



JANUARY 2009

SOUNDPLUS PPO PLAN

A LABOR-MANAGEMENT BENEFIT PLAN
AND SUMMARY PLAN DESCRIPTION





January 14, 2011

To: Sound Health & Wellness Trust SoundPlus Plan Participants

From: Board of Trustees

Re: Plan Changes to Continue our Focus on Healthy Living, Enhanced Care and Controlling Costs

The Trust is continuing its commitment to encourage and reward healthy behaviors among our plan participants. A number of wellness programs are offered by the Trust which are designed to give employees and their families direct access to the medical expertise, information and personalized support they need to make better health decisions and enjoy healthier, happier lives. With healthier employees and families come lower medical costs, which allows us to continue offering excellent medical coverage. As a result, effective January 1, 2011, the following changes have been made to your SoundPlus Plan:

I. Healthcare Reimbursement Arrangement (HRA)

The Trust will continue to fund HRA accounts for eligible employees up to an annual maximum allowance of \$500 for a single employee and \$1,000 for a family subject to meeting certain requirements. For 2011, the funding will consist of the following:

- Automatic funding of \$150 for a single employee and \$300 for an employee with family coverage
plus
- \$350 for a single employee who has taken the Personal Health Assessment (PHA) during the available time period
or
\$350 for an employee and \$350 for a spouse or same sex domestic partner who have taken the PHA during the available time period
or
\$700 for an employee with only a child or children covered who has taken the PHA during the available time period.

How your HRA is used remains unchanged. Refer to your plan booklet.

II. Health Benefits

Effective with claims incurred on or after January 1, 2011, the following changes were made to your plan:

1. **Annual Net Deductible** will be as follows:

	In-Network	Out-of-Network
Employee only coverage	\$250	\$500
Family coverage	\$500	\$1,000

For family coverage, the deductible applies to the family as a whole.

Note: If you (and your enrolled spouse or same sex domestic partner) do not take your Personal Health Assessment (PHA) during the available time period, the above deductible amounts will increase by \$350 for employee only coverage and \$700 for family coverage.

2. **Out-of-Pocket Maximum** per calendar year will be as follows:

	In-Network	Out-of-Network
Employee only coverage	\$2,250	\$4,500
Family coverage	\$4,500	\$9,000

For employees with Family coverage, the "Employee Only coverage" maximum will apply to each covered individual until the "Family coverage" maximum is met.

Note: If you (and your enrolled spouse or same sex domestic partner) do not take your Personal Health Assessment (PHA) during the available time period, the above out-of-pocket maximums will increase by \$350 for employee only coverage and \$700 for family coverage.

3. The maximum number of **Naturopathic** visits will increase from 2 to a total of 5 per calendar year.
4. The maximum number of treatments by an **Acupuncturist** will increase from 5 to a total of 8 per calendar year.
5. The **Emergency Room** visit co-pay will be \$100.
6. The **Chiropractic** maximum benefit under the PPO plan will increase from \$20 to \$30 per visit.

7. **Prescription Drug** co-pays will be as follows:

	30 day supply	60 day supply	90 day supply
Tier 0	\$0	\$0	\$0
Tier 1	\$6	\$12	\$18
Tier 2	\$22	\$44	\$66
Tier 3	\$35	\$70	\$70
Brand if generic available	**	**	**

**Generic co-pay plus the difference in cost between the generic and the brand name drug

8. The **Employee Weekly Disability** (time loss) benefit will be as follows:

Hours Employed in Eligibility Determination Month	Maximum Weekly Benefit
Less than 80	\$0
80 but less than 120	\$180
120 but less than 150	\$240
150 or more	\$300

If you have any questions about these plan changes, please contact:

PPO Plan Participants – (206) 282-4500 or (800) 225-7620, option 2 then option 1

Group Health Plan Participants - 888-901-4636

Sound Health & Wellness Trust Eligible Dependent Children Definition

Effective April 1, 2011, the Plan is expanding the definition of eligible children to include some children up to age 26. Accordingly, the definition of eligible dependent children in your Summary Plan Description benefit plan booklet is revised to read as follows:

- I. Your eligible dependent children are your children under age 26 who are your:
- Natural children
 - Stepchildren
 - Adopted children
 - Children placed with you for adoption
 - Foster children

These children do not have to depend on you for support, do not have to attend school full time, and can be married.

A child is considered placed with you for adoption if you have a legal obligation for total or partial support in anticipation of adopting.

A foster child is one placed by an authorized placement agency or by judgment, decree, or other court order.

- II. Your eligible dependent children also include your unmarried children up to age 19 who are dependent on you for support and are:
- Children for whom you are legal guardian
 - Children for whom you have a legal obligation to support
 - Children of same sex domestic partners

In addition, these same dependent children, age 19 until their 24th birthday, who attend an accredited educational institution of higher learning on a full time basis (as defined by the institution) and otherwise meet the requirements in the three preceding bullets are also eligible. These children must be enrolled in both spring and fall quarters/semesters to continue coverage during the summer. You need to contact the Trust Office every three months to update full-time student status for these children between ages 19 and 24. An accredited educational institution of higher learning is one accredited by an organization recognized by the Council of Higher Education Accreditation and/or the U.S. Department of Education.

Children are considered dependent on you for support if claimed as dependents on your, your spouse's (or former spouse's) or your same sex domestic partner's federal income tax return.

- III. If your otherwise eligible unmarried dependent child reaches the applicable limiting age shown above in Section I or II while covered by this plan and is incapable of self-sustaining employment at that time because of mental or physical handicap, their coverage may be continued. You must provide proof of the incapacity and dependency to the Trust Office within 31 days after the child reaches the limiting age. You may be required to verify the incapacity and dependency from time to time.
- IV. For other than your natural children, you must provide the Trust Office with copies of court papers or other official court documents demonstrating your legal relationship with or obligation to support the child.

Under federal law, the plan also provides medical, dental and vision benefits to certain dependent children (called alternate recipients) if directed to do so by a Qualified Medical Child Support Order (QMCSO) issued by a court or state agency of competent jurisdiction. You and your dependents may obtain a copy of the plan's procedures for processing QMCSOs, without charge, from the Trust office.

Important: If you do not enroll your dependents when they are first eligible or within 60 days of their becoming your dependent, you must wait until the next open enrollment period to enroll your dependents. Also, if you do not notify the Trust Office within 60 days of a change in a dependent's status, they will lose their ability to elect COBRA coverage. In addition, any employee premium changes due to family status changes will be adjusted only from the date that the Trust Office is notified of the family status change.

MESSAGE TO ELIGIBLE EMPLOYEES

We are pleased to present this booklet describing the SoundPlus Plan health benefits available to you and your eligible dependents through the Retail Clerks Welfare Trust d.b.a. Sound Health & Wellness Trust.

This booklet applies to employees hired prior to October 1, 2004 and also to employees hired since October 1, 2004 if they have worked in covered employment for more than 35 consecutive months.

After reading the booklet carefully, contact the Trust Office if you have questions.

*Sincerely,
Board of Trustees*

EMPLOYER TRUSTEES	UNION TRUSTEES
Randy Zeiler	Diane Zahn
Derrick Anderson	David Blitzstein
Nathan Hyde	Mike Hatfield
Frank Jorgensen	David Schmitz
Scott Klitzke Powers	Michael J. Williams
Carl Wojciechowski	Brenda Willis

All questions about benefit interpretations should be referred to the Trust Office. **Telephone contact with the Trust Office does not guarantee eligibility for benefits or benefit payments. Though the Trust Office can provide you with general information on your plan or benefits, your eligibility for benefits and benefit payments will be determined only when a claim is submitted to the Trust.**

To keep your eligibility records accurate, notify the Trust Office in writing about any change in:

- ➔

Address
- ➔

Dependent status (birth, adoption, legal placement for adoption, death, marriage, legal separation, divorce, full-time student, child custody)
- ➔

Designated beneficiary

Submit any changes to the Trust Office on a new enrollment form.

The Trustees have full and exclusive authority, in their discretion, to interpret, construe and apply the terms and conditions of the benefits, Trust agreement, and all policies, procedures, actions and resolutions adopted in administering or operating the Trust or the Plan. They have the authority to remedy possible ambiguities, inconsistencies or omissions and to decide all plan questions. Trustee decisions are final and binding.

Only the full Board of Trustees is authorized to interpret the benefits described in this booklet. **No employer or local union—or representative of any employer or local union—is authorized to interpret this Plan or to act as an agent of the Board of Trustees to guarantee benefit payments.**

The Trust PPO medical, dental schedule and weekly disability benefits are self-funded and are paid in accordance with the rules and regulations of the direct payment plan which are contained in this booklet. Zenith Administrators provides the administration of these benefits.

The Trust Preferred Provider Organization (PPO) for medical benefits is the First Choice Health Network. For mental health and substance abuse services, Optum Behavioral Health is the PPO.

The Trust PPO prescription drug benefit is self-funded and administered by informedRx, an SXC Health Solutions Company (informedRx).

The Trust PPO vision care benefit is self-funded under an administrative services contract the Trust maintains with VSP.

The WDS Preferred dental coverage is self-funded and paid in accordance with the administrative services contract that the Trust maintains with Washington Dental Service (WDS).

DeltaCare dental coverage is fully insured under a policy which the Trust maintains with Washington Dental Service (WDS). Nothing in this booklet will alter the terms or conditions of the DeltaCare contract. Questions which arise concerning this benefit will be resolved by reference to the policy of insurance.

The life and accidental death or dismemberment benefits are fully insured under a policy which the Trust maintains with Metropolitan Life Insurance Company (MetLife). Nothing in this booklet alters the terms or conditions of the MetLife insurance policy. Questions which arise concerning the Life and Accidental Death or Dismemberment benefits are resolved by reference to the policy of insurance.

The Trust also uses other vendors to assist in administering the LiveWell health and wellness program.

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SUMMARY OF BENEFITS

See each benefit section for specifics about covered expenses as well as exclusions and limitations.

MEDICAL BENEFITS

LIVEWELL HEALTH REIMBURSEMENT ARRANGEMENT

**\$500 for employee only
\$1,000 for employee + family
(funded each January 1)**

ANNUAL DEDUCTIBLE

Preferred providers **\$150 for employee only coverage;
\$300 for family coverage**

Nonpreferred providers **\$300 for employee only coverage;
\$600 for family coverage**

REIMBURSEMENT PROVISIONS (COINSURANCE)

Preferred providers **85% after your annual HRA and deductible**

Nonpreferred providers **60% after your annual HRA and deductible**

ANNUAL OUT-OF-POCKET MAXIMUM


Includes only the annual deductible and participant coinsurance

Preferred providers **\$1,000 for employee only coverage;
\$2,000 for family coverage**

Nonpreferred providers **\$2,000 for employee only coverage;
\$4,000 for family coverage**

LIFETIME MAXIMUM

\$1,500,000/person

 *The LiveWell Nurse Line Plus, toll free at (877) 362-9969, is available 24 hours a day, 7 days a week, to help you find the information you need to make informed healthcare decisions.*

PRESCRIPTION DRUGS

COPAYS	30 DAY SUPPLY	60 DAY SUPPLY*	90 DAY SUPPLY*
Tier 0	\$0	\$0	\$0
Tier 1	\$5	\$10	\$15
Tier 2	\$20	\$40	\$60
Tier 3	\$30	\$60	\$60
Brand if generic available	Generic copay plus the difference in cost between the generic and the brand name drug		
Specialty Drugs	See page 54		



* Maintenance only; maintenance drugs in excess of a 30-day supply must be purchased through informedMail or through a pharmacy in the custom network which provides special discounts (see page 57).

VISION CARE

See page 61

DENTAL CARE

Choice of 3 options	<ul style="list-style-type: none">• WDS Preferred: see page 66• DeltaCare: see page 81• Dental Schedule: see page 82
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EMPLOYEE LIFE INSURANCE

\$15,000

DEPENDENT LIFE INSURANCE

\$1,000

EMPLOYEE ACCIDENTAL DEATH OR DISMEMBERMENT

\$15,000

EMPLOYEE WEEKLY DISABILITY (TIME LOSS)

See page 105

ELIGIBILITY

You may become eligible under this plan if:

- ➔ *You were hired before October 1, 2004 (or have more than 35 consecutive months of employment),*
- ➔ *You are in a collective bargaining unit (or participate through a special agreement),*
- ➔ *You work for an employer participating in the Trust, and*
- ➔ *You pay the required weekly employee premiums.*

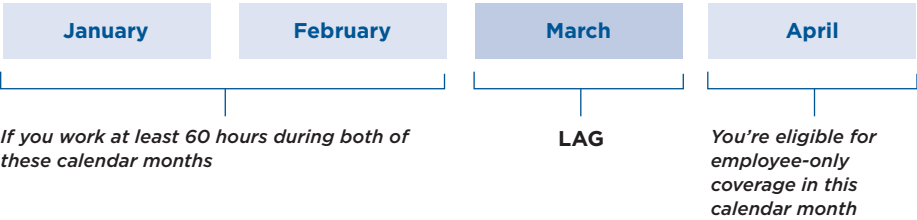
INITIAL EMPLOYEE ELIGIBILITY (ALL BENEFITS EXCEPT DENTAL)

Employee-Only Coverage

You become eligible for employee-only coverage on the first day of the second calendar month after completing two consecutive calendar months of employment if:

- ➔ *You worked at least 60 hours of covered employment in each of these two consecutive months,*
- ➔ *Your employer makes the required contributions for each of these two months, and*
- ➔ *You pay the required weekly employee premiums.*

Example:



If you’re eligible for employee-only coverage, you can choose medical/prescription drug/vision benefits under the Trust PPO or the Group Health Options, Inc. plan.

Family Coverage

You become eligible for family coverage on the first day of the second calendar month after completing two consecutive calendar months of employment if:

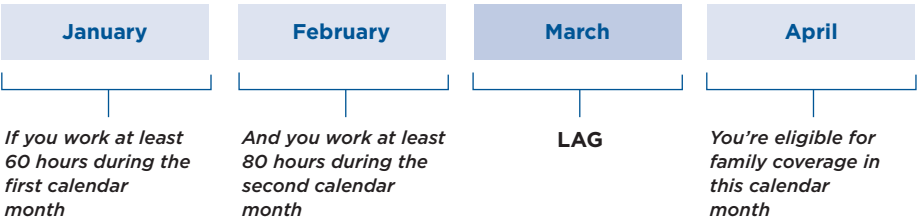
- You worked at least 60 hours of covered employment in the first of these two consecutive months,

→ You worked at least 80 hours of covered employment in the second of these two months,

→ Your employer pays the required contributions for each of these two months, and

→ You pay the required weekly employee premiums (for family coverage).

Example:



As an employee eligible for family coverage, you can choose medical/prescription drug/vision benefits for your family under the Trust PPO or the Group Health Options, Inc. plan.

INITIAL EMPLOYEE ELIGIBILITY (DENTAL BENEFITS)

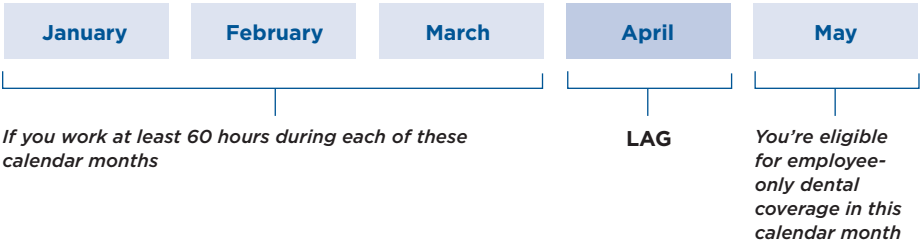
Employee-Only Coverage

You become eligible for employee-only dental coverage on the first day of the second calendar month after completing three consecutive calendar months of employment if:

- You worked at least 60 hours of covered employment in each of these three months,

- ➔ *Your employer makes the required contributions for each of these three months, and*
- ➔ *You pay the required weekly employee premiums.*

Example:



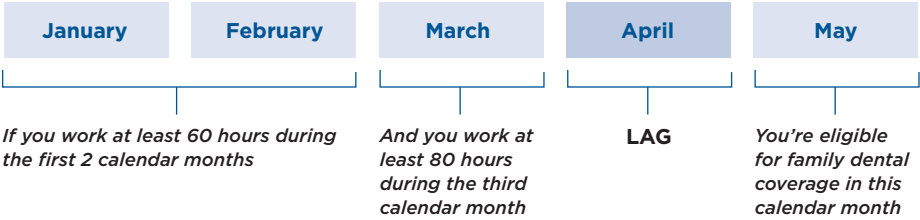
If you're eligible for employee-only dental coverage, you can choose coverage under the WDS Preferred, DeltaCare or Dental Schedule options.

Family Coverage

You become eligible for family dental coverage on the first day of the second calendar month after completing three consecutive calendar months if:

- ➔ *You worked at least 60 hours of covered employment in the first and second of these three consecutive months,*
- ➔ *You worked at least 80 hours of covered employment in the last of these three months,*
- ➔ *Your employer pays the required contributions for each of these three months, and*
- ➔ *You pay the required weekly employee premiums (for family coverage).*

Example:



As an employee eligible for family dental coverage, you can choose coverage for your family under the WDS Preferred, DeltaCare or Dental Schedule options.

CONTINUATION OF ELIGIBILITY

Employee-Only Coverage

Once you become eligible for employee-only coverage, you continue that eligibility on a monthly basis, as long as:

- ➔ *You work at least 60 hours of covered employment in each calendar month,*
- ➔ *The required employer contributions are paid, and*
- ➔ *You pay the required weekly employee premiums.*

This makes you eligible for employee-only coverage on the first day of the second month following the month in which at least 60 hours were worked and the required employer contributions and weekly employee premiums were paid.

If you began work in a covered position with a participating employer before August 1, 1980, you continue to be eligible for employee-only coverage on a monthly basis, as long as:

- ➔ *You work at least 40 hours in each month,*
- ➔ *The required employer contributions are paid, and*
- ➔ *You pay the required weekly employee premiums.*

Family Coverage

Once you attain initial eligibility for and elect family coverage, and enroll any covered dependents, you continue to be eligible for family coverage on a monthly basis, as long as:

- ➔ *You work at least 80 hours of covered employment in each calendar month,*
- ➔ *The required employer contributions are paid, and*
- ➔ *You pay the required weekly employee premiums (for family coverage).*

This makes you eligible for family coverage on the first day of the second month following the month in which at least 80 hours were worked and the required employer contributions and weekly employee premiums were paid.

WHEN ELIGIBILITY ENDS

Employee-Only Coverage

Your eligibility ends on the earlier of:

- ➔ *The last day of the calendar month following the calendar month in which you do not work at least 60 hours of covered employment, or*
- ➔ *The last day of the calendar month in which your employment terminates.*

Example:

If you had worked at least 60 hours of covered employment in March and then you don't work at least 60 hours of covered employment in April, your eligibility ends May 31.

If you had worked at least 60 hours of covered employment in March and then your employment terminates in April, your eligibility ends April 30.

If you began work in a covered position with a participating employer before August 1, 1980, and you continued to have at least one hour of covered employment reported each month, your eligibility ends on the last day of the month when you do not work at least 40 hours of covered employment.

Family Coverage

Your eligibility ends on the earlier of:

- ➔ *The last day of the calendar month following the calendar month in which you do not work at least 80 hours of covered employment, or*
- ➔ *The last day of the calendar month in which your employment terminates.*

Example:

If you had worked at least 80 hours of covered employment in March and then you don't work at least 80 hours of covered employment in April, your family coverage eligibility ends May 31.

If you had worked at least 80 hours of covered employment in March and then your employment terminates in April, your family coverage eligibility ends April 30.

However, if you work between 60 and 80 hours, you keep employee-only coverage.

REINSTATEMENT OF ELIGIBILITY

Employee-Only Coverage

If you lose eligibility under the plan, you become eligible again for employee-only coverage on the first of any calendar month if:

- ➔ *You worked at least 60 hours of covered employment in the second preceding calendar month for which your employer paid the required contributions,*
- ➔ *You were eligible during any of the six consecutive preceding calendar months, and*
- ➔ *You pay the required weekly employee premiums.*

Example:

Suppose your eligibility for employee-only coverage ends on May 31. You resume covered employment with the same employer and work at least 60 hours in July. Your eligibility for employee-only coverage is reinstated for September because you were eligible during one of the six consecutive preceding calendar months with the same employer (with no quit or discharge).

If you began work in a covered position with a participating employer before August 1, 1980, your eligibility is reinstated as described above except 40 instead of 60 hours of covered employment are required. However, if you fail to have at least one hour of covered employment in a month, fail to make COBRA payments for medical benefits or you do not pay the required weekly employee premiums, you’re required to work at least 60 hours in a month to reinstate eligibility for employee-only coverage when you return to covered employment. You must also then continue to work at least 60 hours in a month going forward in order to maintain employee-only coverage.

Family Coverage

If you lose eligibility under the plan, you become eligible again for family coverage on the first of any calendar month if:

- ➔ *You worked at least 80 hours of covered employment in the second preceding calendar month for which your employer paid the required contributions,*

- ➔ *You were eligible during any of the six consecutive preceding calendar months, and*
- ➔ *You pay the required weekly employee premiums (for family coverage).*

Example:

Suppose your eligibility for family coverage ends on May 31. You resume covered employment with the same employer and work at least 80 hours in July. Your eligibility for family coverage is reinstated for September because you were eligible during one of the six consecutive preceding calendar months with the same employer (with no quit or discharge).



Note: *If coverage terminates as the result of uniformed (military) service and you retain reemployment rights, coverage is reinstated without waiting periods, according to federal law. See Military Service Under USERRA (page 18) for more information.*

Employment Between Participating Employers

If you are eligible under this plan and you change employment from one participating employer to another or you transfer from one bargaining unit to another within the same Trust geographic area, you become eligible again for SoundPlus Plan coverage on the first day of the second calendar month if:

- ➔ *You start working for the new participating employer within 30 days, or*
- ➔ *You lose your job because of a store closure and start working for another participating employer within 60 days.*
- ➔ *You pay any required weekly employee contributions.*

ELIGIBLE DEPENDENTS

If you work 80 or more hours in a calendar month and meet all other eligibility rules, your dependents are eligible for coverage on the same date you become eligible, provided you elect family coverage, enroll your dependents, and pay the required weekly employee premiums for family coverage. Eligible dependents must be enrolled with the Trust Office before their benefits begin.

Your eligible dependents include:

- ➔ *Your lawful spouse, if you're not divorced or legally separated.*
- ➔ *Your same sex domestic partner – contact the Trust Office for the necessary forms.*

- ➔ *Your unmarried children under age 19 who depend on you for support, including natural children, stepchildren, adopted children, children placed with you for adoption, children of same sex domestic partners, children for whom you're legal guardian and those you have a legal obligation to support.*
- ➔ *A child is considered placed with you for adoption if you have a legal obligation for total or partial support in anticipation of adopting. Children are considered dependent on you for support if claimed as dependents on your or your spouse's (or former spouse's) federal tax return. For other than natural children, you must provide the Trust Office copies of court papers or other official court documents demonstrating your legal relationship with or obligation to support the child.*
- ➔ *Your unmarried dependent children, age 19 until their 24th birthday, who attend a full-time (as defined by the institution) accredited educational institution of higher learning and otherwise meet the requirements in the preceding bullet. Your dependent child must be enrolled in both spring and fall quarters/semesters to continue coverage during the summer. You need to contact the Trust Office every three months to update full-time student status for your dependent children between ages 19 and 24.*

An accredited educational institution of higher learning is one accredited by an organization recognized by the Council of Higher Education Accreditation and/or the U.S. Department of Education.

