Sound PPO Plan Sound Health & Wellness Trust

2017 EDITION

SOUND HEALTH
& WELLNESS TRUST

APRIL 1, 2017

SOUND PPO PLAN

A LABOR-MANAGEMENT BENEFIT PLAN AND SUMMARY PLAN DESCRIPTION

MESSAGE TO EMPLOYEES:

We are pleased to present this booklet describing the Sound PPO Plan health benefits available to eligible employees and their enrolled dependents through the Sound Health & Wellness Trust.

This booklet applies to:

- Employees hired on or after October 1, 2004, but prior to December 3, 2010, if they had not worked in covered employment for more than 35 consecutive months as of December 3, 2010.
- Employees hired on or after December 3, 2010 if they have not worked in covered employment for more than 60 consecutive months.

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

This booklet is both the Plan Document and the Summary Plan Description for purposes of the Employee Retirement Income Security Act of 1974 (ERISA), as amended. The Trust is also required under federal law to provide you with other documents, including a Summary of Benefits and Coverage (SBC). In the event of an inconsistency between the SBC and this booklet, this booklet will govern.

Sincerely,
Board of Trustees

EMPLOYER TRUSTEES	UNION TRUSTEES
Scott Klitzke Powers	**Todd Crosby**
Brent Bohn	**Emilia (Mia) Contreras**
Frank Jorgensen	**James Crowe**
Yvonne Peters	**Faye Guenther**
Cynthia Thornton	**Joe Mizrahi**
	James To

All questions about benefit interpretations should be referred to Zenith American Solutions (the Trust Office). **The Trust Office does not guarantee eligibility for benefits or benefit payments. Although the Trust Office can provide you with general information on your plan of 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, custody, death, marriage, legal separation, divorce, full-time student)*
- *Designated life insurance beneficiary*

Submit any changes to the Trust Office on a new enrollment form; forms can be found on the Trust's website at **www.soundhealthwellness.com**.

The Trustees have full and exclusive authority, in their discretion, to interpret, construe and apply the terms of the Plan, Trust agreement and all policies, procedures, actions and resolutions adopted in administering or operating the Trust or the Plan, and to make factual determinations regarding the Plan's construction, interpretation and application. They have the authority to remedy possible ambiguities, inconsistencies or omissions and to decide all Plan questions. Trustee decisions are final and binding.

The Board of Trustees has the right and discretionary authority to amend this Plan at any time.

Only the 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.*

See page 150 for information on the funding of each benefit.

This page left intentionally blank.

TABLE OF CONTENTS

SUMMARY OF BENEFITS

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

MEDICAL BENEFITS

LIVEWELL HEALTH REIMBURSEMENT ARRANGEMENT (HRA)	
	Employee only coverage: up to $500 maximum annual funding based on completion of required health and wellness program activities. **Family coverage: up to $1,000 maximum annual funding based on completion of required health and wellness program activities.** **Employees hired on or after December 3, 2010 are not eligible for any HRA funding until after they have completed 12 months of employment.**
ANNUAL DEDUCTIBLE	
Preferred (PPO) providers	**$300 for employee only coverage; $600 for family coverage**
Non-PPO providers	**$600 for employee only coverage; $1,800 for family coverage**
	For employees eligible for HRA funding, if an employee or spouse fails to earn the maximum HRA funding, the annual base deductibles shown above will increase for that year by the amount of unearned HRA funding. **For family coverage, the deductible applies to the family as a whole.**
REIMBURSEMENT PROVISIONS (COINSURANCE)	
Preferred (PPO) providers	**80% after your annual HRA and deductible**
Non-PPO providers	**60% after your annual HRA and deductible**

ANNUAL OUT-OF-POCKET MAXIMUM

Includes only the annual deductible and participant coinsurance

Preferred (PPO) providers	**$2,750 for employee only coverage; $5,500 for family coverage**
Non-PPO providers	**$5,500 for employee only coverage; $16,500 for family coverage**
	For employees eligible for HRA funding, if an employee or spouse fails to earn the maximum HRA funding, the annual out-of-pocket maximums shown above will increase for that year by the amount of unearned HRA funding. **For employees with family coverage, the employee only coverage maximum will apply to each covered individual until the family coverage maximum is met. Additional annual out-of-pocket maximums may apply for essential health benefits (see page 45)**

! *The LiveWell Nurse Line, 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	**$6**	**$12**	**$18**
Tier 2	**$22**	**$44**	**$66**
Tier 3	**$35**	**$70**	**$70**
Brand if generic available	**You pay the appropriate Tier copay plus the difference in cost between the generic and the brand name drug.**		
Specialty Drugs	**See page 73**		

! ** Maintenance only; maintenance drugs in excess of a 30-day supply must be purchased through a pharmacy in the custom network which provides special discounts, or through OptumRx Mail (see page 73).*

VISION CARE

	See page 78

DENTAL CARE

Choice of 3 options	• **DDWA Preferred; see page 84** • **DeltaCare; see page 97** • **Schedule Plan; see page 100**

EMPLOYEE LIFE INSURANCE

$15,000

DEPENDENT LIFE INSURANCE

$1,000

EMPLOYEE ACCIDENTAL DEATH OR DISMEMBERMENT

$15,000

EMPLOYEE WEEKLY DISABILITY (TIME LOSS)

See page 122

All claims must be submitted within one year following the date expenses were incurred. No claim submitted after this deadline will be considered for payment.

! ***Throughout this booklet there are terms that have a defined meaning as shown in the Definitions section beginning on page 140.***

ELIGIBILITY

GENERAL ELIGIBILITY
You may become eligible under the Sound PPO Plan if:

- *You were hired on or after October 1, 2004, but prior to December 3, 2010, and had not worked in covered employment for more than 35 consecutive months as of December 3, 2010; or you were hired on or after December 3, 2010 and have not worked in covered employment for more than 60 consecutive months,*
- *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.*

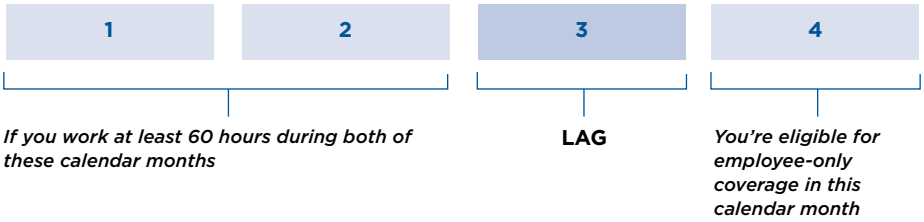
Your months of employment and number of hours worked determine which benefits are available to you and your eligible dependents. See the Coverage section on page 17 for more details.

INITIAL ELIGIBILITY (MEDICAL AND PRESCRIPTION DRUG BENEFITS)

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:



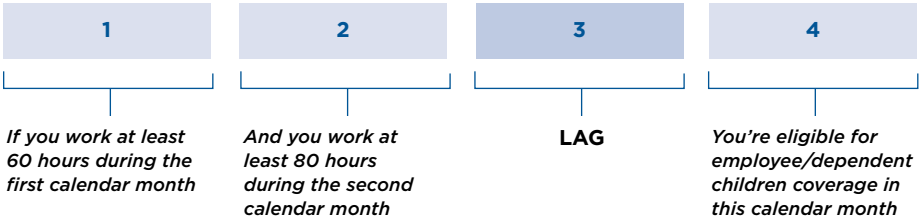
If you're eligible for employee-only coverage, you will receive medical and prescription drug benefits under the Kaiser Permanente Plan. If you live outside the Kaiser Permanente service area, you will receive medical and prescription drug benefits under the Trust's Sound PPO Plan. However, once you have completed your 35th month of employment, you may choose to enroll in either the Sound PPO Plan or the Sound Kaiser Permanente Plan.

Dependent Children Coverage

You and your dependent children become eligible for medical and prescription drug 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,*
- *You complete the enrollment process to enroll your children, either online or by submitting an enrollment form to the Trust Office. You must also submit any required documentation to the Trust Office, such as a birth certificate, to verify dependent status,*
- *Your employer pays the required contributions for each of these two months, and*
- *You pay the required weekly employee premiums (for employee/children coverage).*

Example:



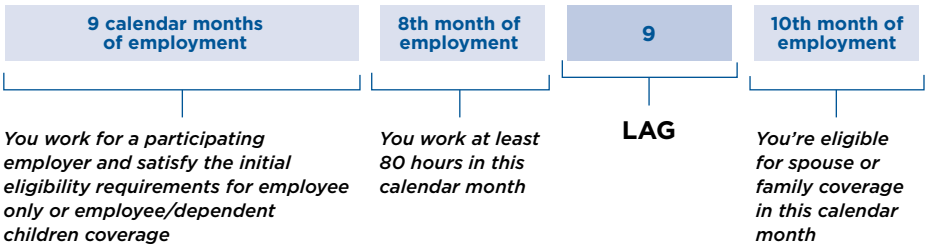
As an employee eligible for employee/dependent children coverage, you can choose to cover your children for medical and prescription drug benefits under the Kaiser Permanente Plan. If you live outside of the Kaiser Permanente service area, medical and prescription drug benefits will be provided under the Trust's Sound PPO Plan. However, once you have completed your 35th month of employment, you may choose to enroll in either the Sound PPO Plan or the Sound Kaiser Permanente Plan.

Spouse/Same Sex Domestic Partner Coverage

You and your spouse or same sex domestic partner (see page 142) become eligible for coverage on the first day of the calendar month after you complete the following requirements:

- *You meet the initial eligibility requirements for employee-only or employee/dependent children coverage (see above),*
- *You worked more than 9 months for a participating employer,*
- *You worked at least 80 hours of covered employment in the second calendar month preceding your 10th month of employment,*
- *You complete the enrollment process to enroll your spouse/domestic partner, either online or by submitting an enrollment form to the Trust Office. You must also submit any required documentation to the Trust Office, such as a marriage certificate or completed same sex domestic partner forms,*
- *Your employer pays the required contributions for each month worked, and*
- *You pay the required weekly employee premiums (for employee/spouse or family coverage).*

Example:



! ***Note:** Your spouse/domestic partner may qualify for medical/prescription drug coverage before your 10th month of employment. This happens if you enroll your spouse/partner within 60 days following the end of the month in which you completed your 1,200 hour of covered employment and you pay the weekly employee premiums. Contact the Trust Office for information on this option.*

! *As an employee eligible for spouse/same sex domestic partner coverage, you can choose to cover your spouse/domestic partner for medical and prescription drug benefits under the Kaiser Permanente Plan. If you live outside of the Kaiser Permanente service area, medical and prescription drug benefits will be provided under the Trust's Sound PPO Plan. However, once you have completed your 35th month of employment, you may choose to enroll in either the Sound PPO Plan or the Sound Kaiser Permanente Plan.*

INITIAL ELIGIBILITY (DENTAL BENEFITS)

After working for a participating employer for 9 months, you and your enrolled dependents may also become eligible for dental benefits in your 10th month of employment. The eligibility requirements for these additional benefits are outlined below.

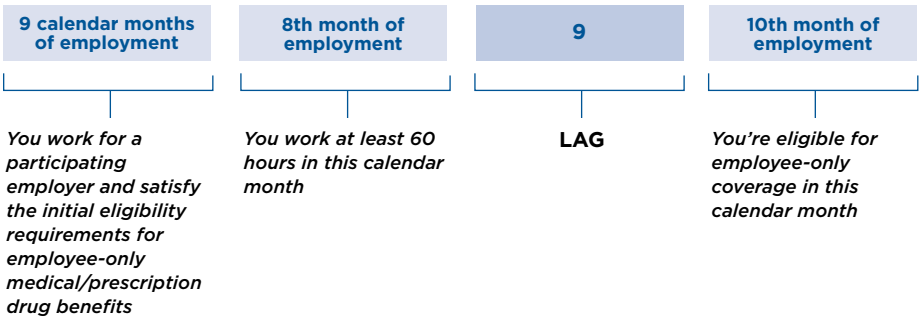
If you are eligible for dental coverage, you can choose coverage under the DDWA Preferred, DeltaCare or Schedule Plan options.

Employee-Only Coverage

You become eligible for employee-only dental coverage on the first day of the calendar month after completing the following requirements:

- *You meet the initial eligibility requirements for employee-only medical/prescription drug benefits (see page 9),*
- *You worked more than 9 months for a participating employer,*
- *You worked at least 60 hours of covered employment in the second calendar month preceding your 10th month of employment,*
- *You enroll, either online or by submitting an enrollment form to the Trust Office, in one of the three dental options,*
- *Your employer makes the required contributions for each month worked, and*
- *You pay the required weekly employee premiums.*

Example:

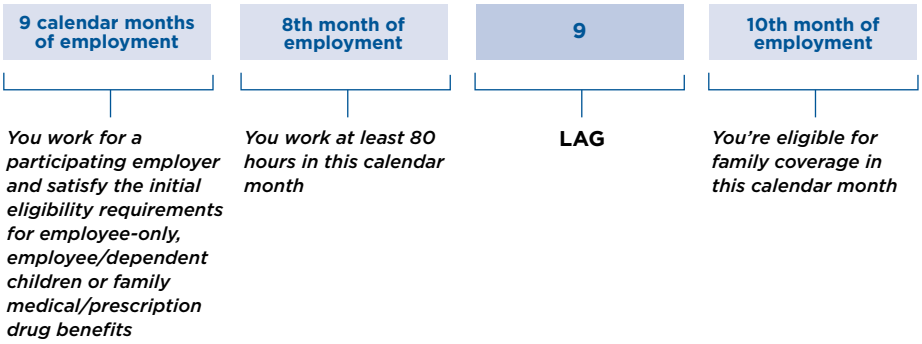


Family Dental Coverage

You become eligible for family (employee/children, employee/spouse, employee/spouse/children) dental coverage on the first day of the calendar month after completing the following requirements:

- *You meet the initial eligibility requirements for employee-only, employee/dependent children or family medical/prescription drug benefits (see page 9),*
- *You worked more than 9 months for a participating employer,*
- *You worked at least 80 hours of covered employment in the second calendar month preceding your 10th month of employment,*
- *You enroll, either online or by submitting an enrollment form to the Trust Office, in one of the three dental options,*
- *Your employer pays the required contributions for each month worked, and*
- *You pay the required weekly employee premiums (for either employee/children, employee/spouse or family coverage).*

Example:



INITIAL ELIGIBILITY (ALL OTHER BENEFITS)

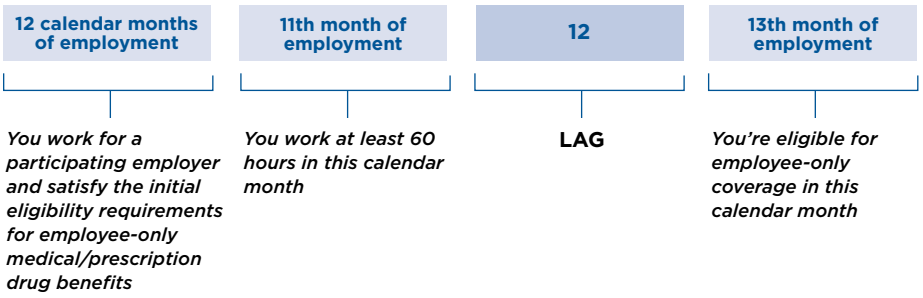
After working for a participating employer for 12 months, you and your enrolled dependents may also become eligible for vision, disability, life and accidental death or dismemberment benefits, and a Health Reimbursement Arrangement (HRA), in your 13th month of employment. The eligibility requirements for these additional benefits are outlined below.

Employee-Only Coverage For All Other Benefits

You become eligible for employee-only coverage for these other benefits on the first day of the calendar month after completing the following requirements:

- *You meet the initial eligibility requirements for employee-only medical/prescription drug benefits (see page 9),*
- *You worked more than 12 months for a participating employer,*
- *You worked at least 60 hours of covered employment in the second calendar month preceding your 13th month of employment,*
- *Your employer makes the required contributions for each month worked, and*
- *You pay the required weekly employee premiums.*

Example:

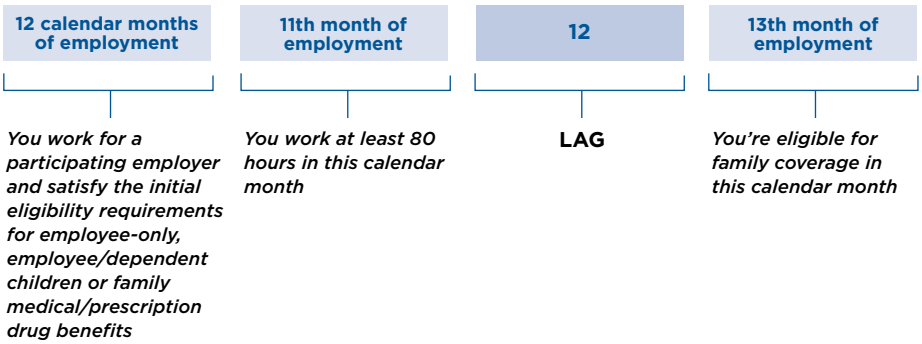


Family Coverage For All Other Benefits

You become eligible for family (employee/children, employee/spouse, employee/spouse/children) coverage for these other benefits on the first day of the calendar month after completing the following requirements:

- *You meet the initial eligibility requirements for employee-only, employee/dependent children or family medical/prescription drug benefits (see page 9),*
- *You worked more than 12 months for a participating employer,*
- *You worked at least 80 hours of covered employment in the second calendar month preceding your 13th month of employment,*
- *Your employer pays the required contributions for each month worked, and*
- *You pay the required weekly employee premiums (for either employee/children, employee/spouse or family coverage).*

Example:



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.

