Sound Kaiser Permanente Plan

Sound Health & Wellness Trust

2017 EDITION

SOUND HEALTH
& WELLNESS TRUST

APRIL 1, 2017

SOUND KAISER PERMANENTE PLAN

A LABOR-MANAGEMENT BENEFIT PLAN AND SUMMARY PLAN DESCRIPTION

MESSAGE TO EMPLOYEES:

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

This booklet applies to:

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

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

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

Sincerely,
Board of Trustees

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

All questions about benefit interpretations should be referred to Zenith American Solutions (the Trust Office). **The Trust Office does not guarantee eligibility for benefits or benefit payments. Although the Trust Office can provide you with general information on your plan of benefits, your eligibility for benefits and benefit payments will be determined only when a claim is submitted to the Trust.**

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

- *Address*
- *Dependent status (birth, adoption, legal placement for adoption, custody, death, marriage, legal separation, divorce, full-time student)*
- *Designated life insurance beneficiary*

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

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

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

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

See page 140 for information on the funding of each benefit.

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TABLE OF CONTENTS

SUMMARY OF BENEFITS

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

MEDICAL BENEFITS

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

ANNUAL OUT-OF-POCKET MAXIMUM Includes only the annual deductible and participant coinsurance.	
MHCN providers*	**$2,750 for employee only coverage; $5,500 for family coverage.**
Community providers	**$5,500 for employee only coverage; $16,500 for family coverage.**
	For employees eligible for HRA funding, if an employee or spouse fails to earn the maximum HRA funding, the annual out-of-pocket maximums shown above will increase for that year by the amount of unearned HRA funding. **For employees with family coverage, the employee only coverage maximum will apply to each covered individual until the family coverage maximum is met.** **Additional annual out-of-pocket maximums may apply for essential health benefits (see page 46).**

! *MHCN providers are those employed by or contracted with Kaiser Permanente Managed Health Care Network.*

! *The Kaiser Permanente Consulting Nurse Helpline, toll free at (800) 297-6877, is available 24 hours a day, 7 days a week, to help you find the information you need to make informed healthcare decisions.*

PRESCRIPTION DRUGS

COPAYS	RETAIL (30 DAY SUPPLY)
Tier 0	**$0**
Tier 1	**$6**
Tier 2	**$22**
Mail Order Prescription Drugs	**Covered subject to the above copayments for each 30 day supply or less.**

VISION CARE

	See page 71

DENTAL CARE

Choice of 3 options	• **DDWA Preferred; see page 74** • **DeltaCare; see page 86** • **Schedule Plan; see page 87**

EMPLOYEE LIFE INSURANCE

$15,000

DEPENDENT LIFE INSURANCE

$1,000

EMPLOYEE ACCIDENTAL DEATH OR DISMEMBERMENT

$15,000

EMPLOYEE WEEKLY DISABILITY (TIME LOSS)

See page 111

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

! *Throughout this booklet there are terms that have a defined meaning as shown in the Definitions section beginning on page 129.*

ELIGIBILITY

GENERAL ELIGIBILITY

You may become eligible under this Kaiser Permanente Plan if:

- *You were hired on or after October 1, 2004, but prior to December 3, 2010, and had not worked in covered employment for more than 35 consecutive months as of December 3, 2010; or you were hired on or after December 3, 2010 and have not worked in covered employment for more than 60 consecutive months,*
- *You are in a collective bargaining unit (or participate through a special agreement),*
- *You work for an employer participating in the Trust, and*
- *You pay the required weekly employee premiums.*

Your months of employment and number of hours worked determine which benefits are available to you and your eligible dependents. See the Coverage section on page 16 for more details.

