Income taxes may be payable as a result of the Trust providing benefits to your domestic partner and his or her children. If your bargaining unit has bargained domestic partner benefits and you are covering a domestic partner, you may wish to consult a tax professional for advice on your personal situation. Domestic partners and their dependent children are not eligible for COBRA self-pay benefits when coverage ends.

Continuation of Coverage



Continuation of Coverage

This section describes various options for continuing vision coverage under specific circumstances.

Quick Guide to Continuing Your Coverage

The Trust offers a number of options for continuing your vision coverage after it would normally end, depending on your situation. The chart below provides an overview of these options, which are described in more detail in the following pages.

Continuing Your Vision Coverage Overview

Continuation option	How long coverage can be continued	Who can be covered	For details
Continues coverage lost due to delinquency of employer contributions	Up to three months	You and your eligible dependents	See page 17
Continues coverage lost due to a strike, lockout or labor dispute	Up to six months	You and your eligible dependents	See page 17
Continues coverage during a military leave	During your military leave (maximum of 24 months)	You and your eligible dependents	See page 17
Continues coverage during a Family or Medical Leave (FMLA)	During your FMLA leave (maximum of 12 weeks)	You and your eligible dependents	See page 18
Total Disability Waiver of Contributions	Up to three months	You and your eligible dependents	See page 19
COBRA (self-pay option)	Normally up to 18 months Up to 29 months if disabled Up to 36 months for dependents in certain circumstances	You and/or your eligible dependents	See page 20

Please note, this chart is only a brief summary and does not describe many details of the continuation options. Please refer to the pages shown in the chart for more detailed descriptions, or call the Trust Administrative Office.

Continuing Coverage Lost Due to Delinquency of Employer Contributions

Vision coverage for you and your eligible dependents may be continued without self-payment for up to three months if your employer is delinquent in Plan contributions and the employer account has been referred for collection. To be eligible for continued coverage, you must provide proof of employment that would have created eligibility had the required employer contribution been made. This continued coverage is for a maximum of three months after employer contributions stop and is available only once for an employer or successor. (This provision does not relieve an employer of any obligation to contribute to the Plan.)

Continuation of Vision Coverage in the Event of a Strike, Lockout or Other Labor Dispute

If your coverage terminates because active work ends as a result of strike, lockout or other labor dispute, your vision coverage may continue during the dispute while the Plan is in effect if you self-pay the required contributions. See pages 20 to 22 for information on COBRA self-pay coverage.

In no event may you continue your benefits beyond *the earliest* of these dates:

- Six months after you stop active work
- Your request that coverage be terminated
- Your failure to make the required self-payment on time
- Your eligibility for similar coverage under another group plan
- Termination of the Plan.

Military Service Under USERRA

If you leave covered employment to perform certain United States military service, you and your covered dependents may have the right to continue vision coverage. If your military service lasts less than 31 days (for example, active duty for training), the Plan will continue to cover you and your dependents. If your military service lasts 31 days or more, you and your dependents will be eligible to continue coverage through self-payment for up to 24 months. When you return to covered employment,

your regular coverage will begin immediately, if you meet the requirements summarized on the following page.

Under the Uniformed Services Employment and Reemployment Rights Act (USERRA), you must notify your employer before taking leave (unless precluded by military necessity or other reasonable cause). You should also tell your employer how long you expect to be gone. Upon release from military duty, you must apply for reemployment as follows:

- Less than 31 days military service — apply immediately, taking into account safe transportation plus an eight-hour rest period
- 31-180 days military service — apply within 14 days
- More than 180 days military service — apply within 90 days.

If you're hospitalized or convalescing, these reemployment deadlines are extended while you recover (but not longer than two years).

The rules above also apply to uniformed service in the commissioned corps of the Public Health Service.

To ensure proper crediting of service under USERRA, have your employer notify the Trust Administrative Office when you go on leave and again when you are reemployed following your return from leave.

If You Take a Family or Medical Leave

To be eligible under the federal Family and Medical Leave Act (FMLA), you must have worked for your current employer for at least 12 months and for at least 1,250 hours in the 12 months before your leave. If you meet these requirements and work for an employer with 50 or more employees within a 75-mile radius, the law requires your employer to continue contributions for your (and your dependents') vision coverage (if covered under the Trust) for up to 12 weeks during a 12-month period if you're on leave due to:

- Birth of a child, or placement for adoption or foster care
- Serious health condition of a child, spouse or parent
- Your own serious health condition.

Contact your employer as soon as you think you're eligible for a family or medical leave since the law requires you to give 30 days notice, or tell your employer immediately if your leave is caused by a sudden, unexpected event. Your employer can tell you of your other rights under FMLA.

If you haven't returned to work when your coverage under FMLA ends, you and your dependents will be able to elect COBRA self-pay coverage, as described on pages 20 to 22.

If you qualify for a Disability Waiver of Contributions, as described in the following section, and your leave falls under FMLA because of your own serious health condition employer contributions are not required by the Trust while you remain qualified for the Disability Waiver of Contributions.

Waiver of Contributions for Total Disability

If you fail to work the specified minimum monthly hours for eligibility because you're totally disabled, and you've submitted proof of the disability from your physician and employer, you may receive a waiver of contributions for up to *three* months if you remain totally disabled. The waiver period will begin on the first of the month following the month your employer's paid coverage ends. This waiver allows continuation of:

- Vision
- Dental — if covered by this Trust
- Medical/prescription — if covered by this Trust
- Life AD&D — if covered by this Trust.

At the conclusion of the waiver period you may elect COBRA and begin making COBRA self-payments, but your combined continuation coverage under the waiver period and COBRA may not exceed 18 months (29 months if disabled, or 36 months for your dependents under certain circumstances).

