www.soundhealthwellness.com

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

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

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

First Choice Health Network
(206) 268-2910 or (800) 843-5127

Optum Behavioral Health
(Mental Health)
(866) 763-0466

informedRx
(800) 456-4803

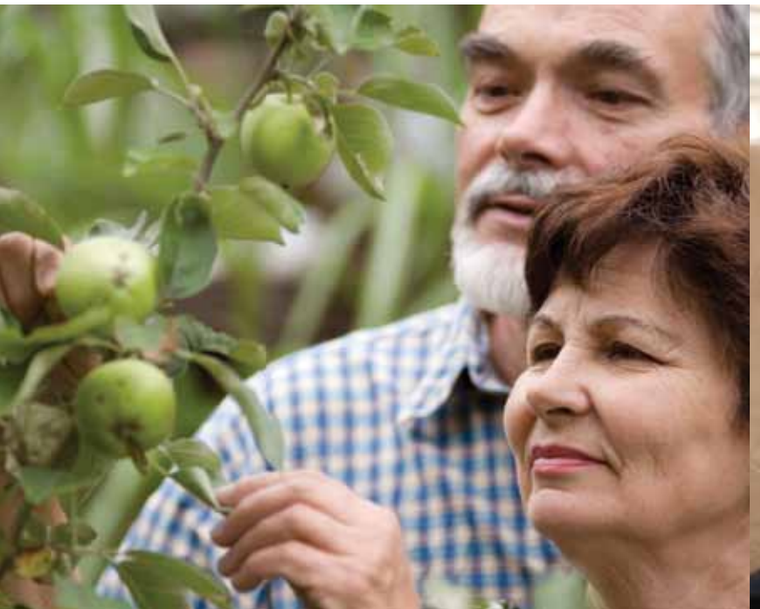
Medical Plan Sound Health & Wellness Retiree Trust 2010 EDITION

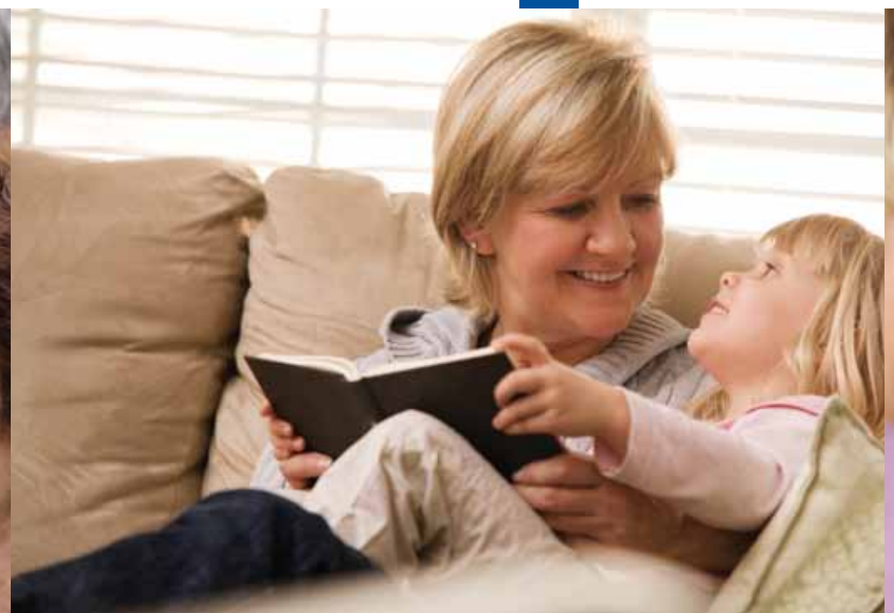
SOUND HEALTH
& WELLNESS RETIREE TRUST

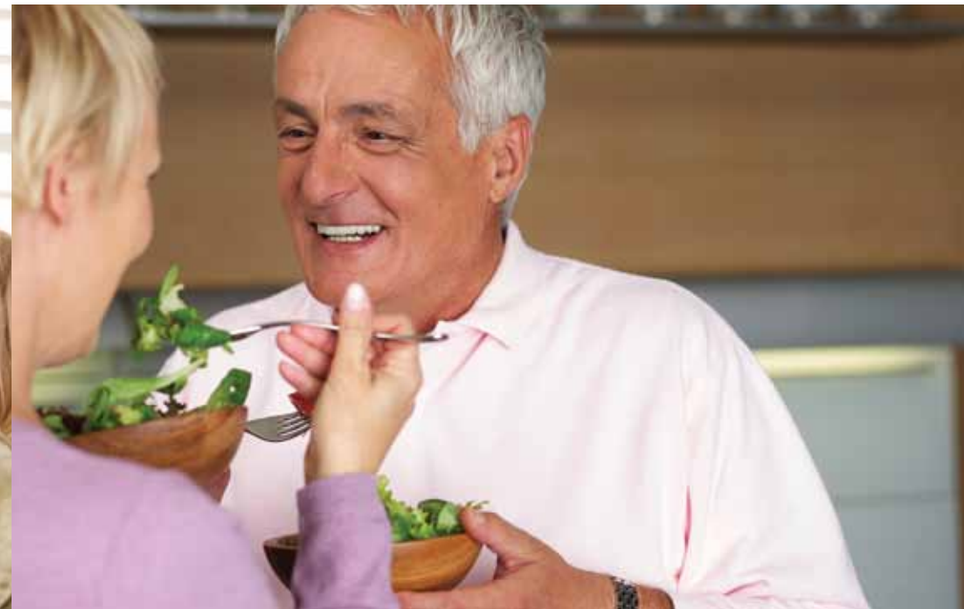
JANUARY 2010

MEDICAL PLAN

A LABOR-MANAGEMENT BENEFIT PLAN AND SUMMARY PLAN DESCRIPTION







201 Queen Anne Ave. N. #100
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SOUND HEALTH
& WELLNESS RETIREE TRUST
FORMERLY KNOWN AS RETAIL
CLERKS RETIREE WELFARE TRUST

Notice of Benefit Improvements and Premium Rate Increase Effective for January 2011 Coverage

This letter is to advise you that **improvements** have been made in your benefits. Effective for services received on and after January 1, 2011, the Board of Trustees is pleased to inform you of the following improvements in your Retiree Welfare benefits:

1. The maximum benefit for prescription drugs is increased to $5,000 annually (from the current maximum of $2,500).
2. Preventive care is covered at 100% with no cost sharing (see the reverse side of this notice for details on the covered preventive care services).

Along with these improvements, retiree health plan rates will increase effective with December 2010 premiums for January 2011 coverage. The action taken by the Board of Trustees to increase rates is due to the continuing increase in costs for health care benefits and the expanded coverage provided effective January 1, 2011. Even with this increase, retirees will continue to pay only a portion of the total actual cost of providing retiree medical benefits. The rate increase is as follows:

Retirees Who Began Retiree Health Coverage October 2004 or After:
Effective with premiums paid in December 2010 for your January 2011 coverage, the premium shall be changed as follows:

Retiree Only	$200.00 (an increase of $20.00/month)
Retiree and Child(ren)	$250.00 (an increase of $20.00/month)
Retiree and Spouse	$400.00 (an increase of $40.00/month)
Retiree, Spouse, and Child(ren)	$450.00 (an increase of $40.00/month)

Retirees Who Began Retiree Medical <u>Prior</u> to October 2004:
Effective with premiums paid in December 2010 for your January 2011 coverage, the premium shall be changed as follows:

Retiree Only	$170.00 (an increase of $20.00/month)
Retiree and Child(ren)	$220.00 (an increase of $20.00/month)
Retiree and Spouse	$340.00 (an increase of $40.00/month)
Retiree, Spouse, and Child(ren)	$390.00 (an increase of $40.00/month)

Retroactive Change / Catch-up Payment

Because notification of this rate change was received after the December payments were processed, a one time adjustment is required to pay the increased January premium. The one time additional cost ($20.00 or $40.00) will be deducted from your January pension check or automatic self-payment, if applicable. If you self-pay your premium, please adjust the amount appropriately. This will be in addition to the new premium for January.

Thereafter, only the new premium for participation will be deducted from your February 2011 and future pension checks or automatic self-payment, if applicable. If you self-pay your premium, please adjust the amount appropriately.

