Puget Sound Electrical Workers Healthcare Trust

Retiree Plan

AUGUST 1, 2020

IBEW 46 The Right Choice.

NECA NATIONAL ELECTRICAL CONTRACTORS ASSOCIATION

Puget Sound Electrical Workers Healthcare Trust

Physical Address 7525 SE 24th Street, Suite 200, Mercer Island, WA 98040 • Mailing Address PO Box 34203, Seattle, WA 98124
Phone (206) 441-4667 or (866) 314-4239 • Fax (206) 505-9727 • Website www.psewtrusts.com

Administered by
Welfare & Pension Administration Service, Inc.

May 14, 2021

TO: All Eligible Plan Participants
Puget Sound Electrical Workers Healthcare Trust

RE: COVID-19 Benefit Extensions

This is a Summary of Material Modification describing changes to your health plan adopted by the Board of Trustees. Please be sure that you and your family read it carefully and keep this document with your Summary Plan Description Booklet.

Dental Personal Protective Equipment – Temporary Extension of Coverage

Effective May 1, 2020 **through September 30, 2021,** the Plan will cover up to $20 per visit for personal protective equipment ("PPE") when billed by dental providers in conjunction with other covered in-office dental services.

Telemedicine – Temporary Extension of Coverage

Effective March 1, 2020 **through September 30, 2021**, the Trust will cover medically necessary charges for telephonic, online or other consultations where the patient is not physically present with the physician or other Covered Provider at the time of the consultation as any other office visit. The temporary waiver will allow coverage for telephonic or other virtual care visits subject to the annual deductible and coinsurance benefits, as follows:

1. For a real-time interactive telephone or audio/video consultation (telehealth/telemedicine) to be covered, the consultation must be diagnosis and treatment focused via a live discussion or video exchange with ongoing participation by the patient and the provider throughout the visit.
2. Reimbursed up to the Allowed Amount as defined in the Summary Plan Description.
3. Reimbursed at 100% of the Allowed Amount for all telephone or audio/video visits related to COVID-19 testing.

As a reminder, active participants and non-Medicare retirees and their eligible dependents have access to 24/7 care via telephone or video chat through Teladoc at no cost to the participant. To schedule a consultation, visit www.Teladoc.com/Premera or call (855) 332-4059.
If you have questions regarding the contents in this notice, please contact the administration office at (866) 314-4239, option 1.

Important Information Relating to COVID-19 and Extension of Deadlines

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

Extensions of Time

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

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

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

COBRA Examples

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

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

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

Special Enrollment Examples

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

Important Note Regarding Retroactivity

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

American Rescue Plan Act (ARPA) COBRA Subsidy

Effective **April 1, 2021,** employees (and their dependents) who lose coverage or who have lost coverage in the past 18 months due to an involuntary termination of employment or reduction in hours may be eligible for up to six months of free (fully subsidized) COBRA coverage (for coverage months April 2021 through September 2021). If you are eligible, free COBRA coverage will be available regardless of whether you previously elected COBRA or are currently on COBRA.

The Trust is reviewing guidance from the federal government before sending out formal notices and applications to potentially eligible participants and dependents. Please watch your mail closely for additional information. When you get the formal notice and application, please fill it out and return it to the Administration Office within 60 days of the date the notice is received to be eligible for free COBRA retroactive to April 1, 2021, if applicable. Free COBRA coverage will not be provided unless it is elected.

Board of Trustees
Puget Sound Electrical Workers Healthcare Trust

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Puget Sound Electrical Workers Healthcare Trust

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Phone (206) 441-4667 or (866) 314-4239 • Fax (206) 505-9727 • Website www.psewtrusts.com

Administered by
Welfare & Pension Administration Service, Inc.

February 2, 2021

TO: All Eligible Plan Participants
Puget Sound Electrical Workers Healthcare Trust

RE: Benefit Changes

This is a Summary of Material Modification describing changes to your health plan adopted by the Board of Trustees. Please be sure that you and your family read it carefully and keep this document with your Summary Plan Description Booklet.

Cologuard Screening

Effective **July 1, 2020,** Cologuard screenings will be covered as a Preventive Care benefit with no cost share for in-network providers. For out of network providers, benefits will be subject to the Plan deductible and coinsurance and be limited to the Usual, Reasonable and Customary allowance. Cologuard is an at-home colon cancer screening test which includes a patented DNA analysis that screens for DNA markers associated with colon cancer. Cologuard will be covered once every three years starting at age 50 for average risk participants or for participants under the age of 50 with an increased risk of colon cancer due to their family history.

For Medicare eligible retirees the testing must meet Medicare coverage guidelines in order to be covered by the Trust's Medicare retiree plan.

Breast Cancer Preventive Medications

Effective November 1, 2020 the Plan will cover prescribed breast cancer prevention medications for participants. This benefit will allow asymptomatic participants over the age of 35 who are at increased risk for breast cancer and at low risk for adverse medication effects to be prescribed one of the following drugs at no cost:

- Tamoxifen
- Raloxifene (Evista)
- Anastrozole
- Letrozole
- Exemestane

Spinal Manipulation Benefits

Effective January 1, 2021, the Calendar Year maximum limit for Acupuncture and Chiropractic Care combined will increase to 24 visits per Calendar Year.

Outpatient Rehabilitation Benefits

Effective January 1, 2021, the Plan will cover up to 45 outpatient rehabilitation visits per Calendar Year subject to Plan terms including medical necessity, deductible and coinsurance provisions. The $60 per visit limit is removed.

COVID-19 Vaccine

During the Public Health Emergency ("PHE") declared by the United States Department of Health and Human Services ("HHS"), the Plan will cover reasonable costs of the COVID-19 vaccine without cost sharing when provided by an in-network or out-of-network provider or pharmacy.

When HHS declares the PHE ended, the Plan will provide coverage for the COVID 19 vaccine as a Preventive Care benefit. Preventive Care benefits provided by an in-network Provider will be paid in full and will not be subject to the Calendar Year deductible or coinsurance. Preventive Care Services provided by an out-of-network Provider will be subject to the Plan deductible and coinsurance. Covered costs include the vaccine administration fee by a health care provider or pharmacy.

Dental Personal Protective Equipment – Temporary Extension of Coverage

Effective May 1, 2020 **through March 31, 2021,** the Plan will cover up to $20 per visit for personal protective equipment ("PPE") when billed by dental providers in conjunction with other covered in-office dental services.

Telemedicine – Temporary Extension of Coverage

Effective March 1, 2020 **through March 31, 2021**, the Trust will cover medically necessary charges for telephonic, online, or other consultations where the patient is not physically present with the physician or other Covered Provider at the time of the consultation as any other office visit. The temporary waiver will allow coverage for telephonic or other virtual care visits subject to the annual deductible and coinsurance benefits, as follows:

1. For a real-time interactive telephone or audio/video consultation (telehealth/telemedicine) to be covered, the consultation must be diagnosis and treatment focused via a live discussion or video exchange with ongoing participation by the patient and the provider throughout the visit.
2. Reimbursed up to the Allowed Amount as defined in the Summary Plan Description.
3. Reimbursed at 100% of the Allowed Amount for all telephone or audio/video visits related to COVID-19 testing.

As a reminder, active participants and non-Medicare retirees and their eligible dependents have access to 24/7 care via telephone or video chat through Teladoc at no cost to the participant. To schedule a consultation, visit www.Teladoc.com/Premera or call (855) 332-4059.

If you have questions regarding the contents in this notice, please contact the administration office at (866) 314-4239, option 1.

Board of Trustees
Puget Sound Electrical Workers Healthcare Trust

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Administered by
Welfare & Pension Administration Service, Inc.

October 9, 2020

TO: Active Participants and non-Medicare Retirees
Puget Sound Electrical Workers Healthcare Trust

RE: Benefit Changes and Extension of Plan Deadlines

This is a summary of material modification describing benefit changes adopted by the Board of Trustees. Please be sure that you and your family read it carefully and keep this document with your Summary Plan Description Booklet.

Continuation of Telehealth Temporary Extension of Coverage

Effective July 31, 2020, the Trust will continue to cover medically necessary charges for telephonic, online or other consultations where the patient is not physically present with the physician, or other Covered Provider at the time of the consultation as any other office visit **through December 31, 2020**. The temporary coverage will allow for telephonic or other audio/video visits subject to the annual deductible and coinsurance, as follows:

- For a real-time interactive telephone or audio/video consultation (telehealth/ telemedicine), the consultation must be diagnosis and treatment focused via a live discussion or video exchange with ongoing participation by the patient and the provider throughout the visit.
- Reimbursed up to the Allowed Amount as defined in the Summary Plan Description.
- Reimbursed at 100% of the allowed amount for all telephone or audio/video visits related to COVID-19 testing.

As a reminder, active participants and non-Medicare retirees and their eligible dependents have access to 24/7 care via telephone or video chat through Teladoc at no cost to the participant. After December 31, 2020, only telemedicine/telehealth treatments provided by Teladoc will continue to be covered.

Gene and Cellular Therapy

The Plan covers non-experimental Gene and Cellular Therapy services from an approved facility and/or provider when determined to be medically necessary. Benefits are subject to all applicable Plan terms, including deductibles, coinsurance, annual out-of-pocket maximums, and general Plan limitations and exclusions. To be covered, Gene and Cellular Therapy services must be provided by a facility or provider that is in the Plan's PPO network or has otherwise been approved by the Plan.

Gene and Cellular Therapy services require preauthorization under the Plan's Health Management Program as outlined in the Plan's Summary Plan Description. The allowed amount is reduced by 25%, up to $1,200, if the preauthorization requirement is not followed.

Gene and Cellular Therapy includes gene and cellular based therapy techniques that modify and/or use a person's genes or cells to treat or cure disease. Gene Therapy, as defined by the Plan, includes medically necessary gene and cellular based therapies provided by an approved Physician, Hospital or other Provider. These therapies may include, but are not limited to:

- Cellular immunotherapies;
- Genetically modified oncolytic viral therapy;
- Other types of cells and tissues from and for use by the same person (autologous) and cells and tissues from one person for use by another person (allogenic) for certain therapeutic conditions.;
- All human gene therapy that seeks to change the function of a gene or alter the biologic properties of living cells for therapeutic use. Examples include therapies using:
    - Luxturna® (Voretigene neparvovec)
    - Zolgensma® (Onasemnogene abeparvovec-xioi)
    - Spinraza® (Nusinersen)
- Products derived from gene editing technologies, including CRISPR-Cas9;
- Oligonucleotide-based therapies. Examples include:
    - Antisense. An example is Spinraza (Nusinersen)
    - siRNA
    - mRNA
    - microRNA therapies

If you have any questions concerning your benefits or eligibility for coverage, you should contact the Administration Office at 1-866-314-4239, option 1 for Claims, option 4 for Eligibility, or visit the Trust website at www.psewtrusts.com.

Board of Trustees
Puget Sound Electrical Workers Healthcare Trust

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Phone (206) 441-4667 or (866) 314-4239 • Fax (206) 505-9727 • Website www.psewtrusts.com

Administered by
Welfare & Pension Administration Service, Inc.

February 4, 2021

TO: All Eligible Retiree and Special Retiree Participants and Beneficiaries
Puget Sound Electrical Workers Healthcare Trust

RE: New 2020 Summary Plan Description – Retiree Plan

The Board of Trustees is pleased to present you with the August 2020 edition of the Retiree Plan Summary Plan Description (Plan booklet) for the Puget Sound Electrical Workers Healthcare Trust. This Plan booklet supersedes the previous versions of the Retiree Plan and Special Retiree Plan booklets. This revised booklet describes the benefits available to eligible retiree participants and their dependents. From time to time the Plan has issued a Summary of Material Modification (SMM's) to provide notice of material benefit changes to the Plan. The enclosed booklet includes all the most recent benefit changes.

The enclosed Plan booklet includes a number of updates to the Plan language to bring it in-line with current practice. These changes include, among other things the following:

- Updates to the discretionary clause and addition of a non-discrimination provision (including foreign language tag lines);
- Addition of requirements for Qualified Medical Child Support Orders ("QMCSO");
- Clarifications throughout the Plan booklet that eligibility and claims will not be processed until all necessary and requested documentation is provided to the Administration Office;
- Addition of Uniformed Services Employment and Reemployment Rights Act language;
- Removal of vasectomy limits;
- Removal of certain Bariatric Surgery limits;
- Addition of benefit for cochlear implants;
- Updates to the prescription drug benefit section, added formulary language and listed exclusions;
- Updates to the claim filing section particularly regarding non-PPO providers;
- Updates to the appeal and external review provision; and
- Addition of a right of recovery provision and updates to the Plan's reimbursement provision, coordination of benefits provision and privacy policy.

Please review the revised and updated Plan booklet carefully. This Plan booklet is also available on the Trust's website at www.psewtrusts.com. We encourage you to visit the Trust's website any time you need forms or have questions about your benefits or eligibility.

Board of Trustees
Puget Sound Electrical Workers Healthcare Trust

PSEW RETIREE PLAN
FOR NON-MEDICARE AND MEDICARE ELIGIBLE RETIREES
BENEFIT BOOKLET
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INTRODUCTION

To Eligible Retirees:

The Board of Trustees of the Puget Sound Electrical Workers Healthcare Trust is pleased to provide you with this updated booklet which describes the Medical, Prescription Drug, Dental, Hearing and Vision benefits available to Non-Medicare and Medicare eligible retirees.

We encourage you to read this booklet carefully so that you are aware of all your health and welfare benefits under the Plan.

The Board of Trustees has delegated to its third-party administrator and other designated entities the authority to provide certain administrative services to the Plan and provide information relating to the amount of benefits, eligibility, and other Plan provisions. The Plan's third-party administrator or any other entity used by the Trust may utilize its internal guidelines and medical protocols in determining whether specific services or supplies are covered under the terms of the Plan. The Plan's third-party administrator does not have the authority to change the provisions of the Plan. An interpretation of the Plan by the Plan's third-party administrator is subject to review by the Board of Trustees. Telephone contact with the Administration Office does not guarantee eligibility for benefits or benefit payments. Eligibility for benefits and benefit payments will be determined only when a claim is submitted to the Administration Office, based on rules of the Trust and Plan.

The Board of Trustees and its Appeal Committee has the full and absolute discretion and authority to interpret and apply the provisions of the Plan, including its rules for eligibility. Only the Board of Trustees and its Appeal Committee is authorized to interpret the Plan. No employer or local union, no representative of any employer or local union, and no individual Trustee is authorized to interpret the Plan nor can any such person act as an agent of the Board of Trustees to guarantee benefit payments. No agreement between an employer and a union may change, override, or otherwise affect the Plan any way, except as the Board of Trustees may permit expressly by resolution. The benefits set forth in this Plan are not guaranteed. The Board of Trustees has the sole and exclusive right to amend, suspend, modify, or terminate the Plan in whole or in part.

To help ensure you receive necessary notices, you should notify the Administration Office if your address or that of any family member changes. You should retain this booklet and keep a copy of any written notices you send the Trust.

If you have any questions, please contact the Administration Office for assistance.

Sincerely,

Board of Trustees

Employer Trustees	**Union Trustees**
Barry Sherman	Janet Lewis
Michael Broberg	Sean Bagsby
Marv Nelson	Gillian Burlingham

Trust Website

The Trust website, www.psewtrusts.com, has been enhanced to provide you with medical claims summary information and paid claims detail. Retirees will only have access to their own personal paid claims history and that of dependents under the age of 13. Spouses and dependent children age 13 and over must request their own PIN. To request a dependent PIN, visit the website and download a Dependent Only PIN form.

The website also includes Trust related material such as forms, plan booklets, and links to the Plan's Preferred Provider networks. We encourage you to visit and use the Trust website. If you have any questions about the contents of the website or access to "My Personal Benefits" information, please feel free to contact the Administration Office at (206) 441-4667 or toll free (866) 314-4239.

Notice Informing Individuals About Nondiscrimination and Accessibility Requirements
Discrimination is Against the Law

Puget Sound Electrical Workers Healthcare Trust complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. The Trust does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Puget Sound Electrical Workers Healthcare Trust:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - ❖ Qualified sign language interpreters
  - ❖ Written information in other formats (large print, audio, accessible electronic formats)
- Provides free language services to people whose primary language is not English, such as:
  - ❖ Qualified interpreters
  - ❖ Information written in other languages

If you or your dependents need these services, contact the Manager of Employee Benefits-Claims, PO Box 34203, Seattle, WA 98124-1203, (866) 314-4239, extension 3500, Fax (206) 441-9110.

You or your dependents may file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at ***http://www.hhs.gov/ocr/office/file/index.html.***

Spanish – ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-866-314-4239.

Chinese – 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電1-866-314-4239。

Vietnamese – CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-866-314-4239.

Korean – 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-866-314-4239 번으로 전화해 주십시오.

Russian – ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-866-314- 4239.

Tagalog – PAUNAWA**:** Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-866-314-4239.

Ukrainian – УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 1-866-314-4239.

Mon-Khmer, Cambodian – ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ 1-866-314-4239.

Japanese – 意事項：日本語を話される場合、無料の言語支援をご利用いただけます。 1-866-314-4239まで、お電話にてご連絡ください。

Amharic – ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ 1-866-314-4239.

Cushite – XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1-866-314-4239.

Arabic – ملحوظة: إذا كنت تتحدث اللغة العربية، فإن خدمات المساعدة اللغوية متوفرة لك مجانًا. اتصل بالرقم 1-866-314-4239.

Punjabi – ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। 1-866-314-4239 'ਤੇ ਕਾਲ ਕਰੋ।

German – ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-866-314-4239.

Laotian – ໂປດຊາບ: ຖ້າ າວ່ າ ທ່ ານ ເ ວ້ ົ າພ າສ າ ລ າ ວ, ກ ານ ບ ໍ ລ ິ ກ ານ ຊ ່ ວ ຍ ເ ສ ີ ມ ຟ ຣ ີ ຂ ້ ນ ພ າສ າ, ໂ ດ ຍ ໍ ່ ບ ເ ສ ັ ຽ ງ ຄ ່ າ, ເ ປ ີ ດ ນ ີ ້ ພ ້ ອ ມ ໃ ຫ ້ ທ ່ ານ. ໂ ທ ຣ 1-866-314- 4239.

ELIGIBILITY AND CONTINUATION OF COVERAGE

Who is Eligible

You are eligible for the Retiree Plan if you meet all of the following requirements:

- You retire from active employment; and
- You have earned 10 years of credited service with, and you are receiving benefits from the Puget Sound Electrical Workers Pension Trust *or* you are receiving benefit payments from the National Electrical Benefit Fund or Pacific Coast Pension Fund (and these benefits were earned while you were working under the jurisdiction of Local Union No. 46); and
- You were covered as an active employee by the PSEW Trust for 6 consecutive months immediately prior to your retirement under 1 of the 3 pension plans named above. For disabled retirees, you will be eligible for retiree medical coverage if you were covered under the active plan for at least 6 of the 12 months immediately before the date you retire.

You are eligible for the Special Retiree Plan if you meet all the following requirements:

- You are over age 62 or Medicare eligible; and
- You retire from active employment
- You have earned 10 years of credited service with, and you are receiving benefits from the Puget Sound Electrical Workers Pension Trust *or* you are receiving benefit payments from the National Electrical Benefit Fund or Pacific Coast Pension Fund (and these benefits were earned while you were working under the jurisdiction of Local Union No. 46); and
- You were covered as an active employee by the PSEW Trust for 60 out of the 72 months immediately prior to your retirement and you were covered for the six-month period immediately prior to your retirement under one of the three pension plans named above.

You are also eligible if you were an active employee of Seattle University, a signatory employer, for a continuous period of ten (10) consecutive years immediately preceding your retirement date during which period you earned 870 hours or more per year, and you were an active participant in the active plan during such ten (10) year period.

Application and Enrollment

You may apply for retiree benefits by contacting:

Puget Sound Electrical Workers Health & Welfare Trust Fund
7525 SE 24th St, Suite 200
Mercer Island, WA 98040

Mailing Address:
PO Box 34203
Seattle, Washington 98124-1203
(206) 441-4667
(866) 314-4239
website: www.psewtrusts.com

If you are eligible, the Administration Office will send you a Retiree Medical Plan application. After you receive this notice of eligibility and application, you have 30 days in which to elect to be enrolled. Thereafter, enrollment is closed. The Administration Office will, upon receipt of your completed application, advise you of the effective date of coverage.

If you are eligible based on NEBF or IBEW Pacific Coast retirement payments only, you must request an application from the Trust within 30 days of the effective date of retirement. After you receive the application, you have 30 days in which to elect to be covered.

You and/your spouse may choose to delay your enroll in the Retiree Medical Plan because you are currently covered by another group health plan or because you have coverage through a state exchange individual plan that provide minimum essential coverage. If you wish to delay enrollment, you must provide the Trust with proof of your other coverage at the time you opt out. If you opt-out you may be able to enroll at a later date provided the following conditions are satisfied:

- You have not had a lapse in coverage;
- You lost the other coverage due to loss of eligibility for a reason other than failure to pay premiums (for example, exhaustion of COBRA, termination of spousal coverage, or eligibility for Medicare);
- If your other coverage was an individual plan through the state exchange, you are seeking enrollment in the Retiree Medical Plan during the state exchange normal annual open enrollment period; and
- You request enrollment in the Retiree Medical Plan within 31 days of the loss of other coverage.

Premium Payment

You will be required to make a monthly premium payment determined by the Board of Trustees. Your premium payment will be taken as an automatic deduction each month from your pension check. If your pension is insufficient to cover your contribution for retiree medical benefits, the Administration Office will send you a supply of payment coupons indicating your required monthly contribution and the due date.

Your payment is due the 15th of the month prior to the month of coverage. The Administration Office must receive your payment by the first day of each month for which you are eligible or coverage will end. If your coverage ends due to failure to pay your premium, you will not be able to reenroll.

Eligibility for Medicare – IMPORTANT!

In order to receive full Plan benefits, all retirees and dependents eligible for Medicare MUST enroll in Medicare Parts A and B when eligible for that coverage. This Plan does not provide benefits for amounts that would have been reimbursed by Medicare Parts A or B, if a Retiree or Dependent fails to enroll in Medicare.