To determine eligibility for waiver of contributions, you must become disabled in a month for which you have eligibility based on an employer contribution or, if you have returned to covered work, for which you have eligibility based on a disability waiver of contributions due to a prior disability. You must also be:

- Totally disabled due to a covered accident or illness (including pregnancy and its complications), and
- Unable to perform the normal duties of your occupation, and
- Not engaged in any occupation for wage or profit (except light-duty work that may be allowed under your collective bargaining agreement), and
- Under a physician's regular care for that injury or sickness.

A subsequent disability separated by less than two weeks of full-time work is considered the same disability unless it is due to a different cause and begins after you return to full-time work.

Self-Pay for Continuing Vision Coverage

COBRA Self-Pay Option

You may be eligible to continue vision coverage after it would otherwise terminate based on a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). If you are an employee covered by the Plan, you and your covered dependents may choose COBRA self-pay coverage for up to 18 months if your coverage terminates for one of these qualifying events:

- A reduction in your hours of employment
- Termination of your employment for reasons other than gross misconduct.

A dependent spouse covered by the Plan may choose COBRA self-pay coverage for up to 36 months if coverage terminates for one of these qualifying events:

- Death of the participating employee
- Divorce from the participating employee
- Participating employee's entitlement to Medicare benefits.

A dependent child covered by the Plan may choose COBRA self-pay coverage for up to 36 months if coverage terminates for one of these qualifying events:

- Death of the participating employee
- Divorce of the participating employee and spouse
- Participating employee's entitlement to Medicare benefits (Part A, Part B or both)
- Participating employee's dependent child no longer meets the eligibility requirement under the Plan.

A spouse or dependent child who elects COBRA self-pay coverage for 18 months due to the employee's termination for reasons other than gross misconduct, or reduction in hours, may be eligible to continue coverage for up to 36 months for a second qualifying event:

- Death of the participating employee
- Participating employee divorces
- Participating employee's entitlement to Medicare benefits (Part A, Part B or both)
- Participating employee's dependent child no longer meets the eligibility requirements under the Plan.

It is your or your dependent's responsibility to inform the Trust Administrative Office of a divorce or loss of dependent status within 60 days from the latest of the following:

- Date of the divorce or loss of dependent status

- Date coverage is lost because of the event
- Date on which you were informed of the responsibility to provide the notice and of the Plan's procedures for notifying the Trust Administrative Office**.**

The employer is responsible for notifying the Trust Administrative Office when the employee's coverage ceases.

You or your dependent could receive a Social Security determination confirming disability at the time of the COBRA qualifying event (or within the first 60 days of continuation coverage due to the event). If this happens, the disabled person and all COBRA-eligible family members may be eligible for up to 29 months of continuation coverage. The Trust Administrative Office must receive a copy of the disability determination within *60 days* of the determination date and *within the original 18-month coverage period.*

If the disabled individual is later determined no longer to be disabled by the Social Security Administration, *you must notify the Trust Administrative Office within 30 days of the determination.* In this case, the 11-month COBRA extension will end as of the effective date the individual is no longer entitled to Social Security disability benefits.

When the Trust Administrative Office is notified that a qualifying event has occurred, it will supply details including:

- Application for COBRA self-pay coverage
- Cost information and payment procedures
- Requirements for continuation of coverage.

Trade Act of 2002

The Trade Act of 2002 created a second COBRA election for workers displaced by the impact of foreign trade and who are determined to be trade adjustment assistance (TAA) eligible individuals. TAA eligible individuals who declined COBRA when they were first eligible can elect COBRA within the 60-days of the first day of the month in which they become TAA eligible individuals. Nonetheless, this election may not be made more than six months after the date the TAA individual's group health plan coverage ended.

TAA eligible individuals are also eligible for a health insurance tax credit of up to 80% of qualified health insurance premiums, including COBRA coverage. You will be notified if this situation applies to you.

If you have questions about your extended ability to elect COBRA coverage or this new tax credit you may call the Health Coverage Tax Credit Customer Contact Center toll-free at 1-866-628-4282. More information about the Trade Act of 2002 is also available at www.doleta.gov/tradeact.

Timing Is Important

Your application and self-payments must be timely. You will be eligible for COBRA self-pay coverage only within the following time frames:

- You have *60 days* to elect COBRA from the later of the date you are notified or the loss of coverage date. You won't be eligible for COBRA self-pay coverage after this 60-day election period ends.
- The first self-payment is due within *45 days* of the date your first payment notice is mailed. Subsequent self-payments will be due no later than the last day of the month for which payment is being made. Your COBRA coverage will terminate automatically unless you make timely payments.

Employees who qualify for a total disability extension and waiver of contributions, described on page 19, may not have to make COBRA payments during the three-month waiver period. However, the combined period under COBRA self-pay coverage and the waiver may not exceed 18 months (29 months if disabled). To qualify for the additional 11-month COBRA disability period, you must qualify for and be receiving Social Security disability benefits. Contact the Trust Administrative Office for details.

COBRA self-pay coverage will be identical to that provided under the Plan to similarly situated active employees or dependents.