- ➔ *Your unmarried dependent children who reach age 19 (or 24 if an eligible student) while covered by this plan and are incapable of self-sustaining employment because of mental or physical handicap.*
- You must provide proof of the incapacity and dependency to the Trust Office within 31 days after the child reaches age 19 (or 24 if an eligible student). You may be required to verify the incapacity and dependency from time to time.*

If you acquire dependents while eligible, their eligibility begins as follows, providing you notify the Trust Office within 60 days of the event:

- ➔ *Your spouse: on the first of the month after your date of marriage.*
- ➔ *A child: on the first of the month after the date the child becomes a newly acquired dependent. However, a newborn natural child is covered from birth, and a newborn adopted child is covered as of the date you take physical custody, if earlier than the adoption date.*

- ➔ *Your same sex domestic partner: on the first of the month after the Trust Office receives the completed forms verifying the domestic partnership.*

Enrollment is retroactive (within the 60-day period) to the date the dependent first became eligible, provided you elect family coverage, enroll the dependents with the Trust Office (within the 60-day period) and make the required weekly employee premiums (for family coverage).

! *Note: If you have eligible dependents, please notify the Trust Office within 60 days of any change in family status – marriage, birth, adoption or legal placement for adoption, marriage of any child, their 19th birthday (24th birthday for dependent students), death of any dependent, divorce, legal separation or termination of domestic partnership. A new enrollment form for this purpose is available from the Trust Office.*

Important: If you do not enroll your dependents when you are first eligible or within 60 days of their becoming your dependent, you must wait until the next open enrollment period to enroll your dependents. Also, if you do not notify the Trust Office within 60 days of a change in a dependent's status (e.g., full-time student or divorce), they will lose their ability to elect COBRA coverage. In addition, any employee premium changes due to family status changes will be adjusted only from the date that the Trust Office is notified of the family status change.

Under federal law, the plan also provides medical, dental and vision benefits to certain dependent children (called alternate recipients) if directed to do so by a Qualified Medical Child Support Order (QMCSO) issued by a court or state agency of competent jurisdiction. You and your dependents may obtain a copy of the plan's procedures for processing QMCSOs, without charge, from the Trust Office.

ELIGIBILITY WHEN DISABLED (“PREMIUM WAIVERS”)

If you stop working because of an illness or injury and fail to qualify for coverage in any month due to that disability, you may continue the same coverage as before your disability by having your reported hours requirement waived for up to three consecutive months if you:

- ➔ *Are disabled by a physician within four days of the last day worked,*
- ➔ *Are under the personal and regular care of a physician or other covered provider,*
- ➔ *Remain **continuously disabled** (in this section, continuously disabled means unable to work in the industry and not engaged in any other occupation for wage or profit; this determination is made by the Board of Trustees at their sole discretion), and*

- ➔ *Work sufficient hours prior to becoming disabled so that you have eligibility in the month prior to your first waiver month.*

Please note, qualification under the Family and Medical Leave Act (FMLA) is not an automatic qualification for eligibility under this provision.

However, if you work under a “light-duty” restriction prescribed by your physician, as a result of a work-related injury or illness covered under state workers’ compensation, a special rule applies:

- ➔ *If the “light-duty” restriction prevents you from earning enough hours to establish eligibility, you continue to be covered for up to three consecutive months. Under no circumstances will you receive more than three consecutive months of eligibility for that disabling condition.*

Successive disability periods separated by less than two weeks of active work are considered a single disability period *unless* the subsequent disability:

- ➔ *Is due to an entirely unrelated injury or sickness, and*
- ➔ *Begins after return to the full-time duties of your regular occupation for at least one day.*

Under no circumstances will you receive more than three months of eligibility for any disabling condition until you reestablish employer-paid eligibility.

If this is an employer approved Family and Medical Leave Act leave (see page 19), the maximum time of COBRA coverage (see page 20) is reduced by any months you’re covered under this disability provision.

A completed weekly disability (time loss) claim form, as described on page 105, must be submitted to the Trust Office to claim eligibility under this provision. Contact the Trust Office for more details.

MILITARY SERVICE UNDER USERRA

If you leave covered employment to perform certain United States military service, you and your enrolled dependents may have the right to continue your medical, dental and vision coverage:

- ➔ *Less than 31 days of military service (e.g., active duty for training): the plan continues to cover you and your dependents.*

- ➔ *31 days of military service or longer: you and your dependents are eligible to continue coverage for up to 24 months through COBRA; see COBRA Coverage on page 20.*

When you return, your regular coverage begins immediately if you meet the requirements summarized below.

Under the Uniformed Services Employment and Reemployment Rights Act (USERRA), you must notify your employer before taking leave (unless prevented by military necessity or other reasonable cause) and should tell your employer how long you expect to be gone. When you're released from military duty, you must apply for reemployment:

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

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



Note: *These rules also apply to uniformed service in the commissioned corps of the Public Health Service.*

To ensure proper crediting of service under USERRA, be sure to let the Trust Office know how long you expect to be gone and notify them when you apply for reemployment after your leave. Please call the Trust Office for more details on coverage under USERRA.

MEDICAL OR FAMILY LEAVE OF ABSENCE

Federal law may apply to family and medical leaves when you work for an employer with 50 or more employees within a 75-mile radius. To be eligible, you must have worked for your current employer for at least 12 months and for at least 1,250 hours in the 12 months before your leave.

Your current medical, dental and vision benefits continue while you're on certain types of family or medical leave, if your employer makes the required contributions. You and your dependents may be entitled to coverage for up to 12 work weeks during a 12-month period if you're on leave due to:

- ➔ *Birth of a child*
- ➔ *Placement of a child for adoption or foster care*

- ➔ *Serious health condition of a child, spouse or parent*
- ➔ *Your own serious health condition that makes you unable to perform the essential functions of your job*

If you think you may be eligible for a family or medical leave, contact your employer immediately. Your employer must make arrangements with the Trust Office to continue your coverage. (The Trust does not administer leave under the Family and Medical Leave Act or determine eligibility for FMLA leave. The Trust only assists employers in complying with the law by providing benefits when you qualify for FMLA leave.)

If you advise your employer that you’re not returning or if you do not return after your family or medical leave, coverage for all plan benefits ends. You and your dependents then may elect COBRA coverage (see below). Contact the Trust Office for more details.

COBRA COVERAGE

Health Benefits

If you or your eligible dependents do not qualify for coverage in any month, you may continue some or all of the benefits lost by making COBRA payments to the Trust, as described below.

Under COBRA payment rules, you may choose from the following options if you had the benefits in the month immediately before you lost coverage:

- ➔ *Medical only*
- ➔ *Medical, vision*
- ➔ *Medical, vision, dental*
- ➔ *Dental only*

Once you elect an option, you may not change it until the next open enrollment period unless you have a change in family status.

You and/or your dependents have a right to continue coverage under any of these options for up to 18 months if you lose coverage because of a reduction in hours or termination of employment.

If Social Security determines you (or a dependent) are disabled when you lose coverage, or are disabled during the first 60 days of COBRA coverage, the disabled individual and other family members who elect COBRA coverage may continue coverage for up to 29 months. If when you lose active coverage you’ve received a Social Security Disability Award, you must provide a copy when you elect COBRA coverage.

Your dependents may choose COBRA coverage for up to 36 months if coverage is lost for any of these reasons:

- ➔ *Your death*
- ➔ *Divorce or legal separation from you*
- ➔ *Termination of your same sex domestic partnership*
- ➔ *You become entitled to Medicare during a period of COBRA coverage*
- ➔ *You elect Medicare as your primary coverage when you're an active employee*
- ➔ *Your dependent no longer meets the definition of an eligible dependent*

If any of these events occurs after you lose eligibility due to reduction in hours or termination of employment, the 18-month continuation period can be extended to a total of 36 months from the first event for the effected dependent.

The maximum time you may make COBRA payments is reduced by any months you're covered under the plan's provisions for Eligibility When Disabled (see page 17).

Life, Accidental Death or Dismemberment and Weekly Disability Benefits

The member may continue these benefits through COBRA for a maximum of six months. They are available only if you were eligible for these benefits when you lost coverage and you elect COBRA for medical benefits at the same time.

Other COBRA Provisions

- ➔ *Once elected, COBRA coverage may be terminated for any of these reasons:*
 - *The Trust no longer provides health coverage to any employees*
 - *The required premium for your COBRA coverage is not paid within 30 days of the first of the month for which the payment applies*
 - *You or your dependents become covered under another group health plan (unless the other plan limits coverage for a preexisting health condition, and the preexisting condition exclusion/limit applies to that individual)*
 - *You or your dependents become entitled to Medicare*

- ➔ *You or a family member has the responsibility to inform the Trust Office of a death, divorce, legal separation, termination of a same sex domestic partnership or a child losing dependent status within 60 days of the event, including a copy of any legal documents verifying the change in status. To extend coverage from 18 to 29 months due to a disability, you or your eligible dependent must notify the Trust Office in writing during the initial 18-month continuation period, including a copy of the Social Security determination letter (within 60 days of the letter's date). Dependents who lose active coverage and receive a Social Security Disability Award must provide a copy when they elect COBRA.*
- ➔ *Your employer has the responsibility to notify the Trust Office when your hours are reduced or your employment terminates.*
- ➔ *The COBRA coverage enrollment form must be returned to the Trust Office within 60 days of the information letter being mailed from the Trust Office. Initial payment must:*
 - *Include all months not covered by employer-paid contributions*
 - *Be received within 45 days of the Trust Office receiving your enrollment form*
- ➔ *If the enrollment form is not returned or payments are not made within these timelines, COBRA coverage is not available.*
- ➔ *The amount of the payment is subject to change.*
- ➔ *If you gain a dependent while participating in COBRA coverage, the usual rules for enrolling new dependents apply. To cover new dependents, you must elect family coverage and make the required monthly payments, if eligible for family coverage.*
- ➔ *To protect your family's COBRA rights, you should keep the Trust Office informed of any changes in the addresses of family members.*

Contact the Trust Office for more details about available options and associated costs.

WHEN COVERAGE ENDS

Employees

Your coverage ends on the earliest of these dates:

- ➔ *Last day of the month in which your employment terminated*
- ➔ *Last day of the month following the month in which you did not work the required number of hours or for which the required contributions were not paid*
- ➔ *Last day of the month you begin active duty with the armed services of any country if the active duty is to exceed 30 days (see Military Service Under USERRA, page 18, for details)*
- ➔ *The date this plan is discontinued, in whole or in part*
- ➔ *Last day of the month in which your employer ceases to be a participating employer*
- ➔ *Last day of the month in which the collective bargaining agreement is terminated*

Dependents

Coverage for your dependents automatically ends on the earliest of these dates:

- ➔ *The date your coverage ends*
- ➔ *Last day of the month a dependent child reaches age 19 (or 24 for unmarried dependent children who continue their education at an accredited institution) or marries, whichever is earlier*
- ➔ *Last day of the month a dependent enters active duty with the armed services of any country if the active duty is to exceed 30 days*
- ➔ *For your spouse, the last day of the month in which you are divorced or legally separated*
- ➔ *For your same sex domestic partner, the last day of the month in which the domestic partnership is terminated*
- ➔ *For a stepchild, the last day of the month in which you are divorced, legally separated or your same sex domestic partnership is terminated and you have no legal financial obligation to support the stepchild*
- ➔ *Last day of the month in which you did not work enough hours for family coverage or did not pay the required family premiums*
- ➔ *Last day of the month when a dependent no longer qualifies as eligible (see page 15 for dependent eligibility details)*

CERTIFICATE OF CREDITABLE COVERAGE

If your coverage under this plan ends and you become eligible for a new health plan, the time you were covered under this plan may be used to reduce the length of any preexisting condition exclusion period in your new plan or may eliminate certain penalties for late enrollment in Medicare.

When your coverage ends, either as an active employee (or dependent) or under COBRA coverage, you'll receive a certificate of creditable coverage containing information your new plan may need.

Check with your new plan's administrator to verify whether the new plan limits coverage for preexisting conditions and how creditable coverage is applied. If your new plan has a preexisting condition limit, present the certificate to your new plan so the administrator knows to apply creditable coverage under this plan to the preexisting limit period under your new plan.

Contact the Trust Office if you need a certificate of creditable coverage.

ENROLLING IN THE SOUNDPLUS PLAN

When you first become eligible for the SoundPlus Plan benefits, you must complete an enrollment form and submit it to the Trust Office. At that time you will have the following enrollment option:

➔ *Medical, prescription drug and vision coverage under the Trust PPO plan or Group Health Options plan. **If you currently have coverage through Group Health Options and do not complete an enrollment form, you will continue to have coverage in the Group Health Options (GHO) plan.***

The coverage option (employee-only, family or opt out) as well as the dental option (WDS Preferred, DeltaCare or Dental Schedule) you had under the Sound Plan will continue until the next annual open enrollment.

MAKING CHANGES

Annual Open Enrollment

An open enrollment will be conducted once each year, usually in the fall, for eligible employees who want to change their current plans or add/delete dependents. Changes made during open enrollment become effective January 1. **If you do not make changes during open enrollment, your current coverages will carry over to the next year; you will not be able to make changes until the next open enrollment.**

Changes in Family Status

If you have a change in family status during the year (such as marriage, divorce, legal separation, starting or terminating a same sex domestic partnership, birth or adoption of a child or death of any dependent) or lose coverage under your spouse's or same sex domestic partner's plan, you will be allowed to revise your family coverage option, provided you notify the Trust Office within 60 days of the change.

If you are enrolled in the Group Health Options medical plan or the DeltaCare dental plan and change your residence such that you move out of the Group Health Options or DeltaCare service area, you can request that you and your enrolled dependents change medical or dental plans. Your new plan will be effective on the first day of the calendar month following the month that the Trust Office receives your new enrollment form.

To make changes to your coverage, obtain a new enrollment form and return it to the Trust Office with appropriate documents. Forms are available from the Trust Office or local union.

SPOUSE OR SAME SEX DOMESTIC PARTNER MEDICAL COVERAGE

If your spouse's or same sex domestic partner's employer offers medical coverage and they are not enrolled in their employer's medical plan, covering your spouse or partner under the Trust PPO plan or Group Health Options plan will cost you an additional monthly premium. You will receive coupons from the Trust Office to make these monthly payments to the Trust Office. If you fail to make the required premium payment by the due date, your spouse or partner will be dropped from your coverage and will not be able to be added again until the next open enrollment, unless you have a change in family status (as noted in the previous section).



Note: *You will not be charged the additional premium if your spouse or partner is not eligible for other coverage through their employer's health plan.*

MEDICAL BENEFITS

As an enrollee in the SoundPlus PPO plan, the benefits described in this section apply to you whether you use a PPO or non-PPO provider.

PREFERRED (PPO) PROVIDERS

The Trust has Preferred Provider Organization (PPO) arrangements with the First Choice Health Network (FCHN) for medical services and Optum Behavioral Health (Optum) for mental health and substance abuse services. These networks of hospitals, physicians and other healthcare professionals agree to provide eligible employees and dependents with efficient, cost-effective services and supplies at discounted rates.

Providers not in the networks are called non-PPO providers. Non-PPO providers and First Choice providers used for mental health and substance abuse services are reimbursed at a lower level of benefits and charges are allowed only up to usual, customary and reasonable (UCR) fees.

Although you may see any provider covered by the plan, you receive higher benefits if you use PPO providers – the choice is yours, each time you use your benefits. Please note that not all First Choice or Optum PPO providers are covered providers under this plan; see the definition of covered provider on page 119.

PPO providers have agreed to:

- ➔

Bill the Trust Office directly, without any payment up front from you
- ➔

Recognize the plan’s contracted fee levels instead of usual, customary and reasonable (UCR) rates, saving you out-of-pocket money

Call the First Choice network directly at (800) 231-6935 or visit their website at www.fchn.com for a list of current medical PPO providers. For mental health or substance abuse providers, call Optum at (866) 763-0466 or visit their website at www.liveandworkwell.com. You should also ask your provider if they are in these networks.

HEALTH REIMBURSEMENT ARRANGEMENT (HRA)

Each January 1 the Plan will fund an HRA account for each eligible employee, based on your level of coverage:

- ➔ *Employee Only Coverage: \$500*
- ➔ *Family Coverage: \$1,000*

This account will be used to pay for covered medical expenses up to the HRA funding level. The HRA will pay the first \$500 (or \$1,000 per family) of covered medical expenses each year before your annual medical deductible is applied. If funds are remaining after the first \$500 (or \$1,000 per family) because of HRA amounts rolled over from a prior year, those remaining funds will be used to cover:

- ➔ *Amounts charged in excess of the plan's maximum allowed dollar amount for covered medical services, within usual, customary and reasonable levels*
- ➔ *Medical deductible and coinsurance amounts*

The HRA cannot be used for prescription drug, dental and vision benefits.

Your HRA account will also not be used to cover in-network preventive services. Preventive services, such as annual physical exams, routine immunizations and screenings are covered at 100% when provided by an in-network provider.

Unused amounts in the HRA at the end of the calendar year may be carried over (rollover) to the following year. The amount that carries over will be calculated based on if an employee first became eligible under the plan in that year and the amounts paid from the HRA in that year. The reduction for eligibility shall be 0% for enrollment in the first quarter, 25% in the second quarter, 50% in the third quarter and 75% in the fourth quarter. For example, if an employee became eligible for employee only coverage on July 1, 2008, they received the \$500 HRA funding for the 2008 calendar year. Because the employee became eligible in the third quarter, the maximum prorated rollover amount would be \$250 (50% of \$500). By December 31, 2008 the employee used \$350 of their HRA, leaving a 2008 balance of \$150. The pro-rated rollover to 2009 will be \$150, the lesser of the pro-rated \$250 and the \$150 remaining 2008 balance.

Once you have received \$500 (\$1,000 family) of non-preventive covered services in a calendar year (or the adjusted amount for partial year participants), you are then subject to the annual medical deductibles and coinsurance percentages described below.

DEDUCTIBLE

	PPO PROVIDERS	NON-PPO* PROVIDERS
Employee only coverage per calendar year	\$150	\$300
Family coverage per calendar year	\$300	\$600



** If you (or your family) use a combination of PPO and non-PPO providers during the year, your annual deductible will not exceed this amount.*

The deductible is the amount of covered medical expenses you and your dependents must pay each calendar year before the plan begins to pay benefits. This deductible coordinates with your HRA and is applied *after* your first \$500 (\$1,000 family) of covered medical expenses each year that are paid from your HRA. Once the family deductible is met, no further deductible amounts are required for any family member for the rest of that year. Non-covered charges do not apply to the deductible.

REIMBURSEMENT PROVISIONS (COINSURANCE)

Once you have met the deductible, the plan covers 85% of PPO provider charges for covered services or 60% of non-PPO providers' UCR charges for covered services.

PPO providers	85%
Non-PPO providers	60%

OUT-OF-POCKET MAXIMUM

	PPO PROVIDERS	NON-PPO* PROVIDERS
Employee only coverage per calendar year	\$1,000	\$2,000
Family coverage per calendar year	\$2,000	\$4,000



** If you (or your family) use a combination of PPO and non-PPO providers during the year, your annual out-of-pocket maximum will not exceed this amount.*

After you or your family reach the annual out-of-pocket maximum, the plan pays 100% for most covered services for the rest of that year.

Only the annual deductible and the participant's coinsurance amounts apply to the out-of-pocket maximum; benefits which exceed plan limits do not apply.

LIFETIME MAXIMUM

The lifetime maximum benefit for each covered person is \$1,500,000. You may apply for reinstatement to the full maximum by furnishing satisfactory evidence that you no longer have any health conditions which require treatment.

HEALTH & WELLNESS PROGRAM: LIVEWELL

Sound Health & Wellness Trust has introduced an extensive health and wellness program called LiveWell, designed to help you live a healthier life, prevent illness and make informed decisions about your healthcare. The components of LiveWell are:

LiveWell Personal Health Assessment (PHA)

Each year, there will be a limited period of time when you or your eligible spouse or same sex domestic partner can take a confidential Personal Health Assessment and receive an incentive. This confidential questionnaire can be taken either online at www.soundhealthwellness.com or on paper by contacting the LiveWell Nurse Line Plus at (877) 362-9969. The PHA will give you a snapshot of your current health status along with information and recommendations for how to get and stay healthy. Your responses to the questions are completely confidential, protected by federal law, and cannot be shared with anyone (including the Trust or your employer) without your permission.

Information you report on the LiveWell PHA may qualify you for the LiveWell Health Coaching or Condition Management programs.

Free Self Care Guide

A free book is available to help you find out what you can do to care for yourself at home, and when it's time to call your doctor. *CareWise® Guide: Self Care from Head to Toe* is a valuable resource to help answer your questions and common medical concerns. Call the Trust Office or email selfcareguide@soundhealthwellness.com to request a copy.

LiveWell Health Coaching

Based on results of your PHA, you may be invited to participate in the LiveWell Health Coaching program. The LiveWell Health Coaching program is a phone-based health education program designed to help you set and meet goals to improve your health and well-being. Your health coach will provide you with educational materials, guidance, and the support you need to begin to make healthy lifestyle changes.

LiveWell Prevention @ 100%

In-network, preventive care is now completely covered – with no deductibles, coinsurance or copays.

LiveWell Nurse Line Plus

24 hours a day, 7 days a week, you can call toll free (877) 362-9969 and knowledgeable registered nurses will confidentially help you find the information you need to make informed decisions. Unlike traditional nurse lines, nurses are available to answer your health-related questions:

- ➔ *Resolve health concerns*
- ➔ *Navigate the healthcare system*
- ➔ *Learn how to care for yourself at home*
- ➔ *Get guidance about medical procedures*
- ➔ *Find a healthcare provider*
- ➔ *Receive healthy living resources*

Health Reimbursement Arrangement (HRA)

This program is summarized in detail on page 28.

LiveWell Tier 0 Prescription Drugs

Certain lower-cost medications have been proven to be as safe and effective as more expensive drugs for many people. The plan has implemented a \$0 copayment tier for some of these medications. For up to date information on drugs in this category go to the Sound Health & Wellness Trust website at www.soundhealthwellness.com.

LiveWell Condition Management

Custom-tailored services are available for participants with chronic conditions such as diabetes, heart disease, asthma and other pulmonary diseases. Program participants can work one-on-one with a personal nurse advocate to improve both their health and their quality of life. You may be contacted for enrollment in the program or you can call (877) 362-9969 anytime to enroll in a Condition Management program or ask questions.

LiveWell Online

From the secure site on the Sound Health & Wellness Trust's web site (www.soundhealthwellness.com), participants can access LiveWell Online, a special health and wellness site where you can find health information, tools and resources to help you create positive lifestyle changes.

LiveWell Quit For Life®

The LiveWell Quit For Life® Program is operated by Free & Clear® to help participants quit tobacco. Participants will receive step-by-step tools

and personalized telephone treatment sessions with a Quit Coach® and free nicotine patches or gum, if recommended by the coach. Bupropion is also covered under the Prescription Drug benefit when prescribed by your physician.

Call 1.866.QUIT.4.LIFE (866.784.8454) to enroll in the program.

INDIVIDUAL CASE MANAGEMENT (ICM)

The plan has contracted with First Choice Health and Optum Behavioral Health to provide case management services in certain healthcare treatment situations. Representatives of First Choice Health will work cooperatively with you and your physician to consider effective alternatives to medical or surgical hospitalizations and other high cost care to make the most efficient use of the plan's benefits. Optum will assist in alternatives to mental health or substance abuse (behavioral health) hospitalizations and other higher cost care. The purpose of these services is to help ensure that you receive appropriate and cost effective care and to provide assistance in navigating the health system if you have a catastrophic medical or behavioral health condition. This is a voluntary program.