Future Changes

The cost of providing retiree health coverage is likely to continue to increase and, therefore, the retiree's payment obligation may be adjusted by the Trustees in the future. The Board of Trustees is providing this program of Retiree Health and Wellness benefits to the extent that money is currently available to pay the cost of the program. The Board of Trustees retains full and exclusive authority at its discretion to determine the expenditures of money for the program. The program may be terminated or modified at any time by the Board of Trustees.

If you have any questions, please contact the Trust Office at 1-800-225-7620.

Sound Health & Wellness Retiree Trust

Preventive Care

Preventive care services, as described below, are covered at 100% of charges (not subject to the deductible), if a PPO provider is utilized, and 50% of charges (subject to the deductible) if a non-PPO provider is used.

Adult Screening Tests. The plan covers:

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

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

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

Certain guidelines may apply.

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

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

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

MESSAGE TO ELIGIBLE EMPLOYEES

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

The following revisions have recently been made to your benefit plan:

Effective September 1, 2009

- *Flu and pneumonia immunizations are covered in full and not subject to the annual deductible*
- *Coverage for same sex domestic partners is added*

Effective January 1, 2010

- *A new rehabilitation benefit is added, replacing the previous benefits for hand therapy, outpatient cardiac rehabilitation, physical therapy and speech therapy (see page 31)*
- *Coverage for naturopaths and acupuncturists is added on a limited basis (see pages 27 and 19)*
- *Weight loss surgery is now covered, subject to certain limitations (see page 35)*
- *Preauthorization is now required for certain services (see pages 17 to 19)*
- *Emergency room treatment now requires a $50 copay per visit (see page 20)*

Please read this booklet carefully for a basic understanding of your benefit program. If you have any questions, please contact the Trust Office for assistance.

Sincerely,
Board of Trustees

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

All questions about benefit interpretations should be referred to the Trust Office. **Telephone contact with the Trust Office does not guarantee eligibility for benefits or benefit payments. Though the Trust Office can provide you with general information on your plan 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, death, marriage, legal separation, divorce, full-time student, child custody)*

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

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

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

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

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

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

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IMPORTANT NOTICE

This Plan is supported in part by money negotiated through collective bargaining. The benefits described in this booklet, while intended to remain in effect indefinitely, cannot be guaranteed for any period of time. The Plan's benefits are not guaranteed lifetime benefits.

The Trustees reserve the right to make any changes in the Plan that they deem necessary, including changing benefits and eligibility, terminating all or a portion of the coverage, and requiring or changing monthly retiree contributions.

SUMMARY OF BENEFITS

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

MEDICAL BENEFITS

ANNUAL DEDUCTIBLE	
	$500 per person per calendar year **$1,500 per family per calendar year**
COINSURANCE	
Preferred provider	**80%**
Nonpreferred provider	**50% of UCR charges***
*Nonpreferred provider outside PPO service area***	**80% of UCR charges***
Other covered expenses	**80% of UCR charges***
All covered providers and expenses	**When the out-of pocket maximum is reached, the plan pays 100% for the rest of the calendar year**
PRESCRIPTION DRUG MAXIMUM	
	$2,500 per person per calendar year
OUT-OF-POCKET MAXIMUM	
	$10,500 per person per calendar year **$31,500 per family per calendar year** **(Includes the annual deductible as well as 20% and 50% copayments)**
LIFETIME MAXIMUM	
	$1,000,000 per person

! ** UCR charges – usual, customary and reasonable charges as defined on page 57.*

*** PPO service area is the state of Washington.*

ELIGIBILITY

The benefits described in this booklet are available to retirees who meet the eligibility requirements shown below. If you have any questions about your eligibility for benefits, please call the Trust Office.

RETIRED EMPLOYEE ELIGIBILITY
To be eligible to participate in the retiree medical plan, you must meet all of the following conditions:

- *You are not covered by an employer sponsored health plan as an active employee, and*
- *You are not eligible for Medicare, and*
- *You are 55 years of age or older, and*
- *You have 15 years of credited service and are receiving a pension through the Sound Retirement Trust, formerly known as the Retails Clerks Pension Trust, or Washington Meat Industry Pension Trust or, you participated in the Sound Health and Wellness Trust for at least 15 years (180 months), and*
- *At the time of your retirement effective date, you have had health coverage through the Sound Health & Wellness Trust for at least 48 of the immediately prior 60 months.*

ENROLLMENT
Retired employees who meet the provisions for eligibility stated above will be covered for benefits when they have enrolled in the plan and pay the required premium. Your monthly premium payment must be received by the 15th of the month prior to the month of coverage.

You must enroll within 8 calendar months of your retirement effective date. If you wish to cover your spouse and other eligible dependents, you must enroll them at the time you enroll for retiree coverage. Enrollment forms and pension deduction forms will be provided by the Trust Office.

However, if you are covered by your spouse's employer-sponsored plan, you may elect to defer coverage in this plan until such other coverage is lost. However, you must still complete the enrollment form electing this deferral and return this form to the Trust Office within 8 calendar months of your retirement effective date. When your coverage under your spouse's employer-sponsored plan ceases, you must notify the Trust Office and submit your payment within 30 days of the date such coverage ceased. A declaration stating the date such coverage ceased must also be submitted.

If you do not enroll by the last day stated above, you will not be eligible to enroll in the future.

ELIGIBLE DEPENDENTS

If you elect to enroll your eligible dependents, they are eligible for coverage on the same date that you become eligible under this plan.

Your eligible dependents are:

- *Your lawful spouse, if you are not divorced or legally separated and your spouse is not eligible for Medicare.*
- *Your same sex domestic partner who is not eligible for Medicare: contact the Trust Office for the necessary forms.*
- *Your unmarried children under age 19 who depend on you for support, including natural children, stepchildren, adopted children, children placed with you for adoption, children of same sex domestic partners, children for whom you are legal guardian and those you have a legal obligation to support, provided they are not eligible for Medicare.*

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

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

- *Your unmarried dependent children who reach age 19 (or 24 if an eligible student) while covered by this plan and are incapable of self-sustaining employment because of mental or physical handicap.*

  You must provide proof of the incapacity and dependency to the Trust Office within 31 days after the child reaches age 19 (or 24 if an eligible student). You may be required to verify the incapacity and dependency from time to time.

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

- *Your spouse: on the first of the month after your date of marriage, provided your spouse is not eligible for Medicare.*
- *A child: on the first of the month after the date the child becomes a newly acquired dependent, provided they are not eligible for Medicare. 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, provided your same sex domestic partner is not eligible for Medicare.*

Enrollment is retroactive (within the 60-day period) to the date the dependent first became eligible, provided you enroll the dependents with the Trust Office (within the 60-day period) and make the required premium payments.

If your spouse is covered by another plan, and is not eligible for Medicare, their eligibility becomes effective on the first day of the month following their loss of coverage by the other plan, provided the required premium payment is made within 60 days of the date such coverage ceased.

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

If you do not notify the Trust Office within 60 days of a change in the dependent's status, they will lose their ability to elect COBRA coverage.

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

WHEN COVERAGE ENDS

Retirees

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

- *On the last day of the calendar month for which the required premium was made. The Trust must receive the required premium by the 15th of the month prior to the month of coverage*
- *On the last day of the calendar month before you become eligible for Medicare*
- *On the date that you have returned to work and have employer sponsored coverage as an active employee*
- *The date this plan is discontinued, in whole or in part*

Dependents

Coverage for your dependents will automatically end on the earliest of the following dates:

- *On the last day of the calendar month for which the required premium was made. The Trust must receive the required premium by the 15th of the month prior to the month of coverage*
- *If the dependent is a child, the last day of the month in which the child reaches their 19th birthday (or their 24th birthday for those unmarried dependent children who continue their formal education) or the child marries, whichever is earlier*
- *On the last day of the month that the dependent enters active duty with the armed services of any country if the period of active duty is to exceed 30 days*
- *If the dependent is your spouse, on the last day of the month in which you are divorced or legally separated from your spouse*

- *If the dependent is a same sex domestic partner, on the last day of the month in which the domestic partnership is terminated*
- *On the last day of the calendar month during which the dependent no longer qualifies as an eligible dependent (see pages 7 to 9 for definition of an eligible dependent)*
- *On the last day of the calendar month before your dependent becomes eligible for Medicare*
- *The date this plan is discontinued, in whole or in part*

REINSTATEMENT

When you become covered under a health plan as an active employee, your retiree medical coverage is suspended for the months you are covered as an active employee. You can reinstate your retiree medical coverage if you begin retiree medical benefits on the first day of the month following the month you lose active coverage. You must notify the Trust Office and submit your payment within 30 days after your active coverage ends. If your coverage as an active employee is through the Sound Health & Wellness Trust, formerly known as the Retail Clerks Welfare Trust, the Trust Office will coordinate your transfer between plans.