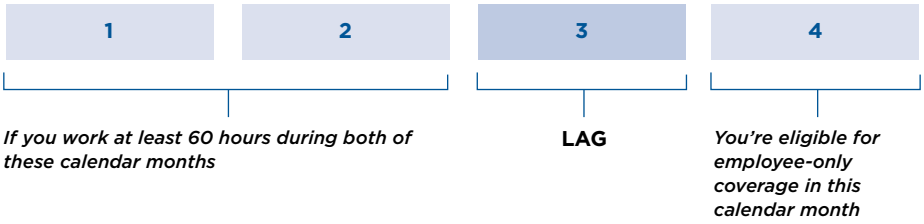
INITIAL ELIGIBILITY (MEDICAL AND PRESCRIPTION DRUG BENEFITS)

Employee-Only Coverage

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

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

Example:



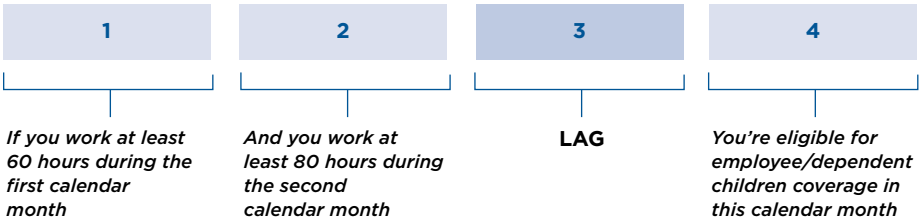
If you're eligible for employee-only coverage, you will receive medical and prescription drug benefits under the Kaiser Permanente Plan. If you live outside the Kaiser Permanente service area, you will receive medical and prescription drug benefits under the Trust's Sound PPO Plan. However, once you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

Dependent Children Coverage

You and your dependent children become eligible for medical and prescription drug coverage on the first day of the second calendar month after completing two consecutive calendar months of employment if:

- *You worked at least 60 hours of covered employment in the first of these two consecutive months,*
- *You worked at least 80 hours of covered employment in the second of these two months,*
- *You complete the enrollment process to enroll your children, either online or by submitting an enrollment form to the Trust Office. You must also submit any required documentation to the Trust Office, such as a birth certificate, to verify dependent status.*
- *Your employer pays the required contributions for each of these two months, and*
- *You pay the required weekly employee premiums (for employee/children coverage).*

Example:



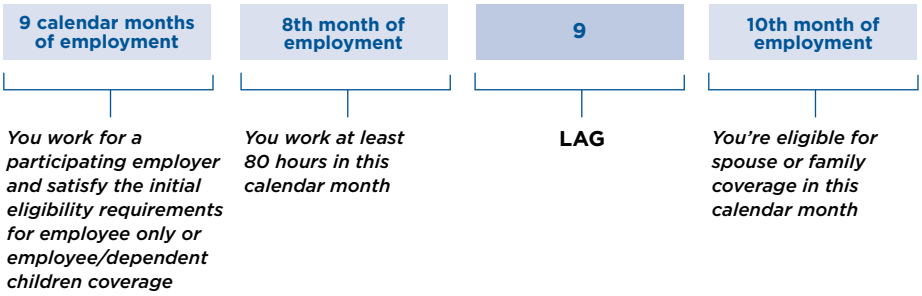
As an employee eligible for employee/dependent children coverage, you can choose to cover your children for medical and prescription drug benefits under the Kaiser Permanente Plan. If you live outside of the Kaiser Permanente service area, medical and prescription drug benefits will be provided under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

Spouse/Same Sex Domestic Partner Coverage

You and your spouse or same sex domestic partner (see page 129) become eligible for coverage on the first day of the calendar month after you complete the following requirements:

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

Example:



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

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

INITIAL ELIGIBILITY (DENTAL BENEFITS)

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

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

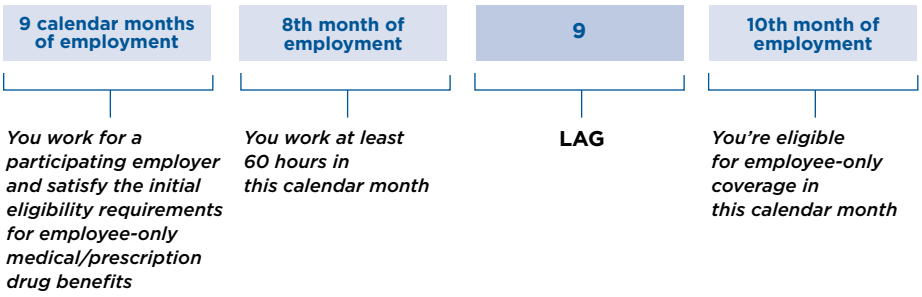
Employee-Only Dental Coverage

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

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

- *Your employer makes the required contributions for each month worked, and*
- *You pay the required weekly employee premiums.*