Retirees and dependents under age 65 and covered by Medicare must submit proof of Medicare eligibility. Please notify the Administration Office in writing within 30 days of receipt of notification of Medicare eligibility.

Eligibility for Your Dependents

You must enroll your eligible dependents to participate in the Plan of benefits at the same time you enroll. You need to enroll your dependents by completing the necessary enrollment forms and submitting those to the Administration Office. The Administration Office shall require you to provide information or documents to verify your dependents' status (for example, a copy of a marriage certificate, birth certificate, adoption papers or divorce decree). If you fail to timely enroll your eligible dependents when you enroll (including providing all the necessary information),

your dependents will not be able to enroll at a later point, except as otherwise provided in the Plan.

If you acquire a new dependent after your initial enrollment (for example through marriage or birth of child) you must enroll your new dependent within 31 days of the date you acquired the new dependent in order for the dependent to be eligible. If you fail to timely enroll your newly eligible dependents within 31 days of the day you acquired the new dependent, your new dependent will not be able to enroll at a later point, except as otherwise provided in the Plan. Also, if your dependent ceases to be eligible due to death or divorce you must notify the Administration Office immediately. All claims paid after your dependent is no longer eligible will be considered overpaid benefits.

Eligible dependents are:

- Your lawfully married spouse.
- Your children up to age 26. Your "children" are your natural children, your stepchildren, your adopted children, children placed with you for adoption, your foster children and other children for whom you have legal guardianship and who depend on you for support and live with you in a regular parent-child relationship.
- Your children age 26 and over, but only if all the following conditions are satisfied:
  a) The child was covered under the Plan as your dependent child immediately before attaining age 26.
  b) The child is unmarried.
  c) The child is incapable of earning a living due to mental or physical incapacity that began before the child attained age 26.
  d) You submit proof of the child's incapacity to the Administration Office within 90 days after the child attains age 26, and
  e) You provide the Trust periodic updates of the child's incapacity and marital status as required by the Trust.
- An "alternate recipient" under a Qualified Medical Child Support Order (QMCSO) within the meaning of section 609 of ERISA (29 U.S.C. §1169).

Qualified Medical Child Support Order

The Plan recognizes Qualified Medical Child Support Orders (QMCSO) and enrolls a retiree's natural dependent children, adopted children, and children placed with the retiree in anticipation for adoption as directed by the order. No eligible dependent child covered by a QMCSO will be denied enrollment on the grounds that the child is not claimed as a dependent on the parent's Federal income tax return or does not reside with the parent.

A QMCSO is any judgment, decree or order (including a domestic relations settlement agreement) issued by a court or by an administration agency under applicable state law which:

- Provides child support or health benefit coverage to a dependent child, or
- Enforces a state law relating to medical child support pursuant to Section 1908 of the Social Security Act which provides in part that if the retiree does not enroll the dependent child, then the non-retiree parent or State agency may enroll the child.

To be qualified, a Medical Child Support Order must clearly specify:

- The name and last known mailing address of the retiree and the name and mailing address of each dependent child covered by the Order,
- A description of the type of coverage to be provided by the Plan to each such dependent child,
- The period of coverage to which the Order applies, and

- The name of each plan to which the Order applies.

If a proposed or final order is received, the Administration Office will notify the retiree and each child named in the order. The order will then be reviewed to determine if it meets the definition of a QMCSO. Within a reasonable time, the retiree and each child named in the order will be notified of the decision. A notice will also be sent to each attorney or other representative named in the order or accompanying correspondence.

A Medical Child Support Order will not qualify if it would require the Plan to provide any type or form of benefit or any option not otherwise provided under this Plan, except to the extent necessary to comply with Section 1908 of the Social Security Act.

If the order is not qualified, the notice will give the specific reason for the decision. The party(ies) filing the order will be given an opportunity to correct the order or appeal the decision through the claim and appeal procedures explained in this Plan booklet.

If the order is qualified, the notice will give instructions for enrolling each child named in the order. A copy of the entire QMCSO and any required self-payments must be received prior to enrollment. Any child(ren) enrolled pursuant to a QMCSO will be subject to all provisions applicable to dependent coverage under the Plan. Payment of benefits by the Plan under a QMCSO to reimburse expenses claimed by a child or his custodial parent or legal guardian shall be made to the child or his custodial parent or legal guardian if so required by the QMCSO.

When Dependent Coverage Begins

Provided that all the requested enrollment documentation is received, coverage for your eligible dependents begins on the later of: 1) the date your coverage begins; or 2) the date your dependents first meet the definition of an eligible dependent as described in this section (for example: date of marriage, date of birth, date of adoption, etc.). Dependents will not be eligible for coverage until all requested enrollment documentation is provided. Please note: If requested enrollment documentation is not provided, the Plan will not pay claims until the documentation is received. Delayed enrollment documentation may result in the denial of claims. Claims submitted or completed more than 12 months after the incurred date will be denied.

When Coverage Ends

Retirees
Your coverage ends on the earliest of the following dates:

- The date you no longer meet eligibility requirements;
- The last day of the month prior to a month for which premium payment is not made;
- The date you become covered as an active employee (including COBRA self-payment under the active plan). If you return to work, your retiree eligibility will end and the eligibility rules of an active participant will apply. Your retiree coverage will become effective on the first day of the month coinciding with or next following the date you retire again; or
- The date of you death or date the plan is discontinued.

Dependents
Dependent coverage ends on the earliest of the following dates:

- The date your coverage ends; or
- The last day of the month in which your dependent no longer meets the definition of an eligible dependent as described in this section.

If you die after you and your dependents become covered, your eligible dependents may continue coverage by paying the required contribution until your spouse remarries or a dependent child reaches the limiting age as long as they continue to meet eligibility requirements.

COBRA Continuation Coverage

COBRA is a Federal law that permits "qualified beneficiaries" to elect to extend health benefits on a self-pay basis when a "qualifying event" occurs. The period of time for which coverage is continued is called "COBRA coverage."

Qualified Beneficiaries
A "qualified beneficiary" means:

- Any individual who is covered under the Plan as a dependent of a retiree on the day before a qualifying event.
- A child who is born to, adopted by, or placed for adoption with a former retiree's spouse during COBRA coverage, provided the Administration Office is timely notified, and the appropriate self-payments are made.

Other dependents of a qualified beneficiary that are newly-acquired during a period of COBRA may be enrolled for coverage by submitting an enrollment form along with the appropriate certificates to the Administration Office within 30 days of becoming a dependent. These dependents will not be considered qualified beneficiaries.

An individual ceases to be a qualified beneficiary if COBRA is not timely elected, or when the Plan's obligation to provide COBRA otherwise ends.

36-Month Qualifying Events
A dependent may elect COBRA for a maximum of 36 months following the date coverage would otherwise end due to one of the following qualifying events:

- Death of the retiree;
- Divorce between the retiree and spouse; or
- The dependent child ceases to meet the Plan's definition of "dependent."

Notice Requirements
The Plan offers COBRA only after it has been notified of a qualifying event by mail, personal delivery, fax, or e-mail. The retiree or the affected qualified beneficiary **must** notify the Administration Office when these qualifying events occur:

a) The retiree and spouse divorce, or
b) The retiree's child loses dependent status (for example, because the child attains age 26).

The retiree or the affected qualified beneficiary must provide this notice to the Administration Office in writing within 60 days of the later of (a) the date of the qualifying event or (b) the date coverage would terminate as a result of the qualifying event. The notice must identify the individual who has experienced a qualifying event, the retiree's name, and the qualifying event which occurred. **If the Administration Office is not notified during the 60-day period, the qualified beneficiary will lose the right to elect COBRA coverage.**

To enroll a child who is born to, adopted by, or placed for adoption with a qualified beneficiary during a period of COBRA coverage, you must notify the Administration Office in writing within 30 days of the birth, adoption or placement for adoption, and provide a copy of the child's birth certificate or adoption papers. **If the Administration Office is not notified within the 30-day period, the child cannot be enrolled for COBRA coverage.**

A qualified beneficiary who first becomes, after the date of the election of COBRA, covered under any other group health plan or under Medicare, must notify the Administration Office in writing of the other coverage or Medicare coverage.

The Administration Office will notify qualified beneficiaries of loss of coverage due to the retiree's death. However, you are encouraged to inform the Administration Office to best ensure prompt handling of your COBRA rights.

Election of COBRA
When the Administration Office is notified of a qualifying event, a COBRA election form is mailed to the qualified beneficiaries. The COBRA election form must be completed and returned to the Administration Office within 60 days of the later of:

a) The date coverage would terminate; or
b) The date the COBRA election form was sent.

If the completed COBRA election form is not sent to the Administration Office by this date, the qualified beneficiaries will lose the right to elect COBRA coverage.

Each qualified beneficiary has an independent right to elect COBRA coverage. A retiree or spouse may elect COBRA on behalf of other qualified beneficiaries in the family. A parent or legal guardian may elect COBRA on behalf of a minor child.

Type of Benefits
The following benefit options are available under COBRA, provided the qualified beneficiary was eligible for such benefits immediately prior to the qualifying event:

- Medical, Prescription Drug, or
- Medical, Prescription Drug, Dental, Hearing and Vision.

Cost and Payment
There is a cost for COBRA. Information regarding the cost will be sent with the COBRA election forms. The first payment is due 45 days from the date the COBRA election form is sent to the Administration Office. The first payment must cover all months since the date coverage would have otherwise terminated. **If the first payment is not made within the 45-day period, COBRA coverage will not commence.** If full, timely initial payment is made within the 45-day period, thereafter payments must be made monthly to continue COBRA coverage. All payments must be sent to the Administration Office.

No claims for benefits will be processed for expenses incurred following the date of the qualifying event, until the appropriate, timely COBRA payment has been made for the applicable period of COBRA coverage.

Termination of COBRA
COBRA coverage ends on the first of the dates indicated below:

- The last day of the month the maximum coverage period for the qualifying event has ended (36 months).
- The last date for which the self-payment was paid, or when the qualified beneficiary does not make the next payment in full when due. Payments must be made within 30 days of the due date.
- The date the qualified beneficiary first becomes, after the date of election of COBRA, covered under any other group health plan.
- The date this Plan discontinues.

COBRA is provided subject to eligibility. The Plan reserves the right to terminate COBRA retroactively if the qualified beneficiary is determined to be ineligible for coverage.

Other Options to Consider

Instead of enrolling in COBRA coverage, there may be other, more affordable coverage options through the Health Insurance Marketplace, Medicare, Medicaid, or other group health plan coverage options. Some of these options may cost less than COBRA coverage.

CALENDAR YEAR DEDUCTIBLE		Non-Medicare Participants		Medicare Participants	
		PPO Providers	Non-PPO Providers	PPO Providers	Non-PPO Providers
– Calendar year deductibles are separate for PPO and non-PPO providers and are not interchangeable. – The deductible is waived for accidents (treatment beginning within 72 hour of Injury), diabetic education, preventive care from a PPO provider, Skilled Nursing Facility, home health care, hospice care, and foot orthotics.	Individual	$300	$750	$0	$0
	Family	$600	$1,500	$0	$0

CALENDAR YEAR OUT-OF-POCKET MAXIMUM		Both Non-Medicare and Medicare Participants	
		PPO Providers	Non-PPO Providers
– Calendar year out-of-pocket maximums are separate for PPO and non-PPO providers and are not interchangeable. – For PPO Providers: The Calendar Year out-of-pocket maximum includes deductibles, coinsurance (including pediatric dental/vision coinsurance) and copays that you are required to pay out-of-pocket. When your total out-of-pocket amount for covered expenses incurred during a Calendar Year reaches the maximum, covered services from PPO providers are covered in full for the remainder of the Calendar Year, up to the Allowed Amount. – For Non-PPO Providers: The Calendar Year out-of-pocket maximum includes only coinsurance that you pay out-of-pocket. Charges in excess of the Allowed Amount, deductibles and copays do NOT apply. Once your total coinsurance amount for covered expenses incurred during a Calendar Year reaches the maximum, your coinsurance for covered expenses will be waived for the remainder of the Calendar Year. You will still be required to pay applicable deductibles and copays. For non-PPO providers, the out-of-pocket maximum does not apply to services for acupuncture, chiropractic care, diabetic education, home health care, foot orthotics, hospice care, massage therapy, naturopathic care, skilled nursing, occupational, speech and physical therapy. – The following expenses do not count toward your out-of-pocket maximums, and you will always be required to pay these amounts: • Charges above the Allowed Amount • Penalties for failure to obtain required preauthorization • Services and items not covered by the Plan	Individual	$5,500	$8,000 per person
	Family	$11,000	

SUMMARY OF MEDICAL BENEFITS

(Active Participants and their Dependents)

This chart explains the benefits payable by the Plan. See also the Exclusions and Definitions sections of this Booklet for important information. All benefits are subject to the deductible except where noted. Coinsurance expenses are separate for each category and are not interchangeable.

IMPORTANT: Non-PPO Providers are paid according to the Usual, Customary and Reasonable Charges as defined in the Definitions section and could result in balance billing to you.

Benefit Description	Explanation and Limitations	Non-Medicare Participants		Medicare Participants	
		Plan Pays - PPO Providers (% of Allowed Amount)	Plan Pays- Non-PPO Providers (% of Allowed Amount)	Plan Pays - PPO Providers (% of Allowed Amount)	Plan Pays- Non-PPO Providers (% of Allowed Amount)
Inpatient Hospitalizations – room and board, and other services	• Care must be preauthorized for non-Medicare eligible participants. The Allowed Amount is reduced by 25%, up to $1,200, if the preauthorization requirement is not followed. • Emergency room copay is $100 per visit (waived if directly admitted to the Hospital as an inpatient or if your visit is due to Injury/accident).	90%	50%	No charge for Medicare approve charges	20% of Medicare limited charge and up to 50% of the difference between Medicare limited charge and billed amount
Physician - home and office visits - x-ray and lab - surgery	• Surgery not performed in an office setting must be preauthorized non-Medicare eligible participants. The Allowed Amount is reduced by 25%, up to $1,200, if the preauthorization requirement is not followed.	90%	50%		
Preventive Care - routine exams - newborn exam - immunizations - cancer screenings	• See Preventive Care in this Plan Booklet for a description of benefits.	100%	50%		
Acupuncture	• Limited to 15 visits per Calendar Year. • Maximum combined with Chiropractic Care.	90%	50%		
Chiropractic Care	• Limited to 15 visits per Calendar Year. • Maximum combined with Acupuncture (including x-rays).	90%	50%		
Chemical Dependency	• Same as any other condition. • Preauthorization required for inpatient services for non-Medicare eligible participants. The Allowed Amount is reduced by 25%, up to $1,200, if preauthorization requirement is not followed.	90%	50%		

SUMMARY OF MEDICAL BENEFITS

(Active Participants and their Dependents)

This chart explains the benefits payable by the Plan. See also the Exclusions and Definitions sections of this Booklet for important information. All benefits are subject to the deductible except where noted. Coinsurance expenses are separate for each category and are not interchangeable.

IMPORTANT: Non-PPO Providers are paid according to the Usual, Customary and Reasonable Charges as defined in the Definitions section and could result in balance billing to you.

Benefit Description	Explanation and Limitations	Non-Medicare Participants		Medicare Participants	
		Plan Pays - PPO Providers (% of Allowed Amount)	Plan Pays- Non-PPO Providers (% of Allowed Amount)	Plan Pays - PPO Providers (% of Allowed Amount)	Plan Pays- Non-PPO Providers (% of Allowed Amount)
Clinical Trial Coverage	• See Clinical Trial in this Plan Booklet for a description of benefits.	90%	50%	No charge for Medicare approve charges	20% of Medicare limited charge and up to 50% of the difference between Medicare limited charge and billed amount
Maternity	• Coverage limited to members and spouses only, except for required preventive services.	90%	50%		
Mental Health Care	• Covered the same as any other condition. • Preauthorization required for inpatient services, including Residential Treatment Facilities, non-Medicare eligible participants. The Allowed Amount is reduced by 25%, up to $1,200, if preauthorization requirement is not followed.	90%	50%		
Ambulance	• Transport to/from the nearest facility available with appropriate services. • Paid at PPO allowed amount, subject to PPO deductible and out-of-pocket maximum, when necessary to protect the patient's life or health. Otherwise, benefits will be based on the PPO status of the ambulance provider.	90%	85%		
Hearing Aids	• Benefit limited to Active and Non-Medicare retiree participants only. Dependents not covered for this benefit • $500 maximum per ear during any 3-year period.	90%	85%		
Skilled Nursing Facility	• Preauthorization required for inpatient services for non-Medicare eligible participants. The Allowed Amount is reduced by 25%, up to $1,200, if preauthorization requirement is not followed. • Not subject to deductible. • Benefit limited to 30 days per Calendar Year.	90%	50%		

SUMMARY OF MEDICAL BENEFITS
(Active Participants and their Dependents)

This chart explains the benefits payable by the Plan. See also the Exclusions and Definitions sections of this Booklet for important information.
All benefits are subject to the deductible except where noted. Coinsurance expenses are separate for each category and are not interchangeable.
IMPORTANT: Non-PPO Providers are paid according to the Usual, Customary and Reasonable Charges as defined in the Definitions section and could result in balance billing to you.

Benefit Description	Explanation and Limitations	Non-Medicare Participants		Medicare Participants	
		Plan Pays - PPO Providers (% of Allowed Amount)	Plan Pays- Non-PPO Providers (% of Allowed Amount)	Plan Pays - PPO Providers (% of Allowed Amount)	Plan Pays- Non-PPO Providers (% of Allowed Amount)
Rehabilitative Facility	• Preauthorization required for inpatient services for non-Medicare eligible participants. The Allowed Amount is reduced by 25%, up to $1,200, if preauthorization requirement is not followed. • Benefit limited to 30 days maximum per Calendar Year. • Must be admitted within one year from condition onset date.	90%	85%	No charge for Medicare approve charges	20% of Medicare limited charge and up to 50% of the difference between Medicare limited charge and billed amount
Outpatient Rehabilitation	• Benefit limited to $60 per visit.	90%	85%		
Home Health Care	• Patient must be homebound. • Not subject to deductible. • Prescription and nursing notes required. • Maximum of 130 visits each Calendar Year.	90%	50%		
Hospice Care	• Not subject to deductible, benefit limited to 6 months per lifetime.	90%	50%		
Dialysis	• Services are not subject to deductible or coinsurance when Medicare becomes the Secondary Payer (usually beginning with the 4th month of End Stage Renal Disease [ESRD] treatment. • Benefits for kidney dialysis are paid at 150% of the current Medicare reimbursement amount when Medicare is the secondary payer under Medicare rules, or 100% of the current Medicare reimbursement amount (subject to coordination of benefits with Medicare) when Medicare is the primary payer under Medicare rules.	90%	50%		

SUMMARY OF PRESCRIPTION DRUG BENEFITS

EnvisionRxPlus Employer Group Retiree Prescription Drug Plan ("EnvisionRxPlus Plan") provides prescription drug benefits to all Medicare Eligible retirees and Medicare eligible spouses and dependents of retirees. The EnvisionRxPlus Plan has a separate plan booklet that is provided by EnvisionRxPlus. Medicare eligible individuals are automatically enrolled into the EnvisionRxPlus coverage unless you notify the Administration Office of your intention to opt-out. The prescription drug benefits set forth in this Plan booklet apply to non-Medicare retirees and dependents only.

For non-Medicare Eligible Retirees, your prescription drug benefit is based on a formulary drug list. A formulary is a list of covered drugs organized into groups, or "Tiers". Each time you fill a prescription you will have to a pay a copay based on the formulary tier your medication falls under:

- Tier 1 - Generic Drugs
- Tier 2 - Preferred Brand-Name Drugs
- Tier 3 - Non-Preferred Brand-Name Drugs

For a full formulary listing, please visit www.envisionrx.com (select the "Preferred Drug Listing" option) or call at 800-361-4542. The formulary list is not all inclusive and does not guarantee coverage of any medication. Some medications may be excluded from coverage.

The prescription drug benefit has a Calendar Year out-of-pocket (OOP) maximum of $1,350 per individual and $2,700 per family for drugs purchased from network retail and mail order pharmacies. Once you reach these maximums during a Calendar Year, all drugs from network pharmacies will be covered at 100% (no copay) for the remainder of the Calendar Year. Copays for drugs purchased at out-of-network pharmacies will not count toward the OOP maximum and will not be covered at 100% once the OOP maximum is reached.

Certain preventive care drugs are covered at 100%.

Certain drugs may be subject to step therapy, prior authorization or quantity limits. For a more detailed description please refer to the Prescription Drug Program section.

Retail	Costco Mail Order
▪ Up to a 30-day supply ▪ Tier 1 - Generic: $10 copay ($3 at Costco) ▪ Tier 2 - Preferred Brand: $25 copay ▪ Tier 3 - Non-Preferred Brand: $50 copay	▪ Up to a 90-day supply ▪ Tier 1 - Generic: $7.50 copay ▪ Tier 2 - Preferred Brand: $62.50 copay ▪ Tier 3 - Non-Preferred Brand: $125.00 copay

SUMMARY OF VISION BENEFITS

- Exam: 100% UCR
- Lenses and Frames: Paid according to vision benefits schedule. See vision section of booklet for additional details.

SUMMARY OF DENTAL BENEFITS – NON-MEDICARE ELIGIBLE PARTICIPANTS ONLY

- Class I: 100% of the Allowed Amount (See dental section of booklet for additional details.)
- Class II: 80% of the Allowed Amount (See dental section of booklet for additional details.)
- Class III: 75% of the Allowed Amount (See dental section of booklet for additional details.)
- Dental Calendar Year Maximum: $2,500 (does not apply to dependent children under age 12)
- Orthodontia: 70% of the Allowed Amount
- Lifetime Orthodontia Maximum: $2,500 maximum

MEDICAL BENEFITS

Benefits for Medicare Eligible Participants

If you are eligible for Medicare, Medicare will pay first and this Plan will pay second. Medicare will be responsible for determining whether a benefit is payable for your medical expenses. The Plan will only pay for medical expenses covered by Medicare.