If you do not return to retiree medical coverage in the month immediately following your last month of active coverage, you cannot be reinstated in the retiree medical plan.

PAYMENT OF MONTHLY PREMIUMS

This plan requires you to contribute part of the cost of the plan each month. The Trust Office will tell you how much to contribute for yourself, your spouse and your children.

Your contribution must be received by the Trust Office by the 15th of the month prior to the month of coverage; otherwise, coverage for you, your spouse, your same sex domestic partner and your children will end and cannot be reinstated.

You can authorize monthly deductions from your pension check if you are receiving benefits from the Sound Retirement Trust, formerly known as the Retail Clerks Pension Trust, or the Washington Meat Industry Pension Trust. This will ensure that your monthly payments are received on time.

COBRA CONTINUATION COVERAGE FOR DEPENDENTS

If coverage ends for your eligible dependents, they may make COBRA self-payments to the Trust and continue all of the benefits lost.

Your covered dependents have a right to choose COBRA coverage for up to 36 months if their medical coverage is lost because of divorce or legal separation from you, termination of your same sex domestic partnership, your death, or your entitlement to Medicare.

Your covered dependent child has the right to choose COBRA coverage for up to 36 months if their medical coverage is lost because the dependent ceases to be an "eligible" dependent under the plan.

Once elected, COBRA coverage may be terminated for any of the following reasons:

- *The Trust no longer provides medical coverage to any retirees*
- *The required contribution for your COBRA coverage is not paid within 30 days of the first day of the month for which the payment applies*
- *Your dependents first become covered under another group health plan after the date of their COBRA election, unless the other plan limits coverage for a pre-existing health condition*
- *Your dependents first become entitled to Medicare, after the date of their COBRA election*

You or a family member has the responsibility to inform the Trust Office of a death, divorce, legal separation, termination of domestic partnership, or a child losing dependent status within 60 days of the event. Please provide the Trust Office with a copy of any legal documentation verifying the change in status.

When notified of the change in dependent status, the Trust Office will mail a COBRA application. The application for COBRA coverage for eligible dependents must be returned to the Trust Office within 60 days of the date that the COBRA information letter was mailed to you or your dependent from the Trust Office. The initial COBRA self-payment must include payments for all months since coverage was lost. This payment must be received within 45 days of the date the Trust Office received the application.

If the application and COBRA self-payments are not made in a timely manner, COBRA coverage will not be available to your eligible dependents.

Contact the Trust Office for more details about the options available and the associated costs. The amount of the COBRA self-payment is subject to change.

CERTIFICATE OF CREDITABLE COVERAGE

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

When your coverage ends, either as a retired employee, a dependent or under COBRA coverage, you will receive a certificate of creditable coverage containing information your new plan may need.

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

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

MEDICAL BENEFITS

Medical benefits are designed to reimburse you for covered expenses incurred for medically necessary treatment of an illness or injury, ordered by a physician or other covered provider, and rendered by a physician or other covered provider.

PREFERRED (PPO) PROVIDERS

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

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

Although you may see any provider covered by the plan, you receive higher benefits if you use PPO providers—the choice is yours, each time you use your benefits. Please note that not all First Choice or Optum PPO providers are covered providers under this plan; see the definition of covered provider on page 52.

PPO providers have agreed to:

- *Bill the Trust Office directly, without any payment up front from you*
- *Recognize the plan's contracted fee levels instead of usual, customary and reasonable (UCR) rates, saving you out-of-pocket money*

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

DEDUCTIBLE

Per Person Per Calendar Year	**$500**
Per Family Per Calendar Year	**$1,500**

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

If two or more members of your family are injured because of the same accident, only one deductible will be charged toward the covered expenses of that accident.

Expenses incurred and applied toward the annual deductible during the last three months of the calendar year will be carried over to apply against the deductible for the next year.

REIMBURSEMENT PROVISIONS (COINSURANCE)

The following table shows the percentage of expenses that the plan will pay:

Preferred Covered Provider	**80%**
Non Preferred Covered Provider	**50% of UCR charges***
Non Preferred Covered Provider Outside the PPO Service Area	**80% of UCR charges***
Other Covered Charges	**80% of UCR charges***

! **** UCR charges – usual, customary and reasonable charges as defined on page 57.***

The PPO Service Area is the state of Washington.

ANNUAL OUT-OF-POCKET MAXIMUM

Per Person Per Calendar Year	**$10,500**
Per Family Per Calendar Year	**$31,500**

The out-of-pocket maximum limits the amount you will pay toward covered expenses in a calendar year. This means that once you or your family has reached the out-of-pocket maximum, the plan pays 100% for most covered medical expenses for the rest of the year.

Only the annual deductible and the participant's 20% and 50% coinsurance amounts apply to the out-of-pocket maximum; benefits which exceed plan limits do not apply.

LIFETIME MAXIMUM

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

HEALTH & WELLNESS PROGRAM: LIVEWELL

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

LiveWell Personal Health Assessment (PHA)

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

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

Free Self Care Guide

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

LiveWell Health Coaching

Based on results of your PHA, you may be invited to participate in the LiveWell Health Coaching program. The LiveWell Health Coaching program is a phone-based health education program designed to help

you set and meet goals to improve your health and well-being. Your health coach will provide you with educational materials, guidance, and the support you need to begin to make healthy lifestyle changes.

LiveWell Nurse Line Plus

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

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

LiveWell Condition Management

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

LiveWell Online

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

LiveWell Quit For Life®

The LiveWell Quit For Life® Program is operated by Free & Clear® to help participants quit tobacco. Participants will receive step-by-step tools and personalized telephone treatment sessions with a Quit Coach® and free nicotine patches or gum, if recommended by the coach. Bupropion is also covered when prescribed by your physician.

Call 1 866 QUIT 4 LIFE (866-784-8454) to enroll in the program.

INDIVIDUAL CASE MANAGEMENT (ICM)

The plan has contracted with First Choice Health and Optum Behavioral Health to provide case management services in certain healthcare treatment situations. Representatives of First Choice Health will work

cooperatively with you and your physician to consider effective alternatives to medical and surgical hospitalizations and other high cost care to make the most efficient use of the plan's benefits. Optum will assist in alternatives to mental health hospitalizations and other higher cost care. The purpose of these services is to help ensure that you receive appropriate and cost effective care and to provide assistance in navigating the health system if you have a catastrophic medical or mental health condition. This is a voluntary program.

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

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

COVERAGE REQUIRING PREAUTHORIZATION

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

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

Inpatient Admissions

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

No benefits are payable for services or inpatient admissions the plan considers not medically necessary. (The definition of medically necessary is on page 56.)

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

Surgical Services

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

- *Breast reduction surgery*
- *Eyelid surgery, such as blepharoplasty*
- *Organ transplants (see page 34)*
- *Reconstructive and/or cosmetic surgery*
- *Removal of breast implants*
- *Stereotactic radiosurgeries (Gamma knife)*
- *Surgical interventions for sleep apnea*
- *Unproven, investigational or experimental services (unless specifically and completely excluded)*
- *Varicose vein surgery/sclerotherapy*
- *Weight loss surgery (see page 35)*

Other Services

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

- *Growth hormones (preauthorization by the Trust Office)*
- *Home healthcare (see page 21)*
- *Home infusion*
- *Hospice care (see page 22)*
- *Medical equipment and prostheses if the purchase price exceeds $2,000 or the monthly rental fee exceeds $500 (see page 26)*

- *Orthognathic surgery (preauthorization by the Trust Office)*
- *PET scans*
- *Rehabilitation services: inpatient*
- *Rehabilitation services: outpatient (preauthorization by the Trust Office)*

COVERED MEDICAL EXPENSES

The plan covers the following services and supplies, provided they are medically necessary, required for the treatment of an illness or injury, ordered by a physician or other covered provider, and rendered by a physician or other covered provider:

Acupuncture treatment by an acupuncturist is covered, up to five visits per calendar year.

Ambulance services for local and air ambulance service to or from a local hospital, or the nearest hospital equipped to furnish necessary medical treatment not available in a local hospital, are covered at 80%. The plan pays 100% of allowed charges for medically necessary transportation for a transfer between hospital facilities.