The plan, through Individual Case Management, may offer alternatives to long-term care at a hospital or skilled nursing facility. ICM will not provide alternative benefits in facilities that are not licensed or do not have appropriate medical supervision. The details are:

- ➔ *Acceptance of these alternatives is voluntary. The employee, or person legally qualified and authorized to act for the employee, will be required to sign a written consent which sets forth terms under which the benefits will be provided.*
- ➔ *The plan's decision to offer alternative benefits is made individually for each patient, subject to the terms set forth in the written consent. Any such decision shall not be construed to alter or change all other provisions of the plan, nor shall it be construed as a waiver of the Trust's right to administer the plan in strict accordance of its terms in other situations.*
- ➔ *These alternatives are not to cover anyone who has simply exhausted their benefits.*
- ➔ *The plan may cease to allow alternative benefits at any time at the Trust's sole discretion by sending written notice to the employee.*
- ➔ *For more information, call First Choice at (206) 268-2910 or (800) 843-5127 for medical or surgical cases.*
- ➔ *Call Optum at (866) 763-0466 for behavioral health case management.*

COVERAGE REQUIRING PREAUTHORIZATION

You must obtain preauthorization for all inpatient admissions and certain services as described in this section.

Preauthorization is required from First Choice for inpatient medical/surgical admissions and Optum Behavioral Health for inpatient mental health or substance abuse admissions to determine medical necessity. In addition, you should contact the Trust Office to confirm eligibility for coverage and that the requested service is a covered benefit. If you do not follow preauthorization procedures for inpatient admissions, you will be responsible for paying the first \$250 in covered charges before the plan begins to pay benefits. This \$250 will not be paid by your HRA and is in addition to any coinsurance amounts you must pay.

Inpatient Admissions

The plan requires you to obtain preauthorization whenever your physician recommends a non-emergency inpatient stay at a hospital or skilled nursing facility. Please call First Choice at (206) 268-2910 or (800) 843-5127 to have your inpatient medical/surgical stay preauthorized for benefits. Call Optum Behavioral Health at (866) 763-0466 to have your inpatient mental health or substance abuse stay preauthorized. You will be asked to provide information to establish medical necessity for the treatment/services.

No benefits are payable for services or inpatient admissions the plan considers not medically necessary. (The definition of medically necessary is on page 124.)

For an emergency admission, please notify First Choice for medical/surgical or Optum for mental health or substance abuse by phone on the first normal work day after your or a covered dependent's admission.

Surgical Services

The plan requires you to obtain preauthorization from First Choice before any of the following services are performed, whether inpatient or outpatient:

- ➔ *Breast reduction surgery*
- ➔ *Eyelid surgery, such as blepharoplasty*
- ➔ *Organ transplants (see page 49)*
- ➔ *Reconstructive and/or cosmetic surgery*
- ➔ *Removal of breast implants*
- ➔ *Stereotactic radiosurgeries (Gamma knife)*
- ➔ *Surgical interventions for sleep apnea*
- ➔ *Unproven, investigational or experimental services (unless specifically and completely excluded)*
- ➔ *Varicose vein surgery/sclerotherapy*
- ➔ *Weight loss surgery (see page 50)*

Other Services

The following services also require preauthorization by First Choice, unless otherwise noted:

- ➔ *Growth hormones (preauthorization by the Trust Office)*
 - ➔ *Home healthcare (see page 37)*
 - ➔ *Home infusion*
 - ➔ *Hospice care (see page 38)*
 - ➔ *Medical equipment and prostheses if the purchase price exceeds \$2,000 or the monthly rental fee exceeds \$500 (see page 41)*
 - ➔ *Orthognathic surgery (preauthorization by the Trust Office)*
 - ➔ *PET scans*
 - ➔ *Rehabilitation services – inpatient*
 - ➔ *Rehabilitation services – outpatient (preauthorization by the Trust Office)*

COVERED MEDICAL EXPENSES

The plan provides benefits for the following services and supplies, provided they are medically necessary for the treatment of an illness or injury and ordered and performed by a physician or other covered provider.

Unless otherwise specified, if treatment/services are provided by a PPO provider, the covered benefit will be paid at 85% after the deductible is met. If the treatment/services are provided by a non-PPO provider, the covered benefit will be paid at 60% of charges (not to exceed UCR) after the deductible is met.

Also, please refer to the medical exclusions and limitations as listed on pages 50–53.

Acupuncture

The plan covers treatment by an acupuncturist to a maximum of five visits per calendar year.

Ambulance (local and air)

The plan pays 85% of medically necessary transportation to and from a local hospital or the nearest hospital equipped to provide necessary medical treatment not available in a local hospital. The plan pays 100% of allowed charges for medically necessary transportation for a transfer between hospital facilities.

Ambulatory Surgical Center

Benefits for covered services and supplies at an approved ambulatory surgical center *except* for:

- ➔ *Physician's professional services*
- ➔ *Private duty or special nursing services (by whatever name they're called)*
- ➔ *Services or supplies received more than 24 hours after a surgical procedure*
- ➔ *Surgical procedure where anesthesia is induced by local anesthetic, unless administered by a physician anesthesiologist (or licensed anesthetist working under their continuous supervision)*

Anesthesia

If anesthesia for a covered medical surgery is administered by a physician other than the operating surgeon, the plan will pay covered benefits. If anesthesia is administered by a hospital employee covered under the hospital benefit, it will be reimbursed under the hospital benefit and will not be covered under this benefit.

Blood Transfusions

Coverage includes the cost of blood, plasma or any other blood-like infusion. Storage of blood is not a covered benefit.

Chiropractic Treatment

Benefits include treatment by a chiropractor for a musculoskeletal disorder (bone, muscle, joint and tendon) up to \$20 per visit, 20 visits per calendar year (not more than one visit per day).

The plan pays up to \$60 per calendar year for diagnostic x-ray and laboratory expenses in connection with chiropractic treatment.

Dental Treatment

Accidental injuries to natural teeth and treatment of a fractured jaw are covered if treatment is performed within six months from the accident. Benefits under the medical plan will not be considered until dental plan benefits are exhausted.

Diagnostic X-ray and Laboratory

X-rays and imaging procedures, audiology exams and testing for a condition other than hearing loss, and laboratory exams if medically necessary for diagnostic purposes are covered.

The plan pays up to \$60 per calendar year for diagnostic x-ray and laboratory expenses in connection with chiropractic treatment. Diagnostic x-rays and laboratory expenses related to accidental dental injuries may also be covered under this plan.

Emergency Treatment

A \$50 copay applies to each emergency room visit. This copay is waived if you are admitted to the hospital as an inpatient. Life endangering medical emergency treatment provided at nonpreferred hospitals will be paid as if they were provided at preferred hospitals, after the \$50 copay.

Hearing Care

Benefits include hearing exams and hearing aid (or other hearing enhancer) to a \$1,000 maximum in a period of three consecutive calendar years.

To receive these benefits, you must be examined by an MD or DO *before* obtaining a hearing aid or hearing enhancer. The Trust needs written certification from the examining physician, within six months before buying the device, that your hearing loss may be lessened by a hearing aid or hearing enhancer. (If you’re replacing a device previously provided under the Trust PPO, the certification requirement is waived.)

To summarize, these benefits cover:

- ➔ *Audiology exam and hearing evaluation by a certified or licensed audiologist (including a follow-up consultation)*
- ➔ *Otology exam by a physician*
- ➔ *The hearing aid (monaural or binaural) prescribed as a result of such examination, which shall include: (1) ear mold(s); (2) the hearing aid instrument; (3) the initial batteries, cords and other necessary ancillary equipment; (4) a warranty; and (5) follow up consultation within 30 days following delivery of the hearing aid*

If you return the covered hearing device before actual purchase, rental charges for its use are covered up to 30 days.

The plan does not cover hearing care charges for:

- ➔ *Batteries or other ancillary equipment other than those obtained when purchasing the device*
- ➔ *Expenses incurred after coverage ends (except for a hearing aid or hearing enhancer ordered before and delivered within 30 days after coverage ends)*
- ➔ *Hearing devices that exceed the specifications prescribed to correct the hearing loss*
- ➔ *Repairs, servicing or alteration of hearing aid or hearing enhancer*
- ➔ *Replacing a hearing aid or hearing enhancer for any reason more than once in three consecutive calendar years*

Home Healthcare

Home healthcare services are covered in full (not subject to deductible), but not more than the usual, customary and reasonable charges for the covered services rendered. Services must be provided by an approved home healthcare agency and be in place of confinement in a hospital or skilled nursing facility for medically necessary treatment of an injury, illness or pregnancy-related condition covered by the plan.

To ensure coverage, call First Choice at (206) 268-2910 or (800) 843-5127 to preauthorize any home healthcare services. More information about preauthorization is on page 33.

Home healthcare services are covered provided that:

- ➔ *Home healthcare services must be for the medically necessary treatment of an illness or injury covered under the plan*
- ➔ *The person must be homebound, which means that leaving home involves a considerable and taxing effort and the patient is unable to use public transportation without the assistance of another*
- ➔ *The physician must establish and submit a written plan of treatment and certify that confinement in a hospital or skilled nursing facility would be required in the absence of home healthcare benefits*

Covered charges include:

- ➔ *Home health aid services when acting under the direct supervision of one of the covered therapists and performing services specifically ordered by the physician*
- ➔ *Laboratory services*
- ➔ *Medical supplies, drugs, and medicines prescribed by a physician and dispensed by the home healthcare agency*
- ➔ *Registered and licensed practical nurse services*
- ➔ *Services of a registered physical therapist, certified occupational therapist, certified speech therapist and certified inhalation therapist*

No benefits are payable for:

- ➔ *Any supplies or services not specifically mentioned in this section*
- ➔ *Homemaker or housekeeping services*
- ➔ *Maintenance or custodial care*

- ➔ *Private duty nursing*
- ➔ *Psychiatric care*
- ➔ *Separate transportation charges*
- ➔ *Services performed by family members*
- ➔ *Supportive environmental materials (handrails, ramps, etc.)*
- ➔ *Social services*
- ➔ *Unnecessary and inappropriate services*

In addition, home healthcare benefits are subject to review for medical necessity, appropriateness, level of care and the setting in which the care is provided.

Home Phototherapy

Services are covered when the plan determines that treatment is medically necessary.

Hospice Care

If you or your eligible dependent is terminally ill with a life expectancy of six months or less, charges of an approved hospice agency are covered in full (not subject to deductible) for the medically necessary treatment for the terminally ill patient. The patient’s physician must establish and periodically review (at least once every three months) a written treatment plan that describes the hospice care to be provided and submit it to First Choice before the commencement of services.

Plan benefits are provided for expenses incurred in connection with inpatient hospice confinement to the same extent as if incurred in an approved hospital.

The services of a physician and of an approved hospice agency are covered in the patient’s home if the patient is homebound, which means that leaving home involves a considerable and taxing effort and the patient is unable to use public transportation without the assistance of another.

Home care services of an approved hospice agency have the following lifetime limits:

- ➔ *60 visits*
- ➔ *14 continuous care visits of four or more hours but less than 16 hours per day (included within the 60 visit maximum)*
- ➔ *Seven continuous care visits of 16 or more hours per day (included within the 60 visit maximum)*
- ➔ *Each visit by any person representing the hospice agency will be charged against the 60 visit maximum*

- ➔ *The patient's family may apply to First Choice for an extension of benefits if the patient's life expectancy extends beyond six months or if the patient exhausts any hospice benefit limits specified above; limited extensions will be granted if it is determined that the treatment is medically necessary*

Covered home care benefits of an approved hospice agency are listed below. All services except for those of a physician must be provided and billed by the hospice agency. Covered charges include:

- ➔ *Drugs and medicines dispensed by or through the hospice agency, that are legally obtainable only upon a physician's written prescription or that would have been provided on an inpatient basis, and insulin*
- ➔ *Home health aide services that are specifically ordered by the physician in the treatment plan*
- ➔ *Medical social services by a person with a Masters Degree in social work*
- ➔ *Medical supplies normally used by hospital inpatients and dispensed by the hospice agency*
- ➔ *Nursing services by a registered nurse (RN) or a licensed practical nurse (LPN)*
- ➔ *Nutritional supplements such as diet substitutes administered intravenously or through hyperalimentation*
- ➔ *Physical therapy services by a licensed physical therapist*
- ➔ *Physician services*
- ➔ *Rental (or purchase if approved by First Choice) of durable medical equipment. Repair or replacement of durable medical equipment necessary due to normal use is covered. Equipment ordered prior to the effective date of coverage is not covered. Equipment ordered while coverage is in effect and delivered within 30 days after termination of coverage is covered*
- ➔ *Respiratory therapy services*
- ➔ *Speech therapy services by a certified speech therapist*

No benefits are payable for charges for any of the following:

- ➔ *Environmental supportive services or equipment, such as, but not limited to, wheelchair ramps or support railings*
- ➔ *Food, clothing, or housing*
- ➔ *Homemaker services*

- ➔ *Psychiatric care*
- ➔ *Respite care*
- ➔ *Services of financial legal counselors*
- ➔ *Services of volunteers*
- ➔ *Services or supplies not included in the written treatment plan, or not specifically set forth as a covered benefit*
- ➔ *Services provided by household members, family, or friends*
- ➔ *Services to other family members, including bereavement counseling*
- ➔ *Spiritual counseling*

Hospital

Benefits include room and board (semiprivate room) as well as medically necessary inpatient services and supplies to treat an accidental injury or illness or other covered condition:

- ➔ *Administration of blood and plasma (including blood bank service charges but not the cost of blood or plasma)*
- ➔ *Diagnostic tests (including electrocardiograms and basal metabolism tests)*
- ➔ *General nursing care*
- ➔ *Intensive care unit or coronary care unit*
- ➔ *Medications*
- ➔ *Nursery charges for an eligible newborn child*
- ➔ *Operating rooms and equipment*
- ➔ *Physical therapy*
- ➔ *Speech therapy*
- ➔ *X-rays, imaging procedures, and laboratory services*

The plan does not cover hospitalization primarily for diagnostic tests, x-rays, imaging procedures, or laboratory tests, or for hospital admissions the plan considers not medically necessary.

To ensure coverage, call First Choice at (206) 268-2910 or (800) 843-5127 to preauthorize any medical/surgical hospitalization or Optum Behavioral Health at (866) 763-0466 for mental health or substance abuse hospitalization. If you do not obtain preauthorization, you will be responsible for paying the first \$250 in covered charges before the plan begins to pay benefits. More information about preauthorization is on page 33.

In addition to authorizing the appropriate length of stay before an admission, the care you receive is reviewed to ensure the need for continued hospitalization. Hospital benefits may be reduced or denied if

hospitalization is determined no longer medically necessary. (The definition of medically necessary is on page 124.)

Injectable Prescription Drugs

Certain injectable drugs, chemotherapy and cancer drugs must be purchased through the mail-order Ascend program (see page 56). You will receive a letter from Ascend regarding these prescriptions.

Mastectomy

The Women's Health and Cancer Rights Act of 1998 requires that your health plan provide benefits for mastectomy-related services due to disease or cancer including reconstruction and surgery to achieve symmetry between the breasts, prostheses and complications resulting from the mastectomy, including lymphedema.

The plan does not provide benefits for prophylactic mastectomies.

Maternity Benefit

The plan provides maternity benefits for any employee or dependent spouse on the same basis as any other illness or injury; **maternity benefits are not provided for dependent children**. Covered expenses also include the services of a licensed midwife during childbirth, but does not cover midwives for newborn baby visits or follow-up visits.

The plan does not provide benefits for any services or supplies provided to dependent children for charges related to pregnancy or childbirth, including all complications thereof, prenatal or postnatal care, or well-baby care of a newborn.

The plan does not provide any benefits if eligibility has terminated prior to the delivery unless the person qualifies for extended medical benefits when disabled.

The plan does not restrict hospital benefits for covered mothers and newborns to less than 48 hours after normal delivery or 96 hours after a cesarean. Authorization isn't needed for these lengths of stay, and First Choice will extend hospitalization if a longer stay is medically necessary.

Medical Equipment and Prostheses

Artificial limbs or eyes, casts, splints, trusses, braces, crutches and other similar appliances are covered, as well as the rental of a wheelchair, hospital-type bed and other equipment for medically necessary treatment. Covered expenses will be limited to the standard model of medically appropriate level of performance and quality required for the diagnosed condition; deluxe or luxury equipment or items for convenience or comfort are not covered by the plan. Rental of equipment is covered up to the purchase price of the equipment only. Repair or replacement of a damaged covered item that can not be repaired will be covered up to the cost of a new item.

Expenses for supplies prescribed while covered under the plan will be covered if delivered within 30 days of the loss of coverage.

Prior authorization is required for medical equipment and prostheses if the purchase price exceeds \$2,000 or the monthly rental fee exceeds \$500 (see pages 33–34).

The plan does not cover the following:

- *Equipment for lifestyle changes or recreational purposes*
 - *Equipment set-up or training on the use of the equipment*
 - *Equipment to control or enhance the environmental setting*
 - *Items that are not for therapeutic use in direct treatment of a covered illness or injury*
 - *Items that are not prescribed by a physician*
 - *Replacement of lost or stolen supplies or equipment; replacement of equipment due to neglect*
 - *Sports equipment or supplies, home exercise equipment or supplies; and fitness center memberships*

Mental and Nervous Disorder Treatment

Inpatient hospital expenses are paid on the same basis as any other illness or injury.

Outpatient services performed by a covered provider for individual therapy are paid on the same basis as any other illness or injury.

Services of a mental health counselor, clinical social worker or marriage and family therapist certified or licensed by the state where services are received are covered if referred by Optum Behavioral Health or a physician or psychologist. Expenses for prescription drugs are covered under the prescription drug benefit.

To ensure coverage, call Optum Behavioral Health at (866) 763-0466 to preauthorize any hospitalization. If you do not obtain preauthorization, you will be responsible for paying the first \$250 in covered charges before the plan begins to pay benefits. More information about preauthorization is on page 33.

In addition to authorizing the appropriate length of stay before an admission, the care you receive is reviewed to ensure the need for continued hospitalization. Hospital benefits may be reduced or denied if hospitalization is determined no longer medically necessary. (The definition of medically necessary is on page 124.)

Naturopath

Services by a naturopath are covered with a maximum of two visits per calendar year.

Neurodevelopmental Therapy

Physician-recommended neurodevelopmental therapy – including speech, physical and occupational therapy – is covered for dependent children under age seven. See the rehabilitation benefit on page 45 for a complete description of benefits provided by the plan.

Nursing

Services by an RN, other than one who lives in your home or is related by blood or marriage, are covered.

Nutritional Support

Medically necessary total parenteral nutrition (TPN) feeding is covered; elemental (chemically defined) feeding when the plan considers it medically necessary. Medically necessary formula for inherited errors of metabolism, such as phenylketonuria, is also covered.

Ocular Prosthesis

Coverage is provided for medically necessary ocular prostheses and related orbital examinations and cleanings. If there are no ocularists or other qualified providers of these services in the First Choice Health Network, services provided by non-PPO providers will be covered at the PPO benefit level.

This PPO exception only applies to ocular prostheses and not to any other type of benefit covered by the plan.

Orthotics

Orthotics or other supportive devices are covered up to \$200 per calendar year when prescribed by a covered provider or chiropractor to treat an injury or medical condition of the foot. Benefits include braces, splints, insoles and foot supports as well as impression casts for fitting these devices and the cost of any repairs. The device must be intended for wear at all times that shoes are worn and not just for specific activities.

This benefit does not cover shoes or supports that are available without a prescription.

Physician Visits

Hospital, home and office visits are covered for illness or injury.

The plan does not cover the following:

-
- ➔ *Follow-up treatment within four weeks after the date surgical benefits are payable*
 - ➔ *Hospital visits after the period covered under the hospital benefit*
 - ➔ *More than one outpatient visit per day to the same physician*

- ➔ *Phone or other consultation fees when a patient is not physically seen by a physician*

Podiatry

Services by a podiatrist or physician for routine foot care are covered up to \$20 per visit (no more than one visit per day), and a maximum of 12 visits per calendar year, for the following:

- ➔ *Performing routine hygienic care, metatarsalgia and bunion care (except when a cutting operation is involved)*
- ➔ *Treating fallen arches and other symptomatic complaints of the feet*
- ➔ *Trimming nails, corns and calluses*

Preventive Care

Preventive care services, as described below, are covered at 100% of charges (not subject to the deductible), if a PPO provider is utilized, and 60% of charges (subject to the deductible) if a non-PPO provider is used.

Adult Screening Tests. The plan covers:

- ➔ *One mammogram for an eligible female, as follows:*
 - *Every two calendar years, under age 40*
 - *Every calendar year, age 40 and over*
- ➔ *One routine Pap and pelvic exam per calendar year*
- ➔ *One routine prostate exam per calendar year*
- ➔ *One prostate specific antigen (PSA) per calendar year*
- ➔ *Prostate cancer screening (at age 50)*
- ➔ *Heart scan, bone density testing and other preventive screenings your physician considers reasonable and medically necessary if not normally performed in a doctor's office or as part of a routine physical exam*
- ➔ *Routine fecal occult blood tests in conjunction with a routine colon/rectal exam, as follows:*
 - *One test, every two calendar years, under age 50*
 - *One test per calendar year, age 50 and over*
 - *Colorectal cancer screening (at age 50)*
 - *Flexible sigmoidoscopy every three to five years*
 - *One colonoscopy every 10 years*

Annual Physical Exams (excluding dependent children under age 19).
The plan pays for routine physical exams, including:

- ➔ *Laboratory and x-ray services when ordered by a physician (other than those described above)*
- ➔ *Physician services for office visits*

Certain guidelines may apply.

Preventive Care Office Visits (dependent children to age 19). The plan covers:

- ➔ *Six visits (including visits for immunizations) up to age 1*
- ➔ *Three visits (including visits for immunizations) from age 1 to age 2*
- ➔ *An annual visit from ages 2 – 18 (includes immunizations).*

Flu and Pneumonia Shots. Flu and pneumonia shots will be covered in full. Participants must submit an itemized receipt indicating the name of the person receiving the flu shot to the Trust Office. Only flu and pneumonia shots provided in the USA will be reimbursed. You can go to any local grocery store, pharmacy or public facility (e.g., fire stations). If you go to a doctor's office you will be reimbursed for the flu or pneumonia shot. If the doctor also charges for an office visit, the office visit will not be covered. Flu and pneumonia shots are not subject to the deductible.

Rehabilitation

Rehabilitation services are limited to a maximum of 45 outpatient visits per condition per calendar year. Inpatient stays are limited to a maximum of 30 days per condition per calendar year. Therapy must be prescribed and provided by a covered provider, as defined by the plan.