Dependent Coverage (Family Coverage)

Once you attain initial eligibility for and elect employee/dependent children or 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 either employee/children, employee/spouse or family coverage).*

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

COVERAGE

If you were hired on or after October 1, 2004, the number of months you work for a participating employer determines which benefits are available to you and your eligible dependents.

MONTHS OF WORK	BENEFITS	WHO IS COVERED
1 – 3	**Waiting Period**	**No Benefits Available**
4 – 9	**Medical and Prescription Drug**	**Employee/Enrolled Dependent Children**
10 – 12	**Medical, Prescription Drug and Dental**	**Employee and Enrolled Dependent Spouse/ Same Sex Domestic Partner and Children (Family)**
13+	**Medical, Prescription Drug, Dental, Vision, Disability, Life, AD&D, and HRA**	**Employee and Enrolled Dependent Spouse/ Same Sex Domestic Partner and Children (Family)**

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.*

Examples:

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.

Dependent Coverage (Family Coverage)

Your dependent's 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.*

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

Examples:

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 employee/dependent children, employee/spouse or 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 employee/dependent children, employee/spouse or family coverage eligibility ends April 30.

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 have continued work with the same employer,*
- *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 termination of covered employment).

If you began work in covered employment 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 continuation coverage payments (see page 29) for medical benefits or you do not pay the required weekly employee premiums, you are 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.

Dependent Coverage (Family Coverage)

If you lose eligibility under the Plan, you become eligible again for dependent children, spouse or family coverage on the first of any calendar month if:

- *You have continued work with the same employer,*
- *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 either employee/children, employee/spouse or family coverage).*

Example:

Suppose your eligibility for employee/dependent children, employee/spouse or 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 this coverage is reinstated for September because you were eligible during one of the six consecutive preceding calendar months with the same employer (with no termination of covered employment).

! ***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 25) 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 Sound Plan coverage on the first day of the second calendar month if you pay any required weekly employee premiums and either:

- *You start working for the new employer within 30 days of the termination date with your prior employer, or*
- *You lose your job because of a store closure and start working for another employer within 60 days.*

If you meet this requirement, the progression of your months to gain SoundPlus Plan coverage will continue.

TRANSFERRING TO THE SOUNDPLUS PLAN

After you have worked 60 consecutive months for a participating employer, you will be transferred into the SoundPlus Plan in your 61st month. At that time, the enrollment and coverage option you had under the Sound Plan will continue until the next open enrollment.

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 dates outlined in the Eligibility section beginning on page 9, provided you elect employee/children, employee/spouse or family coverage, enroll your dependents, provide any documentation required (such as a marriage certificate or birth certificate), and pay the required weekly employee premiums for the coverage selected. Dependents must be enrolled with the Trust Office before their benefits begin.

Your eligible dependents include:

1. *Your spouse, if you're not divorced or legally separated.*
2. *Your same sex domestic partner, provided you or your partner is at least age 62 at the time such domestic partnership is established. Contact the Trust Office for the necessary forms.*
3. *Your children under age 26 who are your natural children, stepchildren, adopted children, children placed with you for adoption, or 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.
4. *Unmarried children under age 19 who are dependent on you for support and are children of your same sex domestic partner, children for whom you are legal guardian, or children you have a legal obligation to support (who do not meet #3 above).*

   In addition, these children will be eligible from age 19 until their 24th birthday, if they attend a full time (as defined by the institution) accredited educational institution of higher learning and otherwise meet the requirements in #4. A 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 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 or your spouse's (or former spouse's) or your same sex domestic partner's federal income tax return.

5. *Unmarried dependent children who reach any of the applicable limiting ages in #3 and #4 above 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 the limiting age. You may be required to verify the incapacity and dependency from time to time

For other than your 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.

Under federal law, the Plan also provides medical, dental and vision benefits to certain 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. The Trust will provide coverage to a child under a QMCSO even if the employee does not have legal custody of the child, the child is not dependent upon the employee for support, and regardless of enrollment season restrictions that otherwise may exist for dependent coverage. If the Trust receives a QMCSO and the employee does not enroll the affected child, the Trust will allow the custodial parent or state agency to complete the necessary enrollment forms on behalf of the child. You and your dependents may obtain a copy of the Plan's procedures for processing QMCSOs, without charge, from the Trust Office.

! ***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, a child reaching their limiting age for coverage, 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 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 loss 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 to the effective date of the family status change.

Special Enrollment

If you acquire dependents while eligible, their eligibility begins as follows, providing the Trust Office receives a completed enrollment form within 60 days of the event and you provide any documentation required (such as a marriage certificate or birth certificate):

- *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 employee/children, employee/spouse or family coverage, enroll the dependents with the Trust Office (within the 60-day period) and make the required weekly employee premiums for the coverage selected.

If you are declining enrollment for yourself or your dependents because of other health insurance or group health coverage, you may be able to enroll yourself and your dependents in this Plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing towards your or your dependents' other coverage). However, you must submit a completed enrollment form within 60 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

You may be able to enroll yourself and your dependents in this Plan if you or your dependents lose eligibility for coverage under Medicaid or the State Children's Health Insurance Program (CHIP). However, to do so, you must submit a completed enrollment form within 60 days of the date that CHIP or Medicaid assistance is terminated for you or your dependents.

In addition, you may be able to enroll yourself and your dependents in this Plan if you or your dependents become eligible to participate in a health insurance premium assistance program under Medicaid or CHIP. However, to do so, you must submit a completed enrollment form within 60 days of the date you or your dependents are determined to be eligible for the premium assistance through Medicaid or CHIP.

To request special enrollment or obtain more information, contact 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 declared disabled by a physician within four days of the last day worked,*
- *Are under the care of a physician or certain covered providers,*
- *Remain continuously disabled, which means unable to work in the industry and not engaged in any other occupation for wage or profit, as determined by the Board of Trustees in 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. You will not 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 illness, and*
- *Begins after return to the full-time duties of your regular occupation for at least one day.*

You will not receive more than three months of eligibility for any disabling condition until you re-establish employer-paid eligibility.

If this is an employer-approved FMLA leave (see page 27), the maximum time of COBRA Coverage (see page 32) is reduced by any months you're covered under this disability provision.

A completed weekly disability (time loss) claim form, as described on page 129, must be submitted to the Trust Office to claim eligibility under this provision. Contact the Trust Office for more details.

MILITARY SERVICE UNDER USERRA

Under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), the Trust provides you the right to elect continued health coverage for up to 24-months if you are absent from employment due to qualified military service, including Reserve and National Guard Duty under federal authority, that meets the rules under USERRA ("USERRA Service").

If you are absent from employment by reason of USERRA Service, you can elect to continue coverage for you and your eligible dependents under the provisions of USERRA. The right to elect USERRA coverage does not apply to dependents who enter military service.

The period of coverage begins on the date on which your absence begins and ends on the earlier of:

- *The end of the 24-month period beginning on the date on which the absence begins; or*
- *The day after the date on which you are required to, but fail to apply under USERRA for or return to a position of employment covered under the Trust. (For example, for periods of USERRA Service over 180 days, generally you must reapply for employment within 90 days of discharge.)*

This right to continue group health coverage does not include any life insurance benefits, accidental death or dismemberment benefits, weekly disability benefits or other similar non-health benefits provided under the Trust. In addition to the rights under USERRA, you and your eligible dependents also may have rights to elect continuation coverage under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). See page 29 for more information.

If you met the Trust's eligibility requirements at the time you entered USERRA Service, you will not be subject to any additional exclusions or a waiting period for coverage under the Plan upon return from USERRA Service, if required under USERRA.

Notice and Election of USERRA Coverage

If you wish to elect USERRA coverage, you must notify the Trust Office within 60 days of the last day of employment unless you are excused from giving advance notice of service under the provisions of USERRA. While you may notify an employer of service orally, the Trust requires that you elect USERRA coverage in writing. Call the Trust Office for the necessary forms.

Paying for USERRA Coverage

If the period of USERRA Service is less than 31 days, there is no charge for this coverage beyond the normal deductible, or co-payments that would be paid if you were employed. If the USERRA Service extends more than 31 days, you must pay 102% of the cost of the coverage unless the employer pays for the coverage under its leave policy. The cost will be determined in the same manner as the cost for COBRA Coverage. You should contact the Trust Office for the current cost.

USERRA coverage requires timely monthly payments. The payment due date is the first day of the month in which USERRA coverage begins. For example, payments for the month of November must be paid on or before November 1st. The payment due for the initial period of USERRA coverage must include payment for the period of time dating back to the date that coverage would have terminated if you had not elected USERRA coverage. There is an initial grace period of 45 days to pay the first premium due starting with the date USERRA coverage was elected. After that, there is a grace period of 30 days to pay any subsequent amounts due. If you timely elect and pay for USERRA coverage, coverage will be provided retroactive to the date of the employee's departure for military service. If payment is not received by the end of the applicable grace period, USERRA coverage will terminate as of the end of the last period for which payment was received. If you fail to pay the full payment by each due date (or within the 30-day grace period), you will lose all USERRA coverage and such continuation coverage cannot be reinstated.

Once a timely election of USERRA coverage has been made, it is your responsibility to make timely payment of all required payments. The Trust will not send notice that a payment is due or that it is late, or that USERRA coverage is about to be terminated due to untimely payment.

Entering and Returning from Service

Under 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 USERRA Service, you must apply for reemployment:

- *Less than 31 days of USERRA 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 USERRA 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

The Family and Medical Leave Act of 1993 (FMLA) generally requires that an employer with 50 or more employees provide employees with up to 12 weeks per year of unpaid leave in the case of the birth or adoption of your child and for your own illness or to care for a seriously ill child, spouse or parent. You may also be entitled to FMLA leave for a qualifying reason that arises in connection with the active military service of your child, spouse, or parent. 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 are on certain types of FMLA leave, if your employer makes the required contributions. You and your eligible dependents may be entitled to coverage for up to 12 work weeks during a 12-month period if you are on FMLA leave due to:

- *Birth of a child*
- *Placement of a child for adoption or foster care*
- *Serious health condition of a child, spouse, same sex domestic partner, or parent*
- *Your own serious health condition that makes you unable to perform the essential functions of your job*

- *A qualifying reason that arises in connection with the active military service of a child, spouse, or parent, including (a) notification of military deployment within 7 days of the deployment date; (b) attending military events and related activities, such as formal ceremonies or military-sponsored family support and assistance meetings; (c) childcare and school activities, such as arranging for or providing childcare, or attending school meetings; (d) making financial and legal arrangements; (e) attending counseling sessions; (f) up to 5 days of rest and recuperation; (g) attendance at post-deployment activities*

You may be entitled to up to 26 weeks of FMLA leave during a 12-month period to care for a family member who is injured in military service.

If you think you may be eligible for a FMLA 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 FMLA 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 are not returning or if you do not return after your FMLA leave, coverage for all Plan benefits ends. You and your eligible dependents then may elect COBRA Coverage (see below). The qualifying event entitling you to COBRA Coverage is the last day of your FMLA leave. Contact the Trust Office for more details.

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 25, 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 covering your employment is terminated*

Dependents

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

- *The date your coverage ends*
- *Last day of the month a child reaches their maximum age for coverage*
- *Last day of the month a child of your domestic partner, child for whom you are legal guardian, or child you have a legal obligation to support marries, to the extent permitted by law*
- *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 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 domestic partnership is terminated and you have no legal financial obligation to support the stepchild*
- *Last day of the month following 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 in which a dependent no longer qualifies as eligible (see page 18 for dependent eligibility details)*

COBRA COVERAGE

The right to COBRA Coverage was created by federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA Coverage may be available to you and other members of your family when group health coverage would otherwise end.

What is COBRA Coverage?

COBRA Coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a “qualifying event.” After a qualifying event, COBRA Coverage must be offered to each person who is a “qualified beneficiary”. You, your spouse and your

children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA Coverage must pay for COBRA Coverage.

If you are an employee, you become a qualified beneficiary if you lose your Plan coverage because of the following qualifying events:

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

If you are the spouse of an employee, you become a qualified beneficiary if you lose your Plan coverage because of the following qualifying events:

- *Your spouse dies;*
- *Your spouse's hours of employment are reduced;*
- *Your spouse's employment ends for any reason other than his or her gross misconduct;*
- *Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both);*
- *You become divorced or legally separated from your spouse; or*
- *Termination of your domestic partnership.*

Your child will become a qualified beneficiary if they lose Plan coverage because of the following qualifying events:

- *The employee dies;*
- *The employee's hours of employment are reduced;*
- *The employee's employment ends for any reason other than his or her gross misconduct;*
- *The employee becomes entitled to Medicare benefits (Part A, Part B, or both);*
- *The parents become divorced or legally separated;*
- *The child stops being eligible for coverage as a "child"; or*
- *Termination of your domestic partnership.*

When is COBRA Coverage Available?

The Trust will offer COBRA Coverage to qualified beneficiaries only after the Trust Office has been notified that a qualifying event has occurred. The employer must notify the Trust Office of the following qualifying events:

- *The end of employment or reduction of hours of employment;*
- *Death of the employee;*
- *The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both); or*
- *The employer's initiation of bankruptcy proceedings.*

For all other qualifying events (divorce or legal separation of the employee and spouse or a child's losing eligibility for coverage as a child), you must notify the Trust Office within 60 days after the qualifying event occurs. You must provide this notice to:

Sound Health & Wellness Trust
Attn: COBRA Representative
201 Queen Anne Avenue North
Suite 100
Seattle, WA 98109-4896

(206) 282-4500
(800) 225-7620, Option 2

How is COBRA Coverage Provided?

Once the Trust Office receives notice that a qualifying event has occurred, COBRA Coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA Coverage. Covered employees may elect COBRA Coverage on behalf of their spouses, and parents may elect COBRA Coverage on behalf of their children.

How Long is COBRA Coverage Provided?

MAXIMUM PERIODS OF COBRA COVERAGE FOR EACH QUALIFYING EVENT

	EMPLOYEE	SPOUSE	CHILD
Employee terminated (for other than gross misconduct)	**18 months**	**18 months**	**18 months**
Employee reduction in hours worked (making employee ineligible for the same coverage)	**18 months**	**18 months**	**18 months**
Employee dies	**N/A**	**36 months**	**36 months**
Employee becomes divorced or legally separated	**N/A**	**36 months**	**36 months**
Employee becomes entitled to Medicare	**N/A**	**36 months**	**36 months**
Dependent child ceases to be dependent	**N/A**	**N/A**	**36 months**

MAXIMUM PERIOD OF OTHER CONTINUATION COVERAGE

	EMPLOYEE	DOMESTIC PARTNER	CHILD
Employee terminates domestic partnership (while not provided under COBRA, the Plan offers the right to extend coverage in this circumstance under the same rules as for COBRA Coverage)	**N/A**	**36 months**	**36 months**

Certain qualifying events, or a second qualifying event during the initial 18-month period of COBRA Coverage, may permit a beneficiary to receive a maximum of 36 months of COBRA Coverage.

Disability Extension of 18-month Period of COBRA Coverage

If you or anyone in your family covered under the Plan is determined by the Social Security Administration (SSA) to be disabled and you notify the Trust Office in a timely fashion, you and your dependents may be entitled to get up to an additional 11 months of COBRA Coverage, for a maximum of 29 months. The disability must begin before the 60th day of COBRA Coverage and must last at least until the end of the 18-month period of COBRA Coverage. To extend coverage from 18 to 29 months due to disability, you or your 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). Both you and the affected dependent(s) are jointly responsible for these notices. If you or your dependent fails to give written notice to the Trust Office within 60 days, the affected person will lose the right to the 11-month extension.

If, during the initial 18-month period, the SSA determines that the person is no longer disabled, the 11-month extension does not apply. If the SSA determines that the person is no longer disabled after the initial 18-month period, the period of COBRA Coverage ends with the first month that begins more than 30 days after the date of the SSA's determination, provided the period of COBRA Coverage does not exceed 29 months.