Ambulatory Surgical Center services and supplies at an approved ambulatory surgical center are covered 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 administrated by a physician, other than the operating surgeon, for a covered medical surgery. If anesthesia is administered by a hospital employee covered under the hospital benefit, it will be reimbursed under the hospital benefit and will not be covered under this benefit.

Blood Transfusions, including the cost of blood, plasma, or any other blood-like infusion. Storage of blood is not a covered benefit.

Dental Treatment for Accidental Injuries to natural teeth, or treatment of a fractured jaw, if treatment is performed within six months from the date of accident.

Diagnostic X-Rays, Laboratory Exams and audiologic examinations and testing for a condition other than hearing loss, if they are medically necessary for diagnostic purposes.

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

Hearing Care charges for an evaluation examination and a hearing aid (or other hearing enhancer), to a $1,000 maximum in a period of three consecutive calendar years.

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

To summarize, these benefits cover:

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

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

The plan does not cover hearing care charges for:

- *Batteries or other ancillary equipment other than those obtained when purchasing the device*
- *Expenses incurred after coverage ends (except for a hearing aid or hearing enhancer ordered before and delivered within 30 days after coverage ends)*
- *Hearing devices which 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 services (in place of confinement in a hospital or skilled nursing facility) by an approved home health care agency.

To ensure coverage, call First Choice at (206) 268-2910 or (800) 843-5127 to preauthorize any home healthcare services. More information about preauthorization is on page 17.

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 establish and submit a written plan of treatment and certify that confinement in a hospital or skilled nursing facility would be required in the absence of home healthcare benefits*

Covered charges include:

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

No benefits are payable for:

- *Any supplies or services not specifically mentioned in this section*
- *Homemaker or housekeeping services*
- *Maintenance or custodial care*
- *Private duty nursing*
- *Psychiatric care*
- *Separate transportation charges*
- *Services performed by family members*
- *Supportive environmental materials (handrails, ramps, etc.)*
- *Social services*
- *Unnecessary and inappropriate services*

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

Home Phototherapy services are covered when the plan determines that treatment is medically necessary.

Hospice Care for a terminally ill participant with a life expectancy of six months or less, for medically necessary treatment by an approved hospice agency. The patient's physician must establish and periodically review (at least once every three months) a written treatment plan that describes the hospice care to be provided and submit it to First Choice before the commencement of services.

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

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

Home care services have the following lifetime limits:

- *60 visits*
- *14 continuous care visits of 4 or more hours but less than 16 hours per day (included within the 60 visit maximum)*
- *7 continuous care visits of 16 or more hours per day (included within the 60 visit maximum)*

- *Each visit by any person representing the hospice agency will be charged against the 60 visit maximum*
- *The patient's family may apply to First Choice for an extension of benefits if the patient's life expectancy extends beyond six months or if the patient exhausts any hospice benefit limits specified above; limited extensions will be granted if it is determined that the treatment is medically necessary*

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

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

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

- *Environmental supportive services or equipment, such as, but not limited to, wheelchair ramps or support railings*
- *Food, clothing, or housing*
- *Homemaker services*
- *Psychiatric care*
- *Respite care*
- *Services of financial legal counselors*
- *Services of volunteers*
- *Services or supplies not included in the written treatment plan, or not specifically set forth as a covered benefit*
- *Services provided by household members, family, or friends*
- *Services to other family members, including bereavement counseling*
- *Spiritual counseling*

Hospital benefits are provided for room and board in a semiprivate room as well as medically necessary inpatient services and supplies to treat an accidental injury or illness or other covered condition. Covered inpatient hospital services and supplies include:

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

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

To ensure coverage, call First Choice at (206) 268-2910 or (800) 843-5127 to preauthorize any medical/surgical hospitalization or Optum Behavioral Health at (866) 763-0466 for mental health 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 17.

In addition to authorizing the appropriate length of stay before an admission, the care you receive is reviewed to ensure the need for continued hospitalization. Hospital benefits may be reduced or denied if hospitalization is determined no longer medically necessary. (The definition of medically necessary is on page 56.)

Other covered services include nursery charges for an eligible newborn child, outpatient surgery and initial emergency room treatment (if rendered within seven days) of an accidental injury or illness.

In the case of a life endangering medical emergency as reported in the emergency room report, the plan pays 80% of the usual, customary and reasonable charges for covered services of a non-preferred accredited hospital. Emergency is defined on page 53.

Remember, you and your physician always make the final decision to proceed with a hospitalization, postpone it or cancel it. Preauthorization and concurrent review decisions are intended only to determine whether the services are medically necessary and whether the plan should pay for them.

Mastectomy Related Services as required by the Women's Health and Cancer Rights Act of 1998. The plan provides benefits for mastectomy-related services due to disease or cancer including reconstruction and surgery to achieve symmetry between the breasts, prostheses and complications resulting from the mastectomy, including lymphedema.

The plan does not provide benefits for prophylactic mastectomies.

Maternity benefits are provided for any retiree, lawful spouse or same sex domestic partner on the same basis as any other illness or injury; maternity benefits are not provided for dependent children. Covered expenses also include the services of a licensed midwife during childbirth, but does not cover midwives for newborn baby visits or follow-up visits.

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

The plan does not provide any benefits if eligibility has terminated prior to the delivery.

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

Medical Equipment and Prostheses, artificial limbs or eyes, casts, splints, trusses, braces, crutches and other similar appliances are covered, as well as the rental of a wheelchair, hospital-type bed and other equipment for medically necessary treatment. Covered expenses will be limited to the standard model of medically appropriate level of performance and quality required for the diagnosed condition; deluxe or luxury equipment or items for convenience or comfort are not covered by the plan. Rental of equipment is covered up to the purchase price of the equipment only. Repair or replacement of a damaged covered item that 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 pages 17–19).

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 expenses incurred as an inpatient in a hospital will be paid on the same basis as for any other illness.

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

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

To ensure coverage, call Optum Behavioral Health at (866) 763-0466 to preauthorize any hospitalization. If you do not obtain preauthorization, you will be responsible for paying the first $250 in covered charges before the plan begins to pay benefits. More information about preauthorization is on page 17.

In addition to authorizing the appropriate length of stay before an admission, the care you receive is reviewed to ensure the need for continued hospitalization. Hospital benefits may be reduced or denied if hospitalization is determined no longer medically necessary. (The definition of medically necessary is on page 56.)

Naturopathic services by a naturopath are covered, up to a maximum of two visits per calendar year.

Neurodevelopmental Therapy treatment— including speech, physical and occupational therapy—when a physician has recommended neurodevelopmental therapy for a dependent child under age seven. See the rehabilitation benefit on page 31 for a complete description of the benefits provided by the plan.

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

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

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

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

Physician Visits at the office, hospital or home for illness or injury, including expenses for a second or third surgical opinion for non-emergency surgical procedures.

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*

Prescription Drugs for medicines administered or prescribed for you or your dependent by a physician will be covered at 80%, to a maximum of $2,500 per calendar year.

The program features a custom network of pharmacies consisting of employers who participate in the Trust. In addition, there is the informedRx pharmacy network. You can use any pharmacy—the choice is yours each time you fill a prescription. However, pharmacies in the custom network and the informedRx network provide discounted prescriptions to the plan. The following describes the benefit options available:

- ***Trust custom network:*** *Take your prescription and your Sound Health & Wellness Retiree Trust ID card to the pharmacy. If you have already met your annual deductible and have not used your $2,500 per person annual maximum benefit, you will only have to pay your 20% coinsurance. If you have not yet met your annual deductible or have used up your $2,500 per person annual maximum benefit, you will have to pay the full discounted amount of your prescription at the pharmacy. The pharmacy will let the Trust Office know what prescriptions they have processed so your deductible is properly updated.*
- ***informedRx network****: You can also fill your prescription at an informedRx pharmacy that is not in the Trust custom network. If you have already met your annual deductible and have not used your $2,500 per person annual maximum benefit, you will only have to pay your 20% coinsurance. If you have not yet met your annual deductible or have used up your $2,500 per person annual maximum benefit, you will have to pay the full discounted amount of your prescription at the pharmacy. The pharmacy will let the Trust Office know what prescriptions they have processed so your deductible is properly updated.*
- ***Out-of-network****: For all pharmacies not in the Trust custom or informedRx networks, you pay the full cost at the time of purchase, file a claim with the Trust Office and wait for reimbursement.*