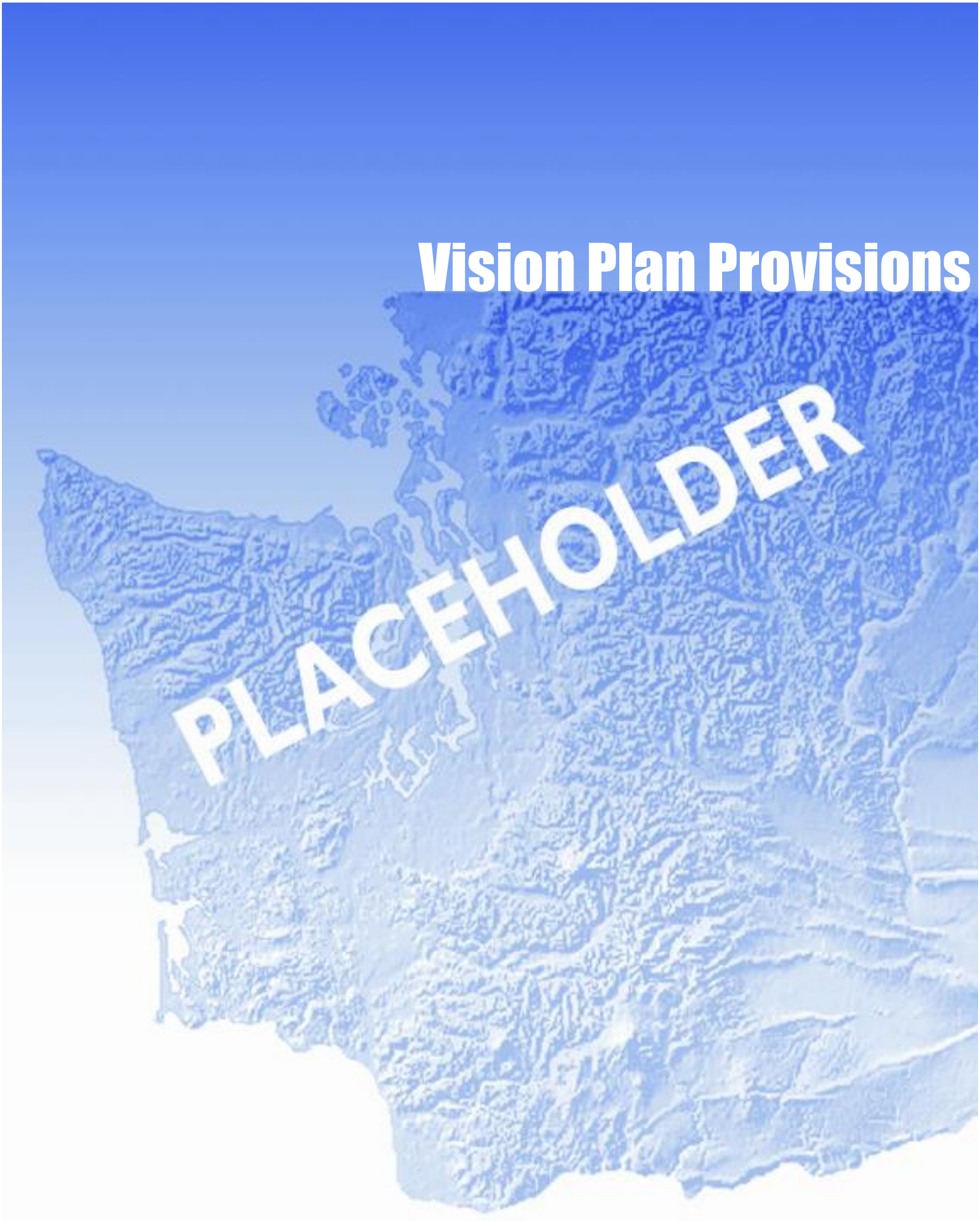
If you have other benefits under the Trust, such as medical and dental plan benefits, you may also be required to self-pay for those benefits in order to self-pay for vision plan benefits. Contact the Trust Administrative Office for details.

COBRA self-pay coverage will terminate before the COBRA eligibility period ends for any of the following reasons:

- Payment for continuation of coverage is not received by the last day of the month for which payment is being made.
- You, your spouse and/or eligible dependents obtain coverage under any other group health plan after the last date to elect COBRA self-pay coverage (unless the other plan excludes or limits your benefits because of a preexisting condition).
- You became entitled to Medicare benefits (Part A or Part B) after the last date to elect COBRA self-pay coverage; however, your dependents may be entitled to further continuation of coverage. (If your spouse or dependent becomes eligible for Medicare for any reason, coverage for that individual will end.)
- The Plan terminates.
- Social Security determines you are no longer disabled during an 11-month disability extension period.

If you have any questions about COBRA coverage or the application of the law, contact the Trust Administrative Office. You may also contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA). Addresses and phone numbers of regional and district EBSA offices are available through EBSA's website at www.dol.gov/ebsa.

Vision Plan Provisions



VISION PLAN PROVISIONS

Schedule of Vision Plan Benefits

	NBN Network Provider	Non-Network Provider
Examination	Paid in full	$ 35
Lenses (per pair)		
• Single Vision	Paid in full*	$ 30
• Bifocal	Paid in full*	$ 40
• Trifocal	Paid in full*	$ 45
• Lenticular	Paid in full*	$ 90
Frames	Paid in full**	$ 30
Contact Lenses (subnormal)	Paid in full	$200
Contact Lenses (elective) In lieu of glasses (frame and lenses).	$150	$ 90

* Paid in Full includes:

- Basic lenses
- Solid color coating and tinting (e.g. sun tints)
- Gradient tinting
- Mirror coating
- UV protection
- Polarized lenses or laminated lenses
- Photochromatic Light-sensitive glass lenses (light and dark shades, e.g. PhotoSun)
- Photochromatic Light-sensitive plastic lenses (such as Transitions); standard grades ***
- Progressive lenses (no-line bifocal); standard grades ***
- Polycarbonate lenses
- Special lens edge treatments (e.g. drilling, notching, grooving, beveling or polishing or coating edges)
- Anti-reflective coating
- Anti-reflective coating + scratch coating; standard grades ***
- Scratch coating; standard grades ***
- Oversize lenses
- Prism and double segments
- Slab off

** Limited to frames selection covered by the Trust Plan. Refer to page 26.

*** Plan pays for standard or basic styles. Patient pays any extra in cost of "Premium" progressives, photochromatic, scratch coating, or anti-reflective + scratch coat lens extras.

Covered Services

Northwest Benefit Network

Northwest Benefits Network (NBN) has developed a network of providers to assure quality care while controlling costs. Your benefits will be maximized when you obtain service from a participating NBN network provider. However, if you wish to obtain services from a non-participating provider, you are free to do so under the Plan, although your out-of-pocket expenses will almost always be greater.