The plan covers the following medically necessary rehabilitation services for disabling conditions to restore or significantly improve function that was lost due to acute injury or illness:

- ➔ *Biofeedback is covered for the treatment of pain*
- ➔ *Cardiac therapy is covered for patients with documented diagnosis of acute myocardial infarction within the preceding 12 months, for patients who have had coronary bypass surgery, and for patients with coronary occlusions or stable angina pectoris. Treatment is covered when medically necessary services are provided and when care is:*

- *Prescribed, provided and monitored by a covered provider, as defined by the plan*
 - *Provided at an approved rehabilitation facility or hospital under the supervision of a physician*
 - *Target cardiac deficiencies documented by medical tests and expected levels of recovery*
 - *Initiated within 12 weeks after acute care treatment for the medical condition ends*
- ➔ *Inpatient rehabilitation coverage requires preauthorization (see page 33). Coverage will be provided at the appropriate level of care (hospital, skilled nursing facility, outpatient) based on medical necessity. Guidelines include, but are not limited to, the following:*
- *The patient's condition must require 24-hour availability of a physician with training and/or experience in rehabilitation*
 - *The physician's involvement must be greater than is normally provided in a skilled nursing facility*
 - *If the medical condition does not allow the patient to obtain outpatient services, the patient must require and receive at least three hours of physical or occupational therapy each day for at least five days per week*
 - *Services must be provided in an approved rehabilitation facility, as defined by the plan; the facility must not be one that primarily provides general care for the elderly, custodial care or because the patient lives alone*
 - *When rehabilitation follows acute care in a continuous inpatient stay, inpatient rehabilitation benefits start on the day care becomes primarily rehabilitative*
- ➔ *Massage therapy (must be ordered by a MD or DO as part of physical therapy)*
- ➔ *Neurodevelopmental therapy*
- ➔ *Occupational therapy*
- ➔ *Outpatient rehabilitation coverage is limited to a maximum of 45 outpatient visits per condition per calendar year for all types of therapy combined. All outpatient rehabilitation must have a treatment plan submitted to the Trust Office in advance to determine medical necessity. Benefits are subject to the following:*
- *The patient must not be confined in a hospital or other medical facility*
 - *The therapy must be part of a formal written treatment plan prescribed by the patient's MD or DO*
 - *Services must be provided by an approved hospital, physician or physical, occupational or speech therapist, as defined by the plan*

- *Services must be reasonably expected to significantly improve self-sustaining function within 90 days of the date outpatient therapy begins*
- *The plan does not cover services considered maintenance or custodial, or when no further improvements are expected*
- *Speech therapy is only covered when required because of brain or nerve damage caused by an accident, disease or stroke, for services necessary for the diagnosis and treatment of swallowing disorders (dysphagia) and for those individuals who have had speech disorders or deficits, but not beyond the maximum restoration of speech. Once the ability for speech has been restored, further benefits for the improvement of the speaking patterns or tonal sounds are not covered*

➔ *Stroke therapy*

The plan does not cover the following:

- ➔ *Services for palliative, recreational, relaxation or maintenance therapy*
- ➔ *Services for on-the-job injuries or work-related injuries or sicknesses*
- ➔ *Services provided by a registered or licensed therapist who resides in your home or is related by blood or marriage*

Skilled Nursing Facility Care

Benefits are covered for confinement in a skilled nursing facility ordered by a physician. The confinement must be for medically necessary treatment of a covered illness (including pregnancy) or injury.

To ensure this coverage, call First Choice at (206) 268-2910 or (800) 843-5127 for preauthorization (see page 33).

Benefits include:

- ➔ *Necessary services and supplies furnished by the facility*
- ➔ *Physician visit every other day up to 15 visits per period of confinement*
- ➔ *Room and board up to the average semiprivate room rate*

The plan does not cover any confinement primarily for rehabilitation or care that can be provided on an outpatient basis. Custodial care, residential treatment or benefits for any personal comfort items are not covered.

Substance Abuse Treatment

A \$5,000 maximum benefit applies during a period of two consecutive calendar years, to a \$10,000 lifetime maximum for substance abuse treatment.

Covered expenses include services at an approved alcoholism and/or drug abuse treatment facility, an approved hospital or a covered provider’s office as well as prescription drugs related to the substance abuse treatment. Treatment is limited to short-term intensive inpatient care and/or outpatient counseling in a nonresidential setting, according to a physician’s prescribed plan.

The patient must complete the course of treatment to be eligible for substance abuse benefits.

To ensure coverage, call Optum Behavioral Health at (866) 763-0466 to preauthorize any inpatient admission. If you do not obtain preauthorization, you will be responsible for paying the first \$250 in covered charges before the plan begins to pay benefits. More information about preauthorization is on page 33.

In addition to authorizing the appropriate length of stay before an admission, the care you receive is reviewed to ensure the need for continuation of the inpatient stay. Benefits may be reduced or denied if an inpatient stay is determined to be no longer medically necessary. (The definition of medically necessary is on page 124.)

The plan does not cover alcoholism and/or drug abuse treatment charges for:

- ➔

Detox (unless followed immediately by inpatient or outpatient covered treatment)
- ➔

Information or referral services
- ➔

Residential care in recovery houses

Surgical Services

Medically necessary surgeries resulting from illness or injury are covered.

Benefits include covered surgical procedures performed in the doctor’s office, hospital or approved ambulatory surgical center. If you’re hospitalized, surgical benefits are in addition to the plan’s hospital benefits.

The plan also covers physician services for insertion, medical management or removal of a contraceptive device such as a diaphragm, intrauterine device (IUD) or implant. (This benefit is limited to devices that can be obtained only by prescription.) Sterilization is also covered.

Operating and cutting procedures are covered if performed by licensed covered providers practicing within the scope of their license.

Assistant Surgeon. Medically necessary services are covered up to 25% of UCR charges for a surgical procedure when performed by an assistant surgeon or physician (other than a hospital intern or resident).

Second Surgical Opinion. To help you understand surgery risks and alternatives, this plan covers a second surgical opinion for nonemergency procedures.

Transplants

Plan benefits include the following transplants, subject to the conditions and limitations specified below, and to those in other sections of the plan:

- ➔ *Bone marrow*
 - ➔ *Cornea*
 - ➔ *Heart*
 - ➔ *Heart/lung (combined)*
 - ➔ *Kidney*
 - ➔ *Kidney/pancreas (combined)*
 - ➔ *Liver*
 - ➔ *Lung, single or bilateral*
 - ➔ *Pancreas*
 - ➔ *Peripheral blood stem cell*

Benefits for all transplants must be authorized in writing by First Choice in advance. Approval will be based on medical necessity, the patient’s medical condition, the qualifications of the providers, appropriate medical indication for the transplant, and appropriate, proven medical procedures for the condition. If a transplant is not successful, only one retransplant will be covered, subject to the same conditions and limitations applicable to the original transplant.

If you or your eligible dependent is the recipient of a donated human organ, the donor’s medical expenses (including compatibility testing of donors and potential donors) are covered under the plan up to the recipient’s benefit limit.

Repair of an organ (e.g., joint or valve replacement) is not considered a transplant. Transplant benefits are subject to all plan conditions and limitations, and no benefits will be provided for the following:

- ➔ *Nonhuman, artificial or mechanical transplants*
- ➔ *Services or supplies in conjunction with experimental or investigational treatment*
- ➔ *Services and supplies for the donor when the donor benefits are available through other group coverage*
- ➔ *Expenses for that portion of treatment funded by government or private entities as part of an approved clinical trial*
- ➔ *Expenses when the recipient is not covered under this plan*
- ➔ *Lodging, food or transportation costs, unless otherwise specifically provided under this plan*
- ➔ *Donor and procurement services and costs incurred outside the United States, unless specifically approved in advance*
- ➔ *Expenses for organ harvesting or storage, unless specifically approved in advance by First Choice on a case-by-case basis*
- ➔ *Living (non-cadaver) donor transplants of the lung, liver, or other organ (except kidney), including selective islet cell transplants of the pancreas, unless the organ donor is a family member of the person seeking the transplant; family member for this purpose means grandparent, parent, child, brother, sister, aunt, uncle, nephew, niece or cousin*
- ➔ *Any expense incurred by you or your eligible dependent on account of donating your human organ or tissue*
- ➔ *Expenses for donor searches*

Weight Loss Surgery

The plan covers medically necessary (as determined by the plan) weight loss surgery when preauthorized, after you have been employed for at least 12 months with a contributing employer. Approval is based on specific plan criteria; please contact the Trust Office for those criteria and contact First Choice for preauthorization (see page 33).

X-ray, Chemo and Radiation Therapy

Medically necessary treatments are covered.

MEDICAL EXCLUSIONS AND LIMITATIONS

The Trust PPO plan does not cover:

1. *Any expense incurred before your date of coverage. An expense is considered incurred on the date you receive the service or supply for which the charge is made.*

2. *Any expense incurred after the termination of your coverage under this plan.*
3. *Any illness, disease or injury for which an employer is required to furnish hospital care or other benefits in whole or in part by state or federal Workers' Compensation laws or other legislation, including Employee's Compensation or Liability Laws of the United States, or a program which provides equivalent coverage, even though the employee or dependent waives his or her rights to such benefits.*
4. *Any service or supply for which no charge is made or no payment is required.*
5. *Any service or supply that is not medically necessary for the care and treatment of illness or injury (except as specified for preventive care benefits).*
6. *Any services or supplies not specifically covered under the Trust PPO medical plan.*
7. *Aquatic therapy, unless part of a formal outpatient rehabilitation program.*
8. *Charges for counseling, education, self-help instruction or training. These include, but are not limited to, services for behavior modification, learning disabilities, vocational assistance, marital counseling, social counseling, conduct disorders, impulse control, cognitive disorders, sexual lifestyle counseling, family therapy, nutritional or fitness guidance, anger management, diabetic or dietetic instruction.*
9. *Charges for missed appointments, telephone consultations when a patient is not physically seen by a physician or completion of claim forms.*
10. *Charges for treatment of temporomandibular dysfunction or temporomandibular joint dysfunction (TMJ).*
11. *Charges for treatment, services or supplies that exceed usual, customary and reasonable fees (see UCR definition on page 125).*
12. *Claims received after the 12-month filing limit.*
13. *Conditions caused by or arising from an act of war, armed invasion or aggression.*
14. *Cosmetic procedures (except as part of treatment of a functional disorder covered by this plan or as a result of an accidental injury occurring while the individual is covered); complications from any cosmetic surgery and cosmetic procedures for psychological or self esteem reasons.*
15. *Court-appointed treatment not covered by the Trust medical plan.*
16. *Custodial care or care when no significant clinical improvement is expected as a result (except hospice care).*

17. *Dental treatment (except natural teeth restorations due to accidental injuries).*
18. *Experimental or investigational services, procedures, medicines, equipment, devices, supplies, facilities or treatment: collectively referred to here as treatment (see definition on page 121). As with other plan interpretations, the Trustees have full and exclusive authority to decide what constitutes experimental or investigational treatment.*
19. *Eye exercises; visual or orthoptic training/therapy.*
20. *Eyeglasses, eye refractions or eye exams to correct vision or fitting of glasses.*
21. *Food supplements, including formula for enteral feeding.*
22. *Genetic testing except when there are medically documented symptoms or signs presented indicating a possible disease presence and genetic testing is needed to identify the disease in order for the attending physician to prescribe appropriate treatment.*
23. *Late fees, finance charges or collection charges imposed by your healthcare provider.*
24. *Massage therapy unless ordered by a doctor as part of covered physical therapy.*
25. *Medical exams or tests not connected with an illness or injury, except as provided under preventive care benefits.*
26. *Postage, handling and taxes related to medical services or supplies.*
27. *Preventive medicine (except as specified under preventive care benefits).*
28. *Private room charges exceeding the hospital's most common charge for semiprivate (two-bed) accommodations.*
29. *Refractive eye surgery to correct vision deficiencies.*
30. *Reversal of tubal ligation or vasectomy, fertility drugs, artificial insemination, in vitro fertilization, embryo transplant or any other confinement, treatment or service related to restoring fertility or promoting conception.*
31. *Services by an institution that is primarily a place of rest, place for the aged, nursing home, convalescent home, residential eating disorder facility, or similar institution.*
32. *Services or supplies covered by other group insurance or medical service program or for which no charge is made or no payment is required from you or your dependents.*
33. *Services or supplies furnished to dependent children of an employee arising from pregnancy or resulting in childbirth, including all complications, prenatal or postnatal care, or for care of their newborn infant.*

34. *Services or supplies received from a physician or other healthcare provider who usually lives in your home or is related by blood or marriage.*
 35. *Services or supplies that are solely for the convenience of the patient, provider, or caregiver.*
 36. *Services performed on teeth, gums or alveolar processes (except to treat tumors or accidental injury).*
 37. *Shoes or foot supports available without prescription.*
 38. *Smoking cessation program, whether or not you have other medical conditions related to or caused by smoking.*
 39. *Treatment for injuries sustained while committing or attempting to commit a felony.*
 40. *Treatment for self-inflicted injuries or injuries sustained in connection with attempted suicide while sane or insane, unless the injuries are the result of a physical or mental health condition.*
 41. *Weight loss treatment or services, unless preauthorized by First Choice and eligibility is approved by the Trust Office, whether or not you have other medical conditions related to or caused by excess weight, except as specifically provided under the prescription drug benefit.*
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PRESCRIPTION DRUGS


informedRx administers the Trust’s prescription drug benefit through three options for your convenience—retail pharmacies, informedMail and Ascend SpecialtyRx (for specialty drugs).

COPAYS

For each prescription (or refill) administered or prescribed by a physician, the plan pays for a 30-day supply, (60-day or 90-day supply for maintenance drugs only) after these copays:

TYPE OF DRUG	30-DAY SUPPLY	60-DAY SUPPLY*	90-DAY SUPPLY*
Tier 0	\$0	\$0	\$0
Tier 1	\$5	\$10	\$15
Tier 2	\$20	\$40	\$60
Tier 3	\$30	\$60	\$60
Brand if generic is available	**	**	**

 * Maintenance-only. Maintenance drugs in excess of a 30-day supply must be purchased through informedMail or through a pharmacy in the custom network which provides special discounts (see page 57).

 ** Generic copay plus the difference in cost between the generic and the brand name drug.

- ➔ Tier 0: some selected highly cost effective medications.
- ➔ Tier 1: most current generics and potentially some cost effective branded medications.
- ➔ Tier 2: most brand name drugs, or more costly or less desirable generics.
- ➔ Tier 3: non-preferred brand drugs and some more costly generics.

RETAIL PHARMACIES

The program features a custom network of pharmacies consisting of employers who participate in the Trust. In addition, there is the informedRx pharmacy network. You can use any pharmacy—the choice is yours each time you fill a prescription. Pharmacies in the custom network and the informedRx network provide discounted prescriptions to the plan. However, to guarantee receiving the most cost effective copayments, always use the custom network and mail order pharmacy as described below.

➔ **Trust custom network.** When you use a Trust custom network pharmacy, simply take your prescription and your Sound Health & Wellness Trust ID card to the pharmacy and pay the appropriate copay.

Be sure to show your Sound Health & Wellness Trust ID card when you fill a prescription. If you do not identify yourself as a plan participant, the Trust will not receive the discount. If you fill a prescription at a custom network pharmacy but do not show your ID card, you will pay an additional processing fee of \$10 for generic and \$20 for brand drug prescriptions for each 30-day supply.

➔ **informedRx network.** If you fill your prescription at an informedRx pharmacy that is not in the Trust custom network, you pay the full cost at the time of purchase, then file a claim with the Trust Office and wait for reimbursement. Be sure to show your Sound Health & Wellness Trust ID card when you fill a prescription. If you do not identify yourself as a plan participant, the Trust will not receive the discount. If you fill a prescription at an informedRx network pharmacy but do not show your ID card, you will pay an additional processing fee of \$10 for generic and \$20 for brand drug prescriptions for each 30-day supply.

➔ **Out-of-network.** For all pharmacies not in the Trust custom or informedRx networks, you pay the full cost at the time of purchase, file a claim with the Trust Office and wait for reimbursement.

If you chose to use a pharmacy that is not in either the custom or informedRx networks, you will pay an additional processing fee of \$10 for generic and \$20 for brand drug prescriptions for each 30-day supply.

If you need help locating a custom network pharmacy, call the Trust Office at (800) 225-7620 or look on the Sound Health & Wellness Trust website at www.soundhealthwellness.com. For an informedRx network pharmacy call informedRx at (800) 456-4803 or visit the informedRx website at www.myinformedrx.com.

If your dependents have other insurance and the other coverage is primary, you'll need to follow that plan's procedures when purchasing prescriptions. Then, to get reimbursed by the Trust for your copay, submit a copy of the prescription receipt and any explanation of benefits form to the Trust Office.

INFORMEDMAIL HOME DELIVERY PHARMACY

You also have the option of using informedMail.

To use informedMail, simply complete a prescription order form (available from the Trust Office, www.soundhealthwellness.com and www.myinformedrx.com), attach your prescription and your check for the appropriate copay and mail to the address on the form. After they receive your copay, informedMail will fill the prescription and ship it to you, along with a reorder form for refills.

To make sure you don't run out of your medicine on your initial fill, allow two or three weeks for receiving your prescription. If you send in a prescription for a new medicine, request a two to three week supply from your doctor or a local pharmacy while you wait for your mail-order medication. For refills through informedMail, please allow seven business days for processing.

You can contact informedMail at (800) 456-4803 with questions.

ASCEND SPECIALTYRX PHARMACY (FOR SPECIALTY DRUGS)

If you take certain specialty drugs, you will receive a letter from informedRx about receiving these drugs through their Ascend SpecialtyRx program. Specialty drugs include, but are not limited to, the following:

- ➔ *Injectable drugs (excluding insulin)*
- ➔ *Oral medications for oncology (cancer)*
- ➔ *Medications for transplants*

You can contact informedRx at (800) 456-4803 or Ascend SpecialtyRx at (800) 850-9122 if you have any questions.

MAINTENANCE PRESCRIPTION DRUGS

Maintenance prescription drugs written for a 30-day supply can be filled at a retail pharmacy. However, any maintenance prescriptions written in excess of a 30-day supply can only be purchased from:

- ➔ *informedMail, as described above*
- ➔ *Certain “custom network” pharmacies; for a list of those pharmacies visit the Trust web site at www.soundhealthwellness.com or contact the Trust Office at (800) 225-7620*

COVERED PRESCRIPTION DRUG EXPENSES

The Trust PPO plan covers charges for:

- ➔ *FDA approved legend prescription drugs when used for an FDA approved condition*
- ➔ *Cysteamine, phosphocysteamine, and dietary supplements recommended by a physician for treating cystinosis*
- ➔ *Dermatological preparations prescribed by a physician and received from a licensed pharmacist*
- ➔ *Hospital take home prescription drugs, birth control pills and diabetic supplies (including insulin, insulin syringe, needles, test strips or equivalent) prescribed by a physician for use outside the hospital*
- ➔ *Prescription drugs, birth control pills and diabetic supplies (including insulin, insulin syringe, needles, test strips and equivalent) from licensed pharmacists*
- ➔ *Prescription drugs, birth control pills and diabetic supplies (including insulin, insulin syringe, needles, test strips and equivalent) supplied out of the physician’s office and charged separately from any other item*
- ➔ *Self-injectable drugs prescribed by a physician*
- ➔ *Therapeutic vitamins, prenatal vitamins while pregnant, cough mixtures, antacids, eye and ear medications prescribed by a physician for a specific illness and received from a licensed pharmacist*
- ➔ *Weight control drugs if prescribed by a physician specifically to treat morbid or severe obesity (the physician may be*

required to give the Trust Office a certification before these can be covered)

- ➔ Certain over-the-counter (OTC) medications when accompanied by a valid prescription; call the Trust Office for details*

Some covered prescription drugs may have limited quantities and/or need to be preauthorized; call the Trust Office for details.

PRESCRIPTION DRUG EXCLUSIONS AND LIMITATIONS

The Trust prescription drug benefits do not cover:

- 1. Any drug not reasonably necessary for the care or treatment of bodily injury or sickness.*
- 2. Any drugs for illness, disease or injury for which an employer is required to furnish hospital care or other benefits in whole or in part by state or federal Worker's Compensation laws or other legislation, including Employee's Compensation or Liability Laws of the United States, or a program which provides equivalent coverage, even though the employee or dependent waives his or her rights to such benefits.*
- 3. Appliances, devices, bandages, heat lamps, braces or splints.*
- 4. Blood and blood plasma.*
- 5. Claims received after the 12-month filing limit.*
- 6. Contraceptives (except birth control pills).*
- 7. Cosmetics or health and beauty aids.*
- 8. Drugs administered or taken while confined in the hospital.*
- 9. Drugs lost, stolen or damaged by neglect.*
- 10. Drugs reimbursable by any government program: national, state, county or municipal.*
- 11. Drugs taken in conjunction with home health, hospice or skilled nursing care.*
- 12. Maintenance prescription drugs in excess of a 30-day supply that are purchased from other than the informedMail or certain "custom network" pharmacies as described on page 57.*
- 13. Medicines not requiring a prescription, unless otherwise indicated.*
- 14. Multiple or nontherapeutic vitamins or dietary supplements.*

15. *Non-maintenance drugs from a retail pharmacy in excess of a 30-day supply; maintenance drugs in excess of a 90-day supply.*
16. *Prescription drugs for substance abuse treatment are excluded from the prescription drug benefit and included under the substance abuse benefit. See page 48.*

Some of these items may be covered under your medical benefits; contact the Trust Office for details.

EXTENDED MEDICAL BENEFITS WHEN DISABLED

If you (or your eligible dependent) are *totally disabled* on the date coverage ends, the following plan benefits continue:

- ➔ *Medical*
- ➔ *Prescription drugs*

As used in this section, totally disabled means you’re unable, because of an injury or illness, to perform any normal activities you were performing on or before the date your (or your eligible dependents’) coverage ends.

These benefits are furnished only for the condition causing the total disability and only if you’re under the continuous care and treatment of a physician or covered provider. Benefits continue up to the maximum amount, or to the end of the calendar year after the calendar year when coverage ends, or when you’re no longer certified as totally disabled by your physician—whichever happens first.

The Trust Office must receive proof of your disability and its continuation within 90 days after coverage ends, then periodically as requested.

If you are covered by another active employer-sponsored benefit plan, this plan pays secondary.

VISION CARE

The Trust has an agreement with VSP to provide vision benefits to you and your eligible dependents. Under this agreement, you can use any provider you wish. However, if you use a VSP network doctor, you may receive higher benefits—and they automatically file claims for you.

COVERED VISION EXPENSES

The following table summarizes your vision care benefits:

COVERED EXPENSE*	IF YOU SEE A VSP NETWORK DOCTOR THE PLAN REIMBURSES...	IF YOU SEE A NON-VSP PROVIDER THE PLAN REIMBURSES...
Exams (once/12 months)	100% after \$10 copay	up to \$35
Lenses (once/12 months) <ul style="list-style-type: none">• Single vision• Bifocal - lined• Trifocal - lined• Lenticular• Tints/photochromic	100% 100% 100% 100% 100%	up to \$30 up to \$40 up to \$45 up to \$90 up to \$5
Frames (once/24 months)	up to \$95	up to \$30
Contacts (once/12 months in place of eyeglass lenses and frames) <ul style="list-style-type: none">• Elective**• Necessary***	100% up to \$130 100%	up to \$55 up to \$200



* You are responsible for additional noncovered cosmetic expenses, such as progressive lenses and coatings.

** Allowance applies to the cost of the contact lenses and the contact lens exam (evaluation and fitting).

*** Covered (with prior VSP approval) following cataract surgery, to correct extreme visual acuity problems that cannot be corrected with spectacle lenses, for certain conditions of anisometropia and for keratoconus.