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

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

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*
- *Dermatological preparations prescribed by a physician and received from a licensed pharmacist*
- *Prescription drugs, birth control pills and diabetic supplies (including insulin, insulin syringe, needles, test strips and equivalent) from licensed pharmacists, as prescribed by a physician*
- *Prescription drugs, birth control pills and diabetic supplies (including insulin, insulin syringe, needles, test strips and equivalent) supplied out of the physician's office and charged separately from any other item*
- *Self-injectable drugs prescribed by a physician*
- *Therapeutic vitamins, prenatal vitamins while pregnant, cough mixtures, antacids, eye and ear medications prescribed by a physician for a specific illness and received from a licensed pharmacist*
- *Weight control drugs if prescribed by a physician specifically to treat morbid or severe obesity (the physician may be required to give the Trust Office a certification before these can be covered)*

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

In addition to the general exclusions listed on pages 36 to 38 the following expenses are excluded from coverage:

1. *Any drug not reasonably necessary for the care or treatment of bodily injury or sickness.*
2. *Appliances, devices, bandages, heat lamps, braces or splints.*
3. *Blood and blood plasma.*
4. *Contraceptives (except birth control pills).*
5. *Cosmetics or health and beauty aids.*
6. *Drugs lost, stolen or damaged by neglect.*
7. *Drugs reimbursable by any government program – national, state, county or municipal.*
8. *Medicines not requiring a prescription (except insulin).*
9. *Multiple or nontherapeutic vitamins or dietary supplements.*
10. *Drugs in excess of a 100-day supply.*

Preventive Care benefits as follows:

For Retirees and Dependents

- *One routine pap smear per calendar year*
- *One mammogram for an eligible female, as follows:*
  - *Every two calendar years, under age 40*
  - *Every calendar year, age 40 and over*
- *Routine fecal occult blood tests in conjunction with a routine colon/rectal exam, as follows:*
  - *One test, every two calendar years, under age 50*
  - *One test per calendar year, age 50 and over*

Benefits for an office visit in conjunction with the above preventive care benefits are provided for the retiree only as described below.

For Retirees Only
The plan pays up to $150 per calendar year for routine physical examinations. Covered services include:

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

This benefit is available for retirees only, dependents are excluded.

For Dependent Children Under Age 2
Benefits are provided for physician or other covered provider visits (either outpatient or inpatient) received during the first 24 months of life.

A maximum of $500 per child is payable under this benefit.

Dependent Children Immunizations
The plan covers charges for routine immunizations and associated office visits of dependent children.

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

Rehabilitation

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

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

- *Biofeedback is covered for the treatment of pain*
- *Cardiac therapy is covered for patients with documented diagnosis of acute myocardial infarction within the preceding 12 months, for patients who have had coronary bypass surgery, and for patients with coronary occlusions or stable angina pectoris. Treatment is covered when medically necessary services are provided and when care is:*
  - *Prescribed, provided and monitored by a covered provider, as defined by the plan*
  - *Provided at an approved rehabilitation facility or hospital under the supervision of a physician*
  - *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*
- *Inpatient rehabilitation coverage requires preauthorization (see page 17). Coverage will be provided at the appropriate level of care (hospital, skilled nursing facility, outpatient) based on medical necessity. Guidelines include, but are not limited to, the following:*
  - *The patient's condition must require 24-hour availability of a physician with training and/or experience in rehabilitation*
  - *The physician's involvement must be greater than is normally provided in a skilled nursing facility*
  - *If the medical condition does not allow the patient to obtain outpatient services, the patient must require and receive at least three hours of physical or occupational therapy each day for at least five days per week*
  - *Services must be provided in an approved rehabilitation facility, as defined by the plan; the facility must not be one that primarily provides general care for the elderly, custodial care or because the patient lives alone*
  - *When rehabilitation follows acute care in a continuous inpatient stay, inpatient rehabilitation benefits start on the day care becomes primarily rehabilitative*

- *Massage therapy (must be ordered by a MD or DO as part of physical therapy)*
- *Neurodevelopmental therapy*
- *Occupational therapy*
- *Outpatient rehabilitation coverage is limited to a maximum of 45 outpatient visits per condition per calendar year for all types of therapy combined. All outpatient rehabilitation must have a treatment plan submitted to the Trust Office in advance to determine medical necessity. Benefits are subject to the following:*
  - *The patient must not be confined in a hospital or other medical facility*
  - *The therapy must be part of a formal written treatment plan prescribed by the patient's MD or DO*
  - *Services must be provided by an approved hospital, physician or physical, occupational or speech therapist, as defined by the plan*
  - *Services must be reasonably expected to significantly improve self-sustaining function within 90 days of the date outpatient therapy begins*
  - *The plan does not cover services considered maintenance or custodial, or when no further improvements are expected*
  - *Speech therapy is only covered when required because of brain or nerve damage caused by an accident, disease or stroke, for services necessary for the diagnosis and treatment of swallowing disorders (dysphagia) and for those individuals who have had speech disorders or deficits, but not beyond the maximum restoration of speech. Once the ability for speech has been restored, further benefits for the improvement of the speaking patterns or tonal sounds are not covered*
- *Stroke therapy*

The plan does not cover the following:

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

Skilled Nursing Facility confinement, provided it is for medically necessary treatment of an injury, illness or pregnancy related condition covered by the plan and is ordered by a physician.

To ensure coverage, call First Choice at (206) 268-2910 or (800) 843-5127 for preauthorization (see page 17).

Benefits include:

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

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

Surgical benefits are provided for medically necessary surgeries resulting from illness or injury.

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

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

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

Assistant surgeon fees, when medically necessary, are also covered, up to 25% of the usual, customary and reasonable fee for the surgical procedure, when performed by an assistant surgeon or physician (other than a hospital intern or resident).

Second surgical opinions for nonemergency procedures are also covered.

Transplants for the following transplants, subject to the conditions and limitations specified below, and to those in other sections of the plan.

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

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

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

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

- *Nonhuman, artificial or mechanical transplants*
- *Services or supplies in conjunction with experimental or investigational treatment*
- *Services and supplies for the donor when the donor benefits are available through other group coverage*
- *Expenses for that portion of treatment funded by government or private entities as part of an approved clinical trial*
- *Expenses when the recipient is not covered under this plan*
- *Lodging, food or transportation costs, unless otherwise specifically provided under this plan*
- *Donor and procurement services and costs incurred outside the United States, unless specifically approved in advance*

- *Expenses for organ harvesting and storage, unless specifically approved in advance by First Choice on a case-by-case basis*
- *Living (non-cadaver) donor transplants of the lung, liver, or other organ (except kidney), including selective islet cell transplants of the pancreas, unless the organ donor is a family member of the person seeking the transplant; family member for this purpose means grandparent, parent, child, brother, sister, aunt, uncle, nephew, niece or cousin*
- *Any expense incurred by you or your eligible dependent on account of donating your human organ or tissue*
- *Expenses for donor searches*

Weight Loss Surgery is covered when medically necessary (as determined by the plan) and preauthorized. Approval is based on specific plan criteria; please contact the Trust Office for those criteria and contact First Choice for preauthorization (see page 17).

X-Ray, Chemo and Radiation Therapy for medically necessary treatment is covered.