NBN network provider lists are updated periodically and are available from the Trust Administrative Office or your local union. A list of network providers can also be obtained by calling 206-726-3278 or 800-732-1123 or going online to the Northwest Administrators, Inc. website at www.nwadmin.com. On the website home page, just click on ***Search NBN Vision Providers*** and add the applicable information for your search.

Schedule of Benefits

The Schedule of Benefits on page 24 summarizes the benefits under the Plan when services are performed by NBN network providers and non-participating providers. Before services begin, you may wish to discuss with your provider what is covered and what is your responsibility so you will know the benefits and amount of your out-of-pocket expense.

Benefit Descriptions and Limitations

Services provided under the Vision Plan are described below. Please note the limitations on these services to avoid any misunderstanding about eligibility or any potential out-of-pocket expenses you may incur. Any additional care, service and/or materials not covered by this Plan may be arranged between you and your provider at your own expense.

The 365 and 730-day time limitations are strictly enforced. When determining eligibility for lenses or frames, the 365 or 730 days are tracked from the date of service recorded on the claim form by the provider. You can verify coverage by calling the Trust Administrative Office or by visiting the Northwest Administrators, Inc. website at www.nwadmin.com. Using the website will require you to register and log in as a Plan Participant.

- Routine vision exam — A complete analysis of the eyes and related structure to determine the presence of vision problems, abnormalities or to determine the need for corrective lenses will be covered once every 365 days from the date of your last covered examination. If you are getting an examination for an eye injury, irritation, or disease, submit your claim for the examination to your medical plan.

- Lenses — If you require a new prescription or a change in your current prescription, the provider will order the proper single vision, bifocal, trifocal or lenticular lenses. One pair of lenses per person is covered once every 365 days from the date the last covered lenses were ordered.

- Frames — If you use a participating NBN network provider, your provider will show you the selection of frames covered in full by your Plan and those which will cost more than your allowed benefit. You may choose any frame you wish; however, if you select one which costs more than allowed under the Plan, you will be responsible for the additional charge. Frames are covered once every 730 days (two full years) from the date the last covered frames were ordered.

- Elective contact lenses — When you choose to receive elective contact lenses in lieu of glasses (frame and lenses), the benefit allowance includes the contact lenses and fitting/evaluation. The contact lens benefit is available once every 365 days from the date your last contact lenses or lenses for glasses were ordered, whichever was later. Contact lenses are provided in lieu of all other hardware (frame and lenses) for 365 days.

- Subnormal vision aid — Contact lenses prescribed as a subnormal vision aid are covered under the Plan for the following conditions:

  - After cataract surgery
  - Keratoconus (bulging cornea)
  - When vision acuity is not correctable to 20/70 in the better eye by use of conventional type lenses, but can be improved to 20/70 or better by the use of contact lenses.

If necessary, NBN will provide lenses and frames in addition to contact lenses after cataract surgery. If a change in prescription is indicated, you will be eligible for an annual examination and lenses again after 365 days, frames after 730 days, and contact lens replacement after 730 days.

Your provider must obtain prior approval from NBN before ordering these lenses. One pair of subnormal vision aid contacts per person is covered once every 730 days from the date your last covered subnormal contact lenses were ordered.

When You are Covered as an Employee and a Dependent, or as a Dependent of Two Employees

If you have coverage under the Trust as an active employee and as a dependent of another employee covered by the Trust, or as a dependent of two covered employees, the coverages will be coordinated so that the sum of the benefits paid under this Plan plus benefits paid under all other plans will not exceed 100% of allowable expenses incurred. Benefits are not transferable or assignable from one family member to another. For example, if you do not wear glasses, another family member may not receive an additional pair because you did not order or need a pair of glasses.

Example #1: Both spouses are covered by the Plan as employees. One spouse obtains elective contacts that cost $200. She submits a claim and the Plan pays $150. The other spouse may submit a claim for the remaining $50 and it will be processed under his coverage as a

secondary plan. The Plan does not allow two pair of contacts or double coverage as an alternative to coordination of benefits.

Example #2: Both spouses are covered as employees and their dependents have coverage under both parents' Plans. A dependent child receives glasses from a network provider and one parent is billed for a $10 Plan copayment and $25 for the portion of the frames cost which exceeds the Plan's frame allowance. The other parent may then submit a claim on behalf of the child for the $35 which was not paid by the Plan. The Plan does not provide for two pair of glasses or double coverage as an alternative to coordination of benefits.