In addition, VSP network doctors agree to:

- ➔ *An average of 30% savings on lens options like progressives and scratch-resistant and anti-reflective coatings*
- ➔ *20% discount to provider's usual and customary fees for additional complete pairs of prescription glasses*
- ➔ *20% off additional complete pairs of glasses and sunglasses, including lens options*
- ➔ *20% discount off your out-of-pocket costs if you choose a frame that exceeds your allowance*
- ➔ *15% discount to contact lens fitting and evaluation. This benefit is available in conjunction with the VSP contact lens allowance or can be used to purchase contacts if glasses are already received*
- ➔ *An average of 15% off the regular price, or 5% off the promotional price, from contracted facilities for laser vision correction*

LOW VISION COVERAGE

Low vision benefits are available (with prior VSP approval) for severe visual problems that are not correctable with regular lenses. Please discuss your options with your provider. Coverage includes:

- ➔ *Supplemental care: 75% (25% copay)*
- ➔ *Supplemental testing: 100%*
- ➔ *Benefit maximum: \$1,000 per two years for services related to low vision*

Low vision care from a non-VSP provider is subject to the same time limits and copays as described above for a VSP network doctor. You pay the non-VSP provider's full fee, then are reimbursed up to what would have been paid to a VSP network doctor in similar circumstances.

OBTAINING VISION CARE

To receive eye care services or eyewear from a VSP network doctor:

- ➔ *Contact VSP by calling (800) 877-7195 or visiting www.vsp.com to determine if your doctor is in the VSP network or to locate a VSP network doctor close to your home or work*

- ➔ *Make an appointment, provide the VSP network doctor with your Social Security number and tell the provider you're a VSP member; before your visit they will verify your eligibility and available benefits*
- ➔ *Pay a \$10 copay, and the cost of any cosmetic options, at the time of service; in most cases the plan then pays 100% for covered services*

There's no need to file a claim—the VSP network doctor does it for you.
To receive service from a non-VSP provider:

- ➔ *Make an appointment with any provider*
- ➔ *Pay the bill in full*
- ➔ *File a claim for reimbursement as outlined on page 110; the plan reimburses you up to the covered amount less a \$10 copay*

All claims must be filed within one year of the date vision services are completed. Reimbursement is made directly to you and is not assignable to the provider.

VISION LIMITATIONS AND EXCLUSIONS

Because this plan is designed to cover your visual needs rather than cosmetic eyewear, there is an extra charge for:

- ➔ *Blended lenses*
- ➔ *Coated or laminated lenses*
- ➔ *Contact lenses (except as noted above)*
- ➔ *Cosmetic lenses and optional processes*
- ➔ *Frames that cost more than the plan allowance*
- ➔ *Oversize lenses (61 mm or larger)*
- ➔ *Progressive multifocal lenses*
- ➔ *UV (ultraviolet) protected lenses*

VSP does not cover:

1. *Claims received after the 12-month filing limit.*
 2. *Experimental procedures or lenses.*
 3. *Eye exam or corrective eyewear required by an employer as a condition of employment.*
 4. *Medical or surgical treatment of the eyes.*
 5. *Orthoptics or vision training or any associated supplemental testing.*
 6. *Plano lenses.*
 7. *Replacement of lost or broken lenses or frames furnished under these vision benefits (except at the normal intervals).*
 8. *Two pair of glasses in place of bifocals.*

DENTAL CARE

You have the choice of three dental plan options:

- ➔ **WDS Preferred Option (#09135).** *This option allows you to see any licensed provider. However, if you use a WDS member dentist, reimbursement will be based on their pre-approved filed fees. If you do not use a WDS member dentist, reimbursement will be based on the maximum allowable fee and you may have greater out-of-pocket expenses. Nearly 90% of dentists in Washington are WDS member dentists. Ask your dentist if they are a WDS member dentist. If you use a WDS Preferred Provider (PPO), your benefits will be greater than if you use a WDS nonpreferred member or nonmember provider. See page 66 for more details about this option.*
- ➔ **DeltaCare Option (#00404).** *DeltaCare is a dental HMO plan administered by WDS. This option requires you to choose from a smaller list of approved dentists and clinics. You choose a DeltaCare primary care dentist who coordinates all of your care, including any referrals to specialists. Dental benefits are paid according to DeltaCare benefit schedules. See page 81 for more details.*
- ➔ **Dental Schedule Option.** *This option allows you to see any licensed dentist. Benefits will be paid according to the schedule of allowances. Dental charges in excess of the schedule will be your responsibility. See page 82 for more details about the Dental Schedule.*

WDS PREFERRED DENTAL OPTION (#09135)

Although you may see any licensed dental provider, you receive higher benefits if you use a Washington Dental Service (WDS) member dentist who is participating in the plan. Once you pay the deductible, covered services are reimbursed as shown in Reimbursement Provisions below.

Call WDS directly at (800) 554-1907 or visit their website at www.DeltaDentalWA.com for a list of current participating providers. You can also ask your provider if they are participating providers (PPO) in the WDS network.

If you enroll in the WDS Preferred Provider plan (PPO), you'll have access to an online oral health tool, the MySmile® personal benefits center. There's no extra cost to you—visit www.DeltaDentalWA.com and you'll find personalized tips for improving oral health and lowering your out-of-pocket costs.

DEDUCTIBLE

The deductible is the amount of covered dental expenses you and your dependents must pay before the plan begins to pay benefits. Once the family deductible is paid, no further deductible amounts are required for any family member in the rest of that year.

Each person per calendar year	\$10
Each family per calendar year	\$30

Noncovered charges do not apply to the deductible. Orthodontic services are not subject to the deductible.

If you haven't already paid the required deductible amount in one year, eligible expenses incurred and applied toward the annual deductible during the last three months of that calendar year are carried over to apply against the deductible for the next year.

REIMBURSEMENT PROVISIONS (COINSURANCE)

	WDS PREFERRED PROVIDERS	WDS NONPREFERRED PROVIDERS	NON-WDS PROVIDERS
<i>Class I (diagnostic and preventive)</i>	100%	75%	75%
<i>Class II (basic procedures)</i>	85%	75%	75%
<i>Class III (major procedures)</i>	50%	40%	40%
<i>Orthodontia</i>	50%	50%	50%

Once you pay the deductible, the plan covers the above percentages for covered services. WDS providers' (nearly 90% of dentists in Washington) reimbursement will be based on their pre-approved filed fees. If you use a non-WDS provider, reimbursement will be based on the maximum allowable fee and you may have greater out-of-pocket expenses.

MAXIMUM BENEFITS

Class I, II and III Services: The maximum benefit for each covered person is \$2,500 per calendar year.

Orthodontic Services: The lifetime maximum benefit for each covered person is \$2,000. Orthodontic benefits already received under the Dental Schedule option also accrue toward this lifetime maximum benefit.

COVERED DENTAL EXPENSES

The following are Class I, Class II and Class III covered dental benefits under this program. Such benefits are available only when rendered by a licensed dentist or other WDS-approved licensed professional when appropriate and necessary as determined by the standards of generally accepted dental practice and WDS.

The amounts payable by WDS for Class I, II and III covered dental benefits are described above. Also, refer to the General Limitations and Exclusions sections as shown on pages 78–80.

CLASS I

Class 1: Diagnostic
Covered Dental Benefits

- ➔ *Routine examination (periodic oral evaluation)*
- ➔ *Comprehensive oral evaluation*
- ➔ *X-rays*
- ➔ *Emergency examination*
- ➔ *Specialist examination performed by a specialist in an American Dental Association recognized specialty (i.e. endodontist, periodontist, etc.)*

Limitations

- ➔ *Routine examination is covered twice in a calendar year*
- ➔ *Comprehensive oral evaluation is covered once in a three-year period, from the date of service, as one of the two covered examinations in a calendar year per eligible person per dental office. Additional comprehensive oral evaluations will be allowed as routine examinations. You will not be responsible for any difference in cost when services are provided by a WDS member dentist*
- ➔ *Complete series or panorex x-rays are covered once in a three-year period from the date of service*
- ➔ *Supplementary bitewing x-rays are covered twice in a calendar year*
- ➔ *Diagnostic services and x-rays related to temporomandibular joints (jaw joints) are not a covered benefit*

Exclusions

- 1. Consultations or elective second opinions.*
- 2. Study models.*
- 3. Caries susceptibility/risk tests.*

Class 1: Preventive
Covered Dental Benefits

- ➔ *Prophylaxis (cleaning)*
- ➔ *Periodontal maintenance*
- ➔ *Fissure sealants*

- ➔ *Topical application of fluoride or preventive therapies (e.g., fluoridated varnishes)*
- ➔ *Space maintainers when used to maintain space for eruption of permanent teeth*

Limitations

- ➔ *Prophylaxis cleaning and/or periodontal maintenance procedures will be limited to two in a calendar year*
- ➔ *Topical application of fluoride or preventive therapies (but not both) is covered twice in a calendar year through age 18*
- ➔ *Fissure sealants are available for children through age 15. If eruption of permanent molars is delayed, sealants will be allowed if applied within 12 months of eruption with documentation from the attending dentist. Payment for application of sealants will be for permanent maxillary (upper) or mandibular (lower) molars with incipient or no caries (decay) on an intact occlusal surface. The application of fissure sealants is a covered benefit once in a lifetime per tooth*
- ➔ *Replacement of a space maintainer previously paid for by WDS is not a covered benefit*

Exclusions

1. *Charges for home use supplies such as toothpaste, toothbrush, water-pick, fluoride, mouthwash, dental floss, etc.*
2. *Cleaning of a prosthetic device.*
3. *Oral hygiene and/or dietary instruction or for a plaque control program (a series of instructions on the care of the teeth).*

CLASS II

Class 2: General Anesthesia

Covered Dental Benefits

General anesthesia when administered in a dental office setting by a licensed dentist or other WDS-approved licensed professional who meets the educational, credentialing and privileging guidelines established by the Dental Quality Assurance Commission of the state of Washington or as determined by the state in which the services are delivered.

Limitations

- ➔ *General anesthesia is covered in conjunction with certain covered oral surgery procedures, as determined by WDS, or when medically necessary, for children through age six, or a physically or developmentally disabled person, when in conjunction with Class I, II, III and orthodontic covered dental procedures. Either general anesthesia or intravenous sedation (but not both) is covered when performed on the same day*
- ➔ *General anesthesia for routine post-operative procedures is not a covered benefit*

Class 2: Intravenous Sedation
Covered Dental Benefits

Intravenous sedation when administered by a licensed dentist or other WDS-approved licensed professional who meets the educational, credentialing and privileging guidelines established by the Dental Quality Assurance Commission of the state of Washington or as determined by the state in which the services are delivered.

Limitations

- ➔ *Intravenous sedation is covered in conjunction with certain covered oral surgery procedures, as determined by WDS; either general anesthesia or intravenous sedation (but not both) is covered when performed on the same day*
- ➔ *Intravenous sedation for routine post-operative procedures is not a covered benefit*

Class 2: Palliative Treatment
Covered Dental Benefits

Palliative treatment for pain.

Limitations

- ➔ *Palliative treatment is not a covered benefit when the same provider performs any other definitive treatment on the same date*

Class 2: Restorative
Covered Dental Benefits

- ➔ *Silver fillings (amalgam) and, in front (anterior) teeth, “white” (resin-based composite or glass ionomer restorations) fillings for treatment of carious lesions (visible destruction of hard tooth structure resulting from the process of dental decay) or fracture resulting in significant loss of tooth structure (missing cusp)*
- ➔ *“White” (resin-based composite or glass ionomer restorations) fillings placed in the buccal (facial) surface of bicuspid*
- ➔ *Stainless steel crowns*

Limitations

- ➔ *Fillings (restorations) on the same surface(s) of the same tooth are covered once in a two-year period from the date of service*
- ➔ *If a resin-based composite restoration is placed in a posterior tooth (except on bicuspid as noted above), an amalgam allowance will be made for such procedure; the difference in cost is your responsibility*
- ➔ *Cosmetic services are not a covered benefit*
- ➔ *Stainless steel crowns on permanent or primary teeth are covered once in a two-year period from the date of service*
- ➔ *Refer to Class III Restorative if teeth are restored with crowns, veneers, inlays or onlays*

Exclusions

1. *Overhang removal, copings, re-contouring or polishing of fillings (restorations).*

Class 2: Oral Surgery
Covered Dental Benefits

- ➔ *Removal of teeth and surgical extractions*
- ➔ *Preparation of the upper jaw or lower jaw and soft tissue of the mouth for insertion of dentures*
- ➔ *Treatment of pathological conditions and traumatic facial injuries of the mouth*

Exclusions

1. Bone grafts for ridge preservation (pelvis or rib grafts to denture supporting ridges).
 2. Bone grafts, of any kind, to the upper or lower jaws not associated with periodontal treatment of teeth.
 3. Ridge extensions for denture support.
 4. Tooth transplants.
 5. Placement of materials in tooth sockets to promote healing.


Class 2: Periodontics (Treatment of Gum Diseases)

Covered Dental Benefits

Surgical and nonsurgical procedures for treatment of the tissues supporting the teeth. Services covered include periodontal scaling/root planing, gingivectomy and limited adjustments to the chewing surface of the teeth (occlusion) for eight teeth or less.

Limitations

- ➔ Periodontal scaling/root planing is covered once in a 24 month period from the date of service
 - ➔ Limited occlusal adjustments are covered once in a 12 month period from the date of service
 - ➔ Periodontal surgery (per site) is covered once in a three year period from the date of service
 - ➔ Periodontal splinting and/or crown and bridgework in conjunction with periodontal splinting, crowns as part of periodontal therapy and periodontal appliances are not a covered benefit



Note: Some benefits are available only under certain conditions of oral health. It is strongly recommended that you have your dentist submit a predetermination of benefits to determine if the treatment is a covered benefit. A predetermination is not a guarantee of payment.

Exclusions

1. Occlusal guard (nightguard) and occlusal splints.
 2. Gingival curettage.
 3. Major (complete) occlusal adjustment to the chewing surface of the teeth.

Class 2: Endodontics (Treatment to Tooth Pulp)

Covered Dental Benefits

- ➔ *Procedures for pulpal and root canal treatment*
- ➔ *Services covered include pulpotomy and apicoectomy*

Limitations

- ➔ *Root canal treatment on the same tooth is covered only once in a two-year period from the date of service*
- ➔ *Re-treatment of the same tooth is allowed when performed by a different dental office*
- ➔ *Refer to Class III Prosthodontics if the root canals are placed in conjunction with a prosthetic appliance*

Exclusions

- Bleaching of teeth*

CLASS III

Class 3: Restorative

Covered Dental Benefits

- ➔ *Crowns, veneers, inlays (as a single tooth restoration—with limitations) or onlays for treatment of visible destruction of hard tooth structure resulting from the process of dental decay, or fracture resulting in significant loss of tooth structure (missing cusp), when teeth cannot reasonably be restored by a less costly treatment*
- ➔ *Crown buildups, subject to limitations*
- ➔ *Post and core, subject to limitations*

Limitations

- ➔ *Crowns, veneers, inlays (as a single tooth restoration—with limitations) or onlays on the same teeth are covered once in a five-year period from the seat date. If a porcelain onlay is placed on a tooth, an allowance for a metallic onlay will be*

made for such procedure. The difference in cost is your responsibility. If a tooth can be restored with a filling material such as amalgam or resin-based composite, an allowance will be made for such a procedure toward the cost of any other type of restoration that may be provided. WDS will allow the appropriate amount for an amalgam restoration (posterior tooth) or resin-based composite restoration (anterior tooth) toward the cost of a laboratory processed resin inlay (as a single tooth restoration—with limitations), onlay, veneer or crown

- ➔ *Crown buildups are a covered benefit when more than 50% of the visible portion of the tooth structure is missing or there is less than 2mm of vertical height remaining for one-half or more of the tooth circumference and there is evidence of decay or other significant breakdown*
- ➔ *Crown buildups are covered once in a two-year period from the date of service*
- ➔ *Crown buildups are not a covered benefit within two years of a restoration on the same tooth*
- ➔ *Crown buildups for the purpose of improving tooth form, filling in undercuts, or reducing bulk in castings are considered basing materials and are not a covered benefit*
- ➔ *A crown used for purposes of re-contouring or repositioning a tooth to provide additional retention for a removable partial denture is not a covered benefit unless the tooth is decayed to the extent that a crown would be required to restore the tooth whether or not a removable partial denture is part of the treatment*
- ➔ *Crowns or onlays are not a covered benefit when used to repair micro-fractures of tooth structure when the tooth displays no symptoms or there are existing restorations with defective margins when there is no decay*
- ➔ *Crowns and/or onlays placed because of weakened cusps or existing large restorations without overt pathology are not a covered benefit*
- ➔ *Crown and bridgework in conjunction with periodontal splinting or other periodontal therapy and periodontal appliances are not a covered benefit*
- ➔ *Post and core are covered once in a five-year period from the date of service on the same tooth*

Exclusions

1. Copings.

Class 3: Prosthodontics (Dentures and Bridges)

Covered Dental Benefits

Dentures, fixed partial dentures (fixed bridges), inlays (only when used as an abutment for a fixed bridge), removable partial dentures and the adjustment or repair of an existing prosthetic device.

Limitations

- ➔ Replacement of an existing prosthetic device is covered only once every five years from the delivery date and only then if it is unserviceable and cannot be made serviceable
 - ➔ Inlays are a covered benefit on the same teeth once in a five-year period from the date of service only when used as an abutment for a fixed bridge
 - ➔ Crowns in conjunction with overdentures are not a covered benefit
 - ➔ Root canals in conjunction with overdentures are not a covered benefit
 - ➔ Fixed prosthodontics for children under 16 years of age are not a covered benefit
 - ➔ Porcelain and resin inlay bridges are not a covered benefit
 - ➔ Full, immediate dentures: WDS will allow the appropriate amount for a full or immediate denture toward the cost of any other procedure that may be provided, such as personalized restorations or specialized treatment
 - ➔ Partial dentures: If a more elaborate or precision device is used to restore the case, WDS will allow the cost of a cast chrome and acrylic partial denture toward the cost of any other procedure that may be provided
 - ➔ Temporary partial dentures: Temporary (stayplate) dentures are a benefit only when replacing anterior teeth during the healing period or in children 16 years of age or under for missing anterior permanent teeth
 - ➔ Denture adjustments and relines: Denture adjustments done more than six months after the initial placement are covered. Relines done more than six months after the initial placement are covered. Subsequent relines or rebases (but not both) will be covered once in a 12-month period from the date of service

Exclusions

- 1. Duplicate dentures.
- 2. Personalized dentures.
- 3. Cleaning of prosthetic appliances.
- 4. Copings.
- 5. Temporary dentures.
- 6. Implants.

ACCIDENTAL INJURY

This dental option will pay 100% of participating providers filed fee or the maximum allowable fee for covered dental benefit expenses arising as a direct result of an accidental bodily injury. However, payment for accidental injury claims will not exceed the unused program maximum. The accidental bodily injury must have occurred while the patient was eligible. A bodily injury does not include teeth broken or damaged during the act of chewing or biting on foreign objects. Coverage includes necessary procedures for dental diagnosis and treatment rendered within 180 days following the date of the accident.

ORTHODONTIC SERVICES

The orthodontic benefit is available only when treatment improves chewing (masticatory) function. Orthodontia is not covered to treat any other condition.

Orthodontic services rendered to employees and enrolled dependents are limited to a \$2,000 maximum lifetime benefit. Not more than \$1,000 of the maximum, or one-half of the plan’s total responsibility shall be payable for treatment during the “construction phase.” The final payment shall be made during the 7th month following the construction phase, providing the employee is eligible and the dependent is in compliance with the age limitation.

If orthodontic services are discontinued for any reason before approved treatment is complete, or if charges are made during a month with no dental coverage, the plan stops benefit payments with the last eligible dental billing.

Orthodontic benefits already received under the Dental Schedule option will be included to determine when the \$2,000 lifetime maximum benefit has been met.

This plan will pay a constant 50% of the lesser of the “maximum allowable fees” or the fees actually charged for orthodontic benefits.

It is strongly suggested that orthodontic treatment be submitted to, and a predetermination be made by, WDS prior to commencement of treatment. A predetermination is not a guarantee of payment. Additionally, payment for orthodontic benefits is based upon your eligibility. If you become ineligible prior to the secondary payment of benefits, the secondary payment is not covered.

Covered Dental Benefits

Treatment of malalignment of teeth and/or jaws (chewing function). Orthodontic records: Exams (initial, periodic, comprehensive, detailed and extensive), X-rays (intraoral, extraoral, diagnostic radiographs, panoramic), diagnostic photographs, diagnostic casts (study models) or cephalometric films.

Limitations

Payment is limited to:

- ➔ *Completion, or loss of eligibility, whichever occurs first*
 - ➔ *Treatment received after coverage begins (claims must be submitted to WDS within 12 months of the start of coverage for orthodontia claims). The initial banding date is the treatment date considered in the timely filing. Treatment that began prior to the start of coverage will be prorated. The initial payment and periodic payments charged by the provider prior to coverage beginning will be deducted from the amount considered for payment.*
 - ➔ *Termination of the treatment plan prior to completion of the case*
 - ➔ *Termination of this program*

Exclusions

- Charges for replacement or repair of an appliance.*
 - Orthodontic retainer adjustment.*
 - Orthognathic surgery (jaw surgery).*
 - No benefits shall be provided for services considered inappropriate and unnecessary, as determined by WDS.*

GENERAL LIMITATIONS

- ➔ *Services for cosmetic reasons is not a covered benefit*
- ➔ *General anesthesia/intravenous (deep) sedation, except as specified for oral surgery procedures. General anesthesia except when medically necessary, for children through age six, or a physically or developmentally disabled person, when in conjunction with covered dental procedures*
- ➔ *Restorations or appliances necessary to correct vertical dimension or to restore the occlusion. Such procedures, which include restoration of tooth structure lost from attrition, abrasion or erosion and restorations for malalignment of teeth, are not covered*

GENERAL EXCLUSIONS

1. *Care for any dental condition, ailment, or injury for which you or your dependent are entitled to receive benefits in whole or in part under occupational coverage voluntarily obtained by the employer or required by Workers' Compensation of the United States or services rendered in a hospital owned or operated by a State or United States Government Agency or any care for which benefits are available under any State or Federal Act, even though the member and/or their dependent waives their right to such benefits.*
2. *Application of desensitizing agents.*
3. *Experimental services or supplies.*
 - *Experimental services or supplies are those whose use and acceptance as a course of dental treatment for a specific condition is still under investigation/observation. In determining whether services are experimental, WDS, in conjunction with the American Dental Association, will consider if:*
 - *The services are in general use in the dental community in the State of Washington;*
 - *The services are under continued scientific testing and research;*
 - *The services show a demonstrable benefit for a particular dental condition; and*
 - *They are proven to be safe and effective.*

- *Any individual whose claim is denied due to this experimental exclusions clause will be notified of the denial within 20 working days of receipt of a fully documented request.*
 - *Any denial of benefits by WDS on the grounds that a given procedure is deemed experimental, may be appealed to WDS. By law, WDS must respond to such appeal within 20 working days after receipt of all documentation reasonably required to make a decision. The 20-day period may be extended only with written consent of the Eligible Person.*
4. *Analgesics such as nitrous oxide, conscious sedation, euphoric drugs or injections.*
 5. *Prescription drugs.*
 6. *In the event an eligible participant fails to obtain a required examination from a WDS-appointed consultant dentist for certain treatments, no benefits shall be provided for such treatment.*
 7. *Hospitalization charges and any additional fees charged by the dentist for hospital treatment.*
 8. *Broken appointments.*
 9. *Patient management problems.*
 10. *Completing insurance forms.*
 11. *Habit-breaking appliances.*
 12. *TMJ services or supplies.*
 13. *This plan does not provide benefits for services or supplies to the extent that benefits are payable for them under any motor vehicle medical, motor vehicle no-fault, uninsured motorist, under-insured motorist, personal injury protection (PIP), commercial liability, homeowner's policy or other similar type of coverage.*
 14. *Claims received after the 12 month filing limit.*
 15. *Charges made after coverage ends, except for the completion within 30 days of single procedures commenced while this coverage was in effect.*
 16. *Charges that exceed the maximum benefits.*
 17. *Conditions caused by or arising from an act of war, armed invasion or aggression.*
 18. *Expenses incurred before you became eligible.*
 19. *Expense incurred from a suicide attempt or intentionally self-inflicted injury or illness.*
 20. *Phone or other consultants when a dentist does not physically see a patient.*

- 21. Replacement of prosthodontic device or orthodontic appliance that is lost, stolen or damaged by neglect.*
 - 22. Separate asepsis or sterilization charges.*
 - 23. Services primarily for patient or provider convenience.*
 - 24. All other services not specifically included in this program as covered dental benefits.*
 - 25. Bleaching of teeth.*
-

WDS shall have the discretionary authority to determine whether services are covered benefits in accordance with the general limitations and exclusions shown in this summary, but it shall not exercise this authority arbitrarily or capriciously or in violation of the provisions of the plan.