Example:

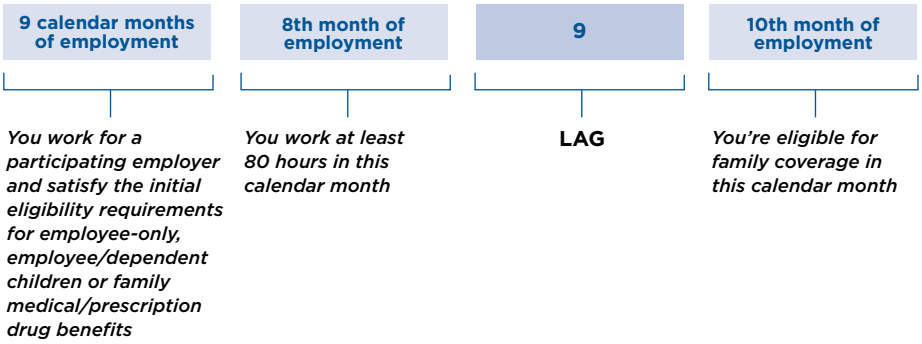


Family Dental Coverage

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

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

Example:



INITIAL ELIGIBILITY (ALL OTHER BENEFITS)

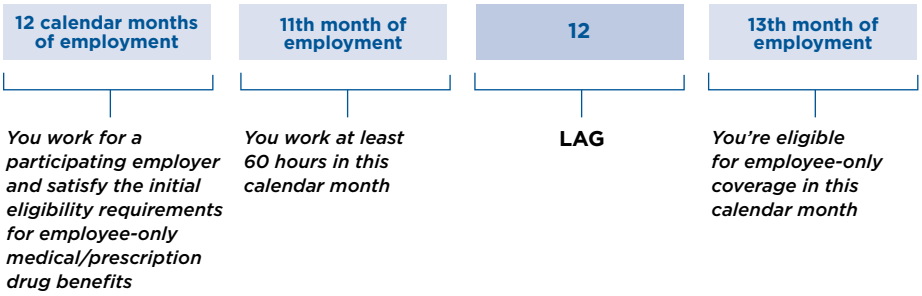
After working for a participating employer for 12 months, you and your enrolled dependents may also become eligible for vision, disability, life and accidental death or dismemberment benefits, and a Health Reimbursement Arrangement (HRA), in your 13th month of employment. The eligibility requirements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

Employee-Only Coverage For All Other Benefits

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

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

Example:

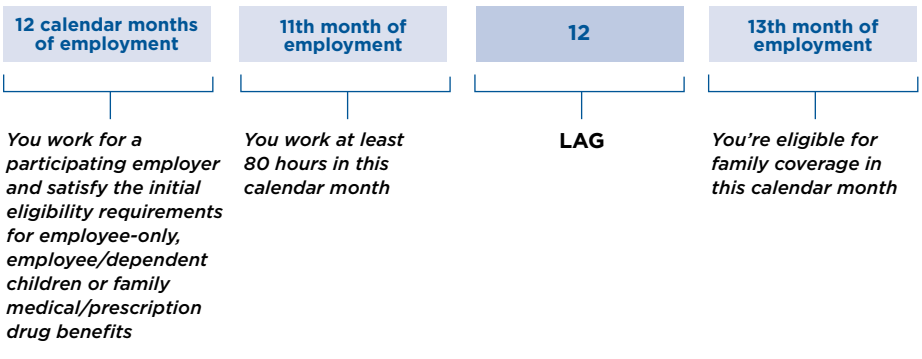


Family Coverage

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

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

Example:



CONTINUATION OF ELIGIBILITY

Employee-Only Coverage

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

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

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

Dependent Coverage (Family Coverage)