Second Qualifying Event Extension of 18-month Period of Cobra Coverage

If your family experiences another qualifying event during the 18 months of COBRA Coverage, your spouse and children can get up to 18 additional months of COBRA Coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any children getting COBRA Coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the child stops being eligible under the Plan as a child. This extension is only available if the second qualifying event would have caused the spouse or child to lose coverage under the Plan had the first qualifying event not occurred.

Health Benefits

Under COBRA Coverage 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, dental*
- *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.

The maximum time you may make COBRA Coverage payments is reduced by any months you're covered under the Plan's provisions for Eligibility When Disabled (see page 24).

Life, Accidental Death or Dismemberment and Weekly Disability Benefits.

The employee may continue life, accidental death or dismemberment, and weekly disability benefits for a maximum of six months if you were eligible for these benefits when you lost coverage and you elect COBRA Coverage for medical benefits at the same time.

Other COBRA Coverage 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 COBRA Coverage is not paid when due*
  - *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)*
  - *The qualified beneficiary becomes entitled to Medicare*
- *COBRA Coverage requires timely election of the coverage. The Trust will, within 14 days of receiving notice of the qualifying event, send to the affected individual a COBRA enrollment form. This form will describe the cost of COBRA Coverage and the conditions under which the coverage will terminate. 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, and*
  - *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.*
- *Ongoing payments are due on the 20th of the month prior to each month of coverage. However, you will have a grace period of 30 days after the first of the month in which to make a payment.*

  You will receive a coupon book from the Trust Office to use when making COBRA Coverage payments. You will not receive a monthly bill from the Trust Office. ***It is your responsibility to make payments to the Trust Office. Late payments will result in termination of COBRA Coverage.***
- *The amount of the payment is subject to change.*
- *If you gain an eligible dependent while participating in COBRA Coverage, the usual rules for enrolling new dependents apply. To cover new dependents, you must enroll the dependent and make the required monthly payments, if eligible for family*

coverage. Coverage for newborn or adopted children will continue for the same time as coverage for children who were properly enrolled in the Plan on the day before the qualifying event. Newborn or adopted children added to your COBRA Coverage also become qualified beneficiaries.

➔ *To protect your family's COBRA Coverage 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.

Cost of COBRA Coverage and Payment

The cost that you must pay to continue benefits is up to 102% of the cost of coverage, as determined annually by the Trust. However, the COBRA Coverage premium for the 11-month disability extension period (if applicable) may cost up to 150% of the cost of coverage. If your former employer alters the level of benefits provided through the Trust to similarly situated active employees, your coverage and cost also will change.

Are There Other Coverage Options Besides COBRA Coverage?

Yes. Instead of enrolling in COBRA Coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan). Some of these options may cost less than COBRA Coverage. You can learn more about many of these options at **www.healthcare.gov.**

For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

If You Have Questions

Questions concerning your COBRA Coverage should be addressed to the Trust Office. For more information about your rights under ERISA, including COBRA, the Affordable Care Act (ACA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit **www.dol.gov/ebsa**. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website). For more information about the Marketplace, visit **www.healthcare.gov**.

Contact Information for COBRA Coverage Administration

Please direct all COBRA related forms, correspondence, payment and inquiries to:

Sound Health & Wellness Trust
Attn: COBRA Representative
201 Queen Anne Avenue North
Suite 100
Seattle, WA 98109-4896

(206) 282-4500
(800) 225-7620, Option 2

Other Rights

This describes your rights under COBRA Coverage and is not intended to describe all of the rights available under ERISA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws.

ENROLLING IN THE SOUND PLAN

When you become eligible for employee/dependent children coverage and then later for employee/spouse or family coverage benefits, you must enroll online or complete an enrollment form and submit it to the Trust Office. You must also submit any required documentation to the Trust Office.

Medical, prescription drug and vision coverage are generally provided under the Kaiser Permanente Plan. If you live outside of the Kaiser Permanente Options service area, you will receive medical, prescription drug and vision benefits under the Trust's Sound PPO Plan as described in this booklet. However, once you have completed your 35th month of employment, you may choose to enroll in either the Sound Kaiser Permanente Plan or the Sound PPO Plan.

You will also have the following enrollment options:

- *Employee-only coverage, employee/dependent children coverage, employee/spouse coverage, family coverage or no coverage (opt out). If you enroll your spouse or domestic partner, you must complete a "Certification of Spouse or Same Sex Domestic Partner Health Coverage" enrollment form and submit it to the Trust Office. If you do not select employee/spouse or family coverage, you will automatically be enrolled in employee-only coverage even if you submit the Spouse or Same Sex Domestic Partner Certification.*
- *Dental benefits have three options available. If you do not indicate an option, you will automatically be enrolled in the DDWA Preferred option.*

  ***DDWA Preferred (#09136)** – A dental PPO (Preferred Provider Organization) network administered by Delta Dental of Washington (DDWA); details about this option begin on page 84.*

  ***DeltaCare (#00405)** – A dental HMO (Health Maintenance Organization) network administered by Delta Dental of Washington (DDWA). Details are available in separate DDWA*

publications. For more information, call DDWA at (800) 650 1583 or visit ***www.DeltaDentalWA.com****.*

Schedule Plan – *The Schedule of Dental Allowances, administered by Delta Dental of Washington (DDWA), specifies the maximum payment allowable for each covered dental procedure; details begin on page 98.*

When you meet the eligibility requirement, you will also be automatically enrolled in the following benefits described in this booklet:

- *Employee and dependent (if applicable) life insurance*
- *Accidental death or dismemberment (only for employees)*
- *Weekly disability (only for employees)*

MAKING CHANGES

After 35 Months of Employment

For employees who have completed their 35th month of employment, they have the option to change their current medical/prescription drug Plan from the Sound Kaiser Permanente Plan to the Sound PPO Plan. The change is effective with their 36th month of employment, provided they submit the appropriate form to the Trust Office.

Annual Open Enrollment

An open enrollment will be conducted once each year, usually in the fall, for employees who want to change their dental plan, opt in or out of coverage or add/delete dependents. Open enrollment also provides those employees who have completed their 35th month of employment the option to change their medical plan. Changes made during open enrollment become effective January 1. *If you do not make changes during open enrollment, your current coverage will carry over to the next year; you will not be able to make changes until the next open enrollment unless certain events occur.*

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 domestic partnership, birth or adoption of a child or death of any dependent) or you lose coverage under your spouse's or domestic partner's plan, or a dependent or domestic partner currently not enrolled loses other insurance coverage, you will be allowed to revise your coverage option, provided you notify the Trust Office within 60 days of the change. This change will be effective the first day of the month following the status change (except newborns who are effective the date of birth). Please

note that your employee premiums will be adjusted no more than 60 days retroactively.

If you are enrolled in the Kaiser Permanente medical plan or the DeltaCare dental plan and you move out of the Kaiser Permanente or DeltaCare service area, you can request that you and your dependents change medical or dental plans, provided you notify the Trust Office within 60 days of the date you change your residence. 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.

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 domestic partner under this 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 (see 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 Sound PPO Plan, the benefits described in this section apply to you whether you use a PPO provider or non-PPO provider.

PREFERRED (PPO) PROVIDERS

The Trust has a Preferred Provider Organization (PPO) arrangement with Aetna through its Choice POS II network. This network of hospitals, physicians and other healthcare professionals (called PPO providers) agree to provide eligible employees and dependents with efficient, cost-effective services and supplies at discounted rates.

Providers not in the Aetna Choice POS II network are called non-PPO providers. Non-PPO providers are reimbursed at a lower level of benefits and charges are allowed only up to usual, customary and reasonable (UCR) fees and the non-PPO provider may bill you for those unpaid amounts.

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 Aetna network providers are covered providers under this Plan; see the definition of covered provider on page 141.

PPO providers have agreed to:

- *Bill the Plan directly, without any payment up front from you*
- *Accept the Plan's contracted fee levels instead of usual, customary and reasonable (UCR) rates, and may not charge more than the maximum amount under the contract – saving you out-of-pocket money*

You can find out if your medical care provider is in the Aetna Choice POS II network by visiting the Trust's website at **www.soundhealthwellness.com**, choose the PPO plan, clicking on Benefits, then selecting Find a Provider. You can also contact your provider and ask them. If you have any additional questions, please call the Trust Office.

HEALTH REIMBURSEMENT ARRANGEMENT (HRA)

Employees hired on or after December 3, 2010 are eligible for the HRA after 12 months of employment. On the first day of the 13th month of employment, the following provisions will apply.

Each January 1, or on your initial HRA eligibility date if you were hired on or after December 3, 2010, the Plan will fund an HRA account for you, based on your level of coverage and completion of certain health and wellness program activities in the prior calendar year. Activity requirements may vary, and will be communicated each year. The HRA annual funding amounts are:

- *Employee Only Coverage: up to $500 in maximum annual funding if you complete all required health and wellness program activities*
- *Family Coverage: up to $1,000 in maximum annual funding if you and your covered spouse or domestic partner complete all required health and wellness program activities*

The HRA account will be used to pay for covered medical expenses up to the annual amount funded each year before your annual medical deductible is applied.

The HRA cannot be used for non-PPO medical expenses, prescription drug, dental and vision benefits.

Your HRA account also cannot be used to pay for services, such as in-network preventive services, that are covered at 100% without deductible (up to the limits of the Plan).

Unused amounts in the HRA at the end of the calendar year will be carried over (rollover) to the following year. HRA amounts rolled over from a prior year will be used to cover:

- *Medical deductible and coinsurance amounts*
- *Emergency room copay amounts*

Once you have received non-preventive covered services in a calendar year equal to your HRA funding for that year, plus any amounts rolled over from prior years, you are then subject to the annual deductibles and coinsurance percentages described below.

DEDUCTIBLE

The deductible is the amount of covered medical expenses you and your eligible dependents must pay each calendar year before the Plan begins to pay benefits.

For new employees hired on or after December 3, 2010 who have not yet completed the 12 months of employment needed to qualify for HRA funding, the base deductible shown in the table below will apply.

For employees who qualify for HRA funding, each year you will have a base deductible that is dependent on your level of coverage (employee only or family) and whether you use PPO providers or non-PPO providers.

The deductible coordinates with your HRA and is applied *after* covered medical expenses equal to your HRA funding for the year are paid from your HRA. If you or your covered spouse fail to earn the maximum annual HRA funding for your level of coverage, your deductible amount for that year will be increased by the amount of unearned HRA funding. For example, an employee with employee-only coverage may earn up to $500 in HRA funding per year. If that employee completes only a portion of the required health and wellness activities for the year and earns $350 in HRA funding, their deductible for that year would be $450 ($300 base deductible plus $150 in unearned HRA funding).

The maximum deductible for a year is equal to the base deductible plus the maximum annual HRA funding available. These amounts are explained in the chart below.

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.

PER CALENDAR YEAR EMPLOYEE ONLY COVERAGE:	PPO PROVIDERS	NON-PPO* PROVIDERS
With maximum HRA funding (base deductible)	**$300**	**$600**
With no HRA funding (maximum deductible)	**$800**	**$1,100**
FAMILY COVERAGE:		
With maximum HRA funding (base deductible)	**$600**	**$1,800**
With no HRA funding (maximum deductible)	**$1,600**	**$2,800**

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

REIMBURSEMENT PROVISIONS (COINSURANCE)
Once you have met the deductible, the Plan covers most covered services at 80% of PPO provider charges or 60% of non-PPO providers' UCR charges.

PPO providers	**80%**
Non-PPO providers	**60%**

MEDICAL OUT-OF-POCKET (OOP) MAXIMUM
After you or your family reach the annual medical out-of-pocket (OOP) maximum, the Plan pays 100% for most covered services for the rest of that calendar year.

For new employees hired on or after December 3, 2010 who have not yet completed the 12 months of employment needed to qualify for HRA funding, the base OOP maximum shown in the table below will apply.

For employees who qualify for HRA funding, each year you will have a base medical out-of-pocket maximum that is dependent on your level of coverage (employee only or family) and whether you use PPO providers or non-PPO providers. Only the annual deductible and the participant's coinsurance amounts apply to the medical out-of-pocket maximum; benefits which exceed Plan limits do not apply.

In addition to the base medical out-of-pocket maximum, if you and your covered spouse fail to earn the maximum annual HRA funding for your level of coverage, your medical out-of-pocket maximum for that year will be increased by the amount of unearned HRA funding. For example, if an employee with employee-only coverage completes only a portion of the required health and wellness activities for the year and earns $350 in HRA funding, their medical out-of-pocket maximum for that year would be $2,900 ($2,750 base medical out-of-pocket maximum plus $150 in unearned HRA funding).

The maximum medical out-of-pocket for a year is equal to the base medical out-of-pocket maximum plus the maximum annual HRA funding available. These amounts are explained in the chart below.

PER CALENDAR YEAR EMPLOYEE ONLY COVERAGE:	PPO PROVIDERS	NON-PPO* PROVIDERS
With maximum HRA funding (base OOP max)	**$2,750**	**$5,500**
With no HRA funding (maximum OOP max)	**$3,250**	**$6,000**

FAMILY COVERAGE:

With maximum HRA funding (base OOP max)	**$5,500**	**$16,500**
With no HRA funding (maximum deductible)	**$6,500**	**$17,500**

For employees with family coverage, the employee only coverage maximum will apply to each covered individual until the family coverage maximum is met.

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

ANNUAL OUT-OF-POCKET MAXIMUM FOR ESSENTIAL HEALTH BENEFITS

In addition to the Plan's out-of-pocket maximums above, the Affordable Care Act (ACA) imposes limitations on how much you pay out-of-pocket for certain in-network provider covered charges.

For covered expenses incurred between January 1, 2016 and December 31, 2017, the ACA medical out-of-pocket maximums that you pay yourself for in-network provider covered charges are:

Per Person	**$4,250**
Per Family	**$8,500**

All of the current medical in-network provider out-of-pocket amounts will also apply to the above medical ACA out-of-pocket maximums. In addition, the following in-network provider out-of-pocket amounts will apply only to the above medical ACA out-of-pocket maximums:

- *The $100 emergency room co-pay;*
- *The 9th through 12th acupuncture visits;*
- *Allowed amounts above the chiropractic $30 allowed per visit;*
- *Allowed amounts above the routine foot care podiatry $20 allowed per visit;*
- *Amounts billed for routine foot care podiatry visits beyond the 12 visits allowed by the Plan;*
- *Pediatric vision co-pays.*

For calendar years after 2017, refer to the annual Summary of Benefits and Coverage (SBC) for the applicable ACA out-of-pocket maximums.

HEALTH & WELLNESS PROGRAM: LIVEWELL

Sound Health & Wellness Trust provides you, and your dependents for some programs, with an extensive health and wellness program called LiveWell. Most LiveWell programs are fully paid for by the Trust so there is little to no cost to you to help you live a healthier life, prevent illness and make informed decisions about your healthcare.

Services are provided by independent service providers, and all programs are confidential and completely voluntary. Complete program information is available online at **www.soundhealthwellness.com.**

The LiveWell programs include:

LiveWell Personal Health Assessment (PHA)

The LiveWell Personal Health Assessment (PHA) is a confidential annual questionnaire that gives you an immediate snapshot of your current health and health risks, and gives you a personal plan for healthy living.

Each year, you and your spouse have a limited period of time to take the confidential PHA to earn Health Reimbursement Arrangement (HRA) funding. Information you provide on the LiveWell PHA may qualify you for other LiveWell programs.

When available, the questionnaire can be taken either online at **www.soundhealthwellness.com** or a paper PHA can be requested by calling (877) 362-9969. (If you or your spouse is under age 18, please contact the Trust Office to take the PHA).

LiveWell Health Coaching

The LiveWell Health Coaching program is a phone-based health education program designed to help you and your spouse, 18 years of age or older, set and meet goals to improve your health and well-being in your choice of areas of back care, blood pressure, cholesterol, exercise, nutrition, stress and weight control. Your health coach will provide you with telephone support, educational materials, guidance, and the support you need to begin to make healthy lifestyle changes.

Based on results of your PHA, you may be invited to participate, or you may also enroll by calling (877) 362-9969.

LiveWell Nurse Line

24 hours a day, 7 days a week, you and your dependents can call or chat online with a knowledgeable registered nurse who will help you find the information you need to make informed medical decisions.

Visit the Trust's website at **www.soundhealthwellness.com**, or call toll free (877) 362-9969.

LiveWell Condition Management

The LiveWell Condition Management is available to you and your covered spouse, 18 years of age and older, who have been diagnosed with diabetes, heart disease, asthma and other pulmonary diseases and identified as being eligible for the program. Condition Management offers additional support outside of the doctor's office, and helps people better manage their condition and follow treatment plans. Program participants may receive information in the mail or work one-on-one with a registered nurse.