DELTACARE DENTAL OPTION (#00404)

DeltaCare is a dental HMO (Health Maintenance Organization) network administered by Washington Dental Service (WDS). Under this option, you must receive services and referrals from your primary care dental office. At the time of treatment, you pay the copayment amount for the service received. A schedule of these is available from WDS and the Trust Office.

Except for emergency care, this option does not cover dental services which are not performed by your DeltaCare primary care dental office or referred by a DeltaCare specialist.

ORTHODONTIC BENEFITS

This option provides coverage for orthodontic treatment plans provided by DeltaCare orthodontists. You pay the copay amounts shown below for covered orthodontic treatment. Coverage includes 24 months of active comprehensive orthodontic treatment, initial examination, diagnosis, consultation, initial banding, de-banding and the retention phase of treatment.

COVERED PATIENT	ORTHODONTIC COPAY
<i>Dependent children to age 19</i>	\$1,200
<i>Adults and covered full-time students</i>	\$1,600

FOR MORE INFORMATION

Details about this option are available in separate WDS publications. For more information, call WDS at (800) 650-1583, visit www.DeltaDentalWA.com or contact the Trust Office.

DENTAL SCHEDULE OPTION

The Dental Schedule option covers services by any licensed dentist, denturist or dental hygienist (under dentist’s supervision). Once you pay the deductible, benefits for basic services are paid according to the Schedule of Dental Allowances on page 85; benefits for orthodontic services are paid as described on page 84.

Dental charges that exceed the allowances are your responsibility. At the time of service you may have the dentist bill you or submit the bill directly to the Trust.

DEDUCTIBLE

<i>Each person per calendar year</i>	\$10
<i>Each family per calendar year</i>	\$30

The deductible is the amount of covered dental expenses you and your dependents must pay before the plan begins to pay benefits. Once the family deductible is paid, no further deductible amounts are required for any family member in the rest of that year. Noncovered charges do not apply to the deductible. Orthodontic services are not subject to the deductible.

If you haven’t already paid the required deductible amount in one year, eligible expenses incurred and applied toward the annual deductible during the last three months of that calendar year are carried over to apply against the deductible for the next year.

MAXIMUM BENEFITS

Basic Services: The annual maximum benefit for each covered person is \$2,500 per calendar year.

Orthodontic Services: The lifetime maximum benefit for each covered person is \$2,000. Orthodontic benefits received under the WDS Preferred option also accrue toward this lifetime maximum benefit.

COVERED BASIC SERVICES

Benefits include necessary dental treatment listed in the Schedule of Dental Allowances and received while you or your dependents are covered. After you pay the deductible, the plan pays the amount charged by your licensed dentist, denturist or dental hygienist (under dentist’s supervision) up to the allowance shown in the schedule for that procedure and annual maximum benefit. **Some procedures require predetermination of benefits (see page 84).**

Covered basic dental services include the following:

Diagnostic and Preventive: Necessary procedures are covered to assist the dentist in evaluating the condition and the dental care required, including:

- ➔ *Complete mouth x-rays once per calendar year: supplementary bitewing x-rays allowed upon request*
 - ➔ *Emergency care as necessary, including palliative care*
 - ➔ *Fluoride treatment once per calendar year*
 - ➔ *Prophylaxis (cleaning) twice per calendar year*
 - ➔ *Routine oral exam twice per calendar year*

Restorative Dentistry: Amalgam, composite resin and plastic fillings, as well as gold restoration and crowns, are covered. Predetermination of benefits may apply to certain procedures in this category (see page 84).

Endodontics (Treatment to Tooth Pulp): Pulpal therapy and root canal filling are covered.

Periodontics (Treatment of Gum Diseases): Benefits include procedures necessary to treat diseases of the gums and bones supporting the teeth.

Oral Surgery: Extraction (pulling of teeth) and other oral surgeries are covered.

Prosthodontics (Dentures and Bridges): Benefits include full or partial dentures and bridges once per five years. Replacement dentures and bridges are covered only if the existing denture or bridge is unserviceable and the plan hasn’t paid for it within the last five years. The five-year period begins on the date the original denture or bridge was placed. Predetermination of benefits is required for certain procedures in this category (see page 84).

EXTENSION OF COVERAGE

Coverage will be extended for plan required predetermined services received within 30 days after termination of eligibility provided the request for plan required predetermination of benefits was received at the Trust Office while you or your dependent were eligible for dental

coverage. Coverage will also be extended for prosthodontic devices that were ordered prior to the termination of eligibility and delivered and placed within 30 days thereafter.

ORTHODONTIC SERVICES

For orthodontic services (including retention), the plan pays 50% of the dentist’s usual, customary and reasonable charges up to the \$2,000 lifetime maximum benefit. Covered services for employees and enrolled dependents include:

- ➔ *Diagnosis: x-rays, models and cephalometric tracings up to one payment per five years*
- ➔ *Initial orthodontic banding and appliances up to 25% of the total orthodontic treatment plan cost*
- ➔ *Payment for subsequent monthly adjustments is based on the remaining charges, extended over the expected length of the treatment plan, with a minimum monthly payment of \$54*

The orthodontic benefit is available only when treatment improves masticatory (chewing) function. There are no benefits available for orthodontia to treat any other condition.

Payments are made after services are received and a claim is received for services rendered. No benefits are provided during any month you’re not actually examined by the dentist.

Orthodontic services are limited to a \$2,000 lifetime maximum benefit and are subject to other plan limitations. Orthodontic benefits received under the WDS Preferred plan also accrue toward this lifetime maximum benefit.

After completion of approved orthodontic services, further orthodontic benefits will be provided, only if at least five years have elapsed from the date the previous treatment was completed, and if the lifetime maximum benefit of \$2,000 has not been reached. If orthodontic services are discontinued for any reason prior to the completion of approved treatment, or if charges are made during a month in which there is no dental coverage, the plan will stop benefit payments with the last eligible charge.

PREDETERMINATION OF DENTAL BENEFITS

Predetermination helps you identify your out-of-pocket expenses prior to authorizing your dentist to complete their recommended treatment plan. During predetermination, emergency palliative treatment is covered to relieve the problem temporarily until the Trust Office completes the process.

Predetermination is required for the following services:

- ➔ *Bridges*
- ➔ *Crowns*
- ➔ *Dental implants*
- ➔ *Gold or porcelain inlays and onlays*
- ➔ *Gold restorations*

A dental treatment plan must be submitted to the Trust Office for predetermination, along with all records, including current x-rays (not over 12 months old). If x-rays and records are not submitted, plan required predetermination will be delayed.

If the procedures shown on the dental treatment plan do not begin within 12 months or if the treatment plan changes, you must submit a new dental treatment plan to the Trust Office. Coverage will be extended for plan required predetermined services received within 30 days after termination of eligibility, provided the request for plan required predetermination of benefits was received at the Trust Office while you were eligible.

Predetermination does not guarantee benefits if actual treatment differs from the predetermined services.

REDIRECTED BENEFITS

There are several ways to treat many dental problems that will produce a satisfactory result. The plan will pay benefits based on the procedure that meets acceptable standards of dental practice that the Trust determines to be the least costly. You may choose a more costly procedure if you wish; however, the Trust will only provide benefits for the least costly. If you choose a more costly treatment, you will be responsible for paying the difference between the charges for the more costly treatment and the benefits paid by the plan. You and your dentist can decide on which treatment you want; however, only benefits allowed by the Trust will be available.

The predetermination estimate procedure described above will help you know what benefits the plan will pay. You will then be able to determine the difference (if any) that you may have to pay yourself.

SCHEDULE OF DENTAL ALLOWANCES FOR BASIC SERVICES

The table below summarizes your dental benefits under the Dental Schedule option for claims incurred on or after October 1, 2007. After you pay the deductible, benefits for basic services are paid according to this schedule.

If the procedure performed is not shown in this Schedule and is not expressly excluded by any of the terms of this plan, a procedure of equivalent gravity and severity may be used as a basis for determining the maximum allowance. The final determination of allowances, if any, is within the sole discretion of the Trust.

ADA CODE	PROCEDURE	MAXIMUM BENEFIT ALLOWANCE \$
Diagnostic		
Exams		
0120	Periodic oral exam	34.00
0140	Limited, problem-focused oral exam	46.70
0150	Comprehensive/initial oral exam	54.10
Radiographs (x-rays)		
Complete mouth		
0210	Intraoral (including bitewings)	82.30
0330	Panoramic	71.70
Intraoral periapical		
0220	First film	17.60
0230	Each additional film	16.30
Bitewings		
0270	Single film	17.60
0272	2 films	27.80
0274	3 to 4 films	39.40
0240	Occlusal single film	27.00
0340	Cephalometric (other than TMJ or orthodontia)	82.20
0470	Study models/diagnostic casts	68.30

ADA CODE	PROCEDURE	MAXIMUM BENEFIT ALLOWANCE \$
Preventive		
Prophylaxis (cleaning and scaling)		
1110	Age 14 and over (adult)	69.40
1120	To age 14 (child)	44.40
Fluoride Application (excluding prophylaxis)		
1204	Age 14 and over (adult)	24.50
1203	To age 14 (child)	26.40
1351	Sealant, each tooth	34.10
Minor Restorations		
Amalgam Restorations		
2140	Primary, permanent – 1 surface	79.00
2150	Primary, permanent – 2 surfaces	107.70
2160	Primary, permanent – 3 surfaces	132.90
2161	Primary, permanent – 4 or more surfaces	159.20
Other Minor Restorations		
2330	Composite resin – 1 surface, anterior	96.10
2331	Composite resin – 2 surfaces, anterior	125.70
2332	Composite resin – 3 surfaces, anterior	158.10
2335	Composite resin – 4 or more surfaces, anterior	184.80

ADA CODE	PROCEDURE	MAXIMUM BENEFIT ALLOWANCE \$
Major Restorations (predetermination required)		
Inlays/Onlays		
2510	Inlay-metallic – 1 surface	356.00
2520	Inlay-metallic – 2 surfaces	396.90
2530	Inlay-metallic – 3 or more surfaces	425.30
2542	Onlay-metallic – 2 surfaces	401.10
2543	Onlay-metallic – 3 or more surfaces	438.90
2910	Recement inlay/onlay	49.70
Crowns		
2740	Porcelain	435.80
2750	Porcelain with metal (gold)	435.80
2780	Gold (3/4 cast)	435.80
2790	Gold (full cast)	435.80
2930	Stainless steel, primary	107.10
2937	Stainless steel, permanent	136.50
Other Services		
2910	Recement inlay/onlay	49.70
2920	Recement crown	62.20
2940	Sedative filling/temporary crown (fractured tooth)	65.10
2950	Core buildup, including any pins	133.40
2957	Pin retention – each tooth	27.30
2952	Cast post/core – in addition to crown	174.30
Endodontics		
Pulp Treatment		
3110	Pulp cap	52.50

ADA CODE	PROCEDURE	MAXIMUM BENEFIT ALLOWANCE \$
3220	Vital pulpotomy	121.80
Root Canal Therapy (includes treatment plan, clinical procedures and follow-up care; excludes final restoration)		
3310	1 root (anterior)	427.40
3320	2 roots (bicuspid)	528.70
3330	3 or more roots (molar)	747.30
3410	Apicoectomy (performed as a separate surgical procedure, including curettage) - first root, anterior	588.10
3421	Apicoectomy (performed as a separate surgical procedure, including curettage) - first root, bicuspid	690.90
3425	Apicoectomy (performed as a separate surgical procedure, including curettage) - first root, molar	634.20
3426	Apicoectomy (performed as a separate surgical procedure, including curettage) - each additional root	246.80
3430	Retrograde filling, each root	176.40
3450	Root amputation, each root	335.90
Periodontics		
9310	Periodontal exam	86.40
4910	Periodontal maintenance (prophylaxis)	113.60
4210	Gingivectomy - each quadrant	420.00
4211	Gingivectomy - each tooth	149.10
4260	Osseous surgery - each quadrant	908.40
4271	Free soft tissue grafts - each site	529.20

ADA CODE	PROCEDURE	MAXIMUM BENEFIT ALLOWANCE \$
Oral Surgery		
Extractions (includes local anesthesia and routine postoperative care)		
7111	Extraction, coronal remnants – deciduous tooth	90.80
7140	Extraction, erupted tooth or exposed root	90.80
7210	Erupted tooth (surgically removed)	178.70
7240	Impacted tooth – completely bony	320.30
7250	Surgical removal of residual tooth roots	196.40
Related Oral Surgical Procedures		
7270	Reimplantation of tooth	315.00
7286	Biopsy of oral tissue (soft)	211.10
7310	Alveoloplasty – each quadrant	188.00
7471	Removal of exostosis – maxilla or mandible	377.00
7510	Incision and drainage of abscess (intraoral)	147.00
7960	Frenulectomy (separate procedure)	284.10
Prosthodontics (predetermination required)		
Dentures		
5110, 5120	Complete upper or lower	661.50
5211, 5212	Partial upper or lower – resin base (including conventional clasps, rests and teeth)	404.30
5213, 5214	Partial upper or lower – cast base (including conventional clasps, rests and teeth)	682.50

ADA CODE	PROCEDURE	MAXIMUM BENEFIT ALLOWANCE \$
5410, 5411	Denture adjustment, upper or lower	39.90
5610	Repair broken denture (no teeth involved)	87.40
5640	Replace broken tooth (per tooth)	83.10
5650	Add tooth to denture	102.10
5710, 5711	Denture rebase, upper or lower	283.50
5750, 5751	Reline denture, upper or lower	286.20
Dental Implants		
6010	Each implant	869.40
	Maximum – each arch	1738.80
	Lifetime maximum	3477.60
Bridgework		
6210	Cast gold pontic	420.00
6240	Porcelain – fused to gold pontic	420.00
6545	Retainer – cast metal for resin-bonded fixed prosthesis	262.50
6750	Porcelain – fused to gold abutment crown	430.50
6790	Cast gold abutment crown	430.50
6930	Recement bridge	92.10
Other Dental Procedures		
9110	Emergency care for pain	83.50
9220	General anesthesia*	320.30
9241	Intravenous conscious sedation/analgesia – first 30 minutes	107.50



** Dentally necessary general anesthesia provided in an approved outpatient ambulatory facility is covered at 80% of UCR.*

ADA CODE	PROCEDURE	MAXIMUM BENEFIT ALLOWANCE \$
9242	Intravenous conscious sedation/analgesia – each additional 15 minutes	55.40
9310	Professional consultation	86.40
Space Maintainers		
1510	Fixed space maintainer (fixed, unilateral)	212.10
1515	Fixed space maintainer (fixed, bilateral)	305.60
9940	Night guard	408.50
TMJ/TMD Therapy		
9310	Exam	86.40
0330	X-rays	71.70
0470	Models	68.30
7880	Device/appliance	408.50
	Appliance adjustment (maximum of 4)	39.90
9951	Occlusal adjustment (limited; maximum of 4)	84.00
9952	Occlusal adjustment (complete)	378.00

EXCLUSIONS

The Dental Schedule option does not cover:

- Care for any dental condition, ailment, or injury for which you or your dependent are entitled to receive benefits in whole or in part under occupational coverage voluntarily obtained by the employer or required by Workers' Compensation of the United States or services rendered in a hospital owned or operated by a State or United States Government Agency or any care for which benefits are available under any state or federal Act, even though the member and/or their dependent waives their right to such benefits.
- Charges for completing claim forms.

3. *Charges for missed appointments.*
4. *Charges made after coverage ends, except:*
 - *Services requiring predetermination that are received within 30 days after dental coverage ends will be covered provided the Trust Office received the predetermination request while the patient was eligible*
 - *Prosthetic devices ordered before and delivered within 30 days after dental coverage ends are covered.*
5. *Charges that exceed the maximum allowance for the procedure.*
6. *Claims received after the 12-month filing limit.*
7. *Conditions caused by or arising from an act of war, armed invasion or aggression.*
8. *Cosmetic services (unless performed as part of treating a covered functional disorder or an accidental injury).*
9. *Crown buildups are a covered benefit when more than 50% of the visible portion of the tooth structure is missing or there is less than 2mm of vertical height remaining for one-half or more of the tooth circumference and there is evidence of decay or other significant breakdown.*
10. *Crown buildups for the purpose of improving tooth form, filling in undercuts, or reducing bulk in castings are considered basing materials and are not a covered benefit.*
11. *Crowns or onlays are not a covered benefit when used to repair micro-fractures of tooth structure when the tooth displays no symptoms or there are existing restorations with defective margins when there is no decay.*
12. *Crowns and/or onlays placed because of weakened cusps or existing large restorations without overt pathology are not a covered benefit.*
13. *Dental procedures not recommended and approved by a dentist.*
14. *Duplicate dentures or dental services.*
15. *Expenses incurred before the patient becomes eligible, including prosthetic devices or crowns prepared before the effective date but placed afterward.*
16. *Expenses incurred from self-inflicted injuries or injuries sustained in connection with attempted suicide while sane or insane, unless the injuries are the result of a physical or mental health condition.*
17. *Experimental or investigational services or supplies, as defined on page 120.*
18. *Home use supplies such as toothpaste, toothbrush, water-pick, fluoride, mouthwash, dental floss, etc.*
19. *Hospital facility charges for treating a dental condition.*

20. *If a patient seeks care from more than one dentist during the course of any treatment, or if more than one dentist renders services for the same dental procedure, the plan will not be liable for more than the amount that it would have been liable from one dentist; nor will the plan be liable for duplication of services.*
 21. *Nitrous oxide.*
 22. *Oral exam or prophylaxis (cleaning of teeth) more often than twice per calendar year.*
 23. *Oral hygiene or dietary instruction for plaque control or care of the teeth.*
 24. *Orthodontic retainer adjustment.*
 25. *Payment for full-mouth x-rays or fluoride treatments more than once per calendar year.*
 26. *Phone or other consultations when a dentist does not physically see a patient.*
 27. *Precision attachments.*
 28. *Prescription drugs (see page 54 for prescription drug coverage).*
 29. *Replacement of a prosthodontic device or orthodontic appliance that is lost, stolen or damaged by neglect.*
 30. *Replacement of dentures (full or partial) or bridges more often than once per five years.*
 31. *Separate asepsis or sterilization charges.*
 32. *Services for which no charge is made or services that would not have been received in the absence of these benefits.*
 33. *Services or supplies provided by a dentist, denturist or dental hygienist who usually lives in your home or is related by blood or marriage.*
 34. *Services or supplies the patient has not actually received (e.g., a crown that's ordered but not placed).*
 35. *Services primarily for patient or provider convenience.*
 36. *Temporary services.*
 37. *Treatment (other than scheduled benefits) of jaw joint problems including temporomandibular joint (TMJ) dysfunction, disorder or syndrome, or any other craniomandibular disorders or conditions of the joint linking the jawbone and skull or muscles, nerves and other tissues relating to that joint.*
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COORDINATION OF BENEFITS

You may have medical and/or dental coverage, such as through your spouse’s employer, in addition to these benefits. The other plan is taken into account when your benefits under this plan are determined. This provision, known as coordination of benefits, may reduce benefits under the plan.

The plan that pays benefits first is considered the primary plan and pays benefits without regard to those payable under other plans. When another plan is primary, this plan pays an amount that, when added to other plan benefits, does not exceed 100% of allowable expenses.

Allowable expenses are any usual, customary and reasonable charges, part or all of which are covered under any of the other plans. Allowable expenses under a health maintenance organization include only the copayments you are required to pay.

The following rules determine which group plan is primary:

-
- ➔ *A plan that has no coordination of benefit provisions pays before a plan that includes such provisions*
 - ➔ *A plan that covers a person other than as a dependent pays before a plan that covers the person as a dependent*
 - ➔ *If a dependent child is covered under both parents’ plans, the child’s primary coverage is through the parent whose birthday comes first in the calendar year, with secondary coverage through the parent whose birthday comes later. If the other plan relies on gender instead of this “birthday rule” to coordinate benefits, the “gender rule” is used*
 - ➔ *If a dependent child’s parents are divorced or separated, and a court decree and/or parenting plan establishes financial responsibility for the child’s healthcare coverage, the plan of the parent with financial responsibility is primary. If the divorce decree is silent, the following guidelines apply:*
 - *The plan of the parent with custody pays benefits first if that parent has not remarried. The plan of the parent without custody pays second*

- *If the parent with custody has remarried, the plans pay in this order: plan of the parent with custody, plan of the spouse of the parent with custody, plan of the parent without custody and plan of the spouse of the parent without custody*
- ➔ *For children whose parents were never married, the same rules apply as for divorced parents*
- ➔ *Benefits of the plan covering the person as an active employee or dependent of an active employee are determined before benefits of the plan covering the person as a retired, COBRA or laid-off employee or dependent of a retired, COBRA or laid-off employee*
- ➔ *If none of the above rules establishes which group plan would pay first, then the plan that has covered the person longer is considered primary*
- ➔ *The Trust excludes coverage for services or charges that would be provided or covered by a health maintenance organization (HMO) or other prepaid arrangement if such HMO or other prepaid arrangement were the only source of coverage. The principal reason for this exclusion is that the Trust receives no corresponding benefits from HMOs or their prepaid programs when services are provided outside the HMO or prepaid arrangement. (In other words, an HMO will not coordinate benefits with the Trust for services provided by the non-HMO provider, even if the HMO would be the primary source of coverage under normal coordination of benefit rules.) Since the Trust has chosen not to duplicate HMO-like plan benefits, any service received from an HMO-like service organization or its affiliated providers is ineligible for consideration of payment of any Trust benefits for services other than those that would not be covered by the HMO-like plan or for which the participant is liable for an out-of-pocket charge in addition to the prepaid capitation fee*

Other plans that provide medical and dental benefits include:

- ➔ *Any type of group coverage, whether insured or not*
- ➔ *Motor vehicle no-fault coverage*

Coordination of benefits does not apply to any individual policy you have.



Note: *If you or your eligible dependents have other coverage and this plan is secondary, you receive faster claim service if you submit the claim to the primary plan first. Then attach a copy of their explanation of benefits and your itemized bill to your claim submission for this plan.*

MEDICARE

For active employees and their dependents, benefits payable under this plan normally are primary and Medicare secondary. However, active employees have the option of electing Medicare as primary coverage. If an employee or dependent spouse age 65 or older makes this election, the plan pays no further medical benefits.

An exception to these rules is Medicare coverage for a person with end stage renal disease. During the first 30 months, coverage through this plan is primary and Medicare is secondary. After 30 months, Medicare becomes primary.