Exclusions

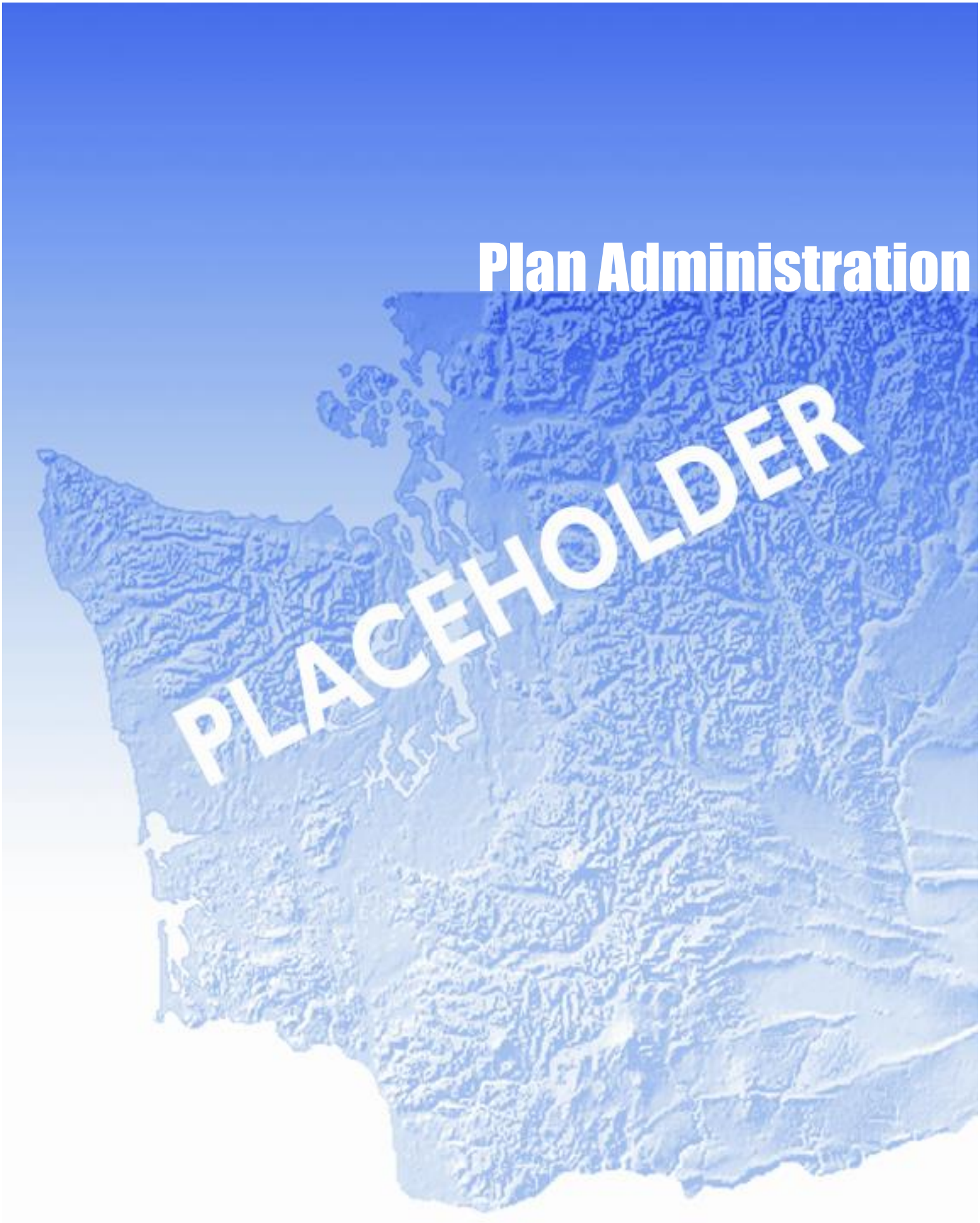
This Plan does not cover:

- The replacement of lenses or frames provided under this Plan that have been lost, damaged or broken, except at the normal intervals when services are otherwise eligible.
- Warranties, maintenance service, care kits, etc.
- Plano (non-prescription) lenses.
- Visual analysis which does not include refraction.
- Special procedures such as orthoptics, visual training, subnormal vision aids other than contact lenses, aniseikonia or similar procedures.
- Medical or surgical treatment of the eyes.
- Services or materials not listed as covered expenses.
- Any expense in excess of the usual, reasonable and customary amount.
- Services or materials provided as a result of any Workers' Compensation law or similar legislation, or received through or required by any government agency or program whether federal, state or any subdivision thereof. If the compensation does not cover the incurred expenses, coordination of benefits provisions will apply.
- Eye examinations required by:
  - An employer as a condition of employment which the employer is required to provide by virtue of a labor agreement; or
  - A government body.
- Dispensing or service fees related to ineligible materials.
- Charges incurred when not eligible.

Limitations

If you select extras or features that are not included, such as high index lenses for cosmetic reasons, a frame that costs more than the Plan allowance, premium or non-standard progressives or light-sensitive lenses, etc., you must pay the extra charge.

Plan Administration



Plan Administration

About the Privacy of Your Health Information

As part of the normal process of administering its health care plans, the Trust, the Plan Sponsor (which is the Board of Trustees) and its health care claims administrators may receive personal health information about you and your covered dependents. Effective April 14, 2003, the use and disclosure of certain types of health information (called protected health information) will be governed by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), a federal law that governs the privacy of individuals' protected
health information.

The Plan Sponsor and the Trust group health care plans (the vision plan described in this booklet) are subject to HIPAA's privacy requirements beginning on April 14, 2003, and HIPAA's privacy protections apply to them.

Participants will receive a copy of the Trust's HIPAA privacy notice separately.

Coordination With Other Vision Benefits

Coordination of Benefits or COB refers to how the Plan coordinates benefits when you or your dependents have vision coverage under more than one plan. COB ensures the total paid under this Plan and all other group plans does not exceed the actual charge for treatment or service.

Definitions

For the purposes of COB, the following definitions apply:

Plan — Means vision benefits provided under any:

- Insured or non-insured group, service, prepayment or other program arranged through an employer, trustee, union or association
- Program required or established by state or federal law (including Medicare Parts A and B, but excluding Medicaid)
- Program sponsored by or arranged for students through a school or other educational institution.

The term *Plan* does not include benefits provided under a student accident policy or under a state medical assistance program where eligibility is based on financial need.

Plan applies separately to parts of any program that contain COB provisions and separately to parts of any program that do not contain COB provisions.

Allowable Expense — All prevailing charges for treatments or services when at least part of those charges is covered under at least one of the plans then in force for the covered person. If a plan provides benefits in other than cash payments, the cash value of those benefits will be both an allowable expense and a benefit paid.

Claim Determination Period — The part of a calendar year when you would receive benefit payments under this Plan if this section were not in force.

Effect on Benefits

Benefits otherwise payable under this Plan for allowable expenses during a claim determination period may be reduced if:

- Benefits are payable under any other plan for the same allowable expenses
- Under the rules listed below, benefits payable under the other plan are to be determined before benefits payable under this Plan.

The reduction will be the amount needed to ensure that the sum of payments under this Plan plus benefits under the other plan is not more than the total of allowable expenses. Each benefit that would be payable without this section will be reduced proportionately. The total amount paid will be charged against any applicable benefit limit of this Plan.

For this purpose, benefits payable under other plans will include those that would have been paid if claims had been made for them. Also, for any person covered by Medicare Part A, benefits payable will include benefits provided by Medicare Part B, whether or not the person is covered under Part B.