The Plan's deductible does not apply to Medicare eligible retirees and dependents. If you use a Preferred (PPO) Provider, you will have no coinsurance. For non-PPO providers, the most you will pay is 20% of the Medicare limited charge plus 50% of the difference between the Medicare limited charge and the billed amount. The Plan's out-of-pocket maximums do apply to Medicare eligible retirees and dependents.

Benefits for Non-Medicare Eligible Participants

The Medical Benefits section of this Plan booklet generally only applies to retirees and dependents who are *not* eligible for Medicare. This section describes the Plan's PPO network, health management programs, medical deductibles, medical out-of-pocket maximums, and medical coinsurance. This section also describes the Plan's available medical benefits, exclusions and definitions.

Preferred (PPO) Providers
The Plan has contracted with Premera Blue Cross for access to preferred provider arrangements through the Premera (Washington and Alaska) network and the national Blue Cross Blue Shield ("BlueCard") network (all other states). Under these preferred provider organization (PPO) arrangements, certain Hospitals, Physicians, and other health care professionals have agreed to discounted fees. Using PPO providers is important for several reasons:

- The PPO provider has agreed to accept their discounted fee as payment in full for the service. They cannot bill you for any amount over their discounted fee.
- The Plan will recognize the PPO discounted fee as the Allowed Amount, and benefits will be based on the discounted fee. For non-PPO providers, the Allowed Amount will be calculated based on usual, customary and reasonable (UCR) fee limits and the provider may bill you for any amount they charge over UCR.
- If you use a PPO provider, in most instances the Plan will pay at a higher coinsurance level, and your out-of-pocket costs will be lower.
- PPO providers will submit claims directly to the Plan, and the Plan will reimburse the provider, meaning less paperwork for you.

Here's an example of how using the network can save you money:

In the PPO network. Let's say you have lab fees of $100 from a PPO provider. The benefit is 90%, after the deductible. Assuming you have already satisfied the deductible, the Plan would pay $90 and you would pay the remaining $10.

Out of network*:* Now let's say that you go to a non-PPO provider for the same lab tests, but this lab charges $120 (there is no network discount). Assuming you have already satisfied the deductible, the Plan would pay 50% up to the usual, reasonable and customary (UCR) limit, which the Plan determines to be $100. So, in this case, the Plan pays $50 (50% of $100 UCR limit) and you pay the remaining $70 (your 50% **plus** the amount charged by the provider over the UCR limit.)

It is to your advantage to make sure that all providers involved in your medical treatment, including surgery, are PPO providers. If you are expecting to have surgery, inform your Physician that any providers involved in your surgery, such as an assistant surgeon or anesthesiologist, should be PPO providers. Also, make sure that any freestanding lab or x-ray service providers used by your Physician for your medical treatment are covered PPO providers.

The Premera Blue Cross PPO service area includes the states of Washington and Alaska. The national Blue Cross Blue Shield PPO service area includes all other states. To locate a PPO provider, log on to http://www.premera.com/sharedadmin or call (800) 810-BLUE (2583).

Exceptions:

- In the event that surgery is performed in a PPO facility by a surgeon who is a PPO provider, and services are rendered by a non-PPO anesthesiologist and/or assistant surgeon, those services will be covered at the PPO level.
- Once per lifetime, ancillary services performed by non-PPO providers will be covered at the PPO level, provided that either a PPO provider referred the non-PPO providers or the facility is a PPO facility.
- In the event that emergency transport is Medically Necessary, services by a non-PPO Ambulance provider will be paid at the PPO Allowed Amount for Ambulance transportation to or from the nearest facility available with appropriate services, when necessary to protect the patient's life or health.
- Emergency services by a non-PPO provider for an emergency medical condition will be covered at the PPO Allowed Amount.

Health Management Program

The Health Management Program is an important Plan feature. How the program works and affects benefit payment levels is described below.

Inpatient and Outpatient Preauthorization

The following services need to be preauthorized for the Plan to pay regular benefit levels:

- Inpatient Hospitalization;
- Chemical Dependency Treatment Facility;
- Rehabilitative Facility;
- Residential Treatment Facility;
- Skilled Nursing Facility;
- Transplants; and
- Surgeries, other than in an office setting.

During the review, medical professionals will examine information from your Physician and compare it to established criteria to determine if the recommended care is Medically Necessary. You or your Physician must initiate this review by calling Comagine Health at one of the numbers listed below.

If the service and level of care is certified as Medically Necessary, and is specifically covered under the Plan, the Plan pays at regular benefit levels. No benefits are provided for treatment that is determined not Medically Necessary.

If you do not follow the preauthorization requirement, but services are later determined Medically Necessary and specifically covered under the plan, **regular Plan benefits for Hospital, facility and surgical fees are reduced by 25% of the Allowed Amount, to a maximum penalty of $1,200.** This penalty does not count toward your annual out-of-pocket maximum.

Comagine Health Contact Information
Toll Free: (800) 783-8606
Seattle Area: (206) 368-8271

Rules for Preauthorization
Rules for Preauthorization vary depending on the type of care you need:

- **Non-Emergencies**
  You or your Physician will need to notify Comagine Health at least 10 days before the scheduled admission or service.
- **Emergency Admissions and Surgery**
  Emergency admissions and emergency surgery do not require preauthorization prior to the admission or service; however, **Comagine Health must be contacted within 48 hours (or within 72 hours for weekends or holidays) of the admission or service.** The call can be made by you, a family member, your Physician, or the facility.
- **Maternity Admissions**
  Preauthorization prior to admission is not required. For maternity Hospital admissions, you or your Physician should call Comagine Health on the first business day after admission for delivery. Also, it is recommended that you or your Physician call Comagine Health when you first learn of your or your spouse's pregnancy.

On-Going Review
Once you have been admitted to a Hospital, Chemical Dependency Treatment Facility, Skilled Nursing Facility, Residential Treatment Facility or Rehabilitative Facility, and Comagine Health has been notified, on-going or concurrent review begins. If your condition requires a longer stay than originally planned, Comagine Health will review additional stay as necessary, using information provided by your Physician. Comagine Health will also assist you and monitor your home health care or hospice care once your Physician has submitted a plan for such care to the Administration Office.

Discharge Planning
If you require continued medical care, but not the intensive services of an inpatient facility, Comagine Health professionals will work with you, your Physician, and the facility to develop a discharge plan that allows an early and safe release from the facility.

Case Management
Case management provides you and your dependents with additional resources to manage health care treatments and costs. This program is designed to provide you and your dependents high quality health care by considering alternatives to inpatient confinement. The case manager will work with the patient and Physician to design an Alternate Care Plan which may include alternative care that may be in addition to coverage under the Plan or may be in lieu of other plan benefits and may include, among other things, possible admission to skilled nursing facilities or rehabilitative facilities, home health care, infusion therapy, and hospice care. Once the Alternate Care Plan has been accepted by the Administration Office, the case manager will follow the patient through his or her course of treatment.

Calendar Year Deductible

The Calendar Year Deductible is the cost of covered medical services you are responsible to pay each Calendar Year before the Plan begins to pay benefits. **The Plan has a separate deductible for PPO and non-PPO providers and they are not interchangeable.** Deductibles apply on both a per individual and per family basis. Once the deductible amount you (or any other individual family member) pay in a Calendar Year reaches the individual deductible, no

deductible will apply for you (or that family member) for the rest of the Calendar Year. Once the total deductible amount you pay for two or more family members in a Calendar Year reaches the family deductible, no deductible will apply for any eligible family member for the rest of the Calendar Year.

There is no Calendar Year Deductible for Medicare participants. The deductibles for non-Medicare participants are as follows:

Calendar Year Deductible	PPO Providers	Non-PPO Providers
Per Individual	$300	$600
Per Family	$7500	$1,500

The deductible is waived for the following:

- Treatment of an accidental Injury (as long as treatment begins within 72 hours of the Injury).
- Preventive care provided by a PPO provider.
- Skilled nursing facility care, home health care, and hospice care.
- Foot orthotics.
- Diabetic Education.
- Medicare eligible retirees and dependents.

Coinsurance

After you satisfy the deductible, you and the Plan share the remaining expenses. This is called "coinsurance." In general, coinsurance amounts for PPO and non-PPO providers are as follows:

Coinsurance	Non-Medicare Participants		Medicare Participants	
	PPO Provider	Non-PPO Provider	PPO Provider	Non-PPO Provider
The Plan Pays	90% of PPO Allowed Amount	50% of Usual, Customary and Reasonable (UCR)	100% of the remaining amount after the Medicare approved charge	Up to 20% of the Medicare approved charge and up to 50% of the difference between the Medicare approved charge and the billed amount
You Pay	10% of PPO Allowed Amount	50% of Usual, Customary and Reasonable (UCR), plus any amount in excess of UCR	$0 (you will have no out-of-pocket for PPO provider)	Up to 20% of the Medicare approved charge and up to 50% of the difference between the Medicare approved charge and the billed amount

For certain services the coinsurance may be different as noted throughout this booklet.

Calendar Year Out-Of-Pocket Maximum – Applies to both Medicare and Non-Medicare Eligible Retirees and Dependents

For most medical benefits, the Plan limits the expenses you have to pay out-of-pocket each Calendar Year. **Calendar year out-of-pocket maximums are separate for PPO and non-PPO providers and are not interchangeable.** Out-of-pocket maximums apply on both a per individual and per family basis. Once your total out-of-pocket expenses for you (or any other individual family member) in a Calendar Year reaches the individual out-of-pocket maximum, the out-of-pocket maximum will be considered met for you (or that family member) for the rest of the Calendar Year. Once your total PPO out-of-pocket expenses for two or more family members in a Calendar Year reaches the family maximum, the PPO out-of-pocket maximum will be considered met for any eligible family member for the rest of the Calendar Year. There is no family out-of-pocket maximum for non-PPO providers. The Calendar Year out-of-pocket maximums are as follows:

Calendar Year Out-of-Pocket Maximum	PPO Providers	Non-PPO Providers*
Per Individual	$5,500	$8,000 per person
Per Family	$11,000	

*For Non-PPO providers the out-of-pocket maximum applies to coinsurance only and excludes certain services.

For PPO providers - The Calendar Year out-of-pocket maximum includes deductibles, coinsurance (including pediatric dental/vision coinsurance) and copays that you are required to pay out-of-pocket. When your total out-of-pocket amount for covered PPO services incurred during a Calendar Year reaches the maximum, covered services from PPO providers are covered in full for the remainder of the Calendar Year, up to the Allowed Amount.

For non-PPO providers – The Calendar Year out-of-pocket maximum includes only coinsurance that you pay out-of-pocket. Once your total coinsurance amount for covered non-PPO expenses incurred during a Calendar Year reaches the individual maximum, your coinsurance for non-PPO covered expenses will be waived for the remainder of the Calendar Year. You will still be required to pay applicable deductibles and copays. For non-PPO providers, the out-of-pocket maximum does **NOT** apply to the following services, and you will continue to pay coinsurance for these services once the out-of-pocket maximum is reached:

- acupuncture care,
- chiropractic care,
- diabetic education,
- foot orthotics,
- home health care,
- hospice care,
- massage therapy,
- naturopathic care,
- physical, occupational and speech therapy, and
- skilled nursing.

The following expenses do **NOT** count toward your out-of-pocket maximums, and you will always be required to pay these amounts:

- Charges above the Allowed Amount
- Penalties for failure to obtain required preauthorization
- Services and items not covered by the Plan

Covered Medical Services and Supplies

The Plan provides coverage for most Medically Necessary services and supplies when used to diagnose or treat an accidental Injury or Illness. The Plan also covers certain preventive care. Coverage is subject to Plan provisions, including the exclusions beginning on page 33 and the definitions beginning on page 36.

The Plan covers the following medical services and supplies for non-Medicare eligible participants. Unless otherwise noted, services and supplies are subject to the applicable Calendar Year deductible, coinsurance and Calendar Year out-of-pocket maximums for PPO and non-PPO providers. If you are eligible for Medicare, the Plan will only pay for medical expenses covered by Medicare.

Acupuncture Care
Covered when Medically Necessary and provided by a licensed Covered Provider acting within the scope of their license. *Note: services from a Non-PPO provider do not apply toward the Calendar Year out-of-pocket maximum, and will not be paid at 100% when the maximum is met.* All benefits for Acupuncture Care combined with Chiropractic Care are limited to a maximum of 15 visits per Calendar Year.

Ambulance (Air and Ground)
The Plan covers professional local Ambulance service used to transport the patient to or from the nearest facility available with appropriate services, when necessary to protect the patient's life or health. Services by a Non-PPO professional local ambulance provider will be paid at the PPO Allowed Amount when the criteria noted above are met.

Chemical Dependency
The Plan covers outpatient services and inpatient services at an approved Chemical Dependency Treatment Facility or Hospital, including Physician services and prescription drugs. Preauthorization is required for inpatient facility services. The Allowed Amount is reduced by 25%, up to $1,200, if the preauthorization requirement is not followed.

All treatment must be the result of a diagnosis or recommendation by a Physician. Coverage will not be provided unless treatment is recognized by the medical profession as appropriate for alcoholism or drug abuse in accordance with broadly accepted standards of medical practice, taking into account the patient's current condition.

Chiropractic Care
Covered when Medically Necessary and provided by a licensed Covered Provider acting within the scope of their license. *Note: services from a Non-PPO provider do not apply toward the Calendar Year out-of-pocket maximum, and will not be paid at 100% when the maximum is met.* All benefits for Chiropractic Care combined with Acupuncture Care are limited to a maximum of 15 visits per Calendar Year.

Clinical Trials
The Plan covers routine patient costs for items and services furnished in connection with an approved clinical trial that would otherwise be covered by the Plan for a patient (or participant) who is not participating in a clinical trial. The Plan 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 that 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.

Cosmetic Surgery
The Plan covers necessary services and supplies for cosmetic surgery only if required for:

- Repair of an accidental Injury that occurs while covered under this Plan and provided that the service or supply is provided within 1 year of the date of Injury;
- Reconstructive breast surgery following or coinciding with a mastectomy and performed as a result of an Illness or Injury, including all reduction stages of the non-diseased breast; and
- Congenital defects of newborn children.

Dental Services
Services of a licensed dentist (DDS or DMD) are provided when such services are directly related to the treatment of accidental Injury to a tooth. Benefits will be provided to a covered patient if the patient is treated within 12 months of the accident. Dental benefits will be paid first under the Dental Plan, subject to those provisions, and then under the Medical Plan. No benefits will be provided under the Medical Plan for Injury caused by biting or chewing. See the Dental Plan, beginning on page 45, for information about dental benefits.

Diabetic Education
The Plan pays 100% of the Allowed Amount up to a maximum of 2 visits per lifetime. The Calendar Year deductible is waived for diabetic education services. *Note: services from a Non-PPO provider do not apply toward the Calendar Year out-of-pocket maximum, and will not be paid at 100% when the maximum is met.*

Dialysis Treatment
The Plan covers hemodialysis or peritoneal dialysis and supplies administered under the direction of a Physician in a Hospital, Health Care Facility, Physician's office or at home.

If you or your eligible dependent has been diagnosed with End Stage Renal Disease (ESRD), you or your dependent may be eligible to enroll in Medicare Part A and B. Although you are not obligated by the Trust to enroll in Medicare, enrolling in both Parts A and B will help protect you from being balance billed by providers of ESRD dialysis services.

When you or your dependent is enrolled in Medicare (or is simply eligible for Medicare) based on ESRD, the following payment rates will apply for both preferred and non-preferred providers:

- When Medicare becomes the "Secondary Payer" under the Medicare rules (usually beginning with the 4th month of ESRD treatment) the Trust, as a "Primary Payer", will pay claims for ESRD services at 150% of the then current Medicare allowable amount. These services will not be subject to deductible or coinsurance. *Note: this rule applies when you are eligible for Medicare, even if you do not enroll in Medicare.* Unless you are enrolled in Medicare, the provider may balance bill you for the difference between 150% of the Medicare allowable and the provider's billed charges.
- When Medicare later becomes the Primary payer (usually beginning with the 34th month of treatment for ESRD), the Trust as Secondary payer, will pay claims for ESRD services at 100% of the then current Medicare allowable amount (subject to coordination of benefits with Medicare). These services will not be subject to deductible or coinsurance. *Note: This rule applies when you are eligible for Medicare even if you do not enroll in Medicare.* Unless you are enrolled in Medicare, the provider may balance bill you for the difference between the Medicare allowable amount and provider's billed charges.

The Trust may, at its sole discretion, agree to a contractual arrangement for payment with a provider of ESRD services. The contract may provide for a different payment rate for ESRD services than described above. But in no circumstances will the contract allow for a payment less than the payments listed above. Any contractual agreement and/or change in payment terms with a provider of ESRD services will be at the sole discretion of the Trust.

Durable Medical Equipment (DME)
The Plan covers the rental (or purchase when approved by the Administration Office) of Durable Medical Equipment. This includes compression stockings, dressings, casts, splints, braces, the first bra following mastectomy surgery, crutches, surgical and orthopedic appliances, prostheses and wheelchairs. The total rental fee for a piece of durable medical equipment will not exceed the full purchase price of that piece of equipment. The equipment must be:

- Prescribed by the patient's Physician.
- Approved by the Administration Office as both effective and the Usual and Customary treatment of the condition.
- Usable only by the patient.
- Manufactured solely for medical use.
- Of no further use when medical need ends.
- Not primarily for the comfort and hygiene of the patient.
- Not for preventive purposes.

Examples of non-covered items include heating pads, air cleaners, deluxe equipment such as motorized wheelchairs or beds, exercise equipment, whirlpool baths, spas or weights.

The Plan covers repair or replacement of Medically Necessary equipment due to normal use, or growth of a child.

Emergency Room
You will be responsible to pay a $100 copayment for each emergency room visit for treatment of an Illness. The $100 copayment is in addition to the Plan deductible and will be waived if you are directly admitted to the Hospital as an inpatient or if your visit is due to Injury/accident.

Foot Orthotics
Benefits for foot orthotics are only available to active participants and Non-Medicare retirees and their dependents only. This benefit is not available to Medicare eligible retirees or their dependents.

Coverage of Medically Necessary foot orthotics is limited to 1 pair every four Calendar Years. The Calendar Year deductible is waived for foot orthotics. *Note: services from a Non-PPO provider do not apply toward the Calendar Year out-of-pocket maximum, and will not be paid at 100% when the maximum is met.*

Foot orthotics or other supportive devices of the feet are braces, splints, custom insoles and supports prescribed by a Physician for the treatment of an Illness or Injury to the foot. Impression casts required for the fitting of these devices are also covered. The device must be worn at all times that shoes are worn and not just for specific activities. Shoes that accompany orthotics are not covered. Over the counter shoe inserts are not covered.

Habilitative Care Services
Habilitative care services are covered when Medically Necessary to treat mental health disorders identified in the current International Classification of Diseases (ICD) and the Diagnostic and Statistical Manual of Mental Disorders (DSM) and physical or structural birth defect (congenital anomaly). To be covered, services must be prescribed and documented to either improve function or maintain function where significant deterioration in function would result without therapy.

Function means the ability to execute skills required for activities of daily living which would be normal and expected based on the age of the patient. The patient must be under the care of a Physician during the time the habilitative services are being provided, and all services must be provided by licensed Covered Providers acting within the legal scope of their license. A formal treatment plan may be required upon request and will be required after the 25th visit. Periodic re-evaluations will also be required.

Covered services under this benefit include:

- Neurological and psychological testing, evaluations and assessments,
- Speech, occupational and physical therapy when provided as part of a formal written treatment plan,
- Neurodevelopmental therapy when provided as part of a formal written treatment plan,
- Applied Behavior Analysis (ABA) therapy for individuals diagnosed with Autism Spectrum Disorder (ASD) when the following conditions are met:
  - A documented comprehensive individual treatment plan is developed based on a functional analysis completed within 6 months of the beginning of treatment,
  - Routine evaluation of data on a regular basis and documentation of demonstrable progress against targeted goals at least once every six months, and
  - The ABA services are provided by, or are under the supervision of, a program manager who is a Board Certified Behavior Analyst (BCBA) or a Physician or Covered Provider whose legal scope of license includes behavior analysis, and
  - Psychotherapy, which may include ABA services.

Hearing Care
Hearing Care benefits are only available for non-Medicare retiree participants—**dependents do not have this coverage (except for cochlear implants described below).**

Hearing Care expenses are covered up to $500 per ear during any three-year period, with the exception of cochlear implants.

Covered Hearing Care expenses include:

- Hearing exam, if that exam results in your purchase of a hearing aid device.
- Hearing aid devices prescribed by a legally qualified Physician or a certified audiologist; if the examining practitioner certified in writing (within three consecutive calendar months immediately before the purchase of the device) that you are suffering a hearing loss and the device may serve to lessen that loss.
- Replacement of hearing aid devices, if you meet the above requirements and a three-year period has elapsed since you received your last hearing aid device.
- The charges for a hearing aid device prescribed and ordered prior to termination of your eligibility and delivered within 30 days following your date of termination are covered.
- Charges for implantation of a U.S. Food and Drug Administration (FDA)-approved cochlear implant device are covered for adults with severe to profound bilateral sensorineural hearing loss who otherwise meet required medical criteria and children (under age 18 for this purpose) who meet required medical criteria. To be covered, the person must have tried standard hearing aids but had limited or no benefit from their use. Preauthorization is required for cochlear implantation.

No benefits are paid for batteries or other ancillary equipment not obtained at the time the hearing aid device was purchased. In addition, repairs, servicing, or alteration on a hearing aid device are not covered.

Home Health Care, Respite Care and Hospice Care

The Plan covers Medically Necessary Home Health Care and Hospice Care in place of inpatient hospitalization. The Calendar Year deductible is waived for Home Health Care and Hospice Care services. *Note: services from a Non-PPO provider do not apply toward the Calendar Year out-of-pocket maximum, and will not be paid at 100% when the maximum is met.*

Conditions for Coverage - The patient must be considered "homebound," which means that leaving home involves a considerable and taxing effort and public transportation cannot be used without the help of another. Before the patient begins receiving Home Health or Hospice Care, the Physician must submit a written treatment plan to the Administration Office. Then, at the beginning of each 30-day period (60-day period for Hospice Care), the Physician must review the treatment plan and certify that the patient's condition and treatment continue to meet the above criteria and submit the updated plan to the Administration Office.