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

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

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

COVERAGE

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

MONTHS OF WORK	BENEFITS	WHO IS COVERED
1 – 3	**Waiting Period**	**No Benefits Available**

4 – 9	**Medical and Prescription Drug**	**Employee/Enrolled Dependent Children**
10 – 12	**Medical, Prescription Drug and Dental**	**Employee and Enrolled Dependent Spouse/Same Sex Domestic Partner and Children (Family)**
13+	**Medical, Prescription Drug, Dental, Vision, Disability, Life, AD&D, and HRA**	**Employee and Enrolled Dependent Spouse/Same Sex Domestic Partner and Children (Family)**

WHEN ELIGIBILITY ENDS

Employee-Only Coverage

Your eligibility ends on the earlier of:

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

Examples:

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

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

Dependent Coverage (Family Coverage)

Your dependent's eligibility ends on the earlier of:

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

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

Examples:

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

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

REINSTATEMENT OF ELIGIBILITY

Employee-Only Coverage

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

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

Example:

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

If you began work in covered employment before August 1, 1980, your eligibility is reinstated as described above *except* 40 instead of 60 hours of covered employment are required. However, if you fail to have at least one hour of covered employment in a month, fail to make COBRA continuation coverage payments (see page 31) for medical benefits or you do not pay the required weekly employee premiums, you are required to work at least 60 hours in a month to reinstate eligibility for employee-only coverage when you return to covered employment. You must also then continue to work at least 60 hours in a month going forward in order to maintain employee-only coverage.

Dependent Coverage (Family Coverage)

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

- *You have continued work with the same employer,*
- *You worked at least 80 hours of covered employment in the second preceding calendar month for which your employer paid the required contributions,*
- *You were eligible during any of the six consecutive preceding calendar months, and*
- *You pay the required weekly employee premiums (for either employee/children, employee/spouse or family coverage).*

Example:

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

! ***If coverage terminates as the result of uniformed (military) service and you retain reemployment rights, coverage is reinstated without waiting periods, according to federal law. See Military Service Under USERRA (page 24) for more information.***

Employment Between Participating Employers

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

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

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

TRANSFERRING TO THE SOUNDPLUS PLAN

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

ELIGIBLE DEPENDENTS

If you work 80 or more hours in a calendar month and meet all other eligibility rules, your dependents are eligible for coverage on the dates outlined in the Eligibility section beginning on page 9, provided you elect employee/children, employee/spouse or family coverage, enroll your dependents, provide any documentation required (such as a marriage certificate or birth certificate), and pay the required weekly employee premiums for the coverage selected. Dependents must be enrolled with the Trust Office before their benefits begin.

Your eligible dependents include:

1. *Your spouse, if you're not divorced or legally separated.*
2. *Your same sex domestic partner, provided you or your partner is at least age 62 at the time such domestic partnership is established. Contact the Trust Office for the necessary forms.*
3. *Your children under age 26 who are your natural children, stepchildren, adopted children, children placed with you for adoption, or foster children.*

These children do not have to depend on you for support, do not have to attend school full time, and can be married. A child is considered placed with you for adoption if you have a legal obligation for total or partial support in anticipation of adopting. A foster child is one placed by an authorized placement agency or by judgment, decree, or other court order.

4. *Unmarried children under age 19 who are dependent on you for support and are children of your same sex domestic partner, children for whom you are legal guardian, or children you have a legal obligation to support (who do not meet #3 above).*

   In addition, these children will be eligible from age 19 until their 24th birthday, if they attend a full time (as defined by the institution) accredited educational institution of higher learning and otherwise meet the requirements in #4. A child must be enrolled in both spring and fall quarters/semesters to continue coverage during the summer. You need to contact the Trust Office every three months to update full-time student status for these children between ages 19 and 24.

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

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

5. *Unmarried dependent children who reach any of the applicable limiting ages in #3 and #4 above while covered by this Plan and are incapable of self-sustaining employment because of mental or physical handicap.*

   You must provide proof of the incapacity and dependency to the Trust Office within 31 days after the child reaches the limiting age. You may be required to verify the incapacity and dependency from time to time.

For other than your natural children, you must provide the Trust Office copies of court papers or other official court documents demonstrating your legal relationship with or obligation to support the child.