SUBROGATION (RIGHT OF RECOVERY)

If you or your dependents incur any medical or dental expense resulting from illness or injury for which there is a right of recovery against a third party or under an automobile, home owners, commercial premises, renter's, medical malpractice or other insurance or liability policy, any plan benefits for the expense are paid on these conditions:

- ➔ *By accepting or claiming benefits, you (or your dependent) agree that the plan is entitled to reimbursement from any judgment, disputed claim settlement or other recovery, up to the full amount of all benefits provided by the plan, but not to exceed the amount of the recovery. The plan is entitled to reimbursement regardless of whether you (or your dependent) are made whole by the recovery, and regardless of the characterization of the recovery, except that the plan will deduct reasonable attorney fees and a pro rata share of the costs from the reimbursement amount, if you (or your dependent) comply with the terms of the plan and the agreement to reimburse.*
- ➔ *The plan may require you (or your dependent) to sign an agreement to reimburse the plan from the proceeds of any recovery before the plan will provide benefits. The plan may require you (or your dependent) 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).*
- ➔ *You (or your dependent) must do nothing to prejudice the plan's right of reimbursement.*
- ➔ *When any recovery is obtained from a third party or insurer, whether by direct payment, settlement, judgment, or any other method, 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, you (or your dependent) 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 that you (or your dependent) 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 subrogation and reimbursement rights.*
 - ➔ *If the plan is not reimbursed in accordance with the agreement to reimburse, the plan may bring an action against you (or your dependent) to enforce its right to reimbursement, or in the alternative may elect to recoup the reimbursement amount by offsetting future benefits otherwise payable to you or your 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. Any legal action to enforce an agreement to reimburse may be brought in the King County Superior Court, at the option of the plan.*
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EMPLOYEE LIFE INSURANCE BENEFIT

BENEFIT

Your life insurance benefit is \$15,000. The amount will be paid to your beneficiary in the event of your death from any cause.

An accelerated benefit option is available if you are terminally ill with less than 12 months to live. This option allows 50% of the life benefit to be paid to you. The remaining 50% of the benefit will be paid to your named beneficiary at your death.

If you wish, benefits can be paid to your beneficiary in equal monthly installments (instead of a lump sum) in accordance with the Group Master Policy. This may be arranged by written election to MetLife.

Contact the Trust Office for more information.

DESIGNATION OF BENEFICIARY

You may designate a beneficiary and change the designation at any time by completing a new enrollment form and returning it to the Trust Office. (Enrollment forms can be obtained from the Trust Office.) Any change takes effect as of the date you signed the notice, but MetLife is not liable for any payments made before the Trust Office receives the notice.

If no beneficiary is living when you die, or if multiple beneficiaries have been designated and the amount of insurance payable to each is not clear, payment will be made as stated in the Group Master Policy.

EXTENDED LIFE BENEFITS WHEN DISABLED

If you become *totally disabled* before reaching age 60, your life insurance benefit remains in effect as long as you're totally disabled and provide the proof MetLife requires.

In this section, totally disabled means, because of illness or injury, you cannot do the important duties of your job and cannot do any other job

for which you're suited by education, training or experience, and you are not engaged in any occupation or employment for pay or profit.

Proof of total disability continuing is required within three months after you've been totally disabled for nine months. Life insurance remains in effect for successive periods of 12 months each, while total disability continues, if you submit proof to MetLife within the three months before each 12 months. Enrollment forms for these extended benefits are available from the Trust Office.

If you convert your life insurance as described below but later qualify for benefits under this section, you must surrender your converted policy before these extended benefits are granted. Premiums paid under the converted policy will be refunded.

CONVERSION PRIVILEGE

If your insurance ends because of employment termination, you may convert this life insurance to an individual policy without medical examination. Any individual life insurance policy MetLife customarily issues, except term insurance, is available.

You need to apply and pay the required premium within 31 days after employment termination or loss of coverage, whichever is later. If you die within this 31 days, the amount of insurance you were entitled to convert is paid to your beneficiary. Enrollment forms for conversion policies are available from the Trust Office.

DEPENDENT LIFE INSURANCE BENEFIT

BENEFIT

Your spouse's or same sex domestic partner's life insurance benefit is \$1,000. The amount will be paid to you in the event of your spouse's or partner's death from any cause.

CONVERSION PRIVILEGE

If your spouse's or partner's insurance ends, they may convert from this group life insurance to an individual policy without medical examination. Any individual life insurance policy MetLife customarily issues, except term insurance, is available.

Your spouse or partner needs to apply and pay the required premium within 31 days after losing coverage. If your spouse or partner dies within this 31 days, the amount of insurance your spouse or partner was entitled to convert is paid to you. Enrollment forms for conversion policies are available from the Trust Office.

EMPLOYEE ACCIDENTAL DEATH OR DISMEMBERMENT BENEFIT

BENEFIT

This benefit is payable to your beneficiary in the event of your death, or to you in the event of your loss, if your death or loss is caused by an accidental injury while you're covered under the Plan. To be covered, your death or loss must occur within one year of the injury.

COVERED LOSS	BENEFIT
<i>Loss of life</i>	\$15,000
<i>Loss of both hands</i>	\$15,000
<i>Loss of both feet</i>	\$15,000
<i>Loss of 1 hand and 1 foot</i>	\$15,000
<i>Loss of sight in both eyes</i>	\$15,000
<i>Loss of 1 hand and sight in 1 eye</i>	\$15,000
<i>Loss of 1 foot and sight in 1 eye</i>	\$15,000
<i>Quadriplegia (total paralysis of both upper and lower limbs)</i>	\$15,000
<i>Loss of 1 hand</i>	\$7,500
<i>Loss of 1 foot</i>	\$7,500
<i>Loss of sight in 1 eye</i>	\$7,500
<i>Paraplegia (total paralysis of both lower limbs)</i>	\$7,500
<i>Hemiplegia (total paralysis of upper and lower limbs on the same side of the body)</i>	\$7,500

If there are multiple losses from the same accident, payment is made only for the loss with the largest amount payable. No loss sustained before the accident can be included in determining the amount payable.

Loss of hands or feet means all of the hand or foot is cut off at or above the wrist or ankle joint; loss of sight means the entire and irrecoverable loss of sight. For paralysis (quadriplegia, paraplegia and hemiplegia), loss means loss of use, without severance, of a limb. Paralysis must be determined by a competent medical authority to be permanent, complete and irreversible.

ACCIDENTAL DEATH OR DISMEMBERMENT EXCLUSIONS

No accidental death or dismemberment benefits are paid for any loss caused directly or indirectly, wholly or in part, by:

- 1. Infection, unless caused by an external wound that can be seen and was sustained in an accident.*
 - 2. Participation in a riot or revolt.*
 - 3. Physical or mental illness; diagnosis of or treatment for the illness.*
 - 4. Suicide or attempted suicide.*
 - 5. War, or warlike action in time of peace, including terrorist acts.*

EMPLOYEE WEEKLY DISABILITY (TIME LOSS) BENEFIT

BENEFIT

If you are totally disabled because of your injury or sickness, you may be eligible for weekly disability benefits. In this section, totally disabled means you are unable to work in the industry and do not engage in other work for wage or profit. You must be under the continuous care and treatment of a physician or covered provider on or after the date of the disability to qualify for this benefit.

The benefit amount is based on your hours of employment reported to the Trust for your eligibility determination month. Your eligibility determination month is two months before you become disabled and stop active work. (For example, if you're disabled in July, the weekly benefit is based on employment hours in May.)

WEEKLY DISABILITY PAYMENT

HOURS EMPLOYED IN ELIGIBILITY DETERMINATION MONTH	MAXIMUM WEEKLY BENEFIT
<i>Less than 80</i>	\$0
<i>80 but less than 120</i>	\$135
<i>120 but less than 150</i>	\$180
<i>150 or more</i>	\$225

Your actual weekly benefit cannot exceed 50% of your average weekly wage, as earned in the eligibility determination month.



Note: An approved FMLA leave does not automatically qualify you for a weekly disability benefit.

Benefits are payable the fourth full day you do not work due to an illness or the first full day you do not work due to an accident. Here's how these waiting periods are calculated:

- ➔ *The waiting period for an illness is calculated from the first day of disability certified by your physician or covered provider if personal medical treatment is received during the first three days.*
- ➔ *When you receive medical treatment more than three days after the first day of illness, benefits begin the day of the first treatment if your physician or covered provider certifies the disability has then existed for three days or more; otherwise benefits begin the fourth day of certified disability, if later.*
- ➔ *If you do not receive medical treatment within three days of an accident, benefits do not begin until the day of the first treatment.*

Benefits are provided up to 26 weeks for any one disability period. Payments for partial weeks of disability are prorated, based on a seven-day week.

Disability periods are counted in this way:

- ➔ *Two or more disability periods due to the same or related illness or injury are considered one disability period unless separated by return to full-time duties of your regular occupation for at least two weeks*
- ➔ *Two or more disability periods due to an unrelated illness or injury are considered one disability period unless separated by return to full-time duties of your regular occupation for one day*

WEEKLY DISABILITY EXCLUSIONS

Weekly disability benefits do not cover:

- Any disability that starts prior to the effective date of your coverage for this benefit.*
- Both an injury and a sickness during any concurrent period.*
- Disability due to environmental conditions.*
- Disability due to intentionally self-inflicted injuries.*
- Disability resulting from participation in a riot.*
- Injury or sickness caused directly or indirectly by war or any act of war, declared or undeclared.*

7. *Injury sustained in the course of employment for wages or profit.*
 8. *Period of disability attributable to grief.*
 9. *Period of disability covered in whole or in part under occupational coverage voluntarily obtained by your employer or required by workers' compensation laws.*
 10. *Period of disability due to family member's illness or accident.*
 11. *Period of disability when you are not following a treatment plan.*
 12. *Period of disability when you are not regularly attended to and seen by a physician or covered provider.*
 13. *Period of time that is not substantiated by objective medical evidence.*
 14. *Period of time when you are not considered continually totally disabled.*
 15. *Period of time when you are unable to drive to work.*
-

TAXATION OF BENEFITS

Weekly disability benefits are subject to federal income tax—federal regulations require these benefit payments be reported to the IRS. The amount paid is on the annual W-2 Form your employer sends to you. You may ask the plan to withhold federal income tax from weekly disability benefits by contacting the Trust Office.

Weekly disability benefits are also subject to Social Security (FICA) tax. The liability for this tax is divided equally between you and your employer. The plan is required by federal law to withhold and deposit your share of FICA tax with the appropriate agency.

SUBMITTING A CLAIM

HOW TO FILE A CLAIM

In a claim, you or your dependents request that the Plan pay a benefit for a specific service or supply. Claims must be submitted within the following time periods:

CLAIM	TIME PERIOD
Medical	12 months from date the service or supply was received
Prescription Drug	12 months after filling the prescription
Vision	12 months from the date the service or supply was received
Dental	12 months from date treatment was received
Life Insurance	As soon as reasonably possible after the death of an insured person
Accidental Death or Dismemberment	No later than 90 days after the date of loss
Weekly Disability (Time Loss)	12 months after disability begins

Unless you or your dependent can establish to the Trustees' satisfaction that it wasn't possible to file within this time, your benefit will be denied. Subject to special provisions for urgent care claims (see page 115), claims must be submitted in writing and to the proper address.

The plan may require more details to process claims. These may involve eligibility, the nature of services or supplies received, coordination of benefits, other insurance, third-party reimbursement or other plan provisions. Not providing required information to the plan may result in the denial of your claim.

Submitting incomplete forms or bills that aren't itemized may delay claim processing.

TRUST PPO MEDICAL AND DENTAL SCHEDULE BENEFITS

Many providers will file claims for you if they have all of the needed information. If your provider does not submit a claim on your behalf, you will need to do the following:

1. *Obtain a claim form from your local union or the Trust Office.*
2. *Complete all sections on the front of the form.*
3. *Attach a fully itemized bill from your provider. For dental services:*
 - *Have your dentist complete their section of the form and return it to the Trust Office. If continued treatment is needed, the dentist should send subsequent bills to the Trust Office*
 - *If dental services are in connection with crowns, bridges, gold or porcelain inlays and onlays, gold restorations and dental implants, a dental treatment plan must be submitted to the Trust Office for predetermination, including current x-rays and records. (See page 84 for more about predetermination.)*
4. *If you have other medical or dental coverage and this plan is secondary, submit the claim to the primary plan first. Once that plan pays, send a copy of its explanation of benefits and a fully itemized bill when you submit your claim to this plan. (See page 95 for coordination of benefit rules.)*
5. *Mail the fully completed form and any attachments to the address at the top of the form.*
6. *If you see a doctor for both vision correction and medical treatments of the eye, submit the bill first to VSP for reimbursing expenses associated with vision correction. Then send a copy of the bill—together with VSP's explanation of benefits—to the Trust Office for reimbursing your medical expenses.*
7. *Submit claims for injuries or accidents incurred on the job to workers' compensation.*
8. *For claim assistance, contact the Trust Office.*

Incomplete forms and bills that are not itemized will be returned to you for completion and will delay payment of your claims. No claim will be accepted unless filed within 12 months from the date the service or supply was received.

VISION BENEFITS (TRUST PPO)

When you see a VSP provider, there is no need to file a claim; the VSP provider will do it for you.

When you choose a non-VSP provider:

- 1. Pay the bill in full.*
 - 2. File a claim for reimbursement. Write your name, Social Security number and Sound Health & Wellness Trust on it, then send the claim along with a copy of the bill to:*
 - VSP*
Out of Network Provider Claims
PO Box 997105
Sacramento, CA 95899-7105
(800) 877-7195
 - 3. Reimbursement is made directly to you and is not assignable to the doctor.*

WDS PREFERRED AND DELTACARE DENTAL BENEFITS

When you see a WDS participating provider or visit your DeltaCare primary dental office, there is no need to file a claim; your dentist will do it for you.

When you choose a non-participating provider, submit an American Dental Association-approved claim form directly to:

- Washington Dental Service*
P.O. Box 75983
Seattle, WA 98175-0983

LIFE INSURANCE AND ACCIDENTAL DEATH OR DISMEMBERMENT BENEFITS

- 1. Notify the Trust Office, and in the case of death, submit a certified copy of the death certificate.*
 - 2. The Trust Office sends all of the information to MetLife for processing.*

WEEKLY DISABILITY BENEFITS (TIME LOSS)

1. Obtain a time loss claim form from your local union or the Trust Office.
2. Complete, sign and date part 1 of the form.
3. Have your physician complete, sign and date part 2 of the form.
4. Have your employer complete, sign and date part 3 of the form.
5. Mail the fully completed form to the address at the top of the form.

PROCEDURES FOR PROCESSING CLAIMS

Properly filed claims are processed according to these guidelines:

Post-Service Claims

Any properly filed claim for health benefits that is not a pre-service, urgent care or concurrent care claim (as defined on the following pages) is processed as a post-service claim. If more information is needed, you (or your dependent) are notified and given 45 days from receiving the notice to provide the information. The time for making a determination is counted from the date the information is requested until the earlier of the date the requested information is received, or 45 days after the requested information is mailed.

A post-service claim ordinarily is processed within 30 days of receipt. This may be extended for an additional 15 days if the Trust Office determines that the extension is necessary due to matters beyond the control of the plan and provides the reason for the extension—including a statement of unresolved issues and information required to resolve them—within the initial 30 days.

Pre-Service Claims

These procedures apply only to processing treatment plans submitted for preauthorization. As explained in more detail on page 32, a hospital preadmission authorization must be requested for all nonemergency inpatient hospital admissions.

The claimant is notified within five days if more information is required to complete a pre-service claim or to allow processing, with specifics on the information needed. The claimant has 45 days from receiving the notice to submit the information. The time for making a determination does not include the period from the date the information is requested until the earlier of the date the requested information is received, or 45 days after the requested information is mailed.

A decision on a pre-service claim ordinarily is made within 15 days. This time may be extended for an additional 15 days if the Trust Office determines that the extension is necessary due to matters beyond the

control of the plan and provides the reason for the extension—including a statement of unresolved issues and information required to resolve them—within the initial 15 days.

If services requiring preauthorization have been provided, and the issue is payment, the claim is processed as a post-service claim.

Urgent Care Claims

Urgent care claims are for services where following the normal claims processing timing rules could seriously jeopardize the claimant's health or ability to regain maximum function, or in the opinion of a physician familiar with the claimant's medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim. Urgent care claims may be filed, orally, or in writing, by the claimant, or physician or covered provider with knowledge of the condition. The claimant is informed as soon as possible, but not more than 24 hours after the claim is received if more information is required to process the claim, with specifics on the information needed.

The claim is resolved as soon as possible, but no more than 48 hours after the plan receives the additional information or the end of the 48 hours the claimant has to provide the information, whichever is earlier. Determinations about whether a claim is urgent are made using the judgment of a prudent layperson with average knowledge of health and dentistry.

If urgent care services have been provided, and the issue is payment, the claim is processed as a post-service claim.

Concurrent Care Claims

Concurrent care claims are claims involving an ongoing course of treatment that has received medical necessity approval from First Choice. While the approved treatment is continuing, the provider or claimant may request additional or extended treatment that results in denial or reduction of the treatment plan. In addition, First Choice may issue notice that approval will be withdrawn before the full course of treatment is completed. The claimant is notified of any denial or reduction at least 30 days in advance to allow time to appeal and obtain a determination on the appeal before the decision takes effect.

Any request to extend treatment that involves urgent care is decided as soon as reasonably practical. The claimant is notified of the determination within 24 hours of when the plan receives the claim, if it's received at least 24 hours before the previously approved treatment ends.

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

NOTICE OF DENIAL

A benefit denial contains this information:

1. *The reason for the denial.*
2. *Reference to the plan provision(s) relied on.*
3. *Description of any additional material needed for the claim, with an explanation of why it is necessary.*
4. *Reference to any internal rule, guideline or protocol used in denying the claim, with a statement that a copy is available without charge upon request.*
5. *An explanation of the medical judgment—applying plan terms to the claimant’s circumstances—if the denial is based on the service or supply being medically necessary or experimental or investigational, or an equivalent exclusion.*
6. *An explanation of the plan’s appeal procedures, including applicable time limits.*

The denial will be mailed to the claimant at the last known address.

OVERPAYMENTS

If you, your dependents or providers receive more benefits than you’re entitled to under the plan, you must restore the full amount of the overpayment to the Trust. Otherwise, any benefits payable to you, your dependents or any providers can be reduced by the overpayment.

If the plan pays benefits another plan should have paid (e.g., on account of coordination of benefits), the plan may recover these benefits from you, your dependent, any provider or the other plan.

DISPOSITION OF UNCASHED CLAIM CHECKS

In the event the Trust issues a check or draft to reimburse an employee or dependent for a claim for benefits which is reimbursable under the plan, and the check or draft is not negotiated, the Trust will honor such a check or draft if presented for payment within three years of the date it was issued.

FILING AN APPEAL

The Board of Trustees has adopted the following procedures to review benefit claim denials.

APPEAL OF BENEFIT DENIAL

The claimant has 180 days from the date of denial to appeal the denial. An appeal must be submitted in writing by the claimant or an authorized representative to the plan's Trust Office address. An appeal must identify the claim involved as well as reasons for the appeal, and provide any pertinent information. Except for urgent care claims, appeals are accepted from an authorized representative only if accompanied by a signed statement from the claimant (or from a parent or legal guardian where appropriate) identifying the representative and authorizing that person to seek benefits. An assignment of benefits is not sufficient to make a provider an authorized representative.

Failure to file a claim appeal within 180 days of the denial will serve as a bar to any claim for benefits or for any form of relief from the plan.

APPEAL PROCEDURES

The procedures below shall be the exclusive procedures available to a claimant who is dissatisfied with an eligibility determination, benefit denial or partial benefit award by the plan or its authorized claim payers. These procedures must be exhausted before a claimant may file suit under Section 502(a) of ERISA.

Information To Be Provided Upon Request

The claimant and/or his or her authorized representative may, upon request and free of charge, have reasonable access to all documents relevant to the claim for benefits. Relevant documents shall include information relied upon, submitted, considered, or generated in making the benefit determination. They will also include internal guidelines, procedures or protocols concerning the denied treatment, without regard to whether such document or advice was relied on in making the benefit determination. Absent a specific determination by the Trustees that disclosure is appropriate, relevant documents do not include any other individual's claim records or information specific to the resolution of the individuals' claims.

If a denial is based on a determination as to medical necessity, an explanation of that determination and how it applies to the claimant's circumstances also are available upon request.

Review by Appeals Committee

Except for urgent care and pre-service claims, an appeal is presented to the Trust's Appeals Committee at its next scheduled monthly meeting after receiving the appeal. The Appeals Committee is appointed by the Trust's third party administrator and will not include any employee of the third party administrator who was involved in the initial processing of the claim. The Appeals Committee reviews the administrative file, containing all documents relevant to the claim, and all additional information the claimant submits. The review is new and independent of the initial denial.

If the denial is based on a medical or dental judgment, the Appeals Committee consults a medical professional with appropriate training and experience in the applicable field of medicine. The plan may have an individual with a different license review the matter if that individual is trained to deal with the condition involved. This professional will not be the individual who made the initial benefit determination or their subordinate. The Appeals Committee will identify by name any individuals consulted for medical or dental advice.

The Appeals Committee makes its decision within 30 days of the date the appeal was received. The claimant will be notified of the Committee's decision as soon as reasonably practical, but not later than five days after the decision is made.

Review by Hearings Committee

If a claimant wishes to appeal a decision of the Appeals Committee, he or she may request a hearing before the Trustees' Hearings Committee, at which the claimant or his or her representative will be allowed to appear in person and present additional evidence or witnesses. These hearings are conducted according to the Trust's Hearing Procedures; copies of which may be obtained from the Trust Office. The Hearings Committee will consist of at least one Employer Trustee and one Labor Organization Trustee. The review by the Hearings Committee is new and independent from either the initial denial or the Appeals Committee decision. A request for a hearing must be made in writing and received by the Trust within 180 days of the date the claimant receives notice of the Appeals Committee's determination.

Hearings are held and decisions made within 30 days of the date the claimant's request is received unless the claimant agrees to a different schedule. The claimant is notified of the Committee's decision as soon as practical, but not later than five days after the decision is made.

Contents of Decision

If the Appeals Committee or Hearings Committee denies an appeal, the claimant is notified of specific reasons for the denial as well as specific plan provision(s) involved, and advised that all information relevant to the claim is available without charge upon request. If the Committee relied on an internal rule, guideline or protocol, the decision identifies it and explains that a copy is available without charge upon request. If the Committee’s decision was based on a medical or dental judgment, the decision explains that judgment, applying the terms of the plan to the claimant’s circumstances. In the case of an appeal denied by the Hearings Committee, the claimant also is notified of his or her rights under Section 502(a) of ERISA.