Coverage Limits - Home Health Care services are covered for a maximum of 130 visits per Calendar Year. Each visit by a member of the Home Health Care team will be considered one Home Health Care visit. Hospice Care services are provided to terminally ill patients in an effort to control the pain and other symptoms associated with terminal Illness. The plan covers Hospice Care services for up to a lifetime maximum of 6 months. Respite Care is covered for up to a maximum of 5 days per 3-month period of Hospice Care. Respite Care is continuous care to provide temporary relief to family members from the duties of caring for a hospice patient.

Covered Services - The Plan covers the following Home Health or Hospice Care services and supplies if they are provided by employees of an approved Home Health or Hospice Care agency and billed through the agency:

- Physician services.
- Intermittent nursing services provided by a registered nurse (RN) or licensed practical nurse (LPN).
- Physical, occupational, speech and inhalation therapy services provided by a licensed therapist when Medically Necessary to maintain the patient's condition or to restore or improve function(s) following severe Illness, Injury or surgery. No benefits will be provided for care that is custodial in nature or when no significant clinical improvement is expected as a result of the therapy.
- Medical social services provided by a person with a master's degree in social work (MSW), up to a maximum of 3 visits.
- Services by an aide who is under the supervision of a registered nurse or licensed therapist, limited to the following: part-time or intermittent care (4 hours or less), including ambulation and exercise; assistance with medications; reporting changes in the patient's condition and needs; completion of appropriate records.
- Rental (or purchase when approved by the Administration Office) of durable medical or surgical equipment as described in this Plan.
- Medical supplies that would have been provided on an inpatient basis. This includes dressings, casts, splints and braces.
- Nutritional supplements (such as diet substitutes) administered intravenously or through hyperalimentation.
- Services and supplies for infusion therapy when specifically preauthorized.
- For Hospice Care, Respite Care services (to provide temporary relief to family members who care for the patient), within the guidelines indicated above.

Hospital, Chemical Dependency Treatment Facility, Residential Facility, Rehabilitative Facility and Skilled Nursing Facility Room, Board, and Other Services and Supplies
The Plan covers Medically Necessary Hospital and inpatient facility services and supplies needed to treat an accidental Injury, Illness, physical disability or other Covered Condition. Facility admission requires preauthorization under the Health Management Program described beginning on page 18. The Allowed Amount is reduced by 25%, up to $1,200, if the preauthorization requirement is not followed. Covered services and supplies include:

- Room and board, including general nursing care, not to exceed the semi-private room rate.
- Intensive and coronary care unit services.
- Other inpatient services and supplies including operating rooms and equipment; surgical dressings and supplies; x-ray and laboratory services; electrocardiograms; anesthesia, including administration and materials; tissue examinations; drugs; respiratory or other gas therapies; and physical, speech and occupational therapy necessary to restore or improve function.
- Outpatient services, including x-ray and laboratory services, for visits to the outpatient department, or emergency room.

Charges for services of a personal nature, such as radio, television, telephone, guest meals, etc., are not covered under the Plan.

Massage Therapy
The Plan covers Medically Necessary massage therapy for treatment of an Illness or Injury, or to alleviate pain, when prescribed by a Physician and provided by a licensed Covered Provider acting within the scope of their license. *Note: services from a Non-PPO provider do not apply toward the Calendar Year out-of-pocket maximum, and will not be paid at 100% when the maximum is met.*

Maternity Care
The Plan covers Medically Necessary maternity care services and supplies (including Certified Nurse Midwives, Licensed Midwives and birthing centers) for retirees and dependent spouses. These conditions include normal delivery, miscarriage, voluntary termination of pregnancy, diagnosis of fetal congenital disorders, and related complications.

The Plan includes a special provision to cover only Severe Complications of Pregnancy for eligible dependent daughters. Severe complications of pregnancy mean physical effects suffered which have been directly caused by the pregnancy, but which would not be considered from a medical viewpoint the effects of a normal pregnancy, and will include but not be limited to conditions such as acute nephritis, nephrosis, cardiac decompensation, missed abortion, ectopic pregnancy which terminated, spontaneous terminations of pregnancy which occur during a period of gestation in which a viable birth is not possible, and similar medical and surgical conditions.

Mental Health Care
The Plan covers outpatient services and inpatient services at an approved Residential Treatment Facility or Hospital, including Physician services and prescription drugs. Preauthorization is required for inpatient Hospital and Residential Treatment Facility services. The Allowed Amount is reduced by 25%, up to $1,200, if the preauthorization requirement is not followed.

Treatment must be provided by a Physician or other licensed or certified Covered Provider acting within the scope of their license or certificate according to the laws of the issuing state.

Naturopathic Care
The Plan covers Medically Necessary Naturopathic care when provided by a licensed Covered Provider. *Note: services from a Non-PPO provider do not apply toward the Calendar Year out-of-pocket maximum, and will not be paid at 100% when the maximum is met.*

Nutritional Therapy/Counseling
The Plan covers Nutritional Therapy/Counseling as follows:

- Screening and one on one counseling visits with a Covered Provider for weight loss for children age 6 and older who are considered obese and for adults with a body mass index of 30kg/meter squared or higher.
- One on one office visits with a Covered Provider to manage diabetes or eating disorders diagnosed by a Physician.

Other Covered Services and Supplies
The Plan also covers the following types of services and supplies:

- Blood bank processing charges (blood or blood derivatives are not covered).
- Oxygen and its administration.
- PKU formula.
- Contraceptive - implantable/injectable and diaphragms.

Physician Services
The services of a licensed Physician (MD or DO) are covered when Medically Necessary to diagnose or treat accidental injuries or Illnesses or other covered conditions.

Physician services are also covered for:

- Home, Hospital, and office visits.
- Medical and surgical services.
- Anesthesia.
- Diagnostic x-ray and lab exams.
- Required and voluntary second surgical opinions.

See Professional Services (Other) for information regarding other Covered Providers.

Preventive Care
The Trust will provide coverage for Preventive Care Services for you and your Covered Dependents. Preventive Care Services provided by a PPO Provider will be paid in full and will not be subject to the Calendar Year deductible or coinsurance. Preventive Care Services provided by a non-PPO Provider will be subject to the Plan deductible and coinsurance.

Preventive Care Services will be limited to Medically Necessary and appropriate services. Where the recommended Preventive Care Service comes with recommendations regarding coverage or frequency, these will be followed. If no guidance on coverage or frequency is given, the Trust may adopt or utilize reasonable medical management techniques to determine the coverage and frequency limit.

Preventive Care Services include, but are not limited to:

- Well-baby care and routine physical examinations, including annual women's examinations, counseling and screening.
- Routine preventive radiology and laboratory services, including, but not limited to, routine mammography, prostate screening, and colonoscopies.
- Immunizations for adults and children according to the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention guidelines. Covered expenses do not include immunizations if you or your Covered Dependent receives them only for purposes of travel, occupation or residence in a foreign country.
- Physician's office services for smoking cessation. Drugs to ease nicotine withdrawal that require a written prescription are covered under the Prescription Drug Benefit.
- Evidence-based tests or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force. These

recommendations include blood pressure and cholesterol screening, diabetes screening for individuals with hypertension, various cancer and sexually transmitted infection screenings, and counseling in defined medically appropriate areas.

- For infants, children, and adolescents, such other evidence informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration.
- With respect to women, such additional preventive care and screenings not described above as provided for in comprehensive guidelines supported by the Health Resources and Services Administration. These guidelines describe recommended coverage of items such:
  - Well-woman visits;
  - Gestational diabetes screening;
  - Human papillomavirus DNA testing, every three years for women age 30 or older;
  - Sexually transmitted infections counseling for sexually-active women;
  - Human immunodeficiency virus (HIV) screening and counseling for sexually active women;
  - Access to all Food and Drug Administration-approved contraceptive methods, sterilization procedures, and patient education and counseling, not including abortifacient drugs;
  - Breastfeeding support, supplies, and counseling;
  - Interpersonal and domestic violence screening and counseling;
  - Mammograms; and
  - Cervical cancer screenings.

Unless otherwise agreed to by the Board of Trustees, any additions to the above list of preventive services will be effective on the first day of the plan year beginning 12 months after the new preventive service is listed.

Professional Services (Other)
The Plan covers other Covered Provider if the care would be covered and is performed by the Covered Provider within the scope of the Covered Provider's license or certification under applicable state law.

Prosthetic Devices
The Plan covers Prosthetic Devices to replace natural limbs and eyes. Duplicate or specialized prosthetics that are not intended for use at all times are not covered (i.e. exercise or sports).

Rehabilitative Therapy
The Plan covers outpatient rehabilitative therapy (physical, occupational and speech therapy) to the extent that the therapy will significantly restore and improve a lost function(s) following a severe Illness, Injury or surgery. No benefits will be provided for care that is custodial in nature, or when no significant clinical improvement is expected as a result of the therapy.

The services must be provided under the referral and direction of the attending Physician and administered by a licensed therapist acting within the scope of the license. The patient must continue under the care of his or her attending Physician during the time the therapy is being provided. Benefits are subject to the following provisions:

- Benefits will not to exceed $60 per visit.
- Treatment must be provided by a licensed physical, occupational or speech therapist.
- Treatment must begin within one year of the date of the onset of the condition being treated.
- Treatment must be ordered by a Physician and a written treatment program may be required by the Administration Office. (A treatment program will be required after the 25th visit.)

Note: services from a Non-PPO provider do not apply toward the Calendar Year out-of-pocket maximum, and will not be paid at 100% when the maximum is met.

The Plan also covers charges for inpatient Rehabilitative Facility care when Medically Necessary to restore and improve function previously normal but lost due to Illness or Injury. Benefits are subject to the following provisions:

- Confinement must occur within one year from the date of onset of the condition.
- Confinement must be authorized by your Physician and a written treatment plan must be submitted to the Administration Office by the Physician prior to admittance.
- Benefits are limited to 30 days each Calendar Year.

Preauthorization is required for inpatient facility services. The Allowed Amount is reduced by 25%, up to $1,200, if the preauthorization requirement is not followed.

Skilled Nursing Facility
The Plan covers charges for a semi-private room and other Medically Necessary services and supplies while confined in a licensed Skilled Nursing Facility, provided the confinement:

- Is ordered by the attending Physician.
- Results from the Illness or Injury that was the cause of the Hospital confinement.
- Is necessary as the person cannot be cared for at home (and would otherwise need to be hospitalized).

Benefits are limited to 30 days of care in a Calendar Year. No benefits are provided for maintenance or Custodial Care or when no significant clinical improvement is expected. The Calendar Year deductible is waived for Skilled Nursing Facility services. *Note: services from a Non-PPO provider do not apply toward the Calendar Year out-of-pocket maximum, and will not be paid at 100% when the maximum is met.*

Preauthorization is required for inpatient facility services. The Allowed Amount is reduced by 25%, up to $1,200, if the preauthorization requirement is not followed.

Sterilization
The Plan covers the Medically Necessary services and supplies required for a vasectomy, but not those related to a reversal. See Preventive Care for benefit information related to tubal ligation.

Surgery
The Plan provides coverage for Medically Necessary surgery on an inpatient or outpatient basis. Preauthorization is required for scheduled surgeries in an inpatient or outpatient facility. The Allowed Amount is reduced by 25%, up to $1,200, if the preauthorization requirement is not followed.

Assistant Surgeon
For Medically Necessary surgical assistance by a Physician or a Physician assistant (PA), the Allowed Amount will be considered as 20% of the Allowed Amount for the corresponding surgery.

Multiple Surgeries
For multiple surgeries performed during the same operative session which are not incidental, or not part of some other procedure, and which add significant time or complexity to the complete procedure, as determined by the Administration Office, claim allowances for benefit processing will be based on:

- 100% of the Allowed Amount for the Primary procedures.
- 50% of the Allowed Amount for the Secondary or additional procedures.

- Procedures or services that are designated as a "separate procedure" per guidelines in the Current Procedural Terminology (CPT) will be handled as separate procedures, not subject to the above rules.

Telemedicine Service (Non-Medicare Eligible Participants only)
The Plan provides 24/7 access to board certified, licensed family practice doctors or pediatricians via phone or video through Teladoc. Teladoc is not a substitute for a primary care doctor, but can be used to diagnose and treat acute, non-emergent medical issues that may arise such as:

Cold and flu	Bronchitis
Sore throat	UTI
Rashes	Fever
Allergies	Asthma
Headaches	

Teladoc doctors can also write short term prescriptions and will send the script electronically to the pharmacy of your choice. After the visit, at your request, the doctor will send electronic chart notes to your primary care doctor.

In addition to general medical services, Teladoc also provides access to dermatologists for diagnosis and treatment of skin conditions, as well as a range of behavioral health specialists, including psychiatrists and counselors. Teladoc's behavioral health service gives you quick and confidential access to licensed providers for help with things like depression, stress, anxiety and other behavioral health issues, all without having to leave home.

Visits with Teladoc will be covered in full by the Trust and you do not have to satisfy your deductible. (Telemedicine is being provided on a trial basis through December 31, 2021. Prior the end of 2021, the Board of Trustees will review the utilization of this telemedicine program and will decide whether to continue the benefit.) To locate a Teladoc provider, log on to www.Teladoc.com/Premera or call (855) 332-4059.

Transgender Healthcare Services
The Plan covers Medically Necessary transgender healthcare services for Gender Dysphoria (also called Gender Identity Disorder), as generally described below. **For more information on coverage requirements for transgender healthcare services, please contact the Administration Office at (866) 314-4239, option 1.**

You and/or your service provider(s) should submit information to the Plan for a coverage determination prior to beginning treatment. Services covered by the Plan include:

- Counseling
- Hormone Therapy
- Gender reassignment surgery
- Services typically associated with one sex, which may continue to be required after transition
- Prescription drugs (as covered under the Prescription Drug Program of this Plan)

To be eligible for coverage you must:

- Be 18 years of age or older,
- Have a well-documented diagnosis of Gender Dysphoria or Gender Identity Disorder meeting the diagnostic criteria of the current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM), and
- In the event of gender reassignment surgery, have no medical contraindications and complete specific evaluation and recommendation requirements.

The Plan does not cover services that are considered cosmetic, not Medically Necessary and/or are otherwise excluded under the Plan. This includes, but is not limited to:

- Rhinoplasty or nose implants
- Face-lifts
- Lip enhancement or reduction
- Facial bone reduction or enhancement
- Blepharoplasty (eyelid surgery)
- Breast Augmentation
- Liposuction
- Reduction thyroid chondroplasty (Adam 's Apple reduction)
- Hair removal (Exception: Hair removal procedures (including electrolysis) may be considered medically necessary to treat tissue donor sites prior to phalloplasty or vaginoplasty.)
- Voice modification surgery or training
- Skin resurfacing
- Travel expenses

Transplants
Preauthorization is required for transplant services. The Allowed Amount is reduced by 25%, up to $1,200, if the preauthorization requirement is not followed.
Generally, the Plan covers the following organ and tissue transplants:

- Heart
- Heart and Lung
- Lung
- Liver
- Kidney
- Pancreas and Kidney
- Cornea
- Bone Marrow
- Stem Cell

If you or a covered dependent receives a human organ or tissue transplant covered by this Plan, certain donor organ procurement costs may also be covered. Benefits are limited to selection, removal of the organ, storage, transportation of the surgical harvesting team and the organ, and other Medically Necessary procurement costs. Donor expenses that are covered under this plan are limited to a maximum of $25,000 per transplant paid at applicable percentages based on the Allowed Amount.

Transplant benefits are subject to all Plan conditions and limitations, and no benefits will be paid for the following:

- Nonhuman, artificial or mechanical transplants.
- Experimental services or supplies.
- Services and supplies for the donor when the donor benefits are available through other group coverage.
- Donor charges when the organ or tissue is received by someone other than you or your eligible dependents.
- Expenses when government funding of any kind is provided.
- Expenses when the recipient is not covered under this Plan.
- Lodging, food, car rental, or other transportation costs.
- Donor and procurement services and costs incurred outside the United States.

- Living (non-cadaver) donor transplants of the lung, liver, or other organ (except kidney), including selective islet cell transplants of the pancreas.

Weight Loss and Bariatric Surgery
The Plan has adopted the Medicare/Medicaid standard requirements for weight loss surgery. Covered surgeries under this plan include Roux-en-Y bypass, open and laparoscopic biliopancreatic diversions, and laparoscopic adjustable gastric banding. Standard requirements include:

- A six-month medically supervised weight loss program through his/her bariatric surgeon, or his/her primary care Physician. *Note: Weight loss programs are not covered by the Trust.*
- A Body Mass Index (BMI) of 35 or higher.
- One or more health problems related to obesity, i.e. diabetes, heart disease, high blood pressure, sleep apnea, weight related severe arthritis or weight related severe respiratory disease.
- A psychological evaluation.
- Participant has been unsuccessful with previous medical treatment of obesity.
- Participant must be between 20 and 70 years old.
- Preauthorization from Comagine Health.

In addition, the surgery must take place at a medical center designated as a Center of Excellence by the American Society for Metabolic and Bariatric Surgery or certified a Level 1 Bariatric Surgery Center by the American College of Surgeons and have met the Center for Medicare and Medicaid Services standards.

Medical Exclusions

No benefits will be provided for any of the following services or conditions or their direct or indirect complications:

- Inpatient confinement for conditions for which patients are not usually confined; services, supplies and settings to the extent that they are not Medically Necessary for treatment of an Injury, Illness or physical disability (even if court-ordered), are not recommended and approved by the attending Physician, are not reasonably priced or are not provided by a Covered Provider.
- Charges for missed appointments.
- Charges for telephonic, online or other consultations where the patient is not physically present with the Physician or other Covered Provider at the time of the consultation.
- Care in any Hospital or facility owned or operated by the federal, state or local government, except as required by law.
- Any services furnished by a rest home, place for the aged, nursing or convalescent home or similar institution.
- Services for medical, surgical or Hospital care received prior to the date your coverage begins under this Plan.
- Experimental treatment, except as specifically provided under approved clinical trial coverage as described in this Plan.
- Custodial Care.
- Charges for the following Home Health and Hospice Care services:
  - Spiritual or bereavement counseling.
  - Services to ineligible family members.
  - Services of volunteers, household members, family or friends.
  - Food, clothing, housing or transportation.
  - Supportive environmental materials, such as, but not limited to, ramps, handrails or air conditioners.

  - Homemaker or housekeeping services.
  - Financial or legal counseling services.
  - Custodial or maintenance care, except that benefits will be provided for palliative treatment if the patient is terminally ill.
  - Services or supplies not included in the written treatment plan, not specifically set forth as a covered benefit, or limited or excluded under the regular limitations and exclusions of this Plan.
- Impotency; frigidity; infertility; artificial insemination; in vitro fertilization; or reversal of sterilization procedures.
- Any condition covered by workers compensation or occupational disease law or injuries occurring in the course of employment or self-employment for wage or profit.
- Any treatment received while on active duty military service for which the federal government is responsible.
- Intentionally self-inflicted Injuries, and Injuries or Illnesses sustained in the following circumstances:
  - Suicide or attempted suicide, unless due to a documented Mental Illness;
  - While engaged in conduct for which the covered person is charged with or indicted with a felony; or
  - While performing any acts of violence or physical force that would not be performed by a reasonably prudent person in similar circumstances.
- Any service billed by a Covered Provider for himself/herself or his/her spouse, children or parents; any service provided by a practitioner who normally resides in your home or is related to you by blood or marriage.
- Obesity, including morbid obesity; weight-loss programs; surgical treatment of obesity; reversal of surgical treatment for obesity; complications arising from surgery or treatment of obesity except as specifically provided under the weight loss and bariatric surgery benefit as described in this Plan.
- Cosmetic surgery or treatment, except as specifically provided.
- Counseling, educational, or training services. This includes vocational assistance and outreach; and family, marital, social, sexual, nutritional, fitness counseling, or relaxation therapy.
- Educational, or training services or supplies for dyslexia, attention deficit disorders, conduct disorders, adolescent behavior problems, learning disabilities and for disorders or delays in the development of a child's language, cognitive, motor, or social skills, including evaluations, except as described under habilitative care services.
- Medical, surgical or Hospital services or supplies incident to the placement of nonhuman or manufactured organs; donor charges when the organ or tissue is received by someone other than you or your eligible dependents; other organ transplants, except as specifically described in the Plan's transplant benefit.
- Travel expenses including lodging, car rental and meals.
- Vitamins or vitamin injections, or herbal remedies, food and nutritional supplements and other medical foods, regardless of whether prescribed by a Covered Provider.
- Hearing aids, including implantable bone conduction hearing devices, except as specifically provided in this Plan.
- Arch supports, corrective shoes and elastic stockings; nail trimming and paring of corns or calluses; foot orthotics, except as specifically provided in this Plan.
- Lenses, except the first intraocular lens following cataract surgery; visual therapy, training or orthoptics; radial keratotomy or other refractive eye surgery.
- Hospital or facility charges due to dental work.
- Any services or supplies received in connection with a Participant or Covered Dependent acting as a Surrogate Mother. "Surrogate Mother" is defined as a woman who becomes

pregnant through natural, artificial or assisted methods for the purpose of carrying the fetus to term for adoption by a third party. This exclusion applies to services or supplies related to becoming pregnant, pregnancy and delivery. This exclusion applies regardless of whether the Surrogate Mother is the biological mother of the child. Additionally, a child born to a Surrogate Mother shall not be considered a Covered Dependent if the child is not the biological child of a Participant or adult Covered Dependent or if the Surrogate Mother has entered into a contract or has an understanding prior to becoming pregnant that she will relinquish the child following its birth. The Plan also does not cover services or supplies provided to an individual not covered by the Plan who acts as a Surrogate Mother for a Participant or Covered Dependent.