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

! ***If you have eligible dependents, please notify the Trust Office within 60 days of any change in family status – marriage, birth, adoption or legal placement for adoption, marriage of any child, a child reaching their limiting age for coverage, death of any dependent, divorce, legal separation or termination of domestic partnership. A new enrollment form for this purpose is available from the Trust Office.***

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

Special Enrollment

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

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

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

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

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

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

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

To request special enrollment or obtain more information, contact the Trust Office.

ELIGIBILITY WHEN DISABLED ("PREMIUM WAIVERS")

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

- *Are declared disabled by a physician within four days of the last day worked,*
- *Are under the care of a physician or certain covered providers,*
- *Remain continuously disabled, which means unable to work in the industry and not engaged in any other occupation for wage or profit, as determined by the Board of Trustees in their sole discretion, and*

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

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

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

- *If the "light-duty" restriction prevents you from earning enough hours to establish eligibility, you continue to be covered for up to three consecutive months You will not receive more than three consecutive months of eligibility for that disabling condition.*

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

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

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

If this is an employer-approved FMLA leave (see page 27), the maximum time of COBRA Coverage (see page 31) is reduced by any months you're covered under this disability provision.

A completed weekly disability (time loss) claim form, as described on page 118, must be submitted to the Trust Office to claim eligibility under this provision. Contact the Trust Office for more details.

MILITARY SERVICE UNDER USERRA

Under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), the Trust provides you the right to elect continued health coverage for up to 24 months if you are absent from employment due to qualified military service, including Reserve and

National Guard Duty under federal authority, that meets the rules under USERRA ("USERRA Service").

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

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

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

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

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

Notice and Election of USERRA Coverage

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

Paying for USERRA Coverage

If the period of USERRA Service is less than 31 days, there is no charge for this coverage beyond the normal deductible, or co-payments that would be paid if you were employed. If the USERRA Service extends more than 31 days, you must pay 102% of the cost of the coverage unless

the employer pays for the coverage under its leave policy. The cost will be determined in the same manner as the cost for COBRA Coverage. You should contact the Trust Office for the current cost.

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

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

Entering and Returning from Service

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

- *Less than 31 days of USERRA Service – apply immediately, taking into account safe transportation plus an eight-hour rest period.*
- *31-180 days of USERRA Service – apply within 14 days.*
- *More than 180 days of USERRA Service – apply within 90 days.*

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

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

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

MEDICAL OR FAMILY LEAVE OF ABSENCE

The Family and Medical Leave Act of 1993 (FMLA) generally requires that an employer with 50 or more employees provide employees with up to 12 weeks per year of unpaid leave in the case of the birth or adoption of your child and for your own illness or to care for a seriously ill child, spouse or parent. You may also be entitled to FMLA leave for a qualifying reason that arises in connection with the active military service of your child, spouse, or parent. To be eligible, you must have worked for your current employer for at least 12 months and for at least 1,250 hours in the 12 months before your leave.

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

- *Birth of a child;*
- *Placement of a child for adoption or foster care;*
- *Serious health condition of a child, spouse, same sex domestic partner, or parent;*
- *Your own serious health condition that makes you unable to perform the essential functions of your job; or*
- *A qualifying reason that arises in connection with the active military service of a child, spouse, or parent, including (a) notification of military deployment within seven days of the deployment date; (b) attending military events and related activities, such as formal ceremonies or military-sponsored family support and assistance meetings; (c) childcare and school activities, such as arranging for or providing childcare, or attending school meetings; (d) making financial and legal arrangements; (e) attending counseling sessions; (f) up to five days of rest and recuperation; (g) attendance at post-deployment activities.*

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

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

If you advise your employer that you are not returning or if you do not return after your FMLA leave, coverage for all Plan benefits ends. You and your eligible dependents then may elect COBRA Coverage (see page 29). The qualifying event entitling you to COBRA Coverage is the last day of your FMLA leave. Contact the Trust Office for more details.