GENERAL EXCLUSIONS APPLYING TO ALL BENEFITS

1. *Any expense incurred before your date of coverage. An expense is considered incurred on the date you receive the service or supply for which the charge is made.*
2. *Any expense incurred after the termination of your coverage under this plan.*
3. *Any illness, disease or injury for which an employer is required to furnish hospital care or other benefits in whole or in part by state or federal Workers' Compensation laws or other legislation, including Employee's Compensation or Liability Laws of the United States, or a program which provides equivalent coverage, even though the employee or dependent waives his or her rights to such benefits.*
4. *Any service or supply for which no charge is made or no payment is required.*
5. *Any service or supply that is not medically necessary for the care and treatment of illness or injury (except as specified for preventive care benefits).*
6. *Any services or supplies not specifically covered under the Trust's medical plan.*
7. *Aquatic therapy, unless part of a formal outpatient rehabilitation program.*
8. *Charges for counseling, education, self-help instruction or training. These include, but are not limited to, services for behavior modification, learning disabilities, vocational assistance, marital counseling, social counseling, conduct disorders, impulse control, cognitive disorders, sexual lifestyle counseling, family therapy, nutritional or fitness guidance, anger management, diabetic or dietetic instruction.*
9. *Charges for missed appointments, telephone consultations when a patient is not physically seen by a physician or completion of claim forms.*
10. *Charges for treatment of temporomandibular dysfunction or temporomandibular joint dysfunction (TMJ).*

11. *Charges for treatment, services or supplies that exceed usual, customary and reasonable fees (see UCR definition on page 57).*
12. *Claims received after the 12-month filing limit.*
13. *Conditions caused by or arising from an act of war, armed invasion or aggression.*
14. *Cosmetic procedures (except as part of treatment of a functional disorder covered by this plan or as a result of an accidental injury occurring while the individual is covered); complications from any cosmetic surgery and cosmetic procedures for psychological or self esteem reasons.*
15. *Court-appointed treatment not covered by the Trust medical plan.*
16. *Custodial care or care when no significant clinical improvement is expected as a result (except hospice care).*
17. *Dental treatment (except natural teeth restorations due to accidental injuries).*
18. *Experimental or investigational services, procedures, medicines, equipment, devices, supplies, facilities or treatment: collectively referred to here as treatment (see definition on page 53). As with other plan interpretations, the Trustees have full and exclusive authority to decide what constitutes experimental or investigational treatment.*
19. *Eye exercises; visual or orthoptic training/therapy.*
20. *Eyeglasses, eye refractions or eye exams to correct vision or fitting of glasses.*
21. *Food supplements, including formula for enteral feeding.*
22. *Genetic testing except when there are medically documented symptoms or signs presented indicating a possible disease presence and genetic testing is needed to identify the disease in order for the attending physician to prescribe appropriate treatment.*
23. *Late fees, finance charges or collection charges imposed by your healthcare provider.*
24. *Massage therapy unless ordered by a doctor as part of covered physical therapy.*
25. *Medical exams or tests not connected with an illness or injury, except as provided under preventive care benefits.*
26. *Postage, handling and taxes related to medical services or supplies.*
27. *Preventive medicine (except as specified under preventive care benefits).*
28. *Private room charges exceeding the hospital's most common charge for semiprivate (two-bed) accommodations.*
29. *Refractive eye surgery to correct vision deficiencies.*

30. *Reversal of tubal ligation or vasectomy, fertility drugs, artificial insemination, in vitro fertilization, embryo transplant or any other confinement, treatment or service related to restoring fertility or promoting conception.*
31. *Services by an institution that is primarily a place of rest, place for the aged, nursing home, convalescent home, residential eating disorder facility, or similar institution.*
32. *Services or supplies covered by other group insurance or medical service program or for which no charge is made or no payment is required from you or your dependents.*
33. *Services or supplies furnished to dependent children of a retiree arising from pregnancy or resulting in childbirth, including all complications, prenatal or postnatal care, or for care of their newborn infant.*
34. *Services or supplies received from a physician or other healthcare provider who usually lives in your home or is related by blood or marriage.*
35. *Services or supplies that are solely for the convenience of the patient, provider, or caregiver.*
36. *Services performed on teeth, gums or alveolar processes (except to treat tumors or accidental injury).*
37. *Shoes or foot supports available without prescription.*
38. *Smoking cessation program, whether or not you have other medical conditions related to or caused by smoking.*
39. *Treatment for injuries sustained while committing or attempting to commit a felony.*
40. *Treatment for self-inflicted injuries or injuries sustained in connection with attempted suicide while sane or insane, unless the injuries are the result of a physical or mental health condition.*
41. *Weight loss treatment or services, unless preauthorized by First Choice and eligibility is approved by the Trust Office, whether or not you have other medical conditions related to or caused by excess weight, except as specifically provided under the prescription drug benefit.*
42. *Charges for the treatment and x-rays of a musculoskeletal disorder (bone, muscle, tendon and joint) when provided or ordered by a licensed chiropractor.*
43. *Routine foot care such as trimming of nails, corns and calluses, treatment of fallen arches or other symptomatic complaints of the feet, impressions casting for orthotics or prosthetics including the prescription thereof, routine hygienic care, metatarsalgia or treatment of bunions except when an open cutting operation is involved.*
44. *Any charges incurred for alcoholism and/or drug abuse treatment.*

COORDINATION OF BENEFITS

You may have medical coverage, such as that provided through your spouse's employer, in addition to coverage under this plan. If you do, the benefits from the other plan are taken into account when your benefits under this plan are determined. This provision, known as coordination of benefits, may reduce the benefits paid under this plan.

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

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

The following rules are used to determine which plan will be considered the primary plan when both plans are retiree welfare plans:

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

- *If the parent with custody has remarried, the plans pay in this order: plan of the parent with custody, plan of the spouse of the parent with custody, plan of the parent without custody and plan of the spouse of the parent without custody*

- *For children whose parents were never married, the same rules apply as for divorced parents*
- *Benefits of the plan covering the person as an active employee or dependent of an active employee are determined before the benefits of the plan covering the person as a retired, COBRA or laid-off employee or dependent of a retired, COBRA or laid-off employee*
- *If none of the above rules establishes which plan would pay first, then the plan that has covered the person longer is considered primary*
- *The Trust excludes coverage for services or charges that would be provided or covered by a health maintenance organization (HMO) or other prepaid arrangement if such HMO or other prepaid arrangement were the only source of coverage. The principal reason for this exclusion is that the Trust receives no corresponding benefits from HMOs or their prepaid programs when services are provided outside the HMO or prepaid arrangement. (In other words, an HMO will not coordinate benefits with the Trust for services provided by the non-HMO provider even if the HMO would be the primary source of coverage under normal coordination of benefit rules). Since the Trust has chosen not to duplicate HMO-like plan benefits, any service received from an HMO-like service organization or its affiliated providers is ineligible for consideration of payment of any Trust benefits for services other than those which would not be covered by the HMO-like plan or for which the participant is liable for an out-of-pocket charge in addition to the prepaid capitation fee*

Other plans which provide medical benefits include the following:

- *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 health coverage and this plan is secondary, you receive faster claims 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 claims submission to this plan.*

SUBROGATION (RIGHT OF RECOVERY)

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

- *By accepting or claiming benefits, you (or your dependent) agree that the plan is entitled to reimbursement from any judgment, disputed claim settlement or other recovery, up to the full amount of all benefits provided by the plan, but not to exceed the amount of the recovery. The plan is entitled to reimbursement regardless of whether you (or your dependent) are made whole by the recovery, and regardless of the characterization of the recovery, except that the plan will deduct reasonable attorney fees and a pro rata share of the costs from the reimbursement amount, if you (or your dependent) comply with the terms of the plan and the agreement to reimburse.*
- *The plan may require you (or your dependent) to sign an agreement to reimburse the plan from the proceeds of any recovery before the plan will provide benefits. The plan may require you (or your dependent) to execute and deliver instruments and papers and do whatever else is necessary to secure the plan's right of reimbursement (including an assignment of rights).*
- *You (or your dependent) must do nothing to prejudice the plan's right of reimbursement.*
- *When any recovery is obtained from a third party or insurer, whether by direct payment, settlement, judgment, or any other method, an amount sufficient to satisfy the plan's reimbursement amount must be paid into an escrow or trust account and held there until the plan's claim is resolved by mutual agreement, arbitration or court order. If the funds necessary to satisfy the plan's reimbursement claim are not*

placed in an escrow or trust account, you (or your dependent) will be personally liable for any loss the plan may suffer as a result.

- *The plan may cease providing benefits if there is a reasonable basis for concluding that you (or your dependent) will not honor the terms of the plan or the agreement to reimburse, or the Trustees of the plan modify the plan provisions relating to subrogation and reimbursement rights.*
- *If the plan is not reimbursed in accordance with the agreement to reimburse, the plan may bring an action against you (or your dependent) to enforce its right to reimbursement, or in the alternative may elect to recoup the reimbursement amount by offsetting future benefits otherwise payable to you or your family members, or by recovery from a source to which benefits were paid. If the plan is forced to bring legal action to enforce the terms of the agreement to reimburse, it shall be entitled to its reasonable attorneys' fees, costs of collection and court costs. Any legal action to enforce an agreement to reimburse may be brought in the King County Superior Court, at the option of the plan.*

SUBMITTING A CLAIM

HOW TO FILE A CLAIM

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

CLAIM	TIME PERIOD
Medical	**12 months from date the service or supply was received**
Prescription Drug	**12 months after filling the prescription**

Unless you or your dependent can establish to the Trustees' satisfaction that it was not possible to file within this time, your benefit will be denied. Subject to special provisions for urgent care claims (see page 45), claims must be submitted in writing and to the proper address.