You may be contacted for enrollment in the program or you can call (877) 362-9969 to learn more about the LiveWell Condition Management program or ask questions.

LiveWell Quit For Life®

The LiveWell Quit For Life® Program helps you and your spouse, 18 years of age or older, quit tobacco for good. Participants receive step-by-step tools, personalized telephone treatment sessions with a Quit Coach®, and free nicotine patches or gum, if recommended by your coach. Bupropion is also covered under your Prescription Drug benefit when prescribed by your physician.

Call (877) 362-9969 to enroll in the program.

LiveWell Fit

With LiveWell Fit, you and your dependents can be reimbursed for their registration fees for up to four approved LiveWell Fit events per calendar year. In addition, you are eligible to receive rewards for participating in events throughout the year.

A list of current approved LiveWell Fit events can be found online at **www.soundhealthwellness.com**.

INDIVIDUAL CASE MANAGEMENT (ICM)

The Plan works with Aetna to provide case management services in certain healthcare treatment situations. Representatives of Aetna will work cooperatively with you and your physician to consider effective alternatives to hospitalizations and other high cost care to make the most efficient use of the Plan's benefits. The purpose of these services is to help 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 (ICM), 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. You, or person legally authorized to act for you, will be required to consent with the terms under which the benefits will be provided.*
- *The Plan's decision to offer alternative benefits is made individually for each patient and does not alter or change all other provisions of the Plan.*
- *These alternatives are not to cover anyone who has simply reached the maximum benefits provided by the Plan for that condition.*
- *The Plan may stop alternative benefits by sending written notice to you.*

COVERAGE REQUIRING PREAUTHORIZATION

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

The Plan works with Aetna to provide preadmission authorization for all elective inpatient admissions to determine medical necessity of the hospitalization and any associated elective procedures as well as the appropriate length of stay. In addition, you should contact the Trust Office to confirm eligibility for coverage and that the requested service is a covered medical expense. If you do not follow preadmission authorization 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. Admissions and services provided during an inpatient stay that are not preauthorized and that are subsequently considered to be not medically necessary will not be considered covered medical expenses.

Inpatient Admissions

The Plan requires that you obtain preadmission authorization at least 72 hours in advance whenever your physician recommends a non-emergency elective inpatient stay of 23 hours or more at a hospital, licensed treatment facility, or skilled nursing facility. Please have your physician call Aetna at (888) 632-3862, option 3, to have your inpatient stay and any procedures preauthorized for benefits. If the proposed procedure/stay is a covered expense, your physician will be asked to provide necessary information to establish the medical necessity for your proposed elective hospital stay and all associated treatment and services.

If Aetna finds a preadmission authorization request to be not medically necessary, the Plan may refer it for an Independent Medical Evaluation

(IME) by a physician of the Trust's choosing in order to determine medical necessity and/or appropriateness. If the IME physician concludes that the admission and related services are medically necessary, then coverage will be provided at the benefit level specified under the Plan. If the IME physician concludes that the requested services are not medically necessary but agrees that an alternative treatment or level of care is appropriate, then coverage for that alternative treatment or level of care will be provided at the benefit level specified in the Plan. If the IME physician agrees that the services are not medically necessary, you will be advised that the services will not be considered covered expenses by the Plan. If the Plan requests that you or your dependent undergo a physical exam by the IME and you refuse, all expenses incurred in conjunction with an elective stay or procedure will not be considered covered expenses by the Plan. (The definition of medically necessary is on page 145. Your claims and appeals rights are on page 132).

For an emergency admission, your physician should notify Aetna by phone on the first normal work day after your or a dependent's admission.

Other Services

The Plan requires preauthorization from Aetna before any of the following services are performed, whether inpatient or outpatient unless otherwise noted:

- *Breast reduction surgery*
- *Eyelid surgery, such as blepharoplasty*
- *Organ transplants (see page 66)*
- *Reconstructive and/or cosmetic surgery*
- *Removal of breast implants*
- *Stereotactic radiosurgeries*
- *Prophylactic mastectomy (see page 58)*
- *Surgical interventions for sleep apnea*
- *Experimental or investigational treatment*
- *Varicose vein surgery/sclerotherapy*
- *Weight loss surgery (see page 68)*
- *Home healthcare (see page 54)*
- *Skilled nursing facility care (see page 65)*
- *Home infusion*
- *Hospice care (see page 56)*
- *Medical equipment and prostheses if the purchase price exceeds $2,000 or the monthly rental fee exceeds $500 (see page 59)*

- *Orthognathic surgery*
- *PET scan/SPECT scan*
- *Rehabilitation services*

If services are not preauthorized, Aetna will complete a post-authorization review for medical necessity.

COVERED MEDICAL EXPENSES

The Plan provides benefits for the following services and supplies, provided they are medically necessary 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 80% 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 68-70.

Acupuncture

The Plan covers treatment by an acupuncturist up to a maximum of eight visits per calendar year.

Ambulance (local and air)

The Plan pays 80% of medically necessary transportation to and from a local hospital or the nearest hospital equipped to provide *medically necessary* treatment not available in a local hospital. The Plan pays 100% of allowed charges for medically necessary transportation for a transfer between hospitals. Cabulances and other related transportation services are not covered.

Ambulatory Surgical Center

Benefits for covered services and supplies at an 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.

Anesthesia for dental services is covered under the dental benefit.

Applied Behavior Analysis (ABA)

Applied Behavior Analysis (ABA) therapy is a covered service when prescribed and monitored by a pediatric neurologist, neurologist, developmental pediatrician, psychologist, or psychiatrist experienced in the diagnosis and monitoring of patients with autism spectrum disorders and when used in the treatment of autism/autism spectrum disorders as defined in the most current version of the Diagnostic and Statistical Manual of Mental Disorders (DSM) (credentialed provider). Coverage requires: (a) utilization of an in network provider when available and (b) utilization of individuals appropriately licensed by the state and/or certified by the Behavior Analyst Certifying Board, **whether the services are provided in network or out of network.** Precertification through the Trust's Utilization Management program is required and will require appropriate diagnostic assessments, individualized treatment plans, and ongoing interval assessments as provided for in the Trust's ABA Coverage Policy. A copy of the Trust's ABA Coverage Policy may be obtained by calling the Trust Office or by visiting the Trust's website.

Blood Transfusions

Coverage includes the cost of blood, plasma or any other blood-like infusion. Storage of blood and the cost of harvesting or collecting for autologous transfusion or directed donations (e.g. platelet pharesis) are not covered benefits.

Chemotherapy

Coverage includes treatment that is FDA approved for the diagnosis. Certain chemotherapy drugs must be purchased through the Trust's specialty prescription drug benefit administrator, US Specialty Care (see page 73).

Chiropractic Treatment

Benefits include treatment by a chiropractor for a musculoskeletal disorder (bone, muscle, joint and tendon) up to $30 per visit, 20 visits per calendar year (not more than one visit per day).

Chiropractic x-rays are limited to one set from one chiropractic visit, per calendar year.

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.

The time limit may be extended when a medical condition prevents the dental work from being completed within six months. Medical benefits will not be considered until dental 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 for one set 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.

Emergency Treatment

A $100 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 non-PPO hospitals will be paid as if they were provided at PPO hospitals, after the $100 copay.

Gender Dysphoria Treatment

Treatment of gender dysphoria will be considered a covered expense, provided that the Trust Policy and other relevant terms of the Plan are met. A copy of the Trust Gender Dysphoria Coverage Policy may be obtained by calling the Trust Office or by visiting the Trust's website. Preauthorization of all treatment services is required. Covered services may include supportive mental health counseling and treatment of any additional co-morbid mental health conditions, appropriate hormonal treatment interventions, orchiectomy, oophorectomy and hysterectomy, as well as genital reconstructive surgery, medically necessary medications and certain surgical procedures where those interventions and treatments comply with the Plan provisions. For services to be considered a covered expense, patients must coordinate care through the Trust's designated Behavioral Health Case Management program. Your physician can begin the process by calling the Trust's utilization management vendor, Aetna, at (888) 632-3862 and selecting the Behavioral Health option. Covered services will not include any service considered to be cosmetic or not medically necessary as determined by the Plan.

Genetic Testing

Genetic testing for the purposes of screening for the presence of occult disease, for the purposes of risk stratification for the development of clinically absent or unapparent disease, for the evaluation of possible prophylactic surgical treatment or any other purpose is not covered unless required by law, except:

- *Governmentally mandated neonatal testing and testing performed in association with amniocentesis and other covered related or equivalent procedures.*
- *Testing where a definitive diagnosis of breast cancer or other hematologic or oncologic diagnosis has been made to determine the medical appropriateness of therapy; subject to medical necessity, experimental or investigational treatment, and all other relevant provisions of the Plan.*
- *Services are covered at 100% of charges (not subject to the deductible), if a PPO provider is used, for testing of individuals with a high probability of possessing a BRCA mutation (as defined in the Trust's Prophylactic Mastectomy and BRCA Testing Policy) and who have undergone appropriate pre-testing evaluation and counseling.*
- *Services are covered at 100% of charges (not subject to the deductible), if a PPO provider is used, for genetic counseling for women with risk factors under the Trust's Prophylactic Mastectomy and BRCA Testing Policy and post-test counseling for those identified as having positive screening results.*

Contact the Trust Office for more information.

The Trust will request only the minimum amount of genetic information necessary for the purpose of determining eligibility for coverage of a prophylactic mastectomy, in accordance with the Genetic Information Non-discrimination Act of 2008 (GINA).

Hearing Care

Benefits include hearing exams and hearing aids (or other non-surgical hearing enhancers) to a $1,000 maximum in a period of three consecutive calendar years.

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

These benefits cover:

- *Audiology exam and hearing evaluation by an audiologist (including a follow-up consultation)*
- *Otology exam by a physician*
- *The hearing aids (monaural or binaural) prescribed as a result of such examination, which includes: (1) ear mold(s); (2) the hearing aid instruments; (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 aids*

If you return the covered hearing devices before actual purchase, rental charges for use of the devices 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 (unless 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), up to the usual, customary and reasonable charges for the covered services rendered. Services must be provided by a home healthcare agency and be in place of confinement in a hospital or skilled nursing facility.

Your physician must call Aetna at (888) 632-3862, option 3 to preauthorize any home healthcare services. More information about preauthorization is on page 48.

Home healthcare services are covered provided that:

- *Home healthcare services must be for the medically necessary treatment of an illness, injury or pregnancy related condition 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 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 aide services when acting under the direct supervision of one of the covered therapists and performing covered services specifically ordered by the physician*
- *Laboratory services*
- *Medical supplies and drugs prescribed by a physician and dispensed by the home healthcare agency*
- *Services of a registered nurse (RN) and licensed practical nurse (LPN)*
- *Services of a registered physical therapist, certified occupational therapist, certified speech therapist and certified respiration 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*
- *Separate transportation charges*
- *Services performed by family members*
- *Supportive environmental materials (handrails, ramps, etc.)*
- *Social 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 a hospice agency are covered at 100% of usual, customary and reasonable charges (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. Your physician must call (888) 632-3862 option 3 to preauthorize any hospice care services. More information about preauthorization is on page 48.

Plan benefits are provided for inpatient hospice confinement to the same extent as if incurred in a hospital.

The services of a physician and of a hospice agency are covered in the patient's home.

Home care services of a 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 Aetna 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 a 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 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*
- *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 Aetna) 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*
- *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 including:

- *Administration of blood and plasma (including blood bank service charges)*
- *Diagnostic tests*
- *General nursing care*

- *Intensive care unit or coronary care unit*
- *Drugs*
- *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 that could be performed as an outpatient, or for hospital admissions the Plan considers not medically necessary.

Your physician must call Aetna at (888) 632-3862, option 3 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 48.

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 to be no longer medically necessary. (The definition of medically necessary is on page 145.)

Injectable Prescription Drugs

Provider administered injectable drugs are covered, subject to all other applicable provisions of the Plan. Certain self-injectable drugs may be covered under the Prescription Drug benefit (see page 73).

Mastectomy

The Women's Health and Cancer Rights Act of 1998 requires that the Plan provide benefits for mastectomy-related services due to disease or cancer if you have had or are going to have a mastectomy.

For individuals receiving mastectomy related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient for: all stages of reconstruction of the breast on which the mastectomy was performed, reconstruction and surgery to produce a symmetrical appearance, and prostheses and physical complications of all stages of mastectomy, including lymphedema.

The Plan does not provide benefits for prophylactic mastectomies except as may be required under the Women's Health and Cancer Rights Act and for covered women who are determined by the Trust to be at an extraordinarily high risk of developing difficult to treat breast

cancer, in accordance with the Trust's Prophylactic Mastectomy and BRCA Testing Policy ("Policy"). No benefits will be provided for prophylactic mastectomies for indications not specifically provided for under the Policy. Preauthorization through Aetna is required for any prophylactic mastectomy. You may find the current Policy at **www.soundhealthwellness.com** under forms and documents or you may contact the Trust Office for a copy.

Maternity Benefit

The Plan provides maternity benefits for any employee or spouse, on the same basis as any other illness or injury. 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, prenatal or postnatal care, or well-baby care of a newborn, except to the extent required by law.

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.

In accordance with federal law, the Plan does not restrict hospital benefits for covered mothers and newborns to less than 48 hours after normal vaginal delivery or 96 hours after a cesarean section or require that a provider obtain authorization from the Plan for prescribing a length of stay within those time periods. Aetna 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 of a damaged covered item or replacement of a damaged covered item, including as a result of normal wear and tear, that cannot 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 page 48).

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. Expenses for drugs are covered under the prescription drug benefit.

Your physician must call Aetna at (888) 632-3862, option 3 to preauthorize any inpatient stay services. 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 48.

In addition to authorizing the appropriate length of stay before an admission, the care you receive is reviewed for the need for continued hospitalization. Hospital benefits may be reduced or denied if hospitalization is determined to be no longer medically necessary. (The definition of medically necessary is on page 145.)

Naturopath

Services by a naturopath are covered with a maximum of five visits per calendar year, provided the naturopath is licensed in the state where services are performed and practicing within the scope of their license.

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 63 for a description of benefits provided.

Nutritional Counseling

Medically necessary nutritional counseling (up to four visits annually) provided by a registered dietician or comparably credentialed professional (e.g. Commission on Dietetic Registration) when ordered by the patient's treating physician as part of a comprehensive treatment plan for a patient with a known history of diabetes, renal failure, hepatic insufficiency, genetic metabolic disorder requiring dietary modifications or morbid obesity when provided as part of a Trust approved Bariatric Management Program.

Nutritional Support

Medically necessary total parenteral nutrition (TPN) feeding is covered; elemental (chemically defined) feeding when 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 PPO provider 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 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 – PPO Providers

Preventive care services are covered at 100% of charges (not subject to the deductible), **if a PPO provider is used.** Covered preventive services for PPO providers include the following:

- *United States Preventive Services Task Force (USPSTF) Grade A and B recommended services such as physical exams, certain cancer screenings and immunizations*
- *Centers for Disease Control (CDC) child, adolescent, catch up and adult immunizations schedules*
- *Health Resources and Services Administration (HRSA) guidelines for infants, children, adolescents and women*

See **www.healthcare.gov** for more information about the preventive services guidelines and recommendations listed above.

The same preventive care service received from both a PPO provider and non-PPO provider is only covered once under the Plan.

Preventive Care – Non-PPO Providers

Preventive care services are covered at 60% of charges (subject to the deductible) ***if a non-PPO provider is used.*** Covered preventive services for non-PPO providers are the same as those listed above for PPO providers.

However, flu and pneumonia shots will be covered at 100% and are not subject to the deductible. If the physician also charges for an office visit, the office visit will not be covered if it is solely for obtaining the flu shot.

! ***Note: The same preventive care service received from both a non-PPO provider and a PPO provider is only covered once under the Plan.***

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 by a referral from a physician, ARNP or PA and meet specific plan criteria; contact the Trust Office for those criteria.

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 for the treatment of pain*
- *Cardiac therapy 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 care is:*
  - *Prescribed, provided and monitored by a covered provider, as defined by the Plan, under the supervision of a physician*
  - *Provided at an approved rehabilitation facility or hospital*
  - *Targeted to cardiac deficiencies documented by medical tests and expected levels of recovery*
  - *Initiated within 12 weeks after acute care treatment for the medical condition ends*
- *Pulmonary therapy for patients with a documented diagnosis within the preceding 12 months. Treatment is covered when care is:*
  - *Prescribed, provided and monitored by a covered provider, under the supervision of a physician*
  - *Provided at an approved rehabilitation facility or hospital*
  - *Targeted to pulmonary 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 48). Coverage will be provided at the appropriate level of care (hospital, skilled nursing facility, outpatient). 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, speech or occupational therapy each day for at least five days per week

- *Services must be provided in an approved rehabilitation facility; 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 physician as part of a physical therapy program)*
- *Neurodevelopmental therapy; see page 51 for coverage of ABA 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. 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 physician*
  - *Services must be provided by an approved hospital, physician or physical, occupational or speech therapist*
  - *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 illnesses*
- *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.