WHEN COVERAGE ENDS

Employees

Your coverage ends on the earliest of these dates:

- *Last day of the month in which your employment terminated;*
- *Last day of the month following the month in which you did not work the required number of hours or for which the required contributions were not paid;*
- *Last day of the month you begin active duty with the armed services of any country if the active duty is to exceed 30 days (see Military Service Under USERRA, page 24, for details);*
- *The date this Plan is discontinued, in whole or in part;*
- *Last day of the month in which your employer ceases to be a participating employer;*
- *Last day of the month in which the collective bargaining agreement covering your employment is terminated.*

Dependents

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

- *The date your coverage ends;*
- *Last day of the month a child reaches their maximum age for coverage;*
- *Last day of the month a child of your domestic partner, child for whom you are legal guardian, or child you have a legal obligation to support marries, to the extent permitted by law;*

- *Last day of the month a dependent enters active duty with the armed services of any country if the active duty is to exceed 30 days;*
- *For your spouse, the last day of the month in which you are divorced or legally separated;*
- *For your domestic partner, the last day of the month in which the domestic partnership is terminated;*
- *For a stepchild, the last day of the month in which you are divorced, legally separated or your domestic partnership is terminated and you have no legal financial obligation to support the stepchild;*
- *Last day of the month following the month in which you did not work enough hours for family coverage or did not pay the required family premiums;*
- *Last day of the month in which a dependent no longer qualifies as eligible (see page 17 for dependent eligibility details).*

COBRA COVERAGE

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

What is COBRA Coverage?

COBRA Coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." After a qualifying event, COBRA Coverage must be offered to each person who is a "qualified beneficiary". You, your spouse and your children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA Coverage must pay for COBRA Coverage.

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

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

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

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

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

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

When is COBRA Coverage Available?

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

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

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

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

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

How is COBRA Coverage Provided?

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

How Long is COBRA Coverage Provided?

MAXIMUM PERIODS OF COBRA COVERAGE FOR EACH QUALIFYING EVENT

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

MAXIMUM PERIOD OF OTHER CONTINUATION COVERAGE

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

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

Disability Extension of 18-month Period of COBRA Coverage

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

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

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

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

Health Benefits

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

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

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

The maximum time you may make COBRA Coverage payments is reduced by any months you're covered under the Plan's provisions for Eligibility When Disabled (see page 23).

Life, Accidental Death or Dismemberment and Weekly Disability Benefits

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

Other COBRA Coverage Provisions

- *Once elected, COBRA Coverage may be terminated for any of these reasons:*
  - *The Trust no longer provides health coverage to any employees;*
  - *The required premium for COBRA Coverage is not paid when due;*
  - *You or your dependents become covered under another group health plan (unless the other plan limits coverage for a preexisting health condition, and the preexisting condition exclusion/limit applies to that individual);*
  - *The qualified beneficiary becomes entitled to Medicare.*
- *COBRA Coverage requires timely election of the coverage. The Trust will, within 14 days of receiving notice of the qualifying event, send to the affected individual a COBRA enrollment form. This form will describe the cost of COBRA Coverage and the conditions under which the coverage will terminate. The COBRA Coverage enrollment form must be returned to the Trust Office within 60 days of the information letter being mailed from the Trust Office. Initial payment must:*
  - *Include all months not covered by employer-paid contributions, and*
  - *Be received within 45 days of the Trust Office receiving your enrollment form.*
- *If the enrollment form is not returned or payments are not made within these timelines, COBRA Coverage is not available.*
- *Ongoing payments are due on the 20th of the month prior to each month of coverage. However, you will have a grace period of 30 days after the first of the month in which to make a payment.*

  You will receive a coupon book from the Trust Office to use when making COBRA Coverage payments. You will not receive a monthly bill from the Trust Office. ***It is your responsibility to make payments to the Trust Office. Late payments will result in termination of COBRA Coverage.***
- *The amount of the payment is subject to change.*
- *If you gain an eligible dependent while participating in COBRA Coverage, the usual rules for enrolling new dependents apply. To cover new dependents, you must enroll the dependent and make the required monthly payments, if eligible for family coverage. Coverage for newborn or adopted children will continue for the same time as coverage for children who were properly enrolled in the Plan on the day before the qualifying event. Newborn or adopted children*

added to your COBRA Coverage also become qualified beneficiaries.