- Dental Care, including services in connection with care, treatment, filling, removal or replacement of teeth or structures directly supporting the teeth, except when necessary due to an accidental Injury to teeth providing the treatment is done within one year of the Injury.
- Expenses incurred for surgery for dental implantology, except when the person is totally edentulous (without teeth) and the ridge is severely resorbed and cannot support regular dentures or when necessary due to an accidental Injury to teeth providing the treatment is done within one year of the Injury.
- Splints, braces, appliances or treatment or service of any type due to any form of temporomandibular joint dysfunction (TMJ) or myofascial pain dysfunction (MPD) except for Medically Necessary surgery, and then benefits will be limited to an annual maximum of $2,000 for all expenses related to the surgery.
- Plasma or any element of blood that can be replaced by a voluntary donor.
- Chelation therapy, biofeedback and other forms of self-care or self-help training and any related diagnostic testing.
- Pregnancy or complications of pregnancy of dependent children, except for services covered under Preventive Care Services for Women or Severe Complications of Pregnancy.
- Charges for filling out forms.
- Amounts in excess of Usual, Customary, and Reasonable Amount.
- Services and supplies in excess of any limitations established by the Plan; contrary to any policies or procedures adopted by the Plan.
- Charges or expenses for which coverage is available under any motor vehicle medical payment insurance plan or any “no fault” insurance policy that provides medical coverage.
- Services for an Injury or Illness caused by the act or omission of another person (known as the third party), including an Injury or Illness covered by any liability policy of the third party, and services for an Injury or Illness for which first-party coverage is available under an automobile insurance policy, homeowners policy, or commercial premises policy. The Plan may agree to advance benefits if the participant agrees to reimburse the Plan as set forth in the Plan’s third-party reimbursement provision.
- Charges for which the individual is not legally obligated to pay or services for which no charge is made to the individual.
- Charges for services or supplies which are not provided or billed in accordance with generally accepted professional standards and/or medical practice, including up-coding, unbundling, duplication, excessive or improperly coded billing charges.
- Charges that are not permitted by the provider’s network agreement or charges made in violation of the provider’s network agreement.
- Shipping and handling charges.
- Charges for claims that are submitted or completed more than one year from the date of service.

Medical Definitions

Allowed Amount
Except where otherwise indicated in the Plan, the Allowed Amount means the fee the Covered Provider accepts as payment full pursuant to its agreement with the PPO network, Medicare reimbursement rate or, if no such agreement exists (non-PPO/non-Medicare), the Usual, Customary and Reasonable (UCR) Amount, as defined by the Plan.

Calendar Year
A Calendar Year is a period beginning January 1 and ending on December 31 of each year.

Calendar Year Deductible
The Calendar Year Deductible is the cost of covered medical services you are responsible to pay before the Plan begins to pay benefits during the Calendar Year.

Chemical Dependency Treatment Facility
A Chemical Dependency Treatment Facility is a facility approved under the laws of the state of Washington or other state as a primary care facility for treatment of alcohol, drug, or chemical abuse.

Covered Provider
A Covered Provider is a person practicing within the scope of his or her state license as a Doctor of Medicine or Doctor of Osteopathy, or to the extent benefits are provided, as a Doctor of Dentistry, Doctor of Podiatry, Doctor of Optometry, Doctor of Chiropractic, Licensed Optician, or Licensed Clinical Psychologist, Licensed Marriage and Family Counselor, Certified Mental Health Counselor, Masters in Social work, Physician Assistant (P.A.), other Mental Health care providers approved or certified by the state in which they practice, Physical Therapist, Speech Therapist, Occupational Therapist, Naturopath, Acupuncturist, Registered Nutritionist or Dietitian and Massage Therapist.

Custodial Care
Custodial Care is care that does not require the continuing services of skilled medical or health professionals and is primarily to assist the patient in activities of daily living. This includes institutional care to support self-care and provide room and board. Types of Custodial Care include help in walking, getting into and out of bed, bathing, dressing, feeding and preparing of special diets, and supervising medications that are ordinarily self-administered.

Durable Medical Equipment
Durable medical equipment is equipment that meets all of the following requirements:

- Is designed for repeated use.
- Is mainly and customarily used for medical purposes.
- Is not generally of use to a person in the absence of a disease or Injury.
- Is usable only by the patient.
- Is not for preventive purposes.
- Is manufactured solely for medical use.

Durable Medical Equipment includes, but is not limited to, such items as: hospital bed, wheelchair, traction apparatus, intermittent positive pressure breathing machine, brace, and crutches.

The items in the list that follows are examples of some, but not all, of the types of equipment that the Plan does not consider to be Durable Medical Equipment: air conditioner; air purifier; heat lamp; heating pad; bed board; orthopedic shoes; corrective device for use in shoes; gravity traction device; exercise bicycle; weight lifting equipment; specially equipped van, deluxe items.

Experimental
In determining whether treatment is Experimental, the Administration Office will consider whether the treatment:

- Is in general use by the medical community.
- Is Medically Necessary for the condition being treated.
- Is under continued scientific testing and research.
- Results in greater benefits for a particular Illness or disease than other generally available services.
- Is proven to be safe and effective.

A treatment will be considered Experimental if:

- Required approval by a U.S. government agency, such as the FDA, has not been granted;
- Is under study, other than part of an approved clinical trial, to determine its maximum tolerated dose, toxicity, safety, efficacy or its efficacy as compared with a standard means of treatment; or
- The prevailing opinion among experts in the pertinent field, as reflected in the medical or scientific literature or in written treatment protocols, is that further studies are necessary to determine its maximum tolerated dose, toxicity, safety, efficacy or efficacy as compared with a standard means of treatment or diagnosis.

Hospital
A Hospital is an institution which has all these characteristics:

- Primarily provides medical treatment to registered inpatients;
- Maintains facilities for diagnosis;
- Provides 24-hour care by registered nurses;
- Maintains permanent facilities for surgery;
- Keeps a daily record for each patient;
- Complies with all licensing and other legal requirements; and
- Is not, except incidentally, a place of rest, for Custodial Care, for the aged, for drug addicts, for alcoholics, for the care of persons with mental, nervous, or emotional disorders or conditions, for the care of senile or mentally deficient persons, a nursing home, a hotel, or similar institution.

Illness
Illness means a bodily disorder, infection, or disease and all related symptoms and recurrent conditions resulting from the same cause. An Illness identified in the current version of the Diagnostic and Statistical Manual of Mental Disorders (DSM) is considered to be a mental health Illness for the purposes of this Plan. If there are multiple diagnoses, only the treatment for the Illness identified under the DSM code is considered mental health treatment. Illness does not include a condition incurred or aggravated while performing a job-related task, engaging in any activity for wage or profit, or for which compensation could be available if application were made under a workers' compensation of occupational Injury law or similar legislation.

Injury
Injury means physical harm sustained as the direct result of a non-occupational accident, effected solely through external means, and all related symptoms and recurrent conditions resulting from the same accident.

Medically Necessary
Medically Necessary means that the service or supply meets all of the tests listed below:

- It is commonly rendered for the treatment or diagnosis of any Injury or disease, including premature birth, congenital defects, and birth defects;
- It is appropriate for the symptoms, consistent with the diagnosis, and is otherwise in accordance with generally accepted medical practice and professionally recognized standards;
- It is not mainly for the convenience of the covered person or of the covered person's Physician or other Covered Provider; and
- It is the most appropriate supply or level of service needed to provide safe and adequate medical care. When applied to confinement in an acute care Hospital or other facility, this means that the covered person needs to be confined as an inpatient due to the nature of the services rendered or due to the covered person's condition and that the covered person cannot receive safe and adequate care through outpatient treatment.

Note: Not all Medically Necessary services and supplies are covered under the Plan.

Physician
A Physician is a person practicing within the scope of his or her license or certification as a Doctor of Medicine or Doctor of Osteopathy.

Rehabilitative Facility
A Rehabilitative Facility is an institution which has each of these characteristics:

- Is licensed.
- Has facilities for the diagnosis and inpatient rehabilitative treatment of disease or Injury with the objective of restoring physical function to the fullest extent possible. (Examples of conditions treated in a Rehabilitative Facility are amputations, spinal cord injuries, head injuries, paraplegia and quadriplegia, CVA, severe arthritis, and paralysis).
- Has facilities or a contract with another Hospital in the area for emergency treatment, surgery, and any other diagnostic or therapeutic services that might be required during a confinement.
- Provides all normal infirmary-level medical services required to treat any disease or Injury occurring during confinement.
- Has a staff of Physicians specializing in physical medicine and rehabilitation directly involved in the treatment program, with one present at all times during the treatment day.
- Is accredited as a medical inpatient Rehabilitative Facility by the Joint Commission on Accreditation of The American Hospital Association and/or the Commission on Accreditation of Rehabilitation Facilities.
- Is not a place for rest, the aged, drug addicts or alcoholics or a chronic disease facility, nursing home, or sheltered workshop.
- Is not primarily for Custodial Care, treatment of mental disorders, special education, vocational counseling, job training, or social adjustment services.

Residential Treatment Facility
A treatment facility that provides programs to treat alcohol and drug dependence or mental conditions but that is not licensed to provide acute setting inpatient Hospital care. The center must be licensed or otherwise approved to provide this care by the state in which it is located.

Severe Complications of Pregnancy
Severe Complications of Pregnancy are conditions requiring Hospital confinement (when the pregnancy is not terminated) which are distinct from a normal pregnancy but are adversely affected by the pregnancy or are caused by the pregnancy. Examples are acute nephritis, nephrosis, cardiac decompensation, ectopic pregnancy requiring surgical termination and similar life threatening conditions of comparable severity requiring medical or surgical intervention. False labor, occasional spotting, caesarian section, miscarriage, Physician prescribed rest during the pregnancy, morning sickness, hyperemesis gravidarum, placenta praevia and similar

conditions associated with the management of a difficult pregnancy are not considered Severe Complications of Pregnancy.

Skilled Nursing Facility
A Skilled Nursing Facility is an institution which primarily provides skilled nursing care to registered inpatients under 24-hour supervision of a Physician or Registered Nurse (RN) and is licensed or otherwise approved as a Skilled Nursing Facility by the state in which it is located.

Usual, Customary and Reasonable (UCR) Amounts
Usual, Customary and Reasonable (UCR) charge means the amount payable to a non-PPO provider as determined by the Plan for a particular service, and subject to the following:

1. Charges for services or supplies which are not provided or billed in accordance with generally accepted professional standards and/or medical practice are not considered UCR regardless of the amount billed;
2. In no event will the UCR charge exceed the amount billed or the amount for which the covered person is responsible;
3. UCR may not reflect the actual billed charges and does not take into account the Covered Provider's training, experience or category of licensure;
4. The Plan's UCR methodology may vary from one particular claim to the next based on the facts and circumstance of the claim, the services provided and the expected cost-savings;
5. The Plan may hire a third-party reviewer to determine the UCR amount consistent with this provision; and
6. Irrespective of the Trust's methodology or UCR determination, the Plan reserves the right to negotiate an acceptable UCR amount directly with a Covered Provider.

For properly billed non-PPO professional service charges, the UCR charge shall be no higher than the 90th percentile identified by a commercially available database selected by the Plan. When there is, in the Plan's determination, minimal data available from the database for a covered service, the Plan will determine the UCR charge by calculating the unit cost for the applicable service category using the database, and multiplying that by the relative value of the covered service assigned by the Medicare resource based relative value scale (supplemented with a commercially available relative value scale selected by the Plan where one is not available from Medicare). In the event of an unusually complex covered service, a covered service that is a new procedure or a covered service that otherwise does not have a relative value that is in the Plan's determination applicable, the Plan will assign one.

For properly billed non-PPO facility charges, UCR means the amount determined by the Plan based on one or more of the following considerations: CMS reported cost-to-charge ratios, historically acceptable reimbursement amounts by similarly situated providers, commercially available benchmarks, Medicare reimbursements amounts, and other CMS-provided statistics.

PRESCRIPTION DRUG PROGRAM FOR MEDICARE ELIGIBLE PARTICIPANTS

All Medicare Eligible retirees and Medicare eligible spouses and dependents of retirees are provided prescription drug benefits the EnvisionRxPlus Employer Group Retiree Prescription Drug Plan ("EnvisionRxPlus Plan"). The EnvisionRxPlus Plan prescription drug benefits are set forth in a separate plan booklet that is provided by EnvisionRx. Medicare eligible individuals are automatically enrolled into the EnvisionRxPlus Plan coverage unless you notify the Administration Office of your intention to opt-out. If you choose to opt-out of the plan, you will lose your prescription drug coverage through the Trust. You will not be allowed to re-enroll in the Trust's prescription drug coverage at a later date. You will still remain covered under the Trust's medical plan and your monthly contribution for medical coverage will not be lowered as a result of opting-out of EnvisionRxPlus Plan coverage offered through the Trust.

The prescription drug benefits set forth in this Plan apply to non-Medicare eligible retirees and dependents only. For information about the EnvisionRxPlus Plan, please contact EnvisionRxPlus Customer Care at 1-844-293-4760, 24 hours a day, 7 days a week. TTY users should call 711.

PRESCRIPTION DRUG PROGRAM FOR NON-MEDICARE ELIGIBLE PARTICIPANTS

The prescription drug benefits described in this section apply to all non-Medicare eligible retirees and their dependents. Prescription drug coverage is available in two convenient ways: either through the Retail Pharmacy program or the Mail Order Pharmacy program. Both programs are administered by EnvisionRx. The Plan Prescription Drug Program includes coverage for preventive drugs as recommended by the United States Preventive Service Task Force.

The Plan uses a prescription drug formulary plan design. A formulary is a list of drugs that have been determined by the Plan's prescription drug benefit manager to be the most clinically and/or cost effective for each disease or condition. The formulary contains both generic and brand name drugs. Prescription drugs not included on the formulary list are not covered by the Plan. If a drug is not on the formulary, you will need to work with your doctor to change the prescription to one that is on the formulary, or pay for the full cost of the drug out of pocket. The formulary list is maintained by EnvisionRx and is updated periodically. You may visit the EnvisionRx website at: www.envisionrx.com and then click on Preferred Drug Listing to view the formulary list or call at 800-361-4542. However, please note, inclusion on the formulary is not a guarantee that the drug will be covered by the Plan. Coverage will ultimately be determined when you request your prescription be filled. If your physician believes that a non-formulary drug is medically necessary for your specific situation, a formulary exceptions appeal process is available through EnvisionRx. To initiate the process, you or your physician will need to call EnvisionRx.

The Formulary drug list is organized into groups or "Tiers" as follows:

Tier 1 – Generic drugs are the first choice whenever possible.

Tier 2 – Preferred Brand Name drugs

Tier 3 – Non-Preferred Brand Name drugs

Retail Pharmacy Program

The Retail Program administered by EnvisionRxOptions is designed for initial and short-term prescriptions. The drug card program provides a maximum of a 30-day supply of medication per prescription from any pharmacy in the EnvisionRxOptions network, including Costco retail pharmacies.

Retail Copayments (up to a 30-day supply)

Tier 1 - Generics: $10 ($3 if filled at a Costco retail pharmacy)

Tier 2 - Preferred Brand-Name Drugs: $25

Tier 3 - Non-Preferred Brand-Name Drugs - $50

If your prescription is for a Brand Name drug that has a Generic equivalent available, you will need to pay the difference between its cost and the cost of the Generic drug plus the appropriate copay. The payment of the cost difference between the Generic and Brand Name Drug will be waived with approval to use a Brand Name Drug (instead of a Generic) through the Step Therapy Program (see page 43 for more information on the Step Therapy program).

Using Network Pharmacies
A list of network pharmacies is available at www.envisionrx.com or call 1-800-361-4542. If you visit a network pharmacy, simply present your Health and Prescription Drug ID card along with the physician's prescription to any network pharmacy and pay only the applicable copay.

Using Non-Network Pharmacies
If you use a non-network pharmacy, you are responsible for paying the pharmacist for the prescription drug. You must then send a claim form to EnvisionRxOptions to receive reimbursement for covered expenses. You may receive a reduced reimbursement since you did not use the Health and Prescription Drug ID card. The copays will also be deducted from your reimbursement.

When using a non-network pharmacy, or if you do not use your card, the Trust will not reimburse you more than the Network Pharmacy Allowance for the prescription drug, minus the applicable copay. Claim forms are available from the Administration Office. The completed claim form must be submitted to EnvisionRxOptions within 12 months from the purchase date. You will receive a reimbursement check within 4 weeks.

Mail Order Pharmacy Program

The Mail Order Pharmacy is designed for maintenance medications for ongoing or chronic conditions. Prescriptions for up to a 90-day supply may be filled by mail through this program.

Mail Order Copayments (up to a 90-day supply):

Tier 1 – Generics: $7.50

Tier 2 - Preferred Brand Name Drugs: $62.50

Tier 3 – Non-Preferred Brand Name Drugs: $125.00

If your prescription is for a Brand Name Drug that has a Generic equivalent available, you will need to pay the difference between its cost and the cost of the Generic Drug plus the appropriate copay. The payment of the cost difference between the Generic and Brand Name Drug will be waived with approval to use a Brand Name Drug (instead of a Generic) through the Step Therapy Program.

If you need a maintenance drug right away, ask your doctor for two prescriptions. Take the first prescription (for a two- or three-week supply) to a participating pharmacy and send the second one (for up to a 90-day supply) to the mail order program. That way, you can begin taking the drug right away.

How to Use the Mail Order Pharmacy

To use the Mail Order Pharmacy, complete a Mail Order Prescription Order Form. (Order forms are available at your local union or the Administration Office.) Please note: A separate form must be used for each family member.

- Step 1 - Fill in the "Customer Information & Order Form" section. Be sure to include all information, including your physician's name. Also, indicate your generic preference.
- Step 2 - If you are getting a new prescription filled, ask your doctors to prescribe up to a 90-day supply of your maintenance drug and give the appropriate number of refills, attach the prescription(s) to the order form and proceed to Step 4.
- Step 3 - If you are submitting the order form for a refill(s) prescription, fill in the Mail Order Pharmacy prescription number and the name of the drug. You will need to get a new written prescription from your physician if you are reordering a prescription which has been filled from another pharmacy.
- Step 4 - Place the order form in an envelope and mail to the address on the form. You may include money for copays; however, the Mail Order Pharmacy will bill you directly for any copay, if necessary. Payment is due upon receipt.

Your prescription will be sent First class mail (except for narcotics) and will usually arrive within one week (please allow up to 10 days).

Costco Specialty Pharmacy
All Specialty drugs must be filled through Costco Specialty Pharmacy. Specialty Drugs are high cost drugs used to treat serious conditions such as Rheumatoid Arthritis, Hepatitis C and Cancer. Many of these drugs are not stocked at retail pharmacies. You will pay the retail copay amounts for Specialty Drugs and will be limited to a 30-day supply each time you fill a prescription.

If you are prescribed a Specialty Drug, Costco Specialty Pharmacy will work with you and your doctor to deliver the medication to your door as well as provide patient support should you have questions about taking the medication or side effects. You can contact Costco Specialty Pharmacy at 1-800-607-6861.

Calendar Year Prescription Drug Out-of-Pocket Maximum
Copays for prescriptions filled at network pharmacies, including retail, mail order and Costco Specialty, will apply to a calendar year prescription drug out-of-pocket (OOP) maximum. Once you reach the OOP maximum, all prescription drugs from network pharmacies will be covered at 100% (no copay) for the remainder of the calendar year. The out-of-pocket maximum applies both per individual and per family. Once an individual reaches the individual OOP maximum, the Plan will pay the individual's covered prescription drugs at 100%. Also, once 2 or more individuals in the same family reach the family OOP maximum, the Plan will pay the family's covered prescription drugs at 100%. The calendar year prescription drug out-of-pocket maximums are as follows:

Calendar Year Prescription Drug Out-of-Pocket Maximum	Network Pharmacies (Retail, Mail Order, and Costco Specialty)	Non-Network Pharmacies
Per Individual	$1,350	No Maximum
Per Family	$2,700	No Maximum

Copays for drugs purchased at non-network pharmacies do not count toward the OOP maximum and will not be covered at 100% once the OOP maximum is reached. *Note: the prescription drug OOP maximum is completely separate from the OOP maximums under the Plan's medical benefit. Copays for prescription drugs do not count toward the medical OOP maximums and vice-versa.*

Step Therapy Program
The step therapy program applies to certain conditions that require taking medications. The purpose of the program is to begin therapy for a medical condition with the most cost-effective medication and only progress to other more costly drugs if the initial medication does not provide adequate therapeutic benefit.

You will be required to try a recognized first line medication (Step 1) before a more costly medication is approved (Step 2). If the Step 1 medication does not provide you with the therapeutic benefit desired, your physician may write a prescription for a Step 2 medication.

Other Requirements and Limitations
- Prior authorization is required for a select list of oral and injectable medications.
- Quantity limits may apply for certain medications.
- The Plan will only cover Cialis to treat Benign Prostatic Hyperplasia (BPH) subject to prior authorization and a Letter of Medical Necessity (LMN) from you doctor. All other drugs to treat Erectile Dysfunction (ED) are not covered.
- A Letter of Medical Necessity (LMN) will be required for all compound medications costing more than $200.

Prescription Drug Exclusions

- Anorectics (any drugs used for the purpose of weight loss).
- Drugs determined by the Food & Drug Administration as lacking substantial evidence of effectiveness for the condition for which they are prescribed.
- Anabolic Steroids.
- Biological sera, blood or blood plasma.
- Infertility medications.
- Vitamins, medical foods, nutritional supplements and similar substances for which no prescription is required, singly or in combination, except to the extend coverage is required as a preventive medicine under the Affordable Care Act.
- Therapeutic devices or appliances, including needles, syringes, support garments and other non-medicinal substances, regardless of intended use, except those listed above.
- Charges for the administration or injection of any drug.
- Drugs labeled "Caution-limited by federal law to investigational use," or experimental drugs, even though a charge is made to the individual.
- Medication which is to be taken by or administered to an individual, in whole or in part, while he or she is a patient in a hospital, rest home, sanitarium, extended care facility, convalescent hospital, nursing home or similar institution which operates on its premises, or allows to be operated on its premises, a facility for dispensing pharmaceuticals.
- Any prescription refilled in excess of the number specified by the physician, or any refill dispensed after one year from the physician's original order.
- Non-legend drugs other than those listed above.
- Medications such as Viagra, Levitra, Stendra, Edex, Caverject, Muse and Cialist will not be covered for erectile dysfunction. The Plan will only cover Cialis for the diagnosis of Benign Prostatic Hyperplasia (BPH) with a Letter of Medical Necessity from your physician and requires prior authorization.
- Sodium fluoride.