Your physician must call Aetna at (888) 632-3862, option 3 for preauthorization (see page 48).

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

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.

Covered expenses include services at an approved alcoholism and/or drug abuse treatment facility, an approved hospital or a covered provider's office. Expenses for drugs are covered under the prescription drug benefit.

Your physician must call Aetna at (888) 632-3862, option 3 to preauthorize any inpatient stay services. 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 48.

In addition to authorizing the appropriate length of stay before an admission, the care you receive is reviewed for the need for continued inpatient stay. Benefits may be reduced or denied if inpatient confinement is determined to be no longer medically necessary. (The definition of medically necessary is on page 145.)

To the extent permitted by law, the Plan does not cover alcoholism and/or drug abuse treatment charges for:

- *Information or referral services*
- *Residential care*

Surgical Services

Medically necessary surgeries resulting from illness or injury are covered.

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

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. Contact the Trust Office for more information.

Prior authorization is required for some surgeries (see page 48).

Transplants

Plan benefits include the following transplants, subject to the Plan conditions and limitations:

- *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 preauthorized in writing by Aetna. 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.

Repair of an organ (e.g., joint or valve replacement) is not considered a transplant.

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, unless the expenses are required to be covered by law*
- *Expenses of the donor when the recipient of the organ 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 Aetna*
- *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 an employer. Approval is based on specific Plan criteria and is subject to enrollment in case management. Your physician must contact Aetna at (888) 632-3862, option 3 for preauthorization (see page 48). Resulting complications from a surgery that is not preauthorized are excluded. A copy of the Trust's Weight Loss Surgery Policy can be obtained by calling the Trust Office or by visiting the Trust's website.

X-ray, Chemo and Radiation Therapy

Medically necessary treatments are covered.

MEDICAL EXCLUSIONS AND LIMITATIONS

In addition to the General Exclusions (see page 125), the Trust PPO Plan does not cover:

1. *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).*
2. *Aquatic therapy, unless part of a formal outpatient rehabilitation program.*
3. *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, fitness guidance, anger management, or nutritional counseling, except as provided under the nutritional counseling benefit (see page 61).*
4. *Charges for missed appointments, telephone consultations when a patient is not physically seen by a physician or completion of claim forms.*
5. *Charges for treatment of temporomandibular dysfunction or temporomandibular joint dysfunction (TMJ).*
6. *Charges for treatment, services or supplies that exceed usual, customary and reasonable fees (see UCR definition on page 146).*
7. *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.*

8. *Custodial care or care when no significant clinical improvement is expected as a result (except hospice care).*
9. *Dental treatment (except natural teeth restorations due to accidental injuries).*
10. *Experimental or investigational treatment except for clinical trials specifically excepted from the Plan's definition of experimental or investigational treatment (see page 142).*
11. *Eye exercises; visual or orthoptic training/therapy.*
12. *Eyeglasses, eye refractions or eye exams to correct vision or fitting of glasses. See page 78 for your vision benefit.*
13. *Food supplements, including formula for enteral feeding.*
14. *Genetic counseling, testing or other services except as expressly stated in the Genetic Testing benefit on page 52.*
15. *Massage therapy unless ordered by a physician, ARNP or PA as part of covered physical therapy program.*
16. *Medical exams or tests not connected with an illness or injury, except as provided under preventive care benefits.*
17. *Postage, handling and taxes related to medical services or supplies.*
18. *Preventive medicine (except as specified under preventive care benefits).*
19. *Private room charges exceeding the hospital's most common charge for semiprivate (two-bed) accommodations.*
20. *Refractive eye surgery to correct vision deficiencies.*
21. *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. The storing of semen and oocytes is also excluded.*
22. *Services by an institution that is primarily a place of rest, place for the aged, nursing home, convalescent home, residential facility, or similar institution, except for covered hospice services.*
23. *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 as a condition of receiving coverage.*
24. *Services or supplies furnished to eligible 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, except as required by law.*
25. *Services or supplies that are solely for the convenience of the patient, provider, or caregiver.*
26. *Services performed on teeth, gums or alveolar processes (except to treat tumors or accidental injury).*
27. *Shoes or foot supports available without prescription.*

28. *Smoking cessation program, whether or not you have other medical conditions related to or caused by smoking, except to the extent required by law.*
29. *Treatment for intentionally self-inflicted injuries that do not result from a physical or mental health condition.*
30. *Weight loss treatment or services, unless preauthorized by Aetna 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.*
31. *Complications of non-covered services.*
32. *Hypnotherapy, and all services related to hypnotherapy.*
33. *Services and supplies related to sexual reassignment surgery not covered under the Trust Gender Dysphoria Coverage Policy. See page 52 for a summary of the covered benefit and see the Trust website for the Policy.*
34. *Lodging, food or transportation, unless otherwise specifically provided under this Plan.*

PRESCRIPTION DRUGS

OptumRx and US Specialty Care administer the Trust's prescription drug benefit through three options for your convenience – retail pharmacies, OptumRx Mail and US Specialty Care (for specialty drugs).

Some prescription drugs may have limited quantities, may need to be preauthorized or may not be covered. Use of manufacturer's coupons or patient assistance programs are not permitted under the Trust prescription drug program unless approved by the Trust. Call the Trust Office for details.

COPAYS

For each drug (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	**$6**	**$12**	**$18**
Tier 2	**$22**	**$44**	**$66**
Tier 3	**$35**	**$70**	**$70**
Brand if generic is available	**	**	**

! ***Maintenance-only. Maintenance drugs in excess of a 30-day supply must be purchased through a pharmacy in the custom network which provides special discounts or through OptumRx Mail (see page 73).***

! ***Appropriate Tier 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 brand name drugs.*
- *Tier 2 – most brand name drugs, or more costly or less desirable generics.*
- *Tier 3 – non-preferred brand drugs and some more costly brand and generic drugs.*

You can contact OptumRx to see which tier your prescription is in.

RETAIL PHARMACIES

The program features a custom network of pharmacies consisting of employers who participate in the Trust. In addition, there is the OptumRx pharmacy network. You can use any pharmacy – the choice is yours each time you fill a prescription. Pharmacies in the custom network and the OptumRx network provide discounted prescriptions to the Plan. However, to receive 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 Trust ID card to the pharmacy and pay the appropriate copay.*

  Be sure to show your 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.

- ***OptumRx network.*** *If you fill your prescription at an OptumRx 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 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 OptumRx 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 OptumRx networks, you pay the full cost at the time of purchase, then 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 OptumRx 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 Trust website at **www.soundhealthwellness.com.** For an OptumRx network pharmacy call OptumRx at (877) 629-3126.

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

OPTUMRX MAIL HOME DELIVERY PHARMACY

You also have the option of using OptumRx Mail.

To use OptumRx Mail, simply complete a prescription order form (available from the Trust Office, and on line at **www.soundhealthwellness.com**), attach your prescription and your check for the appropriate copay and mail to the address on the form. After they receive your copay, OptumRx Mail 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 OptumRx Mail, please allow seven business days for processing.

You can contact OptumRx Mail at (877) 629-3126 with questions.

US SPECIALTY CARE PHARMACY (FOR SPECIALTY DRUGS)

Certain specialty drugs are provided through US Specialty Care's specialty prescription drug program. Specialty drugs include, but are not limited to, the following:

- *Certain self-injectable drugs (excluding insulin)*
- *Oral medications for oncology (cancer), some HIV drugs and a variety of other medications that may require special monitoring or handling, or are extremely costly*

- *Designated drugs included in the Trust's Affordable Therapeutics Program which require procurement through USSC to insure that you pay the lowest available copay*
- *Medications for transplants*

You can contact USSC during the hours of 9:00 a.m. to 5:00 p.m. Pacific Time at (800) 641-8475 if you have any questions.

MAINTENANCE PRESCRIPTION DRUGS

Maintenance drugs are certain designated medications used to treat chronic or long term conditions such as diabetes, arthritis, heart conditions, high cholesterol, digestive, asthma and high blood pressure that are included on the Trust's Maintenance Medication drug list.

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:

- *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*
- *OptumRx Mail, as described above*

PRESCRIPTION DRUG OUT-OF-POCKET (OOP) MAXIMUM

After you or your family reach the annual prescription drug out-of-pocket (OOP) maximum, the Plan waives all copays for that person or family for the rest of that calendar year.

For covered expenses incurred between January 1, 2017 and December 31, 2017, the prescription drug out-of-pocket maximums that you pay yourself for in-network covered prescription drugs are:

Per Person	**$2,900**
Per Family	**$5,800**

Prescription drug copays apply to the out-of-pocket maximum, but any processing fees, cost differentials or non-covered prescription drug expenses will not apply.

For calendar years after 2017 refer to the annual Summary of Benefits and Coverage (SBC) for the applicable ACA out-of-pocket maximums.

COVERED PRESCRIPTION DRUG EXPENSES

The 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*
- *Hospital take home prescription drugs, birth control products 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 products and diabetic supplies (including insulin, insulin syringe, needles, test strips and equivalent) from licensed pharmacists*
- *Self-injectable drugs prescribed by a physician*
- *Therapeutic vitamins, prenatal vitamins while pregnant, and other medications and vitamins as required by law and 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 provide certification before these can be covered)*
- *Certain over-the-counter (OTC) medications when accompanied by a valid prescription; call the Trust Office for details*
- *Prescription drugs used to treat substance abuse will be covered with a Tier 3 copay if they are pre-certified and prescribed by a Trust credentialed provider as part of a comprehensive treatment program. Drugs must be prescribed for an FDA approved usage, and in amounts not to exceed manufacturer's recommended dosages, by an appropriately licensed American Board of Addictions Medicine (ABAM) credentialed specialist, or board certified psychiatrist as part of a comprehensive treatment program. The Trust may provide coverage for drugs on a case by case basis when prescribed by a non-ABAM credentialed clinician as part of a comprehensive treatment program under certain conditions. Contact the Trust Office for more information.*

PRESCRIPTION DRUG EXCLUSIONS AND LIMITATIONS

The Plan does not cover:

1. *Any drug not reasonably necessary for the care or treatment of bodily injury or illness.*
2. *Appliances, devices, bandages, heat lamps, braces or splints.*
3. *Blood and blood plasma.*
4. *Claims received after the 12-month filing limit.*
5. *Cosmetics or health and beauty aids.*
6. *Drugs administered or taken while confined in the hospital.*
7. *Drugs lost, stolen or damaged by neglect.*
8. *Drugs reimbursable by any government program – national, state, county or municipal.*
9. *Drugs taken in conjunction with home health, hospice or skilled nursing care.*
10. *Maintenance prescription drugs in excess of a 30-day supply that are purchased from other than the OptumRx Mail or certain "custom network" pharmacies as described on page 74.*
11. *Medicines not requiring a prescription, unless otherwise indicated.*
12. *Multiple or nontherapeutic vitamins or dietary supplements, except as required by law.*
13. *Non-maintenance drugs from a retail pharmacy in excess of a 30-day supply; maintenance drugs in excess of a 90-day supply.*
14. *Fertility and infertility drugs.*
15. *Growth hormones, unless preauthorized in advance by US Specialty Care.*
16. *Refills before eligible (refill too soon).*
17. *Compound medications unless there is a medical exigency and prior approval is received.*

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 the person is unable, because of an injury or illness, to perform any normal activities they were performing on or before the date the person's coverage ends.

These benefits are furnished only for the condition causing the total disability and only if the person is under the continuous care and treatment of a physician or certain covered providers. Benefits continue up to the maximum amount, or to the end of the calendar year after the calendar year when coverage ends, or when the person is no longer certified as totally disabled by their physician – whichever happens first.

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

If the person is covered by another employer-sponsored benefit plan for active employees, this Plan pays secondary.

VISION CARE

The Trust has an agreement with VSP Vision Care 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 provider, 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 PROVIDER THE PLAN REIMBURSES...	IF YOU SEE A NON-VSP PROVIDER THE PLAN REIMBURSES...
Exams (once/12 months from last date of service)	**100% after $10 copay**	**up to $50**
*Lenses (once/12 months from last day of service)**		
• Single vision	**100%**	**up to $50**
• Bifocal – lined	**100%**	**up to $75**
• Trifocal – lined	**100%**	**up to $100**
• Lenticular	**100%**	**up to $125**
• Tints/photochromic	**100%**	**up to $5**
Frames (once/24 months from last date of service)	**up to $95**	**up to $70**
Contacts (once/12 months in place of eyeglass lenses and frames)		
• Elective	**100% up to $130 for contacts**	**up to $105**
•Contact Lens Exam (fitting and evaluation)	**You pay up to $60 copay**	**N/A**
*• Necessary***	**100%**	**up to $210**

! ***You are responsible for additional non-covered lens options, such as progressive lenses and coatings.***

! ****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 providers agree to:

- ***Glasses and Sunglasses***
  30% off additional glasses and sunglasses, including lens options, from the same VSP provider on the same day of your well vision exam, or get 20% off from any VSP provider within 12 months of your last well vision exam.
- ***Retinal Screening***
  Guaranteed pricing on retinal screening as an enhancement to your well vision exam.
- ***Laser Vision Correction***
  Average 15% off the regular price, or 5% off the promotion price; discounts only available from contracted facilities. After surgery your frames allowance is available once every 24 months from your last date of service.

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 limits and copays as described above for a VSP provider. You pay the non-VSP provider's full fee, then are reimbursed up to what would have been paid to a VSP provider.

OBTAINING VISION CARE

To receive eye care services or eyewear from a VSP provider:

- *Contact VSP by calling (800) 877-7195 or visiting **www.vsp.com** to determine if your provider is in the VSP network or to locate a VSP provider close to your home or work.*
- *When making an appointment, identify yourself as a VSP member, provide the VSP provider with the employee's Social Security number and first and last name; before your visit they will verify your eligibility and available benefits.*
- *The patient will be responsible for the $10 copay, and the cost of any cosmetic options, as well as any frame or contact lens overage.*

There's no need to file a claim—the VSP provider 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 128; 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 can be assignable to the provider if they are willing.

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*

The Plan 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 BENEFITS

This benefit is available only to employees (and their enrolled dependents) who have worked for an employer for more than 9 months and met the other eligibility rules described on page 12.

Delta Dental of Washington (DDWA) administers all of the Trust's dental benefit options under the administrative services contract (Preferred option and Schedule Plan option) or the insurance policy (DeltaCare option). You have the choice of three dental plan options:

- ***DDWA Preferred Option (#09136).*** *This option allows you to see any licensed provider. However, if you use a DDWA dentist, reimbursement will be based on their pre-approved filed fees. If you do not use a DDWA 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 DDWA dentists. Ask your dentist if they are a DDWA dentist. Also, if you use a DDWA preferred dentist, your benefits will be greater than if you use a DDWA non-preferred dentist or a non DDWA dentist. See page 84 for more details about this option.*
- ***DeltaCare Option (#00405).*** *DeltaCare is a dental HMO plan administered by DDWA. 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 97 for more details.*
- ***Schedule Plan Option.*** *This option allows you to see any licensed dentist. However, if you use a DDWA dentist, they will not charge more than their pre-approved filed fees. Benefits will be paid according to the schedule of allowances. Dental charges in excess of the schedule will be your responsibility. See page 98 for more details about the Dental Schedule.*

The following definitions apply to these dental benefits:

DDWA Dentist means a licensed dentist who is under contract with Delta Dental and who has agreed to filed fees for covered services. There are preferred DDWA dentists and non-preferred DDWA dentists. Your costs may be lower with a preferred DDWA dentist.

Dentist means a licensed dentist legally authorized to practice dentistry at the time and in the place services are performed. A dentist does not mean a dental mechanic or any other type of dental technician.

Emergency means the sudden and acute symptoms, including severe pain, that requires immediate dental attention, if failure to provide dental attention would result in serious impairment to oral functions or serious dysfunction of the mouth or teeth, or would place the person's oral health in serious jeopardy.

Filed Fees mean the approved fees that a DDWA dentist has agreed to accept as the total fee for the specific services performed.

Licensed Professional means an individual legally authorized to perform services as defined in his or her license. Licensed professional includes, but is not limited to, denturist, hygienist and radiology technician.

Maximum Allowable Fees means the maximum dollar amount that will be allowed toward the reimbursement for any service provided for a covered dental benefit.