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

Submitting incomplete forms or bills that are not itemized may 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 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 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 39 for coordination of benefit rules.)*
5. *Mail the fully completed form and any attachments to the address at the top of the form.*
6. *Submit claims to worker's compensation plan for on-the-job claims.*
7. *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.

PROCEDURES FOR PROCESSING CLAIMS

Properly filed claims are processed according to these guidelines:

Post-Service Claims

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

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

Pre-Service Claims

These procedures apply only to processing treatment plans submitted for preauthorization. As explained in more detail on page 17, a hospital preadmission authorization must be requested for all nonemergency inpatient hospital admissions.

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

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

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

Urgent Care Claims

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

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

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

Concurrent Care Claims

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

Any request to extend treatment that involves urgent care is decided as soon as reasonably practical. The claimant is notified of the determination within 24 hours of when the plan receives the claim, if it 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. *Reference to the plan provision(s) relied on.*
3. *Description of any additional material needed for the claim, with an explanation of why it is necessary.*
4. *Reference to any internal rule, guideline or protocol used in denying the claim, with a statement that a copy is available without charge upon request.*
5. *An explanation of the medical judgment—applying plan terms to the claimant's circumstances—if the denial is based on the service or supply being medically necessary or experimental or investigational, or an equivalent exclusion.*
6. *An explanation of the plan's appeal procedures, including applicable time limits.*

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

OVERPAYMENTS

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

DISPOSITION OF UNCASHED CLAIM CHECKS

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

FILING AN APPEAL

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

APPEAL OF BENEFIT DENIAL

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

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

APPEAL PROCEDURES

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

Information To Be Provided Upon Request

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

other individual's claim records or information specific to the resolution of the individuals' claims.

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

Review by Appeals Committee

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

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

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

Review by Hearings Committee

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

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

Contents of Decision

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

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

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

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

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

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

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

DEFINITIONS

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

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

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

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

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

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

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 Provider means:

- *A physician as defined on page 56*
- *For pregnancy benefits: midwife licensed in the state where services are performed and practicing within the scope of their license*
- *For nursing benefits: Registered Nurse (RN), Licensed Practical Nurse (LPN) or Nurse Practitioner (ARNP) licensed in the state where services are performed and practicing within the scope of their license*
- *For mental and nervous benefits: psychologist, mental health counselor, clinical social worker or marriage and family therapist licensed or certified in the state where services are performed and practicing within the scope of their license or certification*
- *For various benefits:*
  - *Physician's assistant licensed or registered in the state where services are performed and practicing within the scope of their license/registration. The physician's assistant must be employed by the MD, DO or clinic (under direction of the MD or DO), and any charges must be billed by the MD, DO or clinic. If both the MD, DO or clinic and the physician's assistant charge for a visit on the same day, the plan will recognize only the charges of the lower-cost provider*
  - *Surgical assistant licensed or registered in the state where services are performed and practicing within the scope of their license/registration*
  - *Optometrist licensed in the state where services are performed and practicing within the scope of their license*
  - *Dentist licensed in the state where services are performed and practicing within the scope of their license*

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

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

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

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 nonexperimental or noninvestigational purposes at the time the drug or device is furnished*
- *The drug, device, medical treatment, or procedure has been determined experimental or investigational by the treating facility's institutional review board or other body serving a similar function, and the patient has signed an informed consent document acknowledging such experimental status*
- *Federal law classifies the drug, device or medical treatment under an investigational program*
- *Reliable evidence shows the drug, device, medical treatment or procedure is the subject of ongoing Phase I or Phase II clinical trials or is otherwise under study to determine its maximum tolerated dose, toxicity, safety, efficacy, or efficacy compared with standard means of treatment or diagnosis (except as provided below)*
- *Reliable evidence shows the prevailing opinion among experts regarding the drug, device, medical treatment or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, toxicity, safety, efficacy, or efficacy compared with standard means of treatment or diagnosis (except as provided below)*

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

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

- *Category 1*
  - *The trial is a Phase III or Phase IV trial approved by the National Institutes of Health, the FDA, the Department of Veteran Affairs or an approved research center*
  - *The trial has been reviewed and approved by a qualified institutional review board*
  - *The facility and personnel have sufficient experience or training to provide the treatment or use the supplies*
- *Category 2*
  - *The trial is to treat a condition too rare to qualify for approval under Category 1*
  - *The trial has been reviewed and approved by a qualified institutional review board*
  - *The facility and personnel have sufficient experience or training to provide the treatment or use the supplies*
  - *The available clinical or preclinical data provide a reasonable expectation that the trial treatment will be at least as effective as noninvestigational therapy*
  - *There is no therapy that is clearly superior to the trial treatment*

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

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

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

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

Hospital means an institution that:

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

This definition specifically excludes:

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

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

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

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

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

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

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

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

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

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

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

Preadmission Authorization means calling First Choice to preapprove any physician-recommended nonemergency inpatient medical/surgical stay, and calling Optum Behavioral Health to preapprove any physician-recommended nonemergency inpatient mental health stay, before admittance to a hospital.

Preferred Provider means a hospital, physician or other provider who has agreed to participate in the First Choice Health Network as a preferred provider; for mental health services means a hospital, physician or other provider who has agreed to participate in the Optum Behavioral Health network as a preferred provider.

Retiree means any person who meets the eligibility rules of the plan.

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

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

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

Spouse is defined by the federal 1996 Defense of Marriage Act; coverage is provided for a spouse under a marriage legally recognized in the state of Washington which is between one man and one woman.

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

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

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

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

SUMMARY PLAN DESCRIPTION

NAME OF PLAN
This plan is the Health and Welfare Plan of the Sound Health & Wellness Retiree Trust.

The trust fund through which this plan is provided is known as the Retail Clerks Retiree Welfare Trust d.b.a. Sound Health & Wellness Retiree Trust.

NAME, ADDRESS AND TELEPHONE NUMBER OF BOARD OF TRUSTEES
This plan is sponsored and administered by a joint labor-management Board of Trustees, the name, address, and telephone number of which is:

Board of Trustees of the Retail Clerks Retiree Welfare Trust
c/o Zenith Administrators, Inc.
201 Queen Anne Avenue North
Suite 100
Seattle, Washington 98109-4896
Telephone number: (206) 282-4500

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

IDENTIFICATION NUMBERS
The employer identification number assigned by the Internal Revenue Service is EIN 91-1950259. The plan number is 502.

TYPE OF PLAN
This plan can be described as a welfare plan providing medical and prescription drug benefits.

TYPE OF ADMINISTRATION

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

NAME, ADDRESS AND TELEPHONE NUMBER OF PLAN ADMINISTRATOR

See information for Board of Trustees below.

NAME AND ADDRESS OF AGENT FOR SERVICE OF PROCESS

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

NAMES, TITLES AND ADDRESSES OF TRUSTEES

Employer Trustees	Union Trustees
Randy Zeiler Allied Employers, Inc. 4030 Lake Washington Blvd. NE, Suite 201 Kirkland, WA 98033-7870	**Diane Zahn** UFCW Local No. 21 5030 First Ave. S. Suite 200 Seattle, WA 98134
Derrick Anderson Haggen, Inc. 2211 Rimland Drive Bellingham, WA 98226	**David Blitzstein** UFCW International Union 1775 K Street NW Washington DC 20006
Nathan Hyde Albertsons, Inc. 250 Parkcenter Blvd. Boise, ID 83726	**Todd Crosby** UFCW Local No. 21 5030 First Ave. S. Suite 200 Seattle, WA 98134
Frank Jorgensen Safeway, Inc. 1121 124th Ave. NE Bellevue, WA 98005	**David Schmitz** UFCW Local No. 21 5030 First Ave. S. Suite 200 Seattle, WA 98134
Scott Klitzke Powers Allied Employers, Inc. 4030 Lake Washington Blvd. NE, Suite 201 Kirkland, WA 98033-7870	**Michael J. Williams** UFCW Local No. 81 960 East Main Street Auburn, WA 98002
Carl Wojciechowski Fred Meyer, Inc. 3800 SE 22nd Ave. Portland, OR 97202	**Brenda Willis** UFCW Local No. 21 5030 First Ave. S. Suite 200 Seattle, WA 98134

DESCRIPTION OF COLLECTIVE BARGAINING AGREEMENTS

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

PARTICIPATION, ELIGIBILITY AND BENEFITS

The eligibility rules which determine which retirees and dependents are entitled to benefits are set forth on pages 6 to 12 of this booklet.