- Drugs for work-related injury.
- Drugs which can be purchased over-the-counter without a prescription, regardless of whether a prescription has been provided.
- Cosmetic drugs
- Non-formulary drugs
- Drugs which are Experimental as defined by the Plan
- Non-FDA approved medications or drugs prescribed for off label use
- Compound medications

DENTAL BENEFITS (NOT AVAILABLE TO MEDICARE ELIGIBLE RETIREES OR DEPENDENTS ELIGIBLE FOR MEDICARE)

The Plan covers expenses for necessary dental care provided by any licensed dental provider subject to the plan provisions, limitations and exclusions outlined in this section. The Plan's dental benefits are limited to non-Medicare eligible retirees and their dependents.

Dental Preferred Provider (DPPO) Network

The Plan has a dental preferred provider (DPPO) network arrangement with Cigna. Under this DPPO arrangement, Cigna contracts with a network of dental providers to provide services and supplies at a reduced fee for you and your eligible dependents.

You may use the services of any licensed dental provider. However, if you use a Cigna DPPO provider your out-of-pocket costs will typically be lower. To locate a DPPO provider, log on to www.cignadentalsa.com and select the "Cigna Dental Shared Administration - Dental PPO Plus" option, or call (800) 797-3381.

Calendar Year Maximum Benefit

The maximum amount payable for Class I, Class II and Class III covered dental benefits per eligible person is $2,500 each Calendar Year. This maximum does not apply to children under the age of 12. Charges for dental procedures requiring multiple treatment dates are applied to the Plan maximum on the date the service is completed.

The maximum amount payable per lifetime for orthodontic benefits is $2,500 per each eligible child up to age 26.

The payment level for covered dental expenses arising as a direct result of an accidental bodily Injury is 100% of the Allowed Amount, up to the unused Calendar Year Maximum Benefit.

Estimate of Benefits

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

Covered Services

Class I — Diagnostic (Paid at 100% of the Allowed Amount)

Benefits

- Routine examination.
- X-rays.
- Emergency examination.
- Examination by a specialist in an American Dental Association recognized specialty.
- Comprehensive examinations.

Limitations

- Routine examination is limited to two routine examinations per Calendar Year, with the appointments separated by at least five months.
- Complete mouth or panorex x-rays are covered once in a thirty-six month period.
- Supplementary bitewing x-rays are covered once in a 6-month period.

Exclusions

- Diagnostic services and x-ray related to temporomandibular joints (jaw joints).
- Consultations.
- Study models.

- Caries susceptibility tests.

Class I — Preventive (Paid at 100% of the Allowed Amount)

Benefits

- Prophylaxis (cleaning).
- Fissure sealants.
- Topical application of fluoride.
- Space maintainers when used to maintain space for eruption of permanent teeth.

Limitations

- Prophylaxis (cleaning) is limited to two cleanings per Calendar Year, with the appointments separated by at least five months.
- Periodontal maintenance is limited to one treatment within any 3-month period. Prophylaxis is in addition to periodontal maintenance.
- Topical application of fluoride is covered once in a 6-month period when performed in conjunction with prophylaxis, up to the patient's 19th birthday.
- Fissure sealants are available only for children up to age 14. 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 only once per three Calendar Years 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 the Plan.

Class II — Restorative (Paid at 80% of the Allowed Amount)

Benefits

- Amalgam, synthetic, porcelain and plastic restorations (fillings) for treatment of carious lesions (visible destruction of hard tooth structure resulting from the process of dental decay).

Limitations

- Restorations on the same surface(s) of the same tooth are covered once in a twenty-four month period.
- If a composite or plastic restoration is placed on a posterior tooth, an amalgam allowance will be made for such procedure.
- Refer to Class III — Restorative (Limitations) if teeth are restored with crowns, inlays or onlays.

Exclusions

- Restorations necessary to correct vertical dimension or to restore the occlusion.
- Overhang removal, recontouring, or polishing of restoration.

Class II — Oral Surgery (Paid at 80% of the Allowed Amount)

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 is covered only when administered by a dentist who meets the educational guidelines established by the Dental Quality Assurance Commission of the State of Washington in conjunction with a covered oral surgery procedure.

Exclusions

- Extraoral grafts (grafting of tissues from outside the mouth or use of artificial materials).
- Ridge extension for insertion of dentures (vestibuloplasty).

- Tooth transplants.

Class II — Periodontics (Paid at 80% of the Allowed Amount)
Benefits
- Surgical and nonsurgical procedures for treatment of the tissues supporting the teeth. Services covered include root planing, subgingival curettage, gingivectomy and limited adjustments to occlusion (8 or fewer teeth) such as smoothing of teeth or reducing of cusps.
- Nightguards.

Limitations
- Root planing or subgingival curettage (but not both) are covered once in a 12-month period.
- Limited occlusal adjustments are covered once in a 12-month period.
- Nightguards are a covered benefit only if used for the treatment of bruxism.

Exclusions
- Occlusal splints.
- Periodontal splinting and/or crown and bridgework in conjunction with periodontal splinting.
- Major (complete) occlusal adjustment.
- Periodontal appliances.

Class II — Endodontics (Paid at 80% of the Allowed Amount)
Benefits
- Procedures for pulpal and root canal therapy.
- Services covered include pulp exposure treatment, pulpotomy and apicoectomy.

Limitations
- Root canal treatment on the same tooth is covered only once in a twenty-four month period.
- Refer to Class III — Prosthodontics (Limitations) if the root canals are performed in conjunction with a prosthetic appliance.

Exclusions
- Bleaching of teeth.

Class II — Hospital Calls (Paid at 80% of the Allowed Amount)
Covered Dental Benefits
- Additional fees charged by the dentist for Medically Necessary Hospital treatment.

Class III — Restorative (Paid at 75% of the Allowed Amount)
Benefits
- Crowns, inlays and onlays (whether they are gold, porcelain, plastic, gold substitute castings or combinations thereof) for treatment of carious lesions (visible destruction of hard tooth structure resulting from the process of tooth decay).
- Verification must be provided by the attending dentist that teeth cannot be restored with filling materials such as amalgam, silicate or plastic.

Limitations
- Crowns, inlays or onlays on the same teeth are covered once in a sixty-month period. Stainless steel crowns are covered once in a twenty-four month period. If a tooth can be restored with a filling material such as amalgam, silicate or plastic, an allowance will be made for such a procedure toward the cost of any other type of any restoration that may be provided.

Exclusions
- A crown used as an abutment to a partial denture 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.

- Temporary crowns.

Class III — Prosthodontics (Paid at 75% of the Allowed Amount)

Benefits

- Dentures, bridges, partial dentures, - related items, and the adjustment or repair of an existing prosthetic device.

Limitations

- Replacement of an existing prosthetic device is covered only once every sixty months and only then if it is unserviceable and cannot be made serviceable.
- **Full, immediate and overdentures:** The Plan 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.
- **Root canal therapy:** The Plan will allow root canal therapy when performed in conjunction with overdentures limited to 2 teeth per arch.
- **Partial dentures:** If a more elaborate or precision device is used to restore the case, the Plan 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 6 months after the initial placement are covered. Subsequent relines and jump rebases, but not both, will be covered once in a 12-month period.
- **Implants:** The Plan will allow the appropriate amount for a full or partial denture toward all costs associated with an implant(s) and appliance(s) constructed thereon. The Plan will not pay for replacement of the tooth or teeth placed within a 5 year period.

Exclusions

- Duplicate dentures.
- Cleaning of prosthetic appliances.
- Temporary dentures.
- Removal of implants or attachments to implants.
- Crowns and copings in conjunction with overdentures.

Orthodontic Benefits for Eligible Children

Orthodontic treatment means the necessary procedures of treatment of malalignment of teeth and/or jaws involving surgical or appliance therapy for movement of teeth and post-treatment retention.

Benefits are provided for eligible children up to age 26.

The Plan pays a constant 70% of the lesser of the Allowed Amount fees or the fees actually charged, up to a lifetime maximum of $2,500.

Not more than $1,250 of the annual maximum is allowed for treatment during the “construction phase.” Thereafter, payment is made monthly following the construction phase, to the $2,500 lifetime Maximum Benefit.

All orthodontic treatment must be submitted to and authorized by the Administration Office prior to the beginning of treatment.

Limitations

Benefits will end at:

- Completion, or the limiting age, whichever occurs first.
- Termination of the treatment plan before completion.
- Termination of this program.

Exclusions

- Charges for replacement or repair of an appliance.
- No benefits will be provided for services considered inappropriate and unnecessary, as determined by the Administration Office.

Accidental Injury

The Plan pays 100% of expenses arising as a direct result of an accidental bodily Injury, up to the unused Calendar Year Maximum Benefit. 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.

General Dental Exclusions

- Any condition covered by workers compensation or occupational disease law or injuries occurring in the course of employment or self-employment for profit.
- Dentistry for cosmetic reasons including, but not limited to, laminates or bleaching of teeth.
- Restorations or appliances necessary to correct vertical dimension or to restore the occlusion. Such procedures include restoration of tooth structure lost from attrition and restorations for malalignment of teeth.
- Application of desensitizing medicaments.
- Experimental services or supplies, which 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, the Plan, in conjunction with the American Dental Association, will consider if: (1) the services are in general use in the dental community in the State of Washington; (2) the services are under continued scientific testing and research; (3) the services show a demonstrable benefit for a particular dental condition; and (4) 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.
- Services with respect to treatment of temporomandibular joints (jaw joints).
- Analgesics (such as nitrous oxide or I.V. sedation) or any other euphoric drugs, injections or prescription drugs.
- Hospitalization charges except as specifically provided for dentist charges.
- Charges for telephonic, online or other consultations where the patient is not physically present with the dentist at the time of the consultation.
- Broken appointments, Skype/web hosted services or charges when the patient is not physically seen.
- Patient management problems.
- Completing insurance forms.
- Laboratory examination of tissue specimen.
- Habit breaking appliances (except nightguards for bruxism; see Class II Periodontics).
- All other services not specifically included in this Plan as covered dental benefits.
- Prosthetic devices (including bridges and crowns) that are ordered before you had dental coverage in this Plan or were installed or delivered more than three months after the date your coverage ends.

VISION BENEFITS

The Plan covers expenses incurred for an eye examination, prescription lenses, including contact lenses, and frames in accordance with the schedule below.

Exam and lenses are allowed once each Calendar Year. Frames are allowed once each two Calendar Years, except for children under age 18 who are eligible to receive these benefits once each Calendar Year.

Benefit Payment Levels

Coverage of vision care services and supplies are subject to all Plan provisions. The Plan pays benefits according to the following schedule:

Services and Supplies	Maximum Benefit
Eye Examination	100% of the Usual, Customary and Reasonable Allowance
Lenses (Maximum for Each Lens)	
Single vision	$30
Bifocal	$45
Trifocal	$53
Lenticular	$75
Frames	$80

If cosmetic contact lenses are purchased in lieu of conventional lenses and frames, the Plan will pay up to $140 each two Calendar Years.

If visual acuity is correctable to 20/70 or better only by use of contact lenses or if contact lenses are required due to cataract surgery, then contact lenses are covered up to $200 per pair each Calendar Year.

Safety lenses and frames are covered the same as other lenses and frames.

The Trust has negotiated an agreement with a vision network through National Vision. Vision providers and facilities that have an agreement with National Vision will accept the Trust payment for basic exams and most lenses, frames, and contact lenses as full payment (requiring no copayment).

Vision Exclusions

No vision plan benefits will be provided for:

- Any procedure, service, or supply which is included as a covered medical expense under the Plan.
- Special procedures, such as orthoptics, vision training, subnormal vision aids.
- Plain or prescription sunglasses or other special purpose vision aids or tints including extra charge for blended multifocal lenses, non-glare or scratch resistant coating.
- Medical or surgical treatment of the eyes regardless of reason.
- Replacement or repair of lost or broken lenses and/or frames.
- Contact lens fitting fee.

BENEFIT CLAIMS, APPEALS AND REVIEW

This section explains the Plan rules for filing a claim for Plan benefits and appealing any claim denials.

How to File a Claim

To be considered a claim, you or your dependent must request that the Trust pay a benefit for reimbursement of a specific service or supply. All claims must be submitted in writing (except urgent care claims, as described in this booklet, which may be submitted verbally), include all the information necessary to process the claim, and be received with the timeframes below. Failure to submit the claim and all information the Plan deems necessary to process the claim within the timeframes provided below, will result in the denial of the claim.

Benefit	Time Period
Medical	12 months from the date the service or supply was received
Prescription Drug	12 months from the date the prescription is filled
Vision	12 months from the date the service or supply was received
Dental	12 months from date treatment was received

The Trust may require additional information to process claims or to meet Plan requirements. Additional information may include information demonstrating eligibility, the nature of the services or supplies provided, medical records, itemized billing, other sources of coverage (for coordination of benefits), potential third party reimbursement and compliance with other Plan provisions. Failure to provide this required additional information within the timely filing limitation will result in the denial of a claim.

The Trustees have established the following requirements for filing claims:

Medical/Vision PPO Providers
Medical Benefits: Premera Blue Cross Blue Shield

Vision Benefits: National Vision

Generally, if a PPO provider is used, there are no forms for you to submit. You should show the PPO provider your Plan identification card so he or she knows where to submit the claim.

Benefit payments will be made directly to the PPO provider. **Other than deductible and coinsurance, do not pay the PPO provider bill until you receive the Explanation of Benefits statement from the Administration Office. It will show you the exact amount you owe the PPO provider.**

Claims should be submitted within 90 days after the service was received. If a claim, or information that has been requested to process a claim, is received more than one year after the expenses have been incurred, the claim will be denied.

For assistance locating a PPO provider, contact:

Premera Blue Cross or Blue Cross/Blue Shield (not applicable to those eligible for Medicare)
Toll Free: (800) 810-BLUE (2583)
Website:www.premera.com/sharedadmin

Teladoc (not applicable to those eligible for Medicare)
Toll Free: 1-855-332-4059
Website: www.Teladoc.com/Premera

National Vision
Website: www.nationalvision.com

Medical/Vision Non-PPO Providers

A non-PPO provider may submit claims on your behalf if the non-PPO provider has all of the needed information.

If your non-PPO provider does not submit a claim on your behalf, obtain a medical benefit claim form from the Administration Office, your local union office or the Plan's website, www.psewtrusts.com. Follow the instructions on the back of the claim form when submitting your claim:

Submit the completed claim form and attached itemized bill(s) to:

PSEW Healthcare Trust
P.O. Box 34970
Seattle, WA 98124-1970

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

Claims should be submitted within 90 days after the service was received. If a claim, or information that has been requested to process a claim, is received more than one year after the expenses have been incurred, the claim will be denied.

Non-PPO professionals and facilities which claim payment under the Plan shall be obligated to submit to a prompt audit of their claims by the Plan, notwithstanding any internal rules they may have to the contrary. In the event a non-PPO provider refuses or delays a reasonable audit request by the Plan, the Plan shall have the right to withhold payment to the said non-PPO provider on the claim in question and on other pending or future claims by said non-PPO provider.

Medicare primary claims

The Trust participates in the Medicare Cross Over program. Providers who accept Medicare assignment have their claims submitted to the Trust after Medicare has processed benefits. For providers who do not accept Medicare assignment, submit the completed claim form, attached itemized bill(s) and Explanation of Medicare Benefits to:

PSEW Healthcare Trust
P.O. Box 34970
Seattle, WA 98124-1970

Prescription Drug Benefits

Costco/EnvisionRxOptions Pharmacy Program

See the Prescription Drug benefit section on page 41 for information regarding Costco/EnvisionRxOptions participating pharmacies.

Other Pharmacies

Obtain a claim form ("Member Self-Pay Reimbursement Form") from EnvisionRxOptions at its website, www.envisionrx.com. Complete the form according to its instructions. Mail the completed form and the original paid pharmacy receipts to Envision/Rx Options at its address on the instructions.

Claims should be submitted within 90 days after the service was received. If a claim, information that has been requested to process a claim, is received more than one year after the expenses have been incurred, the claim will be denied.

Mail Order Pharmacy

Obtain a Traditional Mail Order Service Patient Profile Form from Costco Mail Order Pharmacy at its website, www.costco.com or by calling (800) 607-6861. Complete the form according to its instructions.

Submit the claim form to:

Costco Mail Order Pharmacy
802 134th St. SW, Suite 140
Everett, WA 98204

Dental Benefits – Non-Medicare only

Most dentists will submit your completed dental claim form. However, if your dentist does not, you will need to obtain a claim form from the Administration Office, your local union office, or from the Plan's website: www.psewtrusts.com. Complete the member's statement portion of the form, sign and date it and attach a complete itemized billing of charges from your dentist or have them complete their portion of the form.

Claims should be submitted within 90 days after the service was received. If a claim, or information that has been requested to process a claim, is received more than one year after the expenses have been incurred, the claim will be denied.

Submit the completed claim form, together with any required attachments, to:

PSEW Healthcare Trust
P.O. Box 34970
Seattle, WA 98124-1970
(206) 441-4667
(866) 314-4239

For assistance locating a PPO provider, contact:
Cigna Dental PPO Plus at (800) 797-3381 or www.cignadentalsa.com.

Procedures for Processing Claims

Claims which are properly filed will be processed as follows:

Post-Service Health Claims

A post-service health claim is a claim for medical, dental, vision, or prescription drug benefits that is **not** an urgent care health claim, a concurrent health claim or a pre-service health claim (defined below).

The Administration Office will ordinarily process a properly file post-service health claim within 30 days of receipt. If additional time is necessary due to matters beyond the Trust's control, the Administration Office will extend the 30-day period by an additional 15 days if a notice is provided to the claimant within the initial 30-day period. The notice shall advise the claimant of the circumstances requiring the extension of time and the date by which the Administration Office expects to render a decision.

If the extension is necessary because additional information is needed to decide the claim, the claimant will be notified and given 45 days from the date the notice is received to provide the additional required information. The time period for making a benefit determination will be tolled

(*i.e.*, will not run) from the date the Administration Office sends the request for additional information until the earlier of the date the Administration Office received the requested information or the 45 days have passed.

Pre-Service Health Claims
A pre-service health claim is a claim for services that must be preauthorized. The services for which preauthorization are required are:

- All inpatient Hospital, Chemical Dependency Treatment Facility, Rehabilitative Facility, Residential Treatment and Skilled Nursing Facility admissions;
- Surgeries, other than in an office setting; and
- Transplants.

Pre-service health care claims must be submitted in writing to the Utilization Review Manager, which decides the claim. Submit claims by mail or fax:

By mail:

Comagine Health
Attention: Utilization Management Division
10700 Meridian Avenue North, Suite 100
P.O. Box 33400
Seattle, Washington 98133-0400

By fax:

(206) 368-7236 or (877) 810-9265

The claim must identify the claimant, the claimant's specific medical condition or symptom, and the specific treatment, service or product for which preauthorization is requested.

Ordinarily the Utilization Review Manager will notify the claimant of the decision on the pre-service health claim (whether adverse or not) within 5 days after the Utilization Review Manager receives the claim. If additional time is necessary due to matters beyond the control of the Utilization Review Manager, the Utilization Review Manager may extend this 5-day period by an additional 15 days by providing notice to the claimant before the initial 5-day period expires.

If the extension is necessary because additional information is needed to decide the claim, the notice will specifically describe the required information, and the claimant will have 45 days from the date the claimant receives the notice to submit any additional information. The time period for making a determination will be tolled (*i.e.*, will not run) from the date the Utilization Review Manager sends the notice requesting the information until the earlier of the date the Utilization Review Manager receives the information or the 45 days have passed.

If services that require preauthorization have been provided without preauthorization and the issue is what payment, if any, will be made, the Administration Office will process the claim as a post-service health claim.

Urgent Care Health Claims
An urgent care health claim is pre-service health claim, which if the normal time periods above were applied:

- would seriously jeopardize the health of the claimant or the ability of the claimant to regain maximum function (determined by the Utilization Review Manager applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine); or

- in the opinion of a Physician with knowledge of the claimant's medical condition, would subject him or her to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

Urgent care health claims should be submitted to the Utilization Review Manager by fax or by telephone:

By fax:

(206) 368-7236 or (877) 810-9265

By telephone (orally):

(800) 783-8606

The claim must identify the claimant, the claimant's specific medical condition or symptom, and the specific treatment, service or product for which preauthorization is requested. Claims may be submitted by the claimant or a Covered Provider with knowledge of the individual's condition.

Ordinarily the Utilization Review Manager will notify the claimant of the decision on the urgent care health claim (whether adverse or not) as soon as possible, taking into account the medical exigencies, but not later than 72 hours after the claim has been received, unless the claimant fails to provide sufficient information to determine whether, or to what extent, benefits are covered or payable.

If the claimant has failed to provide sufficient information, the Utilization Review Manager will notify the claimant within 24 hours after the Utilization Review Manager receives the claim of the specific additional information needed to complete the claim, which may include information about why the treatment involves urgent care. Claimants will have at least 48 hours to submit the additional information. The Utilization Review Manager will notify the claimant of the decision on the urgent care health claim (whether adverse or not) no later than 48 hours after the earlier of the date the Utilization Review Manager receives the additional information or the end of the 48 hours afforded the claimant to provide the additional information.

If services which constitute urgent care have been provided without preauthorization by the Utilization Review Manager and the issue is what payment, if any, will be made, the Administration Office will process the claim as a post-service claim.

Concurrent Care Health Claims

A claim is a concurrent care health claim when a claimant is receiving an ongoing course of treatment that the Utilization Review Manager has approved as Medically Necessary for a period of time or number of treatments and either:

- the Utilization Review Manager notifies the claimant of its decision to reduce or terminate the initially approved period of time or number of treatments; or
- the claimant makes a request to the Utilization Review Manager for an extension beyond the initially approved period of time or number of treatments.