Non DDWA Dentist means a licensed dentist who is not under contract with Delta Dental.

Specialist means a licensed dentist who meets Delta Dental's accreditation criteria in a specialty.

DDWA PREFERRED DENTAL OPTION (#09136)

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

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

If you enroll in the DDWA Preferred Provider Dental option, 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 eligible 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.

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)

	DDWA PREFERRED PROVIDERS	DDWA NONPREFERRED PROVIDERS	NON-DDWA PROVIDERS
Class I (diagnostic and preventive)	**100%**	**75%**	**75%**
Class II (basic procedures)	**85%**	**75%**	**75%**
Class III (major procedures)	**50%**	**40%**	**40%**

Once you pay the deductible, the Plan covers the above percentages for covered services. DDWA dentists' (nearly 90% of dentists in Washington) reimbursement will be based on their pre-approved filed fees. If you use a non-DDWA dentist, 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.

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 DDWA-approved licensed professional when appropriate and necessary as determined by DDWA.

The amounts payable by DDWA for Class I, II and III covered dental benefits are described above. Also, refer to the General Limitations and Exclusions sections as shown on page 95.

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 routine 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 DDWA dentist*
- *Complete series or panoramic x-rays are covered once in a three-year period from the date of servicece*
- *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. *Carries 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*
- *Space maintainers are covered once in a patient's lifetime for the same missing tooth or teeth through age 13*

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 DDWA-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 DDWA, 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 DDWA-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 DDWA; 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 bicuspids*
- *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 bicuspids 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*

! ***Note: Some benefits are available only under certain conditions of oral health. It is strongly recommended that you have your dentist submit the proposed treatment to DDWA prior to commencement of treatment to determine if the treatment would be a covered benefit.***

Exclusions

1. *Occlusal guard (nightguard) and occlusal splints.*
2. *Gingival curettage.*
3. *Major (complete) occlusal adjustment to the chewing surface of the teeth.*
4. *Periodontal splinting and/or crown and bridgework in conjunction with periodontal splinting, crowns as part of periodontal therapy and periodontal appliances.*

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

1. *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, or onlays on the same teeth are covered once in a five-year period from the seat date*
- *An inlay (as a single tooth restoration) will be considered as elective treatment and an amalgam allowance will be made once in a two-year period, with any difference in cost being the responsibility of the eligible person*
- *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 or post and cores are not a covered benefit within two years of a restoration on the same tooth from the date of service*
- *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*
- *Ceramic substrate/porcelain or cast metal crowns and onlays are not covered for children under 12 years of age*

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: DDWA 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, DDWA 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 a preferred provider's 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.

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, DDWA, 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.*
4. *Analgesics such as nitrous oxide, conscious sedation, euphoric drugs or injections.*
5. *Prescription drugs.*
6. *In the event you fail to obtain a required examination from a DDWA-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. *Orthodontic services or supplies.*
13. *TMJ services or supplies.*
14. *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.

15. *Claims received after the 12 month filing limit.*
16. *Charges made after coverage ends, except for the completion within 30 days of single procedures commenced while this coverage was in effect.*
17. *Charges that exceed the maximum benefits.*
18. *Conditions caused by or arising from an act of war, armed invasion or aggression.*
19. *Expenses incurred before you became eligible.*
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.*
26. *Sleep apnea supplies, such as mandibular advancement devices.*

DELTACARE DENTAL OPTION (#00405)

This is an insured benefit which is governed by the Group Master Policy. This is a summary of that policy.

DeltaCare is a dental HMO (Health Maintenance Organization) network administered by Delta Dental of Washington (DDWA). 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 DDWA 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 to a DeltaCare specialist.

FOR MORE INFORMATION
For more information, call DDWA at (800) 650 1583, visit their website at **www.DeltaDentalWA.com** or contact the Trust Office.

SCHEDULE PLAN OPTION

The Schedule Plan 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 100.

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

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

The deductible is the amount of covered dental expenses you and your eligible 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. Non-covered charges do not apply 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. The lifetime maximum benefit for implants is $3,477.60

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.

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.

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.

EXTENSION OF COVERAGE

Coverage will be extended for dental procedures started prior to the termination of eligibility and completed within 30 days after such termination. This extension is available only for procedures requiring multiple visits and are otherwise benefits under the Plan.

CONFIRMATION OF TREATMENT AND COSTS

Confirmation of treatment and costs helps you identify your out-of-pocket expenses prior to authorizing your dentist to complete their recommended treatment plan. Emergency palliative treatment is covered to relieve the problem temporarily until DDWA completes the process.

The confirmation process is highly recommended for the following services:

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

A dental treatment plan must be submitted to DDWA for confirmation of treatment and costs, along with all records, including current x-rays (not over 12 months old). If X-rays and records are not submitted, the process 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 DDWA.

The confirmation of treatment and costs process does not guarantee benefits.

SCHEDULE OF DENTAL ALLOWANCES FOR BASIC SERVICES

After you pay the deductible, benefits for basic services are paid according to the following 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.

DENTAL SCHEDULE

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**

ADA CODE	PROCEDURE	MAXIMUM BENEFIT ALLOWANCE $
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**
Preventive		
	Prophylaxis (cleaning and scaling)	
1110	Age 14 and over (adult)	**69.40**
1120	To age 14 (child)	**44.40**
	Fluoride Application (excluding prophylaxis)	
1206	Topical fluoride varnish	**24.50**
1208	Topical application of fluoride	**26.40**
1351	Sealant, each tooth	**34.10**
Minor Restorations		
	Amalgam Restorations	
2140	Primary, permanent – 1 surface	**79.00**

ADA CODE	PROCEDURE	MAXIMUM BENEFIT ALLOWANCE $
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**
Major Restorations		
	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**
	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**
2931	Stainless steel, permanent	**136.50**
	Other Services	
2910	Recement inlay/onlay	**49.70**

ADA CODE	PROCEDURE	MAXIMUM BENEFIT ALLOWANCE $
2920	Recement crown	**62.20**
2940	Sedative filling/temporary crown (fractured tooth)	**65.10**
2950	Core buildup, including any pins	**133.40**
2951	Pin retention – each tooth	**27.30**
2952	Cast post/core – in addition to crown	**174.30**
Endodontics		
	Pulp Treatment	
3110	Pulp cap	**52.50**
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**

ADA CODE	PROCEDURE	MAXIMUM BENEFIT ALLOWANCE $
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**
4277	Free soft tissue grafts – each site	**529.20**
Oral Surgery		
	Extractions (includes local anesthesia and routinepostoperative care)	
7111	Extraction, coronal remnants – decidous 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**

ADA CODE	PROCEDURE	MAXIMUM BENEFIT ALLOWANCE $
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**
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**

ADA CODE	PROCEDURE	MAXIMUM BENEFIT ALLOWANCE $
Other Dental Procedures		
9110	Emergency care for pain	**83.50**
9220	General anesthesia*	**320.30**
9243	Intravenous moderate (conscious) sedation/analgesia - each 15 minute increment	**53.75**
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**

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

EXCLUSIONS

The Schedule Plan option does not cover:

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 of federal Act, even though the member and/or their dependent waives their right to such benefits.

2. *Charges for completing claim forms.*
3. *Charges for missed appointments.*
4. *Charges made after coverage ends, except:*
   - *Dental procedures requiring multiple visits that were started while coverage was in effect, and completed within 30 days after dental coverage ends.*
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 prosthodontic devices or crowns prepared before the effective date but placed afterward.*
16. *Experimental or investigational services or supplies.*
17. *Home use supplies such as toothpaste, toothbrush, water-pick, fluoride, mouthwash, dental floss, etc.*
18. *Hospital facility charges for treating a dental condition.*

19. *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.*
20. *Implants are covered once in a lifetime, with a maximum of two implants per arch.*
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 71 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.*
38. *Sleep apnea supplies, such as mandibular advancement devices.*

COORDINATION OF BENEFITS

You may have medical and/or dental or other health 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 change how benefits are paid 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, the Trust pays an amount that, when added to other plan benefits, does not exceed 100% of allowable expenses under this Plan. This provision applies whether or not a claim is filed under Medicare or another plan. The Trust is authorized to obtain information about benefits and services available from Medicare or other plans to implement this rule.

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 as an active employee pays before an active employer health plan that covers the person as a dependent*
- *Benefits of the plan covering the person as an active employee or dependent of an active employee is primary before benefits of the plan covering the person as a retired, COBRA, terminated or laid-off employee or dependent of a retired, COBRA, terminated or laid-off employee*
- *If a dependent child is covered under both married 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. However, for a child who is a child under this Plan and the spouse of an active employee under another plan, the plan that covers that person for the longest is primary

- *If a dependent child's parents are not married, and a court decree and/or parenting plan establishes financial responsibility for the child's healthcare coverage, the plan of the parent with 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*
- *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 reason for this exclusion is that an HMO will not coordinate benefits with the Trust for services provided by a non-HMO provider.

This Plan coordinates with:

- *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

- *The Trust will be the primary payor of medical costs for employees over 65, and spouses over age 65 of employees of any age, with Medicare providing secondary coverage. This means you will be reimbursed first under this Plan (except in the case of End Stage Renal Disease (ESRD), as set forth below). If there are covered expenses not paid by the Trust, Medicare may reimburse you. To get reimbursement from Medicare, you must enroll for Medicare. In addition, to get coverage under Part B of Medicare, you must enroll and pay a monthly premium.*
- *Employees have the option of electing Medicare as primary coverage. However, an employee over age 65 or an employee's spouse over age 65 will automatically continue to be covered by the Trust as primary unless you notify the Trust Office, in writing, that you do not want coverage under the Trust. If you elect your coverage under Medicare to be primary, the Trust cannot by law, pay benefits secondary to Medicare. If an employee or dependent age 65 or older makes this election, it will mean that the individual making this election will not have any Trust coverage – medical, prescription drug, dental, vision, Health Reimbursement Arrangement, disability, life and accidental death and dismemberment coverage or LiveWell health and wellness programs.*

Disabled Employees or Disabled Dependents Under 65

If you are employed and you or your eligible dependent(s) are under age 65 and are entitled to Medicare due to disability, other than for end stage renal disease (ESRD), the Trust will pay benefits as primary.

End Stage Renal Disease (ESRD)

If you or your eligible dependent(s) are entitled to Medicare on the basis of age or disability and then become entitled to Medicare based on ESRD, and the Trust is currently paying benefits as primary, the Trust will remain primary for the first 30 months of your entitlement to Medicare due to ESRD. If the Trust is currently paying benefits secondary to Medicare, the Trust will remain secondary upon your entitlement to Medicare due to ESRD.

If you have any questions about the coordination of benefits under this Plan with Medicare benefits, contact the Trust Office.

SUBROGATION (RIGHT OF RECOVERY)

Were you or your dependent injured in a car accident or other accident for which someone else is liable? If so, that person (or his/her insurance) may be responsible for paying your (or your dependent's) medical and other expenses, and these expenses would not be covered under the Plan.

Waiting for a third party to pay for these injuries may be difficult. Recovery from a third party can take a long time (you may have to go to court). Because of this, as a service to you, the Trust will pay you (or your dependent) benefits based on the understanding **that you are required to reimburse the Trust in full** from **any** recovery you or your dependent may receive, no matter how it is characterized. The Trust advances benefits to you and your dependents only as a service to you. You must reimburse the Trust if you obtain any recovery from another person or entity.

You and/or your dependent are required to notify the Trust within 10 days of any accident or injury for which someone else may be liable. Further, the Trust must be notified within 10 days of the initiation of any lawsuit arising out of the accident and of the conclusion of any settlement, judgement or payment relating to the accident in any lawsuit initiated to protect the Trust's claims.

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

The Plan will also have subrogation rights if you or your dependent choose(s) to serve as a surrogate mother pursuant to a surrogacy agreement and the Trust pays for benefits on your behalf that are the responsibility of the ultimate parent(s). Specifically, if you enter into a surrogacy agreement that requires the ultimate parent(s) to pay for the medical expenses of the surrogate mother, the surrogate mother will be required to reimburse the Trust in full for any such payments made by the Trust on the surrogate mother's behalf to the extent those medical expenses are covered under the surrogacy agreement between the surrogate mother and ultimate parent(s). The Plan is subrogated to the rights of the surrogate mother for payment of medical expenses against the ultimate parent(s) for the recovery of any amount, the payment of

which was the ultimate parent(s) responsibility pursuant to the surrogacy agreement. The surrogate mother is required to notify the Trust within 20 days of entering into such a surrogacy agreement.

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

1. *By accepting or claiming benefits, the covered person agrees that the Plan is entitled to reimbursement from any judgment, direct payment, settlement, disputed claim settlement or any other recovery, up to the full amount of all benefits provided by the Plan. However, in no event shall the Plan's reimbursement exceed the gross amount of your recovery.*

2. *If the covered person complies with the terms of the Plan and the agreement to reimburse the Plan, the Plan will reduce its reimbursement amount by a reasonable share of attorney fees and a pro rata share of the costs. If the Plan has to bring a lawsuit to enforce this reimbursement provision, the Plan shall not reduce its reimbursement amount for reasonable attorney fees and a pro rata share of costs.*

3. *The Plan is entitled to reimbursement regardless of whether the covered person is made whole by the recovery, and regardless of the characterization or apportionment of the recovery. The Plan shall be entitled to first dollar priority from the covered person's recovery after payment of your attorney fees and costs, to the extent applicable.*

4. *Before the Plan will provide benefits, the Plan requires the covered person and the covered person's attorney or personal representative to sign an agreement acknowledging the obligation to reimburse the Plan from the proceeds of any recovery. The Plan requires the covered person to execute and deliver instruments and papers and do whatever else is necessary to secure the Plan's right of reimbursement (including an assignment of rights).*

5. *The covered person has an affirmative obligation to notify the Plan in the event the covered person requests or has requested benefits for services or supplies for an illness or injury for which there is a right of recovery against a third party. This obligation arises on the earlier of the date the covered person makes a formal or informal claim against the third party or investigates whether to make a formal or*

informal claim against the third party. In the event the Plan pays benefits prior to learning or discovering the covered person's third-party claim, such benefits shall be treated as overpaid benefits until the Plan receives a signed agreement from the covered person and the covered person's attorney or personal representative acknowledging the obligation to reimburse the Plan from the proceeds of any potential recovery. The Plan reserves the right to recoup any overpaid benefits by offsetting future benefits otherwise payable to the covered person or the covered person's family members, or by recovering the benefits from a source to which benefits were paid.

6. *The covered person must do nothing to prejudice the Plan's right of reimbursement.*

7. *When any recovery is obtained, an amount sufficient to satisfy the Plan's reimbursement amount must be paid into an escrow or trust account and held there until the Plan's claim is resolved by mutual agreement, arbitration or court order. If the funds necessary to satisfy the Plan's reimbursement claim are not placed in an escrow or trust account, the covered person or any failing party will be personally liable for any loss the Plan may suffer as a result.*

8. *The Plan may cease providing benefits if there is a reasonable basis for concluding the covered person will not honor the terms of the Plan or the agreement to reimburse, or the Trustees of the Plan modify the Plan provisions relating to reimbursement rights.*

9. *In the case of a deceased person, the Plan's rights apply to the decedent's estate, and the estate is required to comply with the Trust's rules and procedures to the same extent as an injured person. The Trust's right to reimbursement applies to any funds recovered from any other party by or on behalf of the estate and to any wrongful death recovery received by the decedent's survivors.*

10. *The Plan shall have a constructive trust, lien and/or an equitable lien by agreement in favor of the Plan on any overpaid or advanced benefits received by the employee, dependent, their estate or a representative of the employee or dependent (including an attorney) that is due to the Plan, and any such amount shall be deemed to be held in trust by the employee or dependent for the benefit of the Plan until paid to the Plan. By accepting benefits from the Plan, the*

employee and dependent consent and agree that a constructive trust, lien, and/or equitable lien by agreement in favor of the Plan exists with regard to any overpayment or advancement of benefits, and in accordance with that constructive trust, lien, and/or equitable lien by agreement, the employee and dependent agree to cooperate with the Plan in reimbursing it for all of its costs and expenses related to the collection of those benefits.

11. *The Plan specifically disavows any claims that a covered person may make under any federal or state common law defense, including but not limited to the common fund doctrine, the double-recovery rule, the make whole doctrine or any similar doctrine or theory, including the contractual defense of unjust enrichment. Accordingly, the Plan's subrogation and reimbursement rights apply on a priority, first-dollar basis to any recovery of the individual from any source without regard to legal fees and expenses of the individual and the individual will be solely responsible for paying all legal fees and expenses. The Plan shall have a priority, first dollar security interest and a lien on any recovery received from any source, whether by suit, settlement or otherwise, whether there is a full or partial recovery and regardless of whether the amounts are characterized or described as payment for medical expenses or as amounts other than for medical expenses of such injury, illness, accident or condition.*

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

This reimbursement and subrogation program is a service to you and your dependents. It provides for the early payment of benefits and also saves the Trust money (which saves you money too) by making sure that the responsible party pays for your injuries.