The benefits to which eligible retirees and dependents are entitled are set forth on pages 13 to 38 of this booklet.

CIRCUMSTANCES WHICH MAY RESULT IN INELIGIBILITY OR DENIAL OF BENEFITS

The circumstances which 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 upon 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, shall be used to continue benefits provided by the then existing benefit plans, until the monies and assets have been exhausted.

SOURCE OF CONTRIBUTIONS

This plan is funded in part through employer contributions, the amount of which is determined through collective bargaining between participating employers and labor organizations, as specified in the collective bargaining agreements and master health and welfare agreement. It is also funded in part by payments from participating retirees. Furthermore, COBRA self-payments are permitted as described on page 11 of this booklet. The amount of payments by participating retirees and the amount of COBRA self-payments are fixed from time to time by the Board of Trustees.

ENTITIES USED FOR ACCUMULATION OF ASSETS AND PAYMENT OF BENEFITS

- *The employer contributions, the retiree payments and the COBRA self-payments are received and held by the Board of Trustees in the Sound Health & Wellness Retiree Trust, formerly known as the Retail Clerks Retiree Welfare Trust, to pay benefits and administrative expenses.*
- *The Trust PPO medical benefits are self-funded and paid according to the direct payment rules in this booklet.*
- *The Trust PPO prescription drug benefit is self-funded and administered by informedRx, Inc., 2441 Warrenville Road, Suite 610, Lisle, IL 60432-3642.*

END OF PLAN YEAR

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

YOUR ERISA RIGHTS

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

RECEIVE INFORMATION ABOUT YOUR PLAN AND BENEFITS

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

CONTINUE HEALTH PLAN COVERAGE

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

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

PRUDENT ACTIONS BY PLAN FIDUCIARIES

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

ENFORCE YOUR RIGHTS

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

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

If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek

assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

ASSISTANCE WITH YOUR QUESTIONS

If you have any questions about your plan, you should contact the Trust Office. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration at (866) 444-3272.

NOTICE OF PRIVACY PRACTICES (HIPAA)

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

USE AND DISCLOSURE OF HEALTH INFORMATION

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

- ***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.*

- ***To conduct healthcare operations.*** *The Trust may use or disclose health information for its own operations to facilitate the administration of the Trust and as necessary to provide coverage and services to all of the Trust's participants. Healthcare operations include such activities as:*
  - *Contacting healthcare providers and participants with information about treatment alternatives and other related functions*
  - *Clinical guideline and protocol development*
  - *Case management and care coordination*
  - *Activities designed to improve health or reduce healthcare costs*
  - *Underwriting, premium rating or related functions to create, renew or replace health insurance or health benefits*
  - *Business management and general administrative activities of the Trust, including customer service and resolution of internal grievances, review and auditing, including compliance reviews, medical reviews, legal services and compliance programs, quality assessment and improvement activities, business planning and development, including cost management and planning-related analyses and formulary development*

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

- ***In connection with judicial and administrative proceedings.*** *If required or permitted by law, the Trust may disclose your health information in the course of any judicial or administrative proceeding in response to an order of a court or administrative tribunal, as expressly authorized by such order or in response to a subpoena, discovery request or other lawful process. The Trust will make reasonable efforts either to notify you about the request or to obtain an order protecting your health information.*
- ***When legally required for law enforcement purposes.*** *The Trust will disclose your health information when required to do so by any federal, state or local law. In addition, as permitted or required by law, the Trust may disclose your health information to a law enforcement official for certain law enforcement purposes including, but not limited to, if the Trust has a suspicion that your death was the result of criminal conduct or in an emergency to report a crime.*

- ***For treatment alternatives.*** *The Trust may use and disclose your health information to tell you about or recommend possible treatment options or alternatives that may be of interest to you.*
- ***For distribution of health-related benefits and services.*** *The Trust may use or disclose your health information to provide to you health-related benefit and service information that may be of interest to you.*
- ***For disclosure to the plan trustees.*** *The Trust may disclose your health information to the Board of Trustees and necessary advisors for plan administration functions performed by the Board of Trustees on behalf of the Trust, such as those listed in this summary, or to handle claim appeals, solicit bids for services, or modify, amend or terminate the plan.*
- ***To conduct health oversight activities.*** *The Trust may disclose your health information to a health oversight agency for authorized activities including audits, civil, administrative or criminal investigations, inspections, licensure or disciplinary action. The Trust, however, may not disclose your health information if you are the subject of an investigation and the investigation does not arise out of or is not directly related to your receipt of healthcare or public benefits.*
- ***In the event of a serious threat to health or safety.*** *The Trust may, consistent with applicable law and ethical standards of conduct, disclose your health information if the Trust, in good faith, believes disclosure is necessary to prevent or lessen a serious and imminent threat to your health or safety or to the health and safety of the public.*
- ***For specified government functions.*** *In certain circumstances, federal regulations require the Trust to use or disclose your health information to facilitate specified government functions related to the military and veterans, national security and intelligence activities, protective services for the president and others, and correctional institutions and inmates.*
- ***For workers' compensation.*** *The Trust may release your health information to the extent necessary to comply with laws related to workers' compensation or similar programs.*

AUTHORIZATION TO USE OR DISCLOSE HEALTH INFORMATION

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

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

YOUR RIGHTS WITH RESPECT TO YOUR HEALTH INFORMATION

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

- ***Right to request restrictions.*** *You may request restrictions on certain uses and disclosures of your health information. You have the right to request a limit on the Trust's disclosure of your health information to someone involved in the payment of your care. However, the Trust is not required to agree to your request. If you wish to request restrictions, please make the request in writing to the Trust's Privacy Contact Person listed below.*
- ***Right to receive confidential communications.*** *You have the right to request that the Trust communicate with you in a certain way if you feel the disclosure of your health information could endanger you. For example, you may ask that the Trust only communicate with you at a certain phone number or by email. If you wish to receive confidential communications, please make your request in writing to the individual identified as the Trust's Privacy Contact Person below. The Trust will attempt to honor your reasonable requests for confidential communications.*
- ***Right to inspect and copy your health information.*** *You have the right to inspect and copy your health information. A request to inspect and copy records containing your health information must be made in writing to the Privacy Contact Person listed below. If you request a copy of your health information, the Trust may charge a reasonable fee for copying, assembling costs and postage, if applicable, associated with your request.*
- ***Right to amend your health information.*** *If you believe that your health information records are inaccurate or incomplete, you may request that the Trust amend the records. That request may be made as long as the information is maintained by the Trust. A request for an amendment of records must be made in writing to the Trust's Privacy Contact Person listed below. The Trust may deny the request if it does not include a reasonable reason to support the amendment. The request also*

may be denied if your health information records were not created by the Trust, if the health information you are requesting be amended is not part of the Trust's records, if the health information you wish to amend falls within an exception to the health information you are permitted to inspect and copy, or if the Trust determines the records containing your health information are accurate and complete.

- ***Right to an accounting.*** *You have the right to request a list of disclosures of your health information made by the Trust for any reason other than for treatment, payment or health operations. The request must be made in writing to the Privacy Contact Person listed below. The request should specify the period for which you are requesting the information, but may not start earlier than April 14, 2003, when the Privacy Rule became effective. Accounting requests may not be made for periods going back more than six years. The Trust will provide the first accounting you request during any 12 month period without charge. Subsequent accounting requests may be subject to a reasonable cost-based fee. The Trust will inform you in advance of the fee, if applicable.*
- ***Right to a paper copy of this notice.*** *You have a right to request and receive a paper copy of this Notice at any time, even if you have received this Notice previously or agreed to receive the Notice electronically. To obtain a paper copy, please contact the Privacy Contact Person listed below. You also may obtain a copy of the current version of the Trust Notice at www.soundhealthwellness.com.*

PRIVACY CONTACT PERSON/PRIVACY OFFICIAL

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

Contact Person
Sound Health & Wellness Retiree Trust
201 Queen Anne Ave. N. Suite 100
Seattle, WA 98109-4896
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.

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.