Order of Benefit Determination

Except as described in the section Medicare Exception below, the benefits payable by a plan that doesn't have a COB provision will be determined before those of a plan that does have a COB provision. In all other instances, the order of determination will be:

1. **Employee/Dependent —** The benefits of a plan that covers the person as an employee participant are determined before those of a plan that covers the person as a dependent participant.

2. **Dependent Child — Parents Not Separated or Divorced.** When this Plan and another plan cover the same child as a dependent of parents who are not separated or divorced, benefits of the plan of the parent whose birthday falls earlier in a calendar year are determined before those of the plan of the parent whose birthday falls later in that year. If both parents have the same birthday, the benefits of the plan that covered the parent longer are determined before those of the plan that covered the other parent for a shorter time.

3. **Dependent Child — Parents Separated or Divorced.** If two or more plans cover a dependent child of divorced or separated parents, benefits for the child are determined in this order:

   - First, the plan of the parent with custody of the child
   - Then, the plan of the spouse of the parent with custody of the child,
     if applicable
   - Finally, the plan of the parent not having custody of the child.

   However, if the specific terms of a court decree state that one of the parents is responsible for the child's health care expenses, and the entity obligated to pay or provide benefits for the plan of that parent has knowledge of those terms, the benefits of that plan are determined first. (This doesn't apply to any claim determination period or plan year when any benefits are actually paid or provided before the entity has that knowledge.)

4. **Active/Inactive Employee.** The benefits of a plan that covers a person as an employee who is neither laid off nor retired, or as that employee's dependent, are determined before the benefits of a plan that covers that person as a laid-off or retired employee or as that employee's dependent. If the other plan doesn't have this rule, and if, as a result, the plans disagree on the order of benefits, this rule will not apply.

5. **Longer/Shorter Length of Coverage.** If none of the above rules determines the order of benefits, the benefits of the plan that has covered a person longer are determined before those of a plan that has covered the person for a shorter time.

Benefit Credit Provision

When this Plan is secondary and its payment is reduced because of the primary plan's benefits, a record is kept of the reduction. The amount will be used to increase this Plan's payments on the patient's later claims in the same calendar year — to the extent there are allowable expenses that would not otherwise be fully paid by this Plan and other plan(s). This provision applies only to the Trust's medical benefits.

Claim Review and Appeal Procedures

The Washington Teamsters Welfare Trust plans have adopted specific procedures and timeframes, required by law, to evaluate and process claims for benefits, as well as appeals of denied claims. The timeframes and rules for making decisions on claims and appeals vary, depending on the type of claim and the benefit plan involved. This section provides information about the specific timelines and information requirements that apply to your vision plan claims and appeals filings and the claim administrator's claims and appeals determinations. The claim administrator, unless otherwise specified, is the Trust Administrative Office.

If your claim for benefits is wholly or partially denied, you or your duly authorized representative may submit a written request for a review of the claim by the Washington Teamsters Welfare Trust Appeals Committee (Appeals Committee). The request for review must be submitted to the Trust office within the timeframe applicable for that benefit plan and type of claim, as described in the following pages.

The length of time the claim administrator has to evaluate and process your claim generally begins on the date the claim is received. The claim administrator will consider the claim and notify you of an adverse decision on the claim, in writing, within the appropriate timeframes described below, unless the claim administrator determines that special circumstances require an extension of time to process the claim. If such an extension is necessary under any of the plans, the claim administrator will notify you of any such extension, the reasons for it, and the date by which the claim administrator expects to render the decision, within the original decision timeframe.

The claim administrator is the Trust Administrative Office.

If you believe that you are entitled to a benefit under the Washington Teamsters Welfare Trust vision plan, or that you are entitled to a greater benefit than the amount you received, then you, your beneficiary (if applicable) or your authorized representative may file a written claim with the Trust Administrative Office.

The claim review and appeal procedures apply to these types of claims

Urgent Health Care Claim (before health care treatment)	A claim or pre-approval request for a vision benefit where treatment delay could seriously jeopardize life, health, the ability to regain maximum function or, in the opinion of a physician who knows the medical condition, would subject the patient to severe pain that cannot be adequately managed without care or treatment that is the subject of the claim.
Pre-Service Health Care Claim (before health care treatment)	Any claim or pre-approval request for a vision benefit, where receipt of benefit is conditioned, in whole or in part, based on advance approval.
Concurrent Health Care Claim (changes in health care treatment)	Any claim involving the reduction or termination of an ongoing course of treatment before the end of that course of treatment if the treatment was previously authorized by the Plan, or a request to extend treatment beyond the authorized time or number of treatments.
Post-Service Health Care Claim (after health care treatment)	Any claim for a vision benefit that is not a pre-service claim.

Vision Plan Claim Procedures

Timeframe for Initial Claim Decisions

The claim administrator will provide notice of an initial claim approval or denial within 30 days. If more time is needed to process claims due to circumstances beyond the claim administrator's control, an extension of up to 15 days is allowed, provided you are notified of the extension within the original 30-day period.

Incomplete Post-Service Claims

If more information is required to process your post-service vision plan claim, you'll be notified within the original 30-day period. If you are notified of the need to provide additional information for a post-service vision plan claim, you will have at least 45 days to supply this information. If you supply the requested information within the 45 days and your claim is denied, the claim administrator will notify you of the denial within 15 days after the requested information is received. If you do not supply the requested information within 45 days, your claim may be denied.

Notice of Initial Claim Denial

If the claim administrator denies the claim, you'll receive written or electronic notice containing:

- Specific reasons for the denial
- References to specific plan provisions on which the denial is based
- List of any additional material or information necessary for you to perfect the claim and an explanation of why it's necessary
- Description of the plan's claim appeal procedure (and applicable time limits), including a statement of your right to bring a civil action under ERISA Section 502(a) if your appeal is denied
- Certain other information in accordance with applicable U.S. Department of Labor regulations.