EMPLOYEE LIFE INSURANCE BENEFIT

This benefit is available only to eligible employees who have worked for an employer for 12 months and met the other eligibility rules as described on page 14.

This benefit is insured by MetLife and is governed by a Group Master Policy. The following is a summary of that policy.

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 24 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 beneficiary at your death.

If you wish, benefits can be paid to your beneficiary in monthly or periodic 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.

Remember to keep your beneficiary designation up to date with any life changes (marriage, divorce, birth of a child, etc.).

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.

Proof of continuing total disability 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, while total disability continues, if you submit proof to MetLife within the three months before each 12-month period. 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 these 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

This benefit is available only to eligible employees who have worked for an employer for 12 months and met the other eligibility rules as described on page 14.

This benefit is insured by MetLife and is governed by a Group Master Policy. The following is a summary of that policy.

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

CONVERSION PRIVILEGE
If your spouse'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 needs to apply and pay the required premium within 31 days after losing coverage. If your spouse dies within these 31 days, the amount of insurance your spouse 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

This benefit is available only to eligible employees who have worked for an employer for 12 months and met the other eligibility rules as described on page 14.

This benefit is insured by MetLife and is governed by a Group Master Policy. The following is a summary of that policy.

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
Loss of life	**$15,000**
Loss of both hands	**$15,000**
Loss of both feet	**$15,000**
Loss of 1 hand and 1 foot	**$15,000**
Loss of sight in both eyes	**$15,000**
Loss of 1 hand and sight in 1 eye	**$15,000**
Loss of 1 foot and sight in 1 eye	**$15,000**
Quadriplegia (total paralysis of both upper and lower limbs)	**$15,000**
Loss of 1 hand	**$7,500**
Loss of 1 foot	**$7,500**

Loss of sight in 1 eye	**$7,500**
Paraplegia (total paralysis of both lower limbs)	**$7,500**
Hemiplegia (total paralysis of upper and lower limbs on the same side of the body)	**$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 or contributed to by:

1. *Physical or mental illness or infirmity, or the diagnosis or treatment of such illness or infirmity;*
2. *Infection, other than infection occurring in an external accidental wound;*
3. *Suicide or attempted suicide;*
4. *Intentionally self-inflicted injury;*
5. *Service in the armed forces of any country or international authority. However, service in reserve forces does not constitute service in the armed forces, unless in connection with such reserve service an individual is on active military duty as determined by the applicable military authority other than weekend or summer training. For purposes of this provision reserve forces are defined as reserve forces of any branch of the military of the United States or of any other country or international authority, including but not limited to the National Guard of the United States or the national guard of any other country;*
6. *Any incident related to:*
   - *Travel in an aircraft as a pilot, crew member, flight student or while acting in any capacity other than as a passenger;*
   - *Travel in an aircraft for the purpose of parachuting or otherwise exiting from such aircraft while it is in flight;*

- *Parachuting or otherwise exiting from an aircraft while such aircraft is in flight, except for self-preservation;*
- *Travel in an aircraft of device used:*
  - *For testing or experimental purposes;*
  - *By or for any military authority; or*
  - *For travel or designed for travel beyond the earth's atmosphere;*

7. *Committing or attempting to commit a felony;*
8. *The voluntary intake or use by any means of:*
   - *Any drug, medication or sedative, unless it is:*
     - *Taken or used as prescribed by a physician; or*
     - *An "over the counter" drug, medication or sedative taken as directed;*
   - *Alcohol in combination with any drug, medication, or sedative; or*
   - *Poison, gas, or fumes;*
9. *War, whether declared or undeclared; or act of war, insurrection, rebellion or riot.*

EMPLOYEE WEEKLY DISABILITY (TIME LOSS) BENEFIT

This benefit is available only to eligible employees who have worked for an employer for 12 months and met the other eligibility rules as described on page 14.

BENEFIT

If you are totally disabled because of your injury or illness, 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 certain covered providers on or after the date of the disability to qualify for this benefit and your disability must be substantiated by objective medical evidence.

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 totally disabled and stop active work. (For example, if you're totally 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
Less than 80	**$0**
80 but less than 120	**$180**
120 but less than 150	**$240**
150 or more	**$300**

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:

1. *Any disability that starts prior to the effective date of your coverage for this benefit.*
2. *Both an injury and an illness during any concurrent period.*
3. *Disability due to environmental conditions.*
4. *Disability due to intentionally self-inflicted injuries that do not result from a physical or mental health condition.*
5. *Disability resulting from participation in a riot.*
6. *Injury or illness 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 covered in whole or in part under occupational coverage voluntarily obtained by your employer or required by workers' compensation laws.*
9. *Period of disability when you are not following a treatment plan.*
10. *Period of disability when you are not regularly attended to and seen by a physician or certain covered providers.*
11. *Period of time that is not substantiated by objective medical evidence.*
12. *Period of time when you are not considered continually totally disabled.*
13. *Both a work related and non-work related injury concurrently.*
14. *Any disability while incarcerated.*

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 Trust 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 Trust is required by federal law to withhold and deposit your share of FICA tax with the appropriate agency.

GENERAL PLAN EXCLUSIONS

With respect to all benefits, unless otherwise specifically provided, this 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, except as specifically indicated.*
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. *Services performed by a provider not licensed in the state where services are performed and not within the scope of the provider's license.*
6. *Any services or supplies not specifically covered under the Plan.*
7. *Claims received after the 12-month filing limit.*
8. *Conditions or injuries caused by or arising from war or any act of war, declared or undeclared, armed invasion or aggression.*
9. *Court-appointed treatment not covered by the Plan.*
10. *Late fees, finance charges or collection charges imposed by the provider.*
11. *Services or supplies received from a physician or other provider who usually lives in your home or is related by blood or marriage.*
12. *Treatment for injuries sustained while committing or attempting to commit a felony.*

SUBMITTING A CLAIM

HOW TO FILE A CLAIM

In a claim, you or your dependents request that the Trust 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 130), 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 within 12 months of the original request may result in the denial of your claim for untimely filing.

Neither you and/or a provider of service may request an adjustment of a claim more than one year after the Trust has requested information, paid and/or denied the claim.

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

TRUST PPO MEDICAL 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 on line at **www.soundhealthwellness.com** or 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.*
4. *If you have other medical 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 109 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 see a non-VSP provider:

1. *Pay the bill in full.*
2. *File a claim for reimbursement. Write the employee's name, date of birth, and last four digits of their Social Security number as well as the patient's name, date of birth and relationship to the employee 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 385018
   Birmingham, AL 35238-5018
   (800) 877-7195
3. *Reimbursement is made directly to you and can only be assignable to the provider if they are willing.*

DDWA PREFERRED, SCHEDULE AND DELTACARE DENTAL BENEFITS

When you see a DDWA 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 (available on the Trust's website) directly to:

Delta Dental of Washington
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 on line at **www.soundhealthwellness.com** or 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

For other than life insurance, accidental death or dismemberment and DeltaCare benefits 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 via an explanation of benefits. A post service claim ordinarily is processed within 30 days of receipt.

Pre-Service Claims

These procedures apply only to processing treatment plans submitted for preauthorization. See each section for the preauthorization rules that apply to that benefit. For example, on page 48, 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 Plan's 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 request for information is mailed to the claimant.

A decision on a pre-service claim ordinarily is made within 15 days. This period 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 the circumstances requiring the extension of time and the date by which the Trust expects to render a decision – 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, physician or covered provider with knowledge of the condition. The Trust will notify the claimant of its benefit determination (whether adverse or not) as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the claim by the Trust, unless the claimant fails to provide sufficient information to determine whether, or to what extent, benefits are covered or payable under the Plan.

If more information is required to process the claim, the claimant is informed regarding the specific information necessary to complete the claim as soon as possible, but not more than 24 hours after the claim is received.

The claim is then resolved as soon as possible, but no more than 48 hours after the Trust receives the additional information or the end of the 48 hours the claimant has to provide the information, whichever is earlier.

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. 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, the Trust 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 sufficiently in advance of the reduction or termination 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 possible, taking into account the medical exigencies. The claimant is notified of the determination within 24 hours of when the Plan receives the claim, if it is 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. *The denial code (if any) and its corresponding meaning.*
3. *A statement regarding the availability of the diagnosis and treatment codes upon request.*
4. *Information sufficient to identify the claim, including the date of service, health care provider and claim amount, if applicable.*
5. *Reference to the Plan provision(s) relied on.*
6. *Description of any additional material needed for the claim, with an explanation of why it is necessary.*
7. *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.*
8. *An explanation of the medical judgment – applying Plan terms to your circumstances – if the denial is based on the service or supply being medically necessary or experimental or investigational, or an equivalent exclusion.*
9. *An explanation of the Plan's appeal procedures and the available external review procedures, including applicable time limits.*
10. *The availability of and contact information for any applicable office of health insurance consumer assistance or ombudsman.*

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

FILING AN APPEAL

The Board of Trustees has adopted the following procedures to review benefit claim denials. These procedures apply for all benefits except life insurance, accidental death or dismemberment and DeltaCare benefits.

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 Trust Office. An appeal must identify the claim involved as well as reasons for the appeal, and provide any pertinent information. The claimant has a right to submit written comments, documents, records, and other information relating to the claim for benefits. 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 and in the external review section are the exclusive procedures available to you if you are dissatisfied with an eligibility determination, benefit denial or partial benefit award by the Trust or its authorized claim payers. These procedures must be exhausted before you may request an external review or may file suit under Section 502(a) of ERISA.

Information to be Provided Upon Request and Automatically (If Applicable)

You or your authorized representative may, upon request and free of charge, have reasonable access to all documents relevant to the claim for benefits. Relevant documents 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.

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

In addition, you will automatically be provided with any and all new information considered, relied upon or generated in connection with your appeal, and/or any new or additional rationale for the decision, as soon as reasonably possible. You will be offered the opportunity for a full and fair review on appeal.

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 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, taking into account all comments, documents, records, and other information submitted by the claimant relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination. 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. 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 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.

Voluntary Review by Hearing Committee

If a claimant wishes to appeal a decision of the Appeals Committee, he or she may request a hearing before the Hearing 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 Hearing Committee will

consist of at least one Employer Trustee and one Labor Organization Trustee. The review by the Hearing 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 at the next regularly scheduled meeting 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.

Appeal Procedures for Pre-Service and Urgent Care Claims

Appeal procedures are modified as follows for appeals involving pre-service 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 Hearing Committee at its next scheduled meeting after the claimant's appeal is received. The claimant is notified of the Committee's decision as soon as practical, but not later than five days after the decision is made.*
- *The claimant or his or her authorized representative may participate, as authorized by the Committee, to the extent the Committee deems necessary. If the claimant wishes to appear in person, the claimant may 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 24 hours after the Plan receives the Urgent Care Claim appeal 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*

Contents of Decision

If the Appeals Committee or Hearing Committee denies an appeal, you will be notified of specific reasons for the denial as well as specific Plan provision(s) involved, the denial code (if any) and its corresponding meaning, and a statement regarding the availability of the diagnosis and treatment codes upon request, and that all information relevant to the claim is available without charge upon request. The notice will also include information sufficient to identify the appeal, including the date of service, health care provider and claim amount, if applicable. If the Committee relied on an internal rule, guideline or protocol, the notice will identify it and explain that a copy is available without charge upon request. If the Committee's decision was based on a medical or dental judgment, the notice will explain that judgment, applying the terms of the Plan to your circumstances. In the case of an appeal denied by the Hearings Committee, you also will be notified of your rights under Section 502(a) of ERISA and the available external review procedures. You also will be notified of the availability of and contact information for any applicable office of health insurance consumer assistance or ombudsman.

You have a right to file suit in federal or state court under Section 502(a) of the Employee Retirement Income Security Act (ERISA) on your claim for benefits; however, you must exhaust your administrative remedies before you have the right to file suit in state or federal court. Failure to exhaust these administrative remedies will result in the loss of your right to file suit as described in "Your ERISA Rights" below.

For all claims and appeals, the Board of Trustees or its designee has the power and sole discretion to interpret, apply, construe and amend the provisions of the Plan and make all factual determinations regarding the construction, interpretation and application of the Plan. The decision of the Board of Trustees is final and binding.

Request for External Review

You must exhaust the Trust's internal claims and appeals process, as described above, before requesting an external review. Once the Trust's internal claims and appeals process is completed, you have four months from the date you receive the final adverse benefit determination (the notice of appeal denial) to file a request for an external review. If the deadline would fall on a Saturday, Sunday or Federal holiday, the deadline is extended to the next day that is not a Saturday, Sunday or Federal holiday.

You may request external review for any denied appeals that involve (1) a question of medical judgment, which includes decisions about medical necessity, appropriateness, health care setting, level of care, effectiveness of a covered benefit, a determination that a treatment is experimental or investigational, or (2) a denial due to a rescission of coverage (meaning a retroactive termination of coverage). External review is not available for any other types of denials, including claims related to eligibility or claims related to life/death benefits or disability benefits, or a legal or contractual interpretation of the Plan's terms.

Requests for external reviews must be sent to:

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

Preliminary Review of External Review Request

Within five business days of receipt of a request for external review, the Trust will complete a preliminary review of the external review request to determine whether:

- *You were covered under the Trust at the time the health care item or service was requested or, in the case of a retrospective review, was covered under the Trust at the time the health care item or service was provided;*
- *The adverse benefit determination that is being appealed does not relate to your failure to meet the applicable eligibility requirements, or to a legal or contractual interpretation of the Plan's terms;*
- *You have exhausted the Trust's internal claims appeal process; and*
- *You have provided all the information and forms required to process an external review.*

Within one business day after completion of this preliminary review, the Trust will issue notification of its decision to you. If the request is not eligible for external review, the Trust's notice will explain the reasons for its ineligibility and provide any other information required, including contact information for the Employee Benefits Security Administration. If the request for external review is incomplete, the Trust will identify what is needed and you will have the longer of 48 hours or the remaining portion of the four-month external review request period to provide the information. If the external review request is complete and eligible for external review, the Trust will refer the matter to an Independent Review Organization (IRO) that is accredited by URAC or a

similar nationally recognized accrediting organization that is independent of the Trust and the IRO.

Review by Independent Review Organization

The assigned IRO will timely notify you in writing of the request's eligibility and acceptance for external review. This notice will include a statement that you may submit in writing to the assigned IRO within 10 business days following the date of receipt of the notice additional information that the IRO must consider when conducting the external review. The IRO is not required to, but may, accept and consider additional information submitted after 10 business days.

Upon receipt of any information you submitted, the assigned IRO will, within one business day, forward the information to the Trust. Upon receipt of any such information, the Trust may reconsider its adverse benefit determination or final internal adverse benefit determination that is the subject of the external review. Reconsideration by the Trust will not delay the external review. The external review may be terminated as a result of the reconsideration only if the Trust decides, upon completion of its reconsideration, to reverse its adverse benefit determination or final internal adverse benefit determination and provide coverage or payment. Within one business day after making such a decision, the Trust will provide written notice of its decision to you and the assigned IRO. The assigned IRO will terminate the external review upon receipt of the notice from the Trust, and the Trust will immediately provide coverage or payment (including immediately authorizing or immediately paying benefits) for the claim.

The IRO will review all of the information and documents timely received. In reaching a decision, the assigned IRO will review the claim de novo, which means that it is not bound by any decisions or conclusions reached during the Trust's internal claims and appeals process. In addition to the documents and information provided, the assigned IRO will consider the following in reaching a decision:

1. *Your medical records;*
2. *The attending health care professional's recommendation;*
3. *Reports from appropriate health care professionals and other documents submitted by the Trust, you and your treating provider;*
4. *The terms of the Plan to ensure that the IRO's decision is not contrary to the terms of the Plan, unless the terms are inconsistent with applicable law;*
5. *Appropriate practice guidelines;*
6. *Any applicable clinical review criteria developed and used by the Trust, unless the criteria are inconsistent with the terms of the Plan or with applicable law; and*

7. *The opinion of the IRO's clinical reviewer or reviewers after considering the information described in this section to the extent the information or documents are available and the clinical reviewer or reviewers consider appropriate.*

The IRO will provide written notice of the final external review decision to the Trust and to you within 45 days after the IRO has received the request to review. The assigned IRO's decision notice will contain:

1. *A general description of the reason for the request for external review, including information sufficient to identify the claim (including the date or dates of service, the health care provider, the claim amount (if applicable), the availability of diagnosis codes and their corresponding meaning, the denial codes (if any); and the reason for the previous denial);*
2. *The date the IRO received the assignment to conduct the external review and the date of the IRO decision;*
3. *References to the evidence or documentation, including the specific coverage provisions and evidence-based standards, considered in reaching its decision;*
4. *A discussion of the principal reason or reasons for its decision, including the rationale for its decision and any evidence-based standards considered in reaching its decision;*
5. *A statement that the determination is binding except to the extent that other remedies may be available under State or Federal law to either the Trust or to you;*
6. *A statement that judicial review may be available to you; and*
7. *Current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman established under the Public Health Service Act to assist individuals with the internal claims and appeals and external review process.*

After a final external review decision, the IRO will make the record available for examination by you, the Trust or State or Federal oversight agency upon request, except where such disclosure would violate State and Federal privacy laws.