Modifications to Appeal Procedures for Pre-Service and Urgent Care Claims

Appeal procedures are modified as follows for appeals involving preservice or urgent care claims:

Pre-Service Claims: Pre-service claim appeals follow the above procedures, with these modifications:

- ➔ *There is only one level of review, by the Appeals Committee; the Committee’s decision is made within 30 days of the date the appeal is received, unless the claimant agrees to a different schedule. The claimant is notified of the Committee’s decision as soon as practical, but not later than five days after the decision is made*
 - ➔ *Appeals involving pre-service claims are reviewed by the Appeals Committee at its next scheduled meeting, time permitting, or by conference call if necessary. The claimant or his or her authorized representative may participate, as authorized by the Committee, to the extent the Committee deems necessary to develop an adequate record. If the claimant wishes to appear in person, the claimant may waive the 30 day limit and schedule a formal hearing for a later meeting of the Committee*

Urgent Care Claims: Urgent care claim appeals follow the above procedures, with these modifications:

- ➔ *An initial decision is made within 72 hours if the initial claim is complete when submitted. If more information is necessary to process the claim, the claim will be resolved no later than 48 hours after the Trust receives the additional information or the end of the 48 hours the claimant has to provide the additional information, whichever is earlier. In addition:*
- An urgent care appeal may be made orally or in writing*
 - A medical or dental professional with knowledge of the claimant's condition may act as an authorized representative without prior written authorization*
 - Information can be provided to the claimant or authorized representative by phone, fax or other expedited method, as long as written or electronic verification is furnished not more than 72 hours later*

DEFINITIONS

The following definitions apply to Trust PPO medical and prescription drug benefits, the dental schedule and the weekly disability benefits described in this booklet:

Accident means an event that is unintentional, unexpected, unusual and unforeseen. Lifting, bending, simple exercise, etc. are not in themselves accidents.

Acupuncturist means an acupuncturist licensed in the state where services are performed and practicing within the scope of their license.

Approved Alcoholism and/or Drug Abuse Treatment Facility means an institution engaged primarily in treating alcoholism and/or drug abuse and licensed or approved for this purpose in the state where it's located.

Approved Ambulatory Surgical Center means an institution engaged primarily in providing outpatient surgical services at the patient's expense and certified by the Washington State Department of Social and Health Services, or equivalent department of another state, to receive Medicare benefits as an ambulatory surgical center.

Approved Home Healthcare Agency means a public or private agency or organization that administers and provides home healthcare and is either a Medicare-certified home healthcare agency or is certified by the Washington State Department of Social and Health Services, or equivalent department of another state, as a home healthcare agency.

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

Audiologist means an individual licensed/certified in the state where services are performed and practicing within the scope of their license.

Average Weekly Wage means the eligible employee's average weekly gross wages, including commissions, overtime and other pay at premium rates, as reported to the Trust by the employer.

Chiropractor means a person who treats musculoskeletal disorders, is licensed in the state where services are performed and is practicing within the scope of their license.

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

Covered Employment means employment for a participating employer subscribing to the Trust, under a collective bargaining agreement or special agreement.

Covered Provider means:

- ➔ *A physician as defined on page 124*
- ➔ *For podiatry (foot care) benefits: podiatrist licensed in the state where services are performed and practicing within the scope of their license*
- ➔ *For pregnancy benefits: midwife licensed in the state where services are performed and practicing within the scope of their license*
- ➔ *For nursing benefits: Registered Nurse (RN), Licensed Practical Nurse (LPN) or Nurse Practitioner (ARNP) licensed in the state where services are performed and practicing within the scope of their license*
- ➔ *For mental and nervous as well as alcoholism and/or drug abuse treatment benefits: psychologist licensed in the state where services are performed and practicing within the scope of their license*
- ➔ *For mental and nervous benefits: mental health counselor, clinical social worker or marriage and family therapist licensed or certified in the state where services are performed and practicing within the scope of their license or certification*
- ➔ *For various benefits:*
 - *Physician's assistant licensed or registered in the state where services are performed and practicing within the scope of their license/registration. The physician's assistant must be employed by the MD, DO or clinic (under direction of the MD or DO), and any charges must be billed by the MD, DO or clinic. If both the MD, DO or clinic and the physician's assistant charge for a visit on the same day, the plan will recognize only the charges of the lower-cost provider*
 - *Surgical assistant licensed or registered in the state where services are performed and practicing within the scope of their license/registration*

- *Optometrist licensed in the state where services are performed and practicing within the scope of their license*
- *Dentist licensed in the state where services are performed and practicing within the scope of their license*

Custodial Care means any care or service designed primarily to assist with the activities of daily living and basic personal needs. These activities may include bathing, dressing, feeding, preparing meals, assisting with walking or getting in and out of bed, and supervising medication that can normally be self-administered.

Denture means a set of artificial teeth. It can be a full or partial denture and a fixed or removable bridge.

Denturist means a denturist licensed in the state where services are performed and practicing within the scope of their license. Denturists are not covered under the DeltaCare plan.

Domestic Partner means a person of the same sex as an eligible employee who, with the employee, share the same regular and permanent residence, have a close personal relationship, are jointly responsible for basic living expenses, are not married to anyone, are each 18 years of age or older, are not related by blood closer than would bar marriage in the State of Washington, were mentally competent to consent to a contract when this domestic partnership began, are each other's sole domestic partner and are responsible for each other's common welfare.

Drugs mean any article that may be dispensed lawfully, as provided under the federal Food, Drug and Cosmetic Act (including any amendments), only with a written or oral prescription from a physician or chiropractor licensed by law to administer it.

Emergency (Trust PPO) means sudden and unexpected onset of acute illness or accidental injury requiring immediate medical or surgical care which, if not received, would jeopardize the patient's life.

Emergency Care (Dental Care) is dental treatment provided after the sudden unexpected onset of a dental condition with acute symptoms, including pain, which is severe enough that the lack of immediate dental attention could result in serious jeopardy to the patient's health.

Employee means any person employed by a participating employer who meets all the applicable eligibility requirements of the Trust.

Experimental or Investigational Treatment (Dental Care) means a service or supply is considered experimental or investigational if any of these conditions is present:

- ➔ *The service or supply is described as an alternative to more conventional therapies in written documents by the provider that performs the services*
- ➔ *The service or supply may be given only with approval of an Institutional Review Board as defined by federal law*
- ➔ *There is an absence of authoritative dental, medical, or scientific literature on the subject, or that literature indicates the service or supply is experimental or investigational or that more research is needed*
- ➔ *The Food and Drug Administration (FDA) has not approved marketing of the service or supply or has it under consideration*
- ➔ *The service or supply is available only through clinical trials sponsored by the FDA, the National Cancer Institute or the National Institutes of Health*

The Board of Trustees has the discretion and authority to determine if a service or supply is or should be considered experimental or investigational. That determination is based on the information and resources available when the service is performed or the supply is provided.

Experimental or Investigational Treatment (Trust PPO) means a service or supply if any of these applies:

- ➔ *The drug or device cannot be lawfully marketed without approval of the FDA and approval for marketing has not been given for regular nonexperimental or noninvestigational purposes at the time the drug or device is furnished*
- ➔ *The drug, device, medical treatment, or procedure has been determined experimental or investigational by the treating facility's institutional review board or other body serving a similar function, and the patient has signed an informed consent document acknowledging such experimental status*
- ➔ *Federal law classifies the drug, device or medical treatment under an investigational program*
- ➔ *Reliable evidence shows the drug, device, medical treatment or procedure is the subject of ongoing Phase I or Phase II clinical trials or is otherwise under study to determine its maximum tolerated dose, toxicity, safety, efficacy, or efficacy compared with standard means of treatment or diagnosis (except as provided below)*

- ➔ *Reliable evidence shows the prevailing opinion among experts regarding the drug, device, medical treatment or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, toxicity, safety, efficacy, or efficacy compared with standard means of treatment or diagnosis (except as provided below)*

For this section, “reliable evidence” means only published reports and articles in peer reviewed authoritative medical and scientific literature; the written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same drug, device, medical treatment or procedure; or the written informed consent used by the treating facility or by another facility studying substantially the same drug, device, medical treatment or procedure.

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

➔ *Category 1*

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

➔ *Category 2*

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

The plan’s administrative agent investigates each claim for benefits that might include experimental or investigational treatment.

The administrator consults with medical professionals, including its own staff, to determine whether the treatment is excluded as experimental or investigational, or whether it is covered as one of the exceptions stated above.

Home Health Aide means an individual employed by an approved home healthcare agency or an approved hospice agency who:

- ➔ *Provides part-time or intermittent personal care, ambulation and exercise*
- ➔ *Performs household services essential to healthcare at home*
- ➔ *Assists with medications ordinarily self-administered*
- ➔ *Reports changes in patients' condition and needs*
- ➔ *Completes appropriate records*
- ➔ *Is under the supervision of an RN or a physical or speech therapist*

Hospital means an institution that:

- ➔ *Operates according to laws governing hospitals in the jurisdiction where it is located*
- ➔ *Is engaged primarily (for compensation from or on behalf of patients) in providing diagnostic and therapeutic facilities for surgical and medical diagnosis, treatment, and care of injured and sick persons by or under supervision of a staff of licensed physicians and surgeons*
- ➔ *Provides 24-hour nursing service by RNs*

This definition specifically excludes:

- ➔ *Any institution that is primarily a place of rest, place for the aged, nursing home, residential treatment facility, or convalescent home*
- ➔ *Any facility operated by a federal or state government or its agencies, unless the patient has a legal responsibility for the expenses incurred in that facility*

Illness/Sickness means any condition marked by a pronounced change from the normal healthy state.

Licensed Pharmacist means a person licensed to practice pharmacy by the government authority having jurisdiction over the licensing and practice of pharmacy.

Medically Necessary or Medical Necessity (Trust PPO) means a procedure, service or supply that meets the following criteria and limitations:

- ➔ *It is appropriate to the diagnosis and/or treatment of the patient's illness or injury*
- ➔ *It is known to be effective in improving health outcomes for the patient's medical condition in accordance with sufficient scientific evidence and professionally recognized standards*
- ➔ *It represents the most economically efficient use of medical services and supplies that may be provided safely and effectively to the patient*
- ➔ *It is not primarily for the convenience of the patient or provider*
- ➔ *When applied to an inpatient, it cannot safely be provided to the patient as an outpatient*

A service or supply may be medically necessary in part only.

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

Naturopath means a naturopath licensed in the state where services are performed and practicing within the scope of their license.

Necessary Dental Treatment or Dentally Necessary (Dental Care) means a procedure or service to establish or maintain a patient's oral health. The fact a procedure, service or supply may be recommended or approved by a dentist does not, of itself, make it dentally necessary.

Occlusal Adjustment means adjusting the way the biting surface of the teeth meet.

Occupational Therapist means a person licensed in the state where their services are performed and practicing within the scope of their license.

Physical Therapist means a person licensed in the state where their services are performed and practicing within the scope of their license.

Physician means a physician or surgeon (MD, DO) licensed in the state where services are performed and practicing within the scope of their license.

Preadmission Authorization means calling First Choice to preapprove any physician-recommended nonemergency inpatient stay before admittance to a hospital.

Preferred Provider (Trust PPO) means a hospital, physician or other provider who has agreed to participate in the First Choice Health Network as a preferred provider.

Self-Inflicted Injuries mean injury to one's self that is foreseeable and expected due to a deliberate and willful act.

Skilled Nursing Facility means a facility that provides primarily convalescent care for patients transferred from an accredited general hospital and is approved by the Joint Commission for Accreditation of Hospitals or by Medicare.

Speech Therapist means a person practicing within the scope of applicable regulatory laws.

Spouse is defined by the 1996 Defense of Marriage Act; coverage is provided for a spouse by a legally recognized marriage between a man and a woman.

Standards of Dental Practice mean the sound dental practices for treatment generally accepted in the community or dental education community. For example, it is a standard of dental practice to get current x-rays before working on a crown or root canal; a dentist would not normally perform work using old x-rays.

Usual, Customary and Reasonable (UCR) means one or all of the following will be considered to determine the actual amount payable for any given service or supply:

- ➔ *Usual fee the provider most frequently charges to most of their patients for a similar service or procedure*
- ➔ *Fees that fall within the customary range charged in a locality by most providers with similar training and experience for performing a similar service or procedure*
- ➔ *Fees resulting from unusual circumstances or complications requiring additional time, skill and experience in connection with a particular service or procedure*

This provision recognizes there will be differences in charges because of factors such as geographic location, provider skill and service complexity. The Trust will make the final determination on whether the fee is UCR.

For preferred providers, Usual, Customary and Reasonable charges are their contracted fee amount.

SUMMARY PLAN DESCRIPTION

NAME OF PLAN

This plan is the Health and Welfare Plan of the Sound Health & Wellness Trust.

The Trust Fund through which this plan is provided is the Retail Clerks Welfare Trust d.b.a. Sound Health & Wellness Trust.

PLAN SPONSOR AND PLAN ADMINISTRATOR

This plan is sponsored and administered by a joint labor-management Board of Trustees; the name, address, and phone number are:

*Board of Trustees of the Retail Clerks Welfare Trust
201 Queen Anne Avenue North
Suite 100
Seattle, WA 98109
(206) 282-4100*

You can find out whether a particular employer or employee organization is a participating plan sponsor and, if so, the organization’s address, by writing to the Trust. The Trust may make a reasonable charge to cover the cost of providing this information. You may want to ask the amount up front.

EMPLOYER IDENTIFICATION NUMBER/PLAN NUMBER

The employer identification number assigned by the Internal Revenue Service is EIN 91-6058475. The plan number is 501.

TYPE OF PLAN

This plan is a health and welfare plan providing medical, prescription drug, vision, dental, life and disability benefits.

TYPE OF ADMINISTRATION

This plan is administered by the Board of Trustees, with the assistance of Zenith Administrators, Inc., a contract administrative organization.

PLAN DOCUMENTS

This booklet—together with the benefit description of DeltaCare coverage—summarizes major plan provisions. In the event of a conflict between the plan documents and this booklet, the plan documents will control. The Trustees have the complete and exclusive discretionary authority to remedy any contradictions between this booklet and any other documents governing the plan.

NAME AND ADDRESS OF AGENT FOR SERVICE OF PROCESS

Each Trustee is an agent for accepting service of legal process on behalf of the Trust. Trustee names and addresses follow.

NAMES, TITLES AND ADDRESSES OF TRUSTEES

EMPLOYER TRUSTEES	UNION TRUSTEES
Randy Zeiler Allied Employers, Inc. 4030 Lake Washington Blvd. NE, Suite 201 Kirkland, WA 98033-7870	Diane Zahn UFCW Local No. 21 5030 First Ave. S. Suite 200 Seattle, WA 98134
Derrick Anderson Haggen, Inc. 2211 Rimland Drive Bellingham, WA 98226	David Blitzstein UFCW International Union 1775 K Street NW Washington DC 2006
Nathan Hyde Albertsons, Inc. 250 Parkcenter Blvd. Boise, ID 83726	Mike Hatfield UFCW Local No. 44 1510 N. 18th Mt. Vernon, WA 98273
Frank Jorgensen Safeway, Inc. 1121 124th Ave. NE Bellevue, WA 98005	David Schmitz UFCW Local No. 21 5030 First Ave. S. Suite 200 Seattle, WA 98134
Scott Klitzke Powers Allied Employers, Inc. 4030 Lake Washington Blvd. NE, Suite 201 Kirkland, WA 98033-7870	Michael J. Williams UFCW Local No. 81 960 East Main Street Auburn, WA 98002
Carl Wojciechowski Fred Meyer, Inc. 3800 SE 22nd Ave. Portland, OR 97202	Brenda Willis UFCW Local No. 21 5030 First Ave. S. Suite 200 Seattle, WA 98134

DESCRIPTION OF COLLECTIVE BARGAINING AGREEMENTS

This plan is maintained under multiple collective bargaining agreements and the master health and welfare agreement. You may obtain copies by writing to the Trustees. The agreements also are available at the Trust Office, and at local union offices, with 10 days advance written request. The Trustees may make a reasonable charge to cover the cost of furnishing the agreements. You may want to ask the amount up front.

PARTICIPATION, ELIGIBILITY AND BENEFITS

You are entitled to participate in this plan if you work under a collective bargaining agreement described above and your employer contributes to the Trust on your behalf and you pay the required weekly employee premiums.

Certain nonunion employees also are entitled to participate through special agreements between their employers and the Board of Trustees.

Eligibility rules governing which employees and dependents are entitled to benefits begin on page 9. Descriptions of the benefits begin on page 27.

CIRCUMSTANCES THAT MAY RESULT IN INELIGIBILITY OR DENIAL OF BENEFITS

The circumstances that may result in disqualification, ineligibility, denial or loss of benefits appear throughout this booklet.

The Board of Trustees has the authority to terminate the Trust. The Trust will also terminate at the expiration of all collective bargaining agreements and special agreements requiring contributions to the Trust. If the Trust terminates, any and all monies and assets remaining in the Trust, after payment of expenses, will be used to continue benefits provided by then existing benefit plans, until the monies and assets are used up.

SOURCE OF CONTRIBUTIONS

This plan is funded through employer and employee contributions, with the amount determined through collective bargaining between participating employers and labor organizations, as specified in the collective bargaining agreements and master health and welfare agreement. Employee COBRA-payments also are permitted as described on page 20, with the amount fixed from time to time by the Board of Trustees.

PLAN ENTITIES

- ➔ *Employer contributions, employee premiums and COBRA payments are received and held by the Board of Trustees in the Retail Clerks Welfare Trust d.b.a. Sound Health & Wellness Trust to pay benefits and administrative expenses.*
- ➔ *The Trust PPO medical, as the well as the dental schedule and weekly disability benefits, are self-funded and paid according to the direct payment rules in this booklet.*
- ➔ *The Group Health Options, Inc. (GHO) medical, prescription drug and vision coverage is self-funded and paid according to the administrative services contract that the Trust has with GHO, 320 Westlake Ave. N., Suite 100, Seattle, WA 98109-5233.*
- ➔ *The Trust PPO prescription drug benefit is self-funded and administered by informedRx, Inc., 2441 Warrenville Road, Suite 610, Lisle, IL 60432-3642*
- ➔ *The Trust PPO vision benefit is self-funded and administered by VSP, 3333 Quality Drive, Rancho Cordova, CA 95670.*
- ➔ *WDS Preferred dental coverage is self-funded and administered by Washington Dental Service, P.O. Box 75983, Seattle, WA 98175-0983.*
- ➔ *DeltaCare dental coverage is fully insured by Washington Dental Service, P.O. Box 75983, Seattle, WA 98175-0983.*
- ➔ *Life and accidental death or dismemberment benefits are fully insured by Metropolitan Life Insurance Company, 200 Park Avenue, New York, NY 10166.*

PLAN YEAR-END

This plan is on a fiscal year basis, ending March 31.

YOUR ERISA RIGHTS

As a Sound Health & Wellness Trust participant you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants be entitled to the following:

RECEIVE INFORMATION ABOUT YOUR PLAN AND BENEFITS

- ➔ *Examine, without charge, at the plan’s Trust 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 plan operation, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The 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 HEALTH PLAN COVERAGE

- ➔ *Continue health coverage for yourself, spouse or other eligible dependents if there is a loss of plan coverage as a result of a qualifying event. You or your dependents may have to pay for this coverage. Review this summary plan description and documents governing the plan to learn your COBRA continuation coverage rights.*

➔ *Reduce or eliminate exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan. You should receive a certificate of creditable coverage, free of charge, from your group health plan or health insurer when you lose coverage under the plan, become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases (if you request it before losing coverage), or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your new coverage.*

PRUDENT ACTIONS BY PLAN FIDUCIARIES

In addition to creating rights for plan participants ERISA imposes duties upon the people responsible for plan operation. The people who operate your plan, called “fiduciaries,” 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 health or welfare benefit or exercising your rights under ERISA.

ENFORCE YOUR RIGHTS

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to \$110 a day until you receive them, unless the materials were not sent because of reasons beyond the administrator’s control. If your claim for benefits is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the plan’s decision or lack of decision concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in federal court.

If 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 Trust Office. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the 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 at (866) 444-3272.

NOTICE OF PRIVACY PRACTICES (HIPAA)

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.

USE AND DISCLOSURE OF HEALTH INFORMATION

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

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- ➔ **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 provide information regarding your coverage or healthcare treatment to 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 healthcare or related services.*
For example, the plan may disclose the name of your treating dentist to a treating orthodontist so that the orthodontist may ask for your dental x-rays.
 - ➔ **To conduct healthcare 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.

Healthcare operations include such activities as:

- *Contacting healthcare providers and participants with information about treatment alternatives and other related functions*
- *Clinical guideline and protocol development*
- *Case management and care coordination*
- *Activities designed to improve health or reduce healthcare costs*
- *Underwriting, premium rating or related functions to create, renew or replace health insurance or health benefits*
- *Business management and general administrative activities of the Trust, including customer service and resolution of internal grievances, review and auditing, including compliance reviews, medical reviews, legal services and compliance programs, quality assessment and improvement activities, business planning and development, including cost management and planning-related analyses and formulary development*

For example, the Trust may use your health information to conduct case management, quality improvement and utilization review or to engage in customer service and the resolution of claim appeals.

➔ ***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 either to 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 required to do so by any federal, state or local law. In addition, 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.

- ➔ **For treatment alternatives.** *The Trust may use and disclose your health information to tell you about or recommend possible treatment options or alternatives that may be of interest to you.*
 - ➔ **For distribution of health-related benefits and services.** *The Trust may use or disclose your health information to provide to you health-related benefit and service information that may be of interest to you.*
 - ➔ **For disclosure to the plan trustees.** *The Trust may disclose your health information to the Board of Trustees and necessary advisors for plan administration functions performed by the Board of Trustees on behalf of the Trust, such as those listed in this summary, or to handle claim appeals, solicit bids for services, or modify, amend or terminate the plan.*
 - ➔ **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 healthcare 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 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.*
 - ➔ **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.*
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AUTHORIZATION TO USE OR DISCLOSE HEALTH INFORMATION

Other than as previously stated, the Trust will not disclose your health information other than with your written authorization. If you have authorized the Trust to use or disclose your health information, you may revoke that authorization in writing at any time.

In addition, 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:

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- ➔ **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 receive confidential communications.** *You have the right to request that the Trust communicate with you in a certain way if you feel the disclosure of your health information could endanger you. For example, you may ask that the Trust only communicate with you at a certain phone number or by email. If you wish to receive confidential communications, please make your request in writing to the individual identified as the Trust’s Privacy Contact Person 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. 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.

➔ **Right to an accounting.** *You have the right to request a list of disclosures of your health information made by the Trust for any reason other than for treatment, payment or health operations. The request must be made in writing to the Privacy Contact Person listed below. The request should specify the period for which you are requesting the information, but may not start earlier than April 14, 2003, when the Privacy Rule became effective. Accounting requests may not be made for periods going back more than six years. 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 also may obtain a copy of the current version of the Trust Notice at www.soundhealthwellness.com.*

PRIVACY CONTACT PERSON/PRIVACY OFFICIAL

To exercise any of these rights related to your health information, contact:

*Contact Person
201 Queen Anne Ave. N. Suite 100
Seattle, WA 98109
Phone (206) 352-9730
Fax (866) 277-3927
Contactperson@zenithadmin.com*

The Trust has also designated the Client Service Manager as its Privacy Official. This person has the same address and phone/fax numbers as listed above.

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 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 Official identified above. The Trust encourages you to express any concerns you may have regarding the privacy of your health information. You will not be retaliated against in any way for filing a complaint.

Trust Office

Sound Health & Wellness Trust
201 Queen Anne Avenue North
Suite 100
Seattle, WA 98109

Claims, Eligibility and Other Questions
(206) 282-4500 or (800) 225-7620

LiveWell

Nurse Line Plus, Personal Health
Assessment, Health Coaching,
Condition Management
(877) 362-9969

First Choice Health Network

(206) 268-2910 or (800) 843-5127

Washington Dental Service

(800) 554-1907 (WDS Preferred)
(800) 650-1583 (DeltaCare)

**Optum Behavioral Health
(Mental Health And Substance Abuse)**

(866) 763-0466

VSP

(800) 877-7195

informedRx

(800) 456-4803