Claim Appeal Procedures

You can use these appeal procedures, if, in response to your claim, you received:

- No reply after the initial decision period, as listed above
- Notice of an extension to the initial decision period, as listed above, then no reply before the end of an extension
- A denial from the claim administrator.

If the vision plan claim is denied, in whole or in part, or if you believe plan benefits have not been properly provided, you, your beneficiary (if applicable), or your authorized representative may appeal the denial. The claim administrator will provide details about your right to appeal, along with the appeals process, address for filing an appeal, and timeframes. If you don't appeal within the designated timeframes, you may lose your right to later file suit in court.

To appeal a claim denial, you must file a written request for appeal pursuant to the procedure provided by the claim administrator within a certain period after receiving the claim denial, as described herein. The appeal must set forth all the grounds on which it is based, all the facts in support of the request, and other matters which you deem pertinent. Plan provisions require that you pursue the claim and appeal rights described here before seeking other legal recourse.

During the appeal, you will receive, upon request and free of charge, reasonable access to and copies of all documents, records and other information relevant to your benefit claim. For this claim procedure, a document, record or other information is considered relevant to a claim if it:

- Was relied on by the claim administrator in making the initial claim decision
- Was submitted, considered or generated in the course of deciding the claim, without regard to whether the document, record or other information was relied upon by the claim administrator in reaching the claim decision
- Demonstrates compliance with the administrative processes and safeguards required under Department of Labor regulations in making the benefit determination.

You may submit any written comments, documents, records or other information relating to your claim. In making its determination on health care claim appeals, the Appeals Committee of the Washington Teamsters Welfare Trust will take into account all the comments, documents, records and other information you submitted relating to the claim, without regard to whether they were submitted or considered by the claim administrator in making the initial claim decision.

The Appeals Committee will conduct a review and make a final decision within a certain period after receiving your written request for review, as described below and on page 37. For certain plans, if the Appeals Committee needs more than this initial period to make a decision due to special circumstances, it will notify you in writing within the initial decision timeframe and explain why more time is required and the date the plan expects to make a decision.

The Appeals Committee will review your denied claim. You or your authorized representative has the right to present relevant information or testimony at the quarterly Appeals Committee meeting scheduled to hear your appeal. You will be notified of the meeting time and date, however a personal appearance is not required. The appeal review will not be conducted by the individual who denied the initial claim or that person's subordinate. The Appeals Committee will not give deference to the original decision on your claim; that is, they will take a fresh look and make an independent decision about the claim within the timeframes.

If your claim was denied based on a medical judgment, the Appeals Committee will consult with a health care professional who has appropriate training and experience in the field of medicine involved in your claim. The health care professional will not be the same person as the one consulted on the initial decision (or a subordinate of that person). A medical judgment includes whether a treatment, drug or other item is experimental, investigational or not medically necessary or appropriate. You also have the right to learn the identity of any medical or other experts who advised on your original claim decision, whether or not the Plan relied on their advice.

Timeframes for Filing and Determination of Vision Plan Appeals

You have 180 days from the date you receive notice of a vision plan claim denial to file your appeal. The Trust Administrative Office will provide notice of appeal decision within five days after the next quarterly meeting of the Appeals Committee if the appeal is received at least 30 days before the meeting, otherwise the decision will be provided within five days after the second quarterly meeting that follows receipt of the appeal. If special circumstances require an extension of time for rendering a decision, the claim administrator will provide notice of the extension within the initial decision timeframe, and a decision will be rendered at the next quarterly meeting, with notice provided within five days after that meeting.

Notice of Decisions on Appeal

The decision on appeal will be in writing. If your appeal is denied, the notice will include:

- Reasons for the denial
- References to specific plan provisions on which the denial is based
- A statement of your right to access and receive copies, upon request and free of charge, of all documents and other information relevant to the claim for benefits
- A statement of your right to bring a civil action under ERISA Section 502(a)
- Certain other information in accordance with applicable U.S. Department of Labor regulations.

If the Appeals Committee does not respond within the applicable timeframe, you should generally consider the appeal denied. Contact the Trust Administrative Office if you have questions.

Administrative Details

The Employee Retirement Income Security Act of 1974 (ERISA) as amended, requires that certain information be furnished to Plan participants and beneficiaries:

Name of Plan

This Plan is known as the Washington Teamsters Welfare Trust Vision Plan EXT.

Name, Address and Telephone Number of Board of Trustees as Plan Sponsor

This Plan is sponsored by a joint labor-management Board of Trustees:

Board of Trustees of the Washington Teamsters Welfare Trust
2323 Eastlake Avenue East
Seattle, Washington 98102-3393
206-329-4900

You can obtain information on whether a particular employer or employee organization is a Plan sponsor (and, if so, their address) by writing to the Trustees. This information is also available to examine at the Trust Administrative Office. The Trustees may impose a reasonable charge for furnishing this information. You may want to inquire about the charge before requesting information.

Employer Identification Number and Plan Number

The employer identification number assigned to the Board of Trustees by the Internal Revenue Service is EIN 91-6034673.

- The Plan number is 501.
- This Plan is a welfare plan that provides vision benefits.