Submit concurrent care health claims to the Utilization Review Manager by fax or by telephone:

By fax:

(206) 368-7236 or (877) 810-9265

By telephone (orally):

(800) 783-8606

The Utilization Review Manager's notice of a termination or reduction will be provided to claimant at a time sufficiently in advance of the reduction or termination to allow the claimant to appeal to the Utilization Review Manager and obtain a determination on review before the reduction or termination takes effect.

If the claimant requests an extension of treatment that involves urgent care, the Utilization Review Manager will decide the claim as soon as possible, taking into account the medical exigencies, and shall notify the claimant of the Utilization Review Manager's determination, whether adverse or not, within 24 hours after it receives extension request, provided that any such extension request is made to the Utilization Review Manager at least 24 hours before the prescribed period of time or number of treatments expires.

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

Claim Denials

Notice of Administrative Denial of Claims
The notice of denial of a claim will provide the following information:

- The specific reason or reasons for the denial, including the denial code, if applicable, and its corresponding meaning.
- A statement regarding the availability of the diagnosis and treatment codes upon request, if applicable.
- Information sufficient to identify the claim, including the date of service, health care provider and claim amount, if applicable.
- A reference to the specific plan provisions on which the decision is based.
- A description of any additional material or information needed to perfect the claim and an explanation of why such material or information is necessary.
- If an internal rule, guideline, protocol or similar criterion has been relied on in denying the claim, a statement that any such internal rule, guideline protocol or other criterion is available free of charge on request.
- If the denial is based on medical necessity or Experimental treatment or similar exclusion or limit, a statement that an explanation of the scientific or clinical judgment for the decision, applying the terms of the plan to the claimant's medical circumstances, will be provided free of charge upon request.
- An explanation of the Trust's appeal procedures and available external review process. In the case of a denial concerning a health claim involving urgent care, the explanation will include a description of the expedited review process applicable to such claims.

The Administration Office or the Utilization Review Manager will mail notice of denial to the claimant at his or her last known address. In the case of a denial concerning a health claim involving urgent care, the Utilization Review Manager may provide the information to the claimant orally within the time frame for notice of decision on urgent care claims, provided that a written or electronic notification is furnished to the claimant not later than 3 days after the oral notification.

Claimant's Access to for Relevant Documents, Records, and Information

The claimant or his or her authorized representative may upon request and free of charge have reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits.

Appeal Procedures

The procedures specified below are the exclusive procedures available to a claimant who is dissatisfied with a benefit claim denial or partial benefit award, rescission, or any other adverse determination (within the meaning of Department of Labor regulations). These appeal procedures must be exhausted before a claimant may file suit under section 502(a) of ERISA.

Claimants must appeal a benefit claim denial or rescission within 180 days from the date the claimant receives the notice of a benefit claim denial, notice of rescission or other advance determination. Failure to file an appeal within the 180-day period will serve as a bar to any claim for benefits or for any other form of relief from the Trust.

The appeal must be submitted by the claimant or the claimant's authorized representative. The appeal must identify the benefit determination involved, set forth the reasons for the appeal and provide any information the claimant believes is pertinent. Appeals will be accepted from an authorized representative of the claimant only if the appeal is accompanied by a written statement signed by the claimant (or parent or legal guardian where appropriate) which identifies the representative and authorizes him or her to seek benefits for the claimant. An assignment of benefits is not sufficient to make a provider an authorized representative.

Submit an appeal of a post-service health benefit claim or rescission to the Administration Office at:

Attn: Appeals
c/o WPAS, Inc.
P.O. Box 34203
Seattle, WA 98124-1203
(206) 441-4667
(866) 314-4239

Appeals Committee Meeting Procedure
An appeal will be presented to the Trust's Appeals Committee at its next quarterly meeting. If an appeal is received less than 30 days before the next quarterly meeting, consideration of the appeal may be postponed until not later than the second quarterly meeting following the Trust's receipt of the appeal. If special circumstances require a further extension of time for processing or the claimant requests an extension of time, the Appeals Committee shall consider the appeal no later than the third quarterly meeting of the Appeals Committee following the Trust's receipt of the appeal.

A copy of administrative file will be provided to the claimant prior to the Appeals Committee consideration of the appeal. The claimant shall be provided with the opportunity to supplement the administrative file and provide any additional documentation the claimant concludes is relevant to the claim.

The claimant or his or her representative will be allowed to appear before the Appeals Committee in person or by telephone conference call and present any evidence or witnesses at the meeting of the Appeals Committee. The Appeals Committee may, in its discretion, direct that a stenographic record be made of any testimony provided. The Appeals Committee may, in its discretion, set any other conditions upon the conduct of the hearing, the testimony or attendance of any individual or address other procedural matters which may occur during a specific hearing.

If the claimant does not elect to appear, the Appeals Committee will determine the appeal based on the administrative file and the comments of any witnesses consulted.

If the initial determination was based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is Experimental or not Medically Necessary or appropriate, the Appeals Committee may consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. A copy of any documents or testimony provided by the health care professional shall be included in the administrative file.

Issuance of a Decision
The Appeals Committee will provide the claimant written notice of its decision within 5 business days after it makes its decision.

If the Appeals Committee decision is an adverse benefit determination of a health benefits claim, the notice will:

- set out the specific reason or reasons for the adverse decision;
- reference the benefit plan provisions involved;
- inform the claimant that all documents; records and other information relevant to the individual's claim is available upon request and free of charge;
- notify the claimant of his or her rights under section 502(a) of ERISA;
- identify any internal rule or guideline relied on (or reference that it is available free of charge); and
- if a denial is based on a medical judgment, an explanation of the medical judgment applying it to the claimant's case or a statement that such information is available.

The review will be de novo and without deference to the initial determination.

Appeal Procedures for Pre-Service Health Care and Urgent Health Care Claims
Appeals involving denial of pre-service health claims, urgent care health claims and concurrent health care claims generally follow the Appeal of Procedures for Denial of Post-Service Health Benefit Claim or Rescission of Coverage above, with the following modifications:

- Pre-Service Health Claims - The claimant or authorized representative must submit an appeal of a denial of a pre-service health claim in writing to the Utilization Review Manager by fax or by mail:

  By fax:
  (206) 368-7236 or 1 (877) 810-9265

  By mail:
  Comagine Health
  Attention: Utilization Management Division
  10700 Meridian Avenue North, Suite 100
  P.O. Box 33400
  Seattle, Washington 98133-0400

- Urgent Care Health Claims - The claimant or the claimant's authorized representative may submit an appeal orally or in writing by fax to the Utilization Review Manager:

  By telephone (orally):
  1-(800) 783-8606

By fax:
(206) 368-7236 or 1-(877) 810-9265

A health care professional with knowledge of the claimant's medical condition may act as an authorized representative of the claimant without a prior written authorization of the claimant.

Information will be provided to the claimant or authorized representative via telephone, facsimile or other similarly available expeditious method.

The Appeals Committee will notify the claimant of the decision on an appeal of a denial of an urgent health care claim as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the appeal.

External Review of Certain Appeal Decisions

External review by an Independent Review Organization ("IRO") is available if the claim on appeal involves medical judgment or the retroactive rescission of health coverage. A request for external review must be filed with the Administration Office within four months from the claimant's receipt of the Trustees' decision on appeal. Requests for external review may be mailed to the following address:

Attn: Appeals
WPAS, Inc.
PO Box 34203
Seattle, WA 98124-1203

Failure to file a request for external review within the four-month period will end the claimant's ability to seek external review.

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

Review by an IRO
If a properly filed request for external review is received, the Plan will provide the IRO with the required documentation in the time required by applicable federal regulations. The IRO will provide a response to the claimant within 45 days after it has received the request to review. If an urgent care claim is submitted to an IRO, a decision will be made within 72 hours.

If the IRO directs that benefits be paid, benefits will be provided under the Plan in accordance with the decision. If the decision continues to be adverse, the claimant has the right to bring a civil action under ERISA § 502(a).

Civil Action for Denied Benefits or Coverage — Deadline for Filing Lawsuit

If the claimant exhausts the claim appeal procedures, and remains dissatisfied with the decision on appeal by the Appeals Committee, he or she has the right to pursue a civil action under section 502(a) of ERISA (29 U.S.C. § 1132(a)).

No legal or equitable action for benefits or coverage may be brought later than one year after the date of the notice of the Appeals Committee's decision to the claimant.

If a claimant requests an external review (see *External Review of Certain Health Claim Appeal Decisions*, above), the deadline for filing a civil action is one year from the date the independent review organization issues its decision.

Sole and Exclusive Procedures

The Plan's Claim and Appeal Procedures are the sole and exclusive procedures available to a claimant who is dissatisfied with an eligibility determination or benefit award, or who is otherwise adversely affected by any action of the Trustees. The Claim and Appeal procedures must be exhausted prior to filing any legal action.

GENERAL PROVISIONS

This section *General Provisions — Medical, Prescription Drug, Vision and Dental Benefits* has provisions that apply to the medical, prescription drug, vision and dental benefits.

Termination of Coverage for Fraud or Intentional Misrepresentation

The Trustees, in their discretion, may retroactively or prospectively terminate coverage under the Plan with respect to any individual (including dependents) when the Trustees, in their discretion, determine that the individual (or a person seeking coverage on behalf of the individual, including an employer) performed an act, practice, or omission that constitutes fraud, or the individual made an intentional misrepresentation of material fact. Termination of coverage includes voiding benefits provided during the period of terminated coverage. For this purpose, an act, practice, or omission that constitutes fraud, or an intentional misrepresentation of material fact includes, but is not limited to:

a) falsifying, withholding, omitting or concealing information to obtain coverage;
b) misrepresenting eligibility criteria for dependents (for example, marital status, age, child status) to obtain or continue coverage for an individual who would not otherwise meet the dependent eligibility criteria;
c) withholding, omitting, concealing, or failing to disclose any medical history or health status when required to calculate benefit payments;
d) making or using any false writing or document in connection with obtaining coverage or payment for health benefits, including falsifying or altering a claim or medical records;
e) permitting an individual who is not eligible for coverage under the Plan to use a Plan identification card or other Plan identifying information to obtain covered services or payment under this Plan;
f) making false or fraudulent representations in connection with delivery of or payment for health benefits, or being untruthful to obtain reimbursement under this Plan; or
g) obtaining, or attempting to obtain, medical care or covered services under this Plan by false or fraudulent pretenses.

In the case of retroactive termination of coverage for fraud or intentional misrepresentation, the Trustees, upon 30 days' notice to affected parties, may terminate coverage retroactive to the date of fraud or material misrepresentation, or, if earlier, retroactive to the first day of coverage obtained through fraud or misrepresentation. A decision to retroactively terminate coverage for fraud or intentional misrepresentation may be appealed under the Plan's claims and appeals procedures.

Benefit claims incurred after the retroactive date of termination shall not be further processed and/or paid under the Plan. Claims incurred after the retroactive date of termination that were paid under the Plan will be treated as overpaid benefits that are subject to reimbursement by the individual.

Right to Recover Overpayments

If the Plan makes a payment for you or your dependents to which you or your dependents are not entitled due to your, your dependents or your employer's providing inaccurate or incomplete information or your or your dependent failure to observe a Plan provision, the Plan has the legal and equitable right to recover the payment from the eligible individual paid or anyone else who benefited from it, including the individual or the provider of services. The Plan may also pursue recovery from any individual or entity responsible for providing misinformation to or failing to provide necessary information to the plan that has resulted in the payment of improper benefits. The Plan's right of recovery includes the right to deduct the amount paid from future benefits

payable on behalf of the participant or beneficiary of the overpayment or any other individual whose eligibility is established by or through the participant or beneficiary.

Subrogation and Reimbursement

The Plan does not provide benefits for services or supplies to the extent that benefits are payable for such services or supplies under any motor vehicle medical, motor vehicle no-fault, uninsured motorist, under-insured motorist, personal Injury protection (PIP), commercial liability, homeowner's policy or other similar type of coverage (collectively referred to as the "third party").

If the covered person requests benefits for services or supplies for an Illness or Injury for which there is an actual or potential right of recovery against a third party, the Plan will advance the requested benefits subject to the following conditions:

- By accepting or claiming benefits, the covered person agrees that the Plan is entitled to reimbursement from any judgment, direct payment, settlement, disputed claim settlement or any other recovery, up to the full amount of all benefits provided by the Plan. However, in no event shall the Plan's reimbursement exceed the gross amount of your recovery.
- If the covered person complies with the terms of the Plan and the agreement to reimburse the Plan, the Plan will reduce its reimbursement amount by a reasonable share of attorney fees and a pro rata share of the costs. If the Plan has to bring a lawsuit to enforce this reimbursement provision, the Plan shall not reduce its reimbursement amount for reasonable attorney fees and a pro rata share of costs.
- The Plan is entitled to reimbursement regardless of whether the covered person is made whole by the recovery, and regardless of the characterization or apportionment of the recovery. The Plan shall be entitled to first dollar priority from the covered person's recovery after payment of your attorney fees and costs, to the extent applicable.
- Before the Plan will provide benefits, the Plan requires the covered person and the covered person's attorney or personal representative to sign an agreement acknowledging the obligation to reimburse the Plan from the proceeds of any recovery. The Plan requires the covered person to execute and deliver instruments and papers and do whatever else is necessary to secure the Plan's right of reimbursement (including an assignment of rights).
- The covered person has an affirmative obligation to notify the Plan in the event the covered person requests or has requested benefits for services or supplies for an Illness or Injury for which there is a right of recovery against a third party. This obligation arises on the earlier of the date the covered person makes a formal or informal claim against the third party or investigates whether to make a formal or informal claim against the third party. In the event the Plan pays benefits prior to learning or discovering the covered person's third-party claim, such benefits shall be treated as overpaid benefits until the Plan receives a signed agreement from the covered person and the covered person's attorney or personal representative acknowledging the obligation to reimburse the Plan from the proceeds of any potential recovery. The Plan reserves the right to recoup any overpaid benefits by offsetting future benefits otherwise payable to the covered person or the covered person's family members, or by recovering the benefits from a source to which benefits were paid.
- The covered person must do nothing to prejudice the Plan's right of reimbursement.
- When any recovery is obtained, an amount sufficient to satisfy the Plan's reimbursement amount must be paid into an escrow or trust account and held there until the Plan's claim is resolved by mutual agreement, arbitration or court order. If the funds necessary to satisfy the

Plan's reimbursement claim are not placed in an escrow or trust account, the covered person or any failing party will be personally liable for any loss the Plan may suffer as a result.

- The Plan may cease providing benefits if there is a reasonable basis for concluding the covered person will not honor the terms of the Plan or the agreement to reimburse, or the Trustees of the Plan modify the Plan provisions relating to reimbursement rights.
- The Plan shall have a constructive trust, lien and/or an equitable lien by agreement in favor of the Plan on any overpaid or advanced benefits received by the participant, dependent, or a representative of the participant or dependent (including an attorney) that is due to the Plan, and any such amount shall be deemed to be held in trust by the participant or dependent for the benefit of the Plan until paid to the Plan. By accepting benefits from the Plan, the participant and dependent consent and agree that a constructive trust, lien, and/or equitable lien by agreement in favor of the Plan exists with regard to any overpayment or advancement of benefits, and in accordance with that constructive trust, lien, and/or equitable lien by agreement, the participant and dependent agree to cooperate with the Plan in reimbursing it for all of its costs and expenses related to the collection of those benefits

If the Plan is not reimbursed within a reasonable period of time following the recovery or if there is a reasonable basis for concluding that the covered person will not honor the terms of the Plan or the agreement, the Plan may bring an action against the covered person to enforce its right to reimbursement. Also, the Plan may elect to recoup the reimbursement amount by offsetting future benefits otherwise payable to the covered person or the covered person's family members, or by recovery from a source to which benefits were paid. If the Plan is forced to bring legal action to enforce the terms of the agreement to reimburse, it shall be entitled to its reasonable attorneys' fees, costs of collection and court costs.

Motor Vehicle Personal Injury Protection

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

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

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

Disputed Workers' Compensation Claims

The Plan does not provide benefits for expenses incurred in connection with accidental bodily Injury or Illness arising out of or in the course of employment, or which are compensable under any workers' compensation or occupational disease act or law. If a dispute arises concerning whether an Injury or Illness is work-related, and the covered person appeals the denial of the claim by a state or federal workers' compensation agency or insurer, the Plan may advance payment of benefits pending resolution of the appeal, provided the covered person submits

documentation indicating the basis for denial of the claim and signs and returns an agreement to reimburse the Plan 100% of the amount of such benefits, or the amount recovered if less, upon recovery on the workers' compensation claim. Reimbursement is required regardless of whether recovery is through acceptance of the claim, award, settlement, or disputed claim settlement, or any other method of recovery, and regardless of whether the covered person is made whole by the recovery. The amount to be reimbursed to the Plan shall not be reduced for attorney fees or costs incurred by the covered person. The covered person shall do nothing to prejudice the Plan's right to reimbursement and the Plan may offset future benefit payments, including those of family members, by denying such payments until the benefits provided under this provision have been repaid. Following recovery on the workers compensation claim, no further benefits will be provided related to the Injury or Illness.

Coordination of Benefits

This Plan is designed to help you meet the cost of medical, dental and vision care expenses. Since it is not intended that you receive greater benefits than the actual expenses incurred, the amount payable under this Plan will take into account any coverage you have under other "plans," as defined below. This means the benefits under this Plan will be coordinated with the benefits of the other "plans."

When coordinating with other plans, this Plan will pay either its regular benefits in full, or a reduced amount. This reduced amount plus the benefits payable by the other plans will equal 100% of "allowable expenses." "Allowable expenses" mean any necessary, Usual, Customary and Reasonable expense partially or completely covered under any other plan during the Calendar Year while the person is covered under this Plan.

If, because of the coordination provision, this Plan does not pay its regular benefit, a record is kept of the reduction. This amount will be used to increase your later claim payments under the Plan in the same Calendar Year, to the extent there are allowable expenses that otherwise would not be fully paid by this Plan and the other plans. Therefore, on a later claim you may receive a greater benefit under our Plan than would normally be allowed.

"Plan" means any plan under which medical, dental, or vision benefits or services are provided by group insurance, any other arrangement of coverage for individuals in a group (whether on an insured or uninsured basis), or an individual policy of insurance, provided the policy contains a coordination of benefits provision.

The following guidelines have been established to ensure that all plans coordinate benefits in a consistent manner. The primary plan pays benefits first. The secondary plan pays benefits second (after the primary plan has paid).

Order of Benefit Determination

Group plans determine the sequence in which they pay benefits, or which plan pays first, by applying a uniform set of order of benefit determination rules that are applied in the specific sequence outlined below. This Plan uses the order of benefit determination rules established by the National Association of Insurance Commissioners (NAIC) and which are commonly used by insured and self-funded plans. Any group plan that does not use these same rules always pays its benefits first.

When two group plans cover the same person, the following order of benefit determination rules establish which plan is the primary plan that pays first and which is the secondary plan that pays second. If the first of the following rules does not establish a sequence or order of benefits, the next rule is applied, and so on, until an order of benefits is established. These rules are:

Rule 1: Non-Dependent or Dependent
A. The plan that covers a person other than a dependent, for example, as an employee, retiree, member or subscriber as is the primary plan that pays first; and the plan that covers the same person as a dependent is the secondary plan that pays second.

B. There is one exception to this rule. If the person is also a Medicare beneficiary, and Medicare is secondary to the plan covering the person as a dependent; and primary to the plan covering the person as a retired employee; then the order of benefits is reversed, so that the plan covering the person as a dependent pays first; and the plan covering the person as a retired employee pays second.

Rule 2: Dependent Child Covered Under More Than One Plan
A. The plan that covers the parent whose birthday falls earlier in the Calendar Year pays first; and the plan that covers the parent whose birthday falls later in the Calendar Year pays second, if:

1. the parents are married;
2. the parents are not separated (whether or not they ever have been married); or
3. a court decree awards joint custody without specifying that one parent has the responsibility for the child's health care expenses or to provide health care coverage for the child.

B. If both parents have the same birthday, the plan that has covered one of the parents for a longer period of time pays first; and the plan that has covered the other parent for the shorter period of time pays second.

C. The word "birthday" refers only to the month and day in a Calendar Year; not the year in which the person was born.

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

If the specific terms of a court decree state that both parents are responsible for the dependent child's health care expenses or health care coverage, the plan that covers the parent whose birthday falls earlier in the Calendar Year pays first, and the plan that covers the parent whose birthday falls later in the Calendar Year pays second.

E. If the parents are not married, or are separated (whether or not they ever were married), or are divorced, and there is no court decree allocating responsibility for the child's health care services or expenses, the order of benefit determination among the plans of the parents and their spouses (if any) is:

1. The plan of the custodial parent pays first; and
2. The plan of the spouse of the custodial parent pays second; and
3. The plan of the non-custodial parent pays third; and
4. The plan of the spouse of the non-custodial parent pays last; and
5. If there is no custodial parent (i.e. the child is over age 18), the plan that covers the parent whose birthday falls earlier in the Calendar Year pays first, and the plan that covers the parent whose birthday falls later in the Calendar Year pays second.

Rule 3: Active/Retired
A. The plan that covers a person either as an active employee (that is, an employee who is neither laid-off nor retired), or as that active employee's dependent, pays first; and the plan that covers the same person as a retired employee, or as that retired employee's dependent, pays second.

B. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.

C. If a person is covered as a laid-off or retired employee under one plan and as a dependent of an active employee under another plan, the order of benefits is determined by Rule 1 rather than by this rule.

Rule 4: Continuation Coverage
A. If a person whose coverage is provided under a right of continuation under federal or state law is also covered under another plan, the plan that covers the person as an employee, retiree, member or subscriber (or as that person's dependent) pays first, and the plan providing continuation coverage to that same person pays second.

B. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.

C. If a person is covered other than as a dependent (that is, as an employee, former employee, retiree, member or subscriber) under a right of continuation coverage under federal or state law under one plan and as a dependent of an active employee under another plan, the order of benefits is determined by Rule 1 rather than by this rule.