Expedited External Review

You may request an expedited external review if you receive:

- *An adverse benefit determination involving your medical condition for which the time frame for completion of the Trust's expedited internal review process would seriously jeopardize your life or health or would jeopardize your ability*

to regain maximum function and you have filed a request for an expedited internal appeal; or

- *A final adverse benefit determination, if you have a medical condition where the timeframe for completion of a standard external review would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function, or if the final adverse benefit determination concerns an admission, availability of care, continued stay, or health care item or service for which you received Emergency services, but have not been discharged from a facility.*

If the Trust receives a request for expedited external review, it will proceed immediately to determine whether the request meets the reviewability requirements for a standard external review and will notify you of its determination. If the Trust determines that you are eligible for a standard external review, the Trust will assign an IRO and will provide all necessary documents and information considered in making the adverse benefit determination or final adverse benefit determination to the IRO electronically or by telephone or facsimile or by any other available expeditious method.

The assigned IRO will consider other appropriate information or documents described above under the procedures for standard review. In reaching a decision, the assigned IRO will review the claim de novo, which means that it is not bound by any decisions or conclusions reached during the Trust's internal claims and appeals process.

The IRO will notify the Trust and you of its determination as expeditiously as your medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request for an expedited external review. If the notice is not in writing, within 48 hours after the date of providing the notice, the IRO must provide written confirmation of the decision to you and the Trust.

Actions Following the Decision of the IRO

If the IRO directs that benefits be paid, the Trust will provide benefits under its Plan in accordance with the decision. If the decision is adverse to you, you have the right to pursue a suit pursuant to ERISA Section 502(a). Any legal action seeking to overturn a denial or an action that has otherwise adversely affected you must be brought within 180 days of the latest of the following events: the initial denial with no appeal being made; the final adverse benefit determination by the Trust; or the IRO's denial.

DEFINITIONS

The following definitions apply to the medical, prescription drug and weekly disability benefits described in this booklet. Definitions that specifically apply to the dental benefits begin on page 83. **Except where otherwise indicated, whenever the following terms are used in this booklet, they have the following meanings:**

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

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 is located.

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.

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. Please see the Employee Weekly Disability Benefit section (page 122) for the calculation of the average weekly wage.

Child or Children means your natural children, stepchildren, adopted children, children placed with you for adoption and foster children, as well as children who are dependent on you for support **and** are children of your domestic partner, children for whom you are legal guardian, or children who you have a legal obligation to support, who meet all of the eligibility requirements of the Trust as dependents.

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 obligated to contribute to the Trust, under a collective bargaining agreement or special agreement.

Covered Provider means:

- *A physician* as defined on page 145*
- *For podiatry (foot care) benefits – podiatrist**
- *For pregnancy benefits – midwife**
- *For nursing benefits – Registered Nurse (RN), Licensed Practical Nurse (LPN) or Advanced Registered Nurse Practitioner (ARNP)*
- *For mental and nervous as well as alcoholism and/or drug abuse treatment benefits – psychologist**
- *For mental and nervous benefits – mental health counselor, clinical social worker or marriage and family therapist*
- *For rehabilitation benefits – occupational therapist, physical therapist, speech therapist and massage therapist*
- *For gender dysphoria benefits – for mental health evaluation and treatment, a board certified psychiatrist, psychologist, or an in-network master's level provider with a degree in a clinical behavioral science field from a nationally accredited credentialing board and are qualified to evaluate and treat you as noted above. For medical services, as defined throughout the covered provider and physician definitions*
- *For various benefits:*
  - *Physician's Assistant* employed by the physician or clinic (under direction of the physician). If both the physician 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*
  - *Advanced Registered Nurse Practitioner (ARNP)**
  - *Surgical assistant*
  - *Optometrist*
  - *Dentist**
  - *Acupuncturist*
  - *Audiologist*
  - *Chiropractor*
  - *Naturopath*

All covered providers must be licensed in the state which services are performed and the services must be within the scope of the provider's license. For certain services, the Trust requires that you use a credentialed provider, which is a covered provider with certain expertise

in the area of treatment, as determined by the Trustees. Please contact the Trust Office for more information.

! ***Provider that can certify disability for Employee Weekly Disability benefits (see page 122), Extended Medical benefits (see page 77) and eligibility Premium Waivers (see page 24).***

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.

Deductible means the amount of covered expenses you and your eligible dependents must pay each calendar year before the Plan begins to pay benefits.

Dependent means your spouse, domestic partner and children who meet all of the eligibility requirements of the Trust.

Domestic Partner – see definition of spouse.

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

Emergency 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.

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

Employee Only Coverage means benefits that are provided to an eligible employee.

Employer or Participating Employer means any employer obligated by a collective bargaining agreement or special agreement to make contributions to the Trust, under the rules of the Trust Agreement.

Experimental or Investigational Treatment 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 non-experimental or non-investigational purposes at the time the drug or device is furnished*
- *The drug, device, medical treatment, or procedure has been determined experimental or investigational by the treating facility's institutional review board or other body serving a similar function, and the patient has signed an informed consent document acknowledging such experimental status*

- *Federal law classifies the drug, device or medical treatment under an investigational program*
- *Reliable evidence shows the drug, device, medical treatment or procedure is the subject of ongoing Phase I or Phase II clinical trials or is otherwise under study to determine its maximum tolerated dose, toxicity, safety, efficacy, or efficacy compared with standard means of treatment or diagnosis (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)*

Exceptions:
A service or supply will not be considered experimental or investigational if it is part of a clinical trial 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 non-investigational therapy*
  - *There is no therapy that is clearly superior to the trial treatment*

The Trust Office investigates each claim for benefits that might include experimental or investigational treatment in consultation 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 and whether it is medically necessary under the Plan.

Family Coverage means benefits are provided to an eligible employee and child(ren), employee and spouse, or employee, spouse and child(ren).

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*

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.

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.

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

Medically Necessary or Medical Necessity 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.

Participant means an employee or dependent who is eligible and enrolled for benefits under this Plan.

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

Physician means a physician or surgeon with a medical degree (either MD or DO) licensed in the state where services are performed and practicing within the scope of his or her license.

Plan means the plan of benefits described in this booklet.

PPO Provider (Preferred Provider) for medical services means a hospital, physician or other covered provider who has agreed to participate in the Aetna Choice POS II network as a preferred provider.

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

Self-Inflicted Injuries mean intentional 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.

Spouse means the individual who is legally married to the employee, as recognized under the laws of the state or jurisdiction in which the marriage was performed and who meets all of eligibility requirements of the Trust as a dependent.

For purposes of this document, spouse also means a person of the same sex as an employee who is legally registered with the State of Washington as a domestic partner of such employee and who meets all of the eligibility requirements of the Trust as a dependent. In addition, either the employee or such individual's domestic partner must be at least age 62 at the time such domestic partnership is established.

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 PPO providers (preferred providers), the Usual, Customary and Reasonable charge is its contracted fee amount.

SUMMARY PLAN DESCRIPTION

NAME OF PLAN
This Plan is the Sound Health & Wellness Trust.

The trust fund through which this Plan is provided is the Sound Health & Wellness Trust.

PLAN SPONSOR AND PLAN ADMINISTRATOR
The Board of Trustees of the Sound Health & Wellness Trust is the Plan Sponsor and Plan Administrator. Its address and phone number are:

Board of Trustees of the Sound Health & Wellness Trust
201 Queen Anne Avenue North
Suite 100
Seattle, WA 98109
(206) 282-4100

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 Board of Trustees has contracted with Zenith American Solutions, a contract administrative organization, to provide administrative services. Zenith is the “Trust Office”.

PLAN DOCUMENTS
This booklet – together with the benefit description of DeltaCare coverage – summarizes major Plan provisions. 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

The Trust Office is an agent for accepting services of legal process on behalf of the Trust.

Zenith American Solutions
For the Board of Trustees of the Sound Health & Wellness Trust
201 Queen Anne Avenue North
Suite 100
Seattle, WA 98109

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
Scott Klitzke Powers, Chairman Allied Employers, Inc. 811 Kirkland Ave Suite 100 Kirkland, WA 98033	**Todd Crosby, Secretary** UFCW Local No. 21 5030 First Ave. S. Suite 200 Seattle, WA 98134
Brent Bohn Albertsons, Inc. 1421 S. Manhattan Ave. Fullerton, CA 92831	**Emilia (Mia) Contreras** UFCW Local No. 21 5030 First Ave. S. Suite 200 Seattle, WA 98134
Frank Jorgensen Safeway, Inc. 1121 124th Ave. NE Bellevue, WA 98005	**James Crowe** UFCW Local No. 21 5030 First Ave. S Suite 200 Seattle, WA 98134
Yvonne Peters Allied Employers, Inc. 811 Kirkland Ave. Suite 100 Kirkland, WA 98033	**Faye Guenther** UFCW Local No. 21 5030 First Ave S. Suite 200 Seattle, WA 98134
Cynthia Thornton Fred Meyer, Inc. 3800 SE 22nd Ave. Portland, OR 97202	**Joe Mizrahi** UFCW Local No. 21 5030 First Ave. S. Suite 200 Seattle, WA 98134
	James To 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 between employers and UFCW local unions, and the master health and welfare agreement. You may obtain copies by writing to the Trust Office. The agreements also are available at the Trust Office, and at local union offices. 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 employees not covered by a collective bargaining agreement also are eligible 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 41.

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 as permitted by the Trust, until the monies and assets are used up, unless some other disposition is required by law.

SOURCE OF CONTRIBUTIONS

This Plan is funded through employer and employee contributions, with the amount determined through collective bargaining between employers and labor organizations, as specified in the collective bargaining agreements and master health and welfare agreement. You can find out whether a particular employer is a participating employer and, if so, the employer'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.

Employee COBRA-payments also are permitted as described on page 29, with the amount fixed from time to time by the Board of Trustees.

TYPE OF FUNDING

- *Employer contributions, employee premiums and COBRA payments are received and held by the Board of Trustees in the Sound Health & Wellness Trust to pay benefits and administrative expenses.*
- *The Trust PPO medical and weekly disability benefits are self-funded.*
- *The Kaiser Foundation Health Plan of Washington Options, Inc. medical, prescription drug and vision coverage is self-funded and administered by Kaiser Permanente, 320 Westlake Ave. N., Suite 100, Seattle, WA 98109-5233.*
- *The Trust PPO prescription drug benefit is self-funded and administered by OptumRx PBM of Maryland, Inc., 1600 McConnor Parkway, Schaumburg, IL 60173.*
- *The Trust PPO vision benefit is self-funded and administered by VSP, 3333 Quality Drive, Rancho Cordova, CA 95670.*
- *The Preferred Dental and Dental Schedule coverages are self-funded and administered by Delta Dental of Washington, P.O. Box 75983, Seattle, WA 98175-0983.*
- *DeltaCare dental coverage is fully insured by Delta Dental of Washington, 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

This Plan year is April 1 through March 31.

Right to Receive and Release Necessary Information

For the purpose of applying the terms of this Plan, this Plan may (without the consent of or notice to any person) release to or obtain from any insurance company or other organization or person any information with respect to any person that the Trust considers to be necessary for those purposes. Any person claiming benefits under this Plan must furnish to the Trust any information that may be necessary to implement this provision.

Facility of Payment

Whenever payments that should have been made under this Plan have been made under any other health plan, the Trust will have the right in its sole discretion, to pay over to any organization making the other payments any amounts that it may determine, in order to satisfy the intent of this Plan. Amounts so paid will be considered to be benefits paid under this Plan and to the extent of those payments the Trust will be fully discharged from liability under this Plan.

Overpayments

If you, your dependents or providers receive more benefits than you are 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 Trust pays benefits another plan should have paid (such as an account of coordination of benefits), the Trust may recover these benefits from you, your dependent, any provider or the other plan. Whenever payments have been made by the Trust in excess of the correct or maximum amount under the Plan, the Trust has the right to recover these payments from any persons to or for or with respect to whom these payments were made; any insurance companies any other organizations.

The Trust has constructive trust, lien and/or an equitable lien by agreement in favor of the Trust on any overpaid or advanced benefits received by you, your dependent or a representative of you or your dependent (including an attorney) that is due to the Trust under this section, and any such amount is deemed to be held in trust by you or your dependent for the benefit of the Trust until paid to the Trust. By accepting benefits from the Trust, you and your dependent agree that a constructive trust, lien and/or equitable lien by agreement in favor of the Trust exists with regard to any overpayment or advancement of benefits. Under that constructive trust, lien, and/or equitable lien by agreement, you and your dependent agree to cooperate with the Trust in reimbursing it for all of its costs and expenses related to the collection of those benefits.

In the event you, or if applicable, your dependent, fail to reimburse the Trust and the Trust is required to pursue legal action against you or your dependent to obtain repayment of the benefits advanced by the Trust, you or your dependent or beneficiary shall pay all costs and expenses, including attorneys' fees and costs, incurred by the Trust in connection with the collection of any amounts owed the Trust or the enforcement of any of the Trust's rights to reimbursement. You or your dependent also are required to pay interest at the rate determined by the Trustees from time to time from the date that the Trust is paid the full amount owed.

Disposition of Uncashed Claim Checks

In the event the Trust issues a check or draft to a health care provider or 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.

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 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 Trust'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 $147 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:**

- ***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 contacting healthcare providers and participants with information about treatment alternatives and other related functions such as:

- *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.*
- ***For notice of a breach of unsecured health information.*** *The Trust may release your health information to notify appropriate authorities of a breach of unsecured protected health information.*
- ***For emergency situations.*** *Your health information may be used or disclosed to a family member or close personal friend involved in your care in the event of an emergency or to a disaster relief entity in the event of a disaster. If you do not want this information to be shared, you may request that these types of disclosures be restricted as outlined later in this Notice.*

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 conversations with your mental health professional during a counseling session. They do not include summary information about your mental health treatment. The Plan may use and disclose such notes when needed to defend against litigation filed by you.

YOUR RIGHTS WITH RESPECT TO YOUR HEALTH INFORMATION

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

- ***Right to request restrictions.*** *You may request restrictions on certain uses and disclosures of your health information. You have the right to request a limit on the Trust's disclosure of your health information to someone involved in the payment of your care. However, the Trust generally is not required to agree to your request. The Trust is required to agree to your request for restrictions in the case of a disclosure for payment purposes where you have paid the health care provider in full, out-of-pocket. 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.***

Request access to your health information in an electronic form by writing to the Privacy Contact Person listed below.

Receive notice of a breach of unsecured protected health information if it affects you by writing to the Privacy Contact Person listed below.

PRIVACY CONTACT PERSON/PRIVACY OFFICIAL
To exercise any of these rights related to your health information, contact:

Privacy Contact Person
201 Queen Anne Ave. N. Suite 100
Seattle, WA 98109
Phone: (206) 352-9730 or (866) 277-3927
Fax: (206) 285-1701
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.

You will be notified if your protected health information has been breached. You will be notified by first class mail within 60 days of the event. A breach occurs when there has been an unauthorized use or disclosure under HIPAA that compromises the privacy or security of protected health information. The notice will provide you with the following information: (1) a brief description of what happened, including the date of the breach and the date of discovery of the breach; (2) the steps you should take to protect yourself from potential harm resulting from the breach; and (3) a brief description of what steps are being taken to investigate the breach, mitigate losses, and to protect against further breaches. Please note that not every unauthorized disclosure of health information is a breach that requires notification; you may not be notified if the health information that was disclosed was adequately secured – for example, computer data that is encrypted and inaccessible without a password – or if it is determined that there is a low probability that your health information has been compromised.

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.

www.soundhealthwellness.com

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

Delta Dental of Washington
(800) 554-1907 (DDWA Preferred)
(800) 650-1583 (DeltaCare)
(800) 554-1907 (Schedule Plan)

VSP
(800) 877-7195

OptumRx
(877) 629-3126

US SpecialtyCare Pharmacy (USSC)
(800) 641-8475