Type of Administration

The Plan's benefits are administered by the Board of Trustees with the assistance of this administrative organization:

Northwest Administrators, Inc.
2323 Eastlake Avenue East
Seattle, Washington 98102-3393
206-329-4900

Name and Address of Agent for Service of Legal Process

Each member of the Board of Trustees is designated as an agent for accepting service of legal process on behalf of the Plan. The names and addresses of the Trustees are below:

Legal process can also be served upon:

Northwest Administrators, Inc.
2323 Eastlake Avenue East
Seattle, Washington 98102-3393

Names and Addresses of Board of Trustees

Employer Trustees

Jerry D'Ambrosio
11019 SE 60th Street
Bellevue, Washington 98006

John H. Mack
PO Box 80681
Seattle, Washington 98108

Yvonne Peters
Allied Employers, Inc.
4030 Lake Washington Boulevard NE
Suite 201
Kirkland, Washington 98033-7870

H.L. "Buzz" Ravenscraft
6631 113th Place SE
Bellevue, Washington 98006-6429

Doug Ruygrok
Safeway Stores, Inc.
618 Michillinda Ave.
Arcadia, California 91007-6300

Harry Smith
United Parcel Service
13035 Gateway Drive, Suite 149
Seattle, Washington 98168-3395

Dan White
15231 24th Ave SW
Burien, WA 98166-2016

Randy Zeiler
Allied Employers, Inc.
4030 Lake Washington Boulevard NE
Suite 201
Kirkland, Washington 98033-7870

Employee Trustees

Steven Chandler
Teamsters Local Union No. 38
2601 Everett Avenue
PO Box 1548
Everett, Washington 98206

Chuck Eggert
Teamsters Local Union No. 231
1700 North State Street
PO Box "H"
Bellingham, Washington 98227-0298

John Emrick
Teamsters Local Union No. 313
220 S 27th Street
Tacoma, Washington 98402

Rick Hicks
Teamsters Local Union No. 174
14675 Interurban Ave S, Suite 303
Tukwila, Washington 98168-4614

Al Hobart
Joint Council of Teamsters No. 28
14675 Interurban Ave S, Suite 301
Tukwila, Washington 98168-4614

Justin "Buck" Holliday
Teamsters Local Union No. 690
1912 N. Division
Spokane, Washington 99207

Joe Tessier
Teamsters Local Union No. 117
14675 Interurban Ave S, Suite 307
Tukwila, Washington 98168-4614

John A. Williams
IBT Warehouse Division
25 Louisiana Avenue NW
Washington DC 20001-2198

Description of Collective Bargaining Agreements

This Plan is maintained under many collective bargaining agreements between various employers and labor organizations. You may obtain a copy of these collective bargaining agreements by writing to the Trust Administrative Office. This information is also available to examine at the Trust Administrative Office. The Trustees may impose a reasonable charge for furnishing the collective bargaining agreements. You may want to inquire about the charge before requesting a copy.

Eligibility and Benefits

Employees are entitled to participate in the Plan if they work under a collective bargaining agreement requiring contributions on their behalf and the employer makes those contributions to the Trust. The eligibility rules describing which employees and dependents are entitled to benefits begin on page 10. The benefits are described beginning on page 24.

Termination of Eligibility

An employee or dependent who is eligible for benefits may become ineligible as a result of one or more of the following circumstances:

- The employee's failure to work the required hours to maintain eligibility (or failure to make a self-payment, where authorized). See When Coverage Ends on page 11 and COBRA Self-Pay Option on page 20.
- The failure of the employee's employer to report the hours and remit contributions on the employee's behalf to the Trust Fund.
- An eligible dependent is no longer a dependent as described on page 12 or attains a disqualifying age as shown on page 12.
- Termination of the governing collective bargaining agreement or the Trust.

Future of the Plan and Trust Fund

The Board of Trustees has authority to terminate the Trust Fund. The Trust Fund will also terminate when collective bargaining agreements and special agreements requiring the payment of contributions expire. In the event of termination, the Board of Trustees will:

- Use the Trust Fund to pay expenses incurred up to the date of termination and expenses incident to the termination.
- Distribute the balance, if any, of Trust Fund assets to carry out the purpose of the Trust.
- Upon termination, the Board of Trustees may transfer remaining Trust Fund assets to the Trustees of any fund established to provide substantially the same or greater benefits than this Plan. In no event will any of the funds revert to or be recoverable by any employee, employer or union.

Source of Contributions

This Plan is funded through employer contributions; the amount is specified in the collective bargaining agreements. Also, self-payments by employees are permitted as outlined in this Plan booklet. The amount of the total plan cost is changed from time to time by the Board of Trustees, including employer contributions alone or a combination of employer contributions and employee self-payments.

Entities Used for Accumulation of Assets and Payment of Benefits

Employer contributions are received and held in trust by the Board of Trustees pending the payment of benefits or premiums. The Trustees pay benefits directly from the Trust Fund.

Plan Year

This Plan is on a 12-month fiscal year basis beginning July 1 and ending the following June 30.

ERISA Rights and Protections

As a participant in the Trust, you are entitled to certain rights and protections under ERISA, which provides that all Plan participants be entitled to:

- Examine, without charge, at the Trust Administrative Office and at other specified locations, such as work sites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the Department of Labor and available at the Public Disclosure room of the Employee Benefits Security Administration.
- Obtain, upon written request to the Trust Administrative Office, copies of documents governing Plan operation, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Trust Administrative Office may make a reasonable charge for the copies.
- Receive a summary of the Trust's annual financial report. The Trust Administrative Office is required by law to furnish each participant with a copy of this summary annual report.
- Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the Plan to learn the rules governing these COBRA continuation coverage rights.
- Reduce or eliminate exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan. You should receive a certificate of creditable coverage, free of charge, from your Plan or insurer when you lose coverage under the Plan, when you become entitled to elect COBRA continuation coverage and when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you

request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after enrolling.

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for operation of the Plan. The people who operate your Plan, called “fiduciaries,” have a duty to do so prudently and in the interest of you and other 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.

If your claim for a welfare benefit is denied or ignored, in whole or in part, you must receive a written explanation of the reason for the denial. You have the right to have the Plan review and reconsider your claim.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of documents or the latest annual report for 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 Trust 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 Trust’s control. If your claim for benefits is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the Plan’s decision or lack of decision concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in federal court. If fiduciaries misuse the Plan’s money, or if you are discriminated against for asserting your rights, you may seek assistance from the 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.

If you have any questions about your Plan, contact the Trust Administrative Office. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Trust Administrative Office, contact the nearest office of the Employee Benefits Security Administration, Department of Labor, listed in your phone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, Department of Labor 200 Constitution Avenue NW, Washington, DC 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.