Rule 5: Longer/Shorter Length of Coverage
A. If none of the four previous rules determines the order of benefits, the plan that covered the person for the longer period of time pays first; and the plan that covered the person for the shorter period of time pays second.

B. To determine how long a person was covered by a plan, two plans are treated as one if the person was eligible for coverage under the second plan within 24 hours after the first plan ended.

C. The start of a new plan does not include a change:

1. in the amount or scope of a plan's benefits;
2. in the entity that pays, provides or administers the plan; or
3. from one type of plan to another (such as from a single employer plan to a multiple employer plan).

D. The length of time a person is covered under a plan is measured from the date the person was first covered under that plan. If that date is not readily available, the date the person first became a member of the group will be used to determine the length of time that person was covered under the plan presently in force.

Rule 6: Other Plan has no COB rules
If the other coverage has no COB rules, this Plan will always pay secondary.

Right to Collect and Release Needed Information
In order to receive benefits, the claimant must give the Trust any information that is needed to coordinate benefits. With the claimant's consent, the Plan may release to or collect from any person or organization any needed information about the claimant.

Facility of Payment
If benefits which this Plan should have paid are instead paid by another plan, this Plan may reimburse the other plan. Amounts reimbursed are Plan benefits and are treated like other Plan benefits in satisfying Plan liability.

Participant Rewards Program

The Board of Trustees has adopted a reward program for vigilant Plan members. If you find an error on a medical or dental provider's bill that has been paid by the Trust, the Plan will pay you 25% of the overcharged amount (based on the Plan's payment provisions) up to a maximum of $1,000.

Provider fraud is one example where careful attention to your Explanation of Benefits pays off. In one instance an out of state provider submitted a claim for services that were never rendered. When the member alerted the Administration Office, payment to the provider was stopped, the authorities were notified of potential fraud, and the member received the maximum reward of $1,000.

There are also lesser instances where you may be the only one to know that you didn't receive the service being billed. Sometimes the billing office reads the doctor's notes incorrectly and bills for services you didn't get. It might be that your doctor or Hospital accidentally bills for the wrong services. Whatever the case, you can save the Plan money and earn a bonus by looking over every Explanation of Benefits you receive.

PLAN ADMINISTRATION

The Board of Trustees has the responsibility and the full and absolute discretion and authority to control and manage the operation and administration of the Plan, including without limitation, the authority to:

- make and enforce such rules and regulations as it shall deem necessary or proper for the efficient administration of the Plan;
- interpret and apply the provisions of this Plan, and any writing, decision, instrument or account in connection with the operation of the Plan or otherwise;
- determine all considerations affecting the eligibility of any individual to be or become covered under the Plan;
- determine eligibility for and amount of benefits under the Plan for any covered individual;
- determine all other questions or controversies, of whatsoever character, including factual determinations, arising in any manner or between any parties or persons in connection with the administration or operation of the Plan;
- authorize and direct all disbursements of benefits under the Plan; and
- delegate and allocate specific responsibilities, obligations and duties of the Board of Trustees, to one or more employees, agents or such other persons, including without limitation third party administrators, as the Board of Trustees deems appropriate.

The decision of the Board of Trustees shall be final and binding upon all persons dealing with the Plan or claiming any benefit under the Plan.

No employer or local union, no representative of any employer or local union, and no individual Trustee is authorized to interpret the Plan nor can any such person act as an agent of the Board of Trustees to guarantee benefit payments. No agreement between an employer and a union may change, override or otherwise affect the Plan any way, except as the Board of Trustees may permit expressly by resolution.

The Board of Trustees also has the power to purchase contracts or policies of insurance for the purpose of providing benefits under the Plan. To the extent benefits of the Plan are insured, the eligibility for and amount of benefits are determined based upon the terms and subject to the conditions of the governing insurance contract or policy, by the appropriate party designated in the policy or contract.

Amendment and Termination of Benefit Plan

The Board of Trustees has the sole and exclusive right, at any time and from time-to-time, for any reason, without prior notice to, and without the consent of any person, to amend, suspend, modify or terminate the Benefit Plan in whole or in part. This includes the right to amend, suspend, modify or terminate the benefits, deductibles, maximums, exclusions, limitations, definitions, eligibility for coverage and eligibility for benefits described in the Benefit Plan and the policies of administration adopted by the Board of Trustees. If the Benefit Plan is amended, suspended, terminated, or modified, the rights of participants and covered dependents are limited to eligible charges incurred before the effective date of the amendment, suspension, modification or termination.

SUMMARY PLAN DESCRIPTION

Name of Plan
For purposes of the Employee Retirement Income Security Act, including annual reporting on Form 5500, this plan is known as the Puget Sound Electrical Workers Healthcare Plan.

Plan Sponsor
This plan is sponsored and administered by a joint labor-management Board of Trustees, the name, address and telephone number of which is:

Board of Trustees
Puget Sound Electrical Workers Healthcare Trust
c/o Welfare & Pension Administration Service, Inc.
Street Address:
7525 S.E. 24th Street, Suite 200
Mercer Island, WA 98040

Mailing Address:
P.O. Box 34203
Seattle, WA 98124-1203
(206) 441-4667
(866) 314-4239

www.PSEWTrusts.com

Participants and beneficiaries may receive from the Plan Administrator, upon written request, information as to whether a particular employer or employee organization is a sponsor of the Plan and, if the employer or employee organization is a Plan sponsor, the sponsor's address. The Trustees may impose a reasonable charge to cover the cost of furnishing this information. Participants and beneficiaries may wish to inquire as to the amount of the charges before requesting such information. The employer identification number assigned to the Trust Fund by the Internal Revenue Service is 91-6029124.

Plan Number
The plan number is 501.
This is a welfare plan, providing health benefits.

Plan Administrator
The plan administrator is the Board of Trustees of the Puget Sound Electrical Workers Healthcare Trust. This Plan is administered by the Board of Trustees, with the assistance of a contract administrative organization:

Welfare & Pension Administration Service, Inc.
P.O. Box 34203
Seattle, WA 98124-1203
(206) 441-7574
(800) 331-6158
www.PSEWTrusts.com

Name and Address of Agent of Service of Process
The Board of Trustees has designated its legal counsel as agent for the purpose of accepting service of legal process on behalf of the Trust.

McKenzie Rothwell Barlow and Coughran, PS
1325 Fourth Ave., Suite 910
Seattle WA 98101

Each member of the Board of Trustees is also an agent for purposes of accepting service of legal process on behalf of the Trust. The names and addresses of the Trustees are listed below.

Names, Titles and Addresses of Trustees

Employer Trustees	Union Trustees
Barry Sherman Puget Sound Chapter NECA 16001 Aurora Avenue N, Suite 200 Shoreline, WA 98133-5653	Janet Lewis IBEW Local 46 19802 62nd Avenue S, Suite 105 Kent, WA 98032-4004
Michael Broberg Prime Electric 3460 161st Avenue SE Bellevue, WA 98008-5758	Sean Bagsby IBEW Local 46 19802 62nd Avenue S, Suite 105 Kent, WA 98032-4004
Marv Nelson Nelson Electric, Inc. 9620 Stone Avenue N, Suite 201 Seattle, WA 98103-3378	Gillian Burlingham IBEW Local 46 19802 62nd Avenue S, Suite 105 Kent, WA 98032-4004

Collective Bargaining Agreements
This plan is maintained pursuant to more than one collective bargaining agreement. Copies of such agreements may be obtained by participants and beneficiaries upon written request to the Trustees. Further, such agreements are available for examination by participants and beneficiaries at the Administration Office, and at local union offices, upon 10 days advance written request. The Trustees may impose a reasonable charge to cover the cost of furnishing the agreements. Participants and beneficiaries may wish to inquire as to the amount of the charges before requesting copies.

Participation, Eligibility and Benefits
The eligibility rules that determine which retirees and dependents are entitled to benefits are described on pages 5 through 6 of this booklet. A summary of the benefits is described on pages 11 through 16 of this booklet.

Eligible dependents will be terminated if they cease to meet the definitions of dependents shown on pages 6 and 6 of this booklet.

This Plan contains provisions whereby benefits may be reduced or denied even though a retiree or dependent is covered. These provisions include, but are not limited to:

- The failure to file a claim with the Administration Office within 12 months of the date the expense is incurred.
- Failure to submit a complete and truthful benefit application.
- Where the eligible individual has other coverage, benefits may be reduced or denied.

The Board of Trustees has the authority to terminate the Plan. The Plan will also terminate upon the expiration of all collective bargaining agreements and special agreements requiring the payment of contributions to the Trust Fund. In the event of termination of the Plan, any and all monies and assets remaining in the Trust Fund, after the payment of expenses, will be used for

the continuance of benefits by then existing plans, until such monies and assets have been exhausted.

Source of Contributions
The Plan is funded through employer contributions, the amount of which is specified in the underlying collective bargaining agreements or special agreements.

Entities Used for Accumulation of Assets and Payment of Benefits
The employer contributions are received and held in trust by the Board of Trustees pending the payment of claims, premiums and administrative expenses. The Board of Trustees pays benefits directly for covered medical, dental, vision and non-Medicare prescription expenses. Medicare prescription drug expenses are paid pursuant to an insurance contract.

End of Plan Year
This Plan's fiscal year ends July 31.

STATEMENT OF ERISA RIGHTS

As a participant in the Puget Sound Electrical Workers Healthcare Plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants will be entitled to:

Receive Information About Your Plan and Benefits

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

Continue Group Health Plan Coverage

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

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

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.

Under ERISA, there are steps you can take to enforce the above rights. For instance:

- If you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator.
- If you have a claim for benefits which is denied or ignored, in whole or in part, you may request a hearing before the Board of Trustees. If you are dissatisfied with the determination of the Trustees, you may file suit in a state or Federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in Federal court.
- If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these

costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

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

Newborns' and Mothers' Health Protection Act of 1996
Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Women's Health and Cancer Rights Act of 1998
On October 21, 1998, the federal government passed the Women's Health and Cancer Rights Act of 1998. One of the provisions of this act requires group health plans to notify health plan members of their rights under this law.

What benefits does the law guarantee?

Under this law, group health plans that provide medical and surgical benefits in connection with a mastectomy must provide benefits for certain reconstructive surgery. This includes:

- Reconstruction of the breast on which a mastectomy has been performed.
- Surgery and reconstruction of the other breast to produce a symmetrical appearance.
- Prostheses and physical complications of all stages of mastectomy, including lymphedemas.

The law also states that "the services will be considered in a manner determined in consultation with the attending Physician and the patient." In other words, you and your Physician will determine the most appropriate treatment for your individual situation.

Coverage of these services is subject to the terms and conditions of the Plan, including the Plan's normal copayment, annual deductibles and coinsurance provisions.

Amendment and Termination
The Board of Trustees has the sole and exclusive right to amend, suspend, modify or terminate the Plan in whole or in part. See *Amendment and Termination of Benefit Plan*, page 68.

Upon voluntary termination of the Trust, all assets remaining in the Trust after payment of all expenses shall be used for the continuance of benefits provided in the Plan until such assets have been depleted.

Benefits Not Guaranteed
None of the benefits provided by this Plan are insured by any contract of insurance. There is no liability on the Board of Trustees or any other individual or entity to provide payments over and beyond the amount in the Trust collected and available for such purpose. No retiree or dependent shall have any accrued or vested rights to benefits under this Plan.

Information Available to You

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

The foregoing is a Summary Plan Description required by federal law. Of necessity, many of the substantive plan provisions mentioned in the Summary Plan Description have been set forth in summary or capsulized form. For a complete and detailed description, please refer to the material contained in this booklet.

All questions with respect to Plan participation, eligibility for benefits, or the nature and amount of benefits, or with respect to any matter of Trust Fund or Plan administration, should be referred to the Administration Office.

The only party authorized by the Board of Trustees to answer questions concerning the Trust Fund and Plan is the Administration Office. No participating employer, employer association, no labor organization, nor any individual employed thereby, has any authority in this regard.

IMPORTANT ADDRESSES AND PHONE NUMBERS

Contact the Administration Office for Information on the Medical, Prescription Drug, Dental and Vision Benefits:

Puget Sound Electrical Workers Healthcare Trust

Street Address:
7525 S.E. 24th St Ste 200
Mercer Island, WA 98040

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

Telephone Numbers:
(206) 441-4667
(866) 314-4239

Website:
www.psewtrusts.com

For Information on Preferred Providers, contact:
Premera Blue Cross (Washington and Alaska)
Blue Cross/Blue Shield (all other states)
Toll Free: (800) 810-BLUE (2583)
Website: www.premera.com

For Information on the Prescription Benefit Manager contact:
Actives and Non-Medicare Retirees:
EnvisionRxOptions
Toll Free: (800) 361-4542
www.envisionrx.com

Medicare Retirees:
EnvisionRxOptions
Toll Free (844) 293-4760
Website: www.envisionrxplus.com

For Information on Preferred Dental Providers, contact:
Cigna
Toll Free (800) 797-3381
Website: www.cignadentalsa.com

For Information on the Utilization Review Manager, contact:
Comagine Health
Toll Free: (800) 783-8606
Seattle Area: (206) 368-8271

PRIVACY POLICY AND PROCEDURES

The Trust's privacy practices were effective April 14, 2003, and are administered in accordance with regulations adopted by the Department of Health and Human Services at 45 CFR § 164. The Board of Trustees adopted the following provisions:

Protected Health Information
The term "Protected Health Information" ("PHI") has the same meaning as in 45 CFR § 164.501.

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

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

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

- The Trustees will not use or disclose any PHI received from the Plan, except as permitted in these procedures or as required by law.
- The Trustees will ensure that any of their subcontractors or agents to whom they may provide PHI that was received from the Plan, agree to written contractual provisions that impose at least the same obligations to protect PHI as are imposed on the Trustees.
- The Trustees will not use or disclose PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Trustees.

- The Trustees will report to the Plan any known impermissible or improper use or disclosure of PHI not authorized by these procedures of which they become aware.
- The Trustees will make their internal practices, books, and records relating to the use and disclosure of PHI received from the Plan available to the Department of Health and Human Services ("DHHS") or its designee for the purpose of determining the Plan's compliance with HIPAA.
- When the PHI is no longer needed for the purpose for which disclosure was made, the Trustees must, if feasible, return to the Plan or destroy all PHI that the Trustees received from or on behalf of the Plan. This includes all copies in any form, including any compilations derived from the PHI. If return or destruction is not feasible, the Trustees agree to restrict and limit further uses and disclosures to the purposes that make the return or destruction infeasible.

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

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

Effective Mechanism for Resolving Issues of Noncompliance
Anyone who suspects an improper use or disclosure of PHI may report that occurrence to the Plan Privacy Official.

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

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

NOTICE OF PRIVACY PRACTICES

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

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

Protected Health Information
Protected health information generally means information that: (1) is created or received by a health care provider, health plan, employer, or health care clearinghouse; and (2) relates to the past, present, or future physical or mental health or condition of an individual, the provision of health care to an individual, or the past, present, or future payment for the provision of health care to an individual; and (3) identifies the individual, or there is a reasonable basis to believe the information can be used to identify the individual.

Use and Disclosure of Health Information
Your health information may be used and disclosed without an authorization for the purposes listed below. The health information used or disclosed will be limited to the minimum necessary, as defined under the Privacy Rules.

To Make or Obtain Payment. The Trust may use or disclose your health information to make payment to or collect payment from third parties, such as other health plans or providers, for the care you receive. For example, the Trust may use your health information to pay claims, or share information regarding your coverage or health care treatment with other health plans to coordinate payment of benefits.

To Facilitate Treatment. The Trust may disclose information to facilitate treatment which involves the provision, coordination or management of health care or related services. For example, the Plan may disclose the name of your treating Physician to another treating Physician for the purpose of obtaining x-rays.

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

In Connection with Judicial and Administrative Proceedings. If required or permitted by law, the Trust may disclose your health information in the course of any judicial or administrative proceeding in response to an order of a court or administrative tribunal as expressly authorized by such order or in response to a subpoena, discovery request or other lawful process. The Trust will make reasonable efforts to either notify you about the request or to obtain an order protecting your health information.

When Legally Required for Law Enforcement Purposes. The Trust will disclose your health information when it is required to do so by any federal, state or local law. Additionally, as permitted or required by law, the Trust may disclose your health information to a law enforcement official for certain law enforcement purposes, including, but not limited to, if the Trust has a suspicion that your death was the result of criminal conduct or in an emergency to report a crime.

To Conduct Health Oversight Activities. The Trust may disclose your health information to a health oversight agency for authorized activities including audits, civil, administrative or criminal investigations, inspections, licensure or disciplinary action. The Trust, however, may not disclose your health information if you are the subject of an investigation and the investigation does not arise out of or is not directly related to your receipt of health care or public benefits.

In the Event of a Serious Threat to Health or Safety. The Trust may, consistent with applicable law and ethical standards of conduct, disclose your health information if the Trust, in good faith, believes that such disclosure is necessary to prevent or lessen a serious and imminent threat to your health or safety or to the health and safety of the public.

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

To Your Personal Representative. The Trust may disclose your health information to an individual who is considered to be your personal representative under applicable law.

To Individuals Involved in Your Care or Payment for Your Care. The Trust may disclose your health information to immediate family members, or to other individuals who are directly involved in your care or payment for your care.

To Business Associates. The Trust may disclose your health information to its Business Associates, which are entities or individuals not employed by the Trust, but which perform functions for the Trust involving protected health information, such as claims processing, utilization review, or legal, consulting, accounting or administrative services. The Trust's Business Associates are required to safeguard the confidentiality of your health information.

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

For Disclosure to the Plan Trustees. The Trust may disclose your health information to the Board of Trustees (which is the plan sponsor) and to necessary advisors for plan administration functions, such as those listed in this summary, or to handle claim appeals, solicit bids for services, or modify, amend or terminate the Plan. The Trust may also disclose information to the Trustees regarding whether you are participating or enrolled in the Plan.

Authorization to Use or Disclose Health Information

Other than as stated above, the Trust will not disclose your health information other than with your written authorization. Authorization forms are available from the Privacy Contact Person, listed below. If you have authorized the Trust to use or disclose your health information, you may

revoke that authorization in writing at any time. The revocation should be in writing, include a copy of or reference your authorization and be sent to the Privacy Contact Person, listed below.

Special rules apply to disclosure of psychotherapy notes. Your written authorization will generally be required before the Plan will use or disclose psychotherapy notes. Psychotherapy notes are separately filed notes about your observations with your mental health professional during a counseling session. They do not include summary information about your mental health treatment. The Plan may use and disclose such notes when needed to defend against litigation filed by you.

Your Rights with Respect to Your Health Information
You have the following rights regarding your health information that the Trust maintains:

Right to Request Restrictions. You may request restrictions on certain uses and disclosures of your health information. You have the right to request a limit on the Trust's disclosure of your health information to someone involved in the payment of your care. However, the Trust is not required to agree to your request. If you wish to request restrictions, please make the request in writing to the Trust's Privacy Contact Person listed below.

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

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

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

If the Trust denies a request for amendment, you may write a statement of disagreement. The Trust may write a rebuttal statement and provide you with a copy. If you write a statement of disagreement, then your request for amendment, your statement of disagreement, and the Trust's rebuttal will be included with any future release of the disputed health information.

Right to an Accounting. You have the right to request a list of disclosures of your health information made by the Trust. The request must be made in writing to the Privacy Contact Person listed below. The request should specify the time period for which you are requesting the

information, but may not start earlier than **April 14, 2003** when the Privacy Rules became effective. Accounting requests may not be made for periods of time going back more than six (6) years. An accounting will not include disclosure made to carry out treatment, payment, and health care operations; disclosures that were made to you; disclosures that were incident to a use or disclosure that is otherwise permitted by the Privacy Rules; disclosures made pursuant to an authorization; or in other limited situations. The Trust will provide the first accounting you request during any 12-month period without charge. Subsequent accounting requests may be subject to a reasonable cost-based fee. The Trust will inform you in advance of the fee, if applicable.

Right to a Paper Copy of this Notice. You have a right to request and receive a paper copy of this Notice at any time, even if you have received this Notice previously or agreed to receive the Notice electronically. To obtain a paper copy, please contact the Privacy Contact Person, listed below. You will also be able to obtain a copy of the current version of the Trust's Notice at its web site, ***www.psewtrusts.com.***

Right to Opt Out of Fundraising Communications. If the Trust participates in fund raising, you have the right to opt-out of all fund raising communications.

Privacy Contact Person. To exercise any of these rights related to your health information you should contact the Privacy Contact Person listed below. The Trust has also designated a Privacy Official, listed below.

Privacy Contact Person
Assistant Manager – Employee Benefits - Claims
Welfare & Pension Administration Service, Inc.
PO Box 34203
Seattle, WA 98124
Phone No: (206) 441-7574 or Toll Free: (800) 331-6158
Fax No: (206) 441-9110

Privacy Official
Manager – Employee Benefits - Claims
Welfare & Pension Administration Service, Inc.
PO Box 34203
Seattle, WA 98124
Phone No: (206) 441-7574 or Toll Free: (800) 331-6158
Fax No: (206) 441-9110

Duties of the Trust
The Trust is required by law to maintain the privacy of your health information as set forth in this Notice and to provide to you this Notice of its duties and privacy practices. The Trust is required to abide by the terms of this Notice, which may be amended from time to time. The Trust reserves the right to change the terms of this Notice and to make the new Notice provisions effective for all health information that it maintains. If the Trust changes its policies and procedures, the Trust will revise the Notice and will provide a copy of the revised Notice to you within 60 days of the change. You have the right to express complaints to the Trust and to the Secretary of the Department of Health and Human Services if you believe that your privacy rights have been violated. Any complaints to the Trust should be made in writing to the Privacy Contact Person identified above. The Trust encourages you to express any concerns you may have regarding the privacy of your health information. You will not be retaliated against in any way for filing a complaint.

The Trust is prohibited by law from using or disclosing genetic health information for underwriting purposes.

www.PSEWTrust.com

(206) 441-4667
(866) 314-4239

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