To protect your family's COBRA Coverage rights, you should keep the Trust Office informed of any changes in the addresses of family members.

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

Cost of COBRA Coverage and Payment

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

Are There Other Coverage Options Besides COBRA Coverage?

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

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

If You Have Questions

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

Contact Information for COBRA Coverage Administration

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

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

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

Other Rights

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

ENROLLING IN THE SOUND PLAN

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

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

You will also have the following enrollment options:

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

  ***DDWA Preferred (#09136)** – A dental PPO (Preferred Provider Organization) network administered by Delta Dental of Washington (DDWA); details about this option begin on page 74.*

DeltaCare (#00405) *– A dental HMO (Health Maintenance Organization) network administered by Delta Dental of Washington (DDWA). Details are available in separate DDWA publications. For more information, call DDWA at (800) 650-1583 or visit* ***www.DeltaDentalWA.com.***

Schedule Plan *– The Schedule of Dental Allowances, administered by Delta Dental of Washington (DDWA), specifies the maximum payment allowable for each covered dental procedure;* *details begin on page 87.*

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

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

MAKING CHANGES

After 35 Months of Employment

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

Annual Open Enrollment

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

Changes in Family Status

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

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

If you are enrolled in the Kaiser Permanente medical plan or the DeltaCare dental plan and you move out of the Kaiser Permanente or DeltaCare service area, you can request that you and your dependents change medical or dental plans, provided you notify the Trust Office within 60 days of the date you change your residence. Your new plan will be effective on the first day of the calendar month following the month that the Trust Office receives your new enrollment form.

To make changes to your coverage, obtain a new enrollment form and return it to the Trust Office with appropriate documents.

SPOUSE OR SAME SEX DOMESTIC PARTNER MEDICAL COVERAGE

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

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

MEDICAL BENEFITS

As an enrollee in the Sound Kaiser Foundation Health Plan of Washington Options, Inc. Plan, the benefits described in this section apply to you whether you use a Managed Health Care Network (MHCN) provider or community provider.

This section sets forth the benefits and medical care access requirements for the Kaiser Permanente Plan. If you have questions regarding Kaiser Permanente care access requirements or how benefits have been paid, please contact the Kaiser Permanente Customer Service Center (206) 901-4636 or toll free (888) 901-4636.

ACCESSING CARE

Participants are entitled to covered services from either of the following options:

MHCN Provider: when care is provided by Kaiser Permanente's Managed Health Care Network provider or referred by a MHCN personal physician.

Community Provider: when care is provided by a community provider or preferred community provider on a self-referred basis.

Benefits paid under the community provider option will not be duplicated under the MHCN option and benefits paid under the MHCN option will not be duplicated under the community provider option.

Participants may choose either health care delivery option at any time during or for differing episodes of illness or injury, except during a scheduled inpatient admission.

Under the Kaiser Permanente Plan, the level of benefits available for services received at or upon referral by MHCN providers is generally greater than the level of benefits available for services received from community providers. In order for services to be covered at the higher benefit level, services must be obtained from MHCN providers at MHCN facilities, except as follows:

- *Emergency care*
- *Visits with MHCN-Designated self-referral specialists (see below)*
- *Care provided pursuant to a referral. Referrals must be requested by the participant's MHCN personal physician and approved by Kaiser Permanente*
- *Other services as specifically set forth in the Kaiser Permanente Plan*

Some services are covered only when obtained from or upon referral by a MHCN provider.

All inpatient admissions prescribed by a community provider must be authorized in advance by Kaiser Permanente.

A listing of MHCN personal physicians, referral specialists, women's MHCN health care providers and MHCN-Designated self-referral specialists is available by contacting Kaiser Permanente customer service at (206) 901-4636 or (888) 901-4636, or by accessing Kaiser Permanente's website at **www.kp.org/wa.**

Primary Care

Participants must select a MHCN personal physician when enrolling under the Kaiser Permanente Plan. One personal physician may be selected for an entire family, or a different personal physician may be selected for each family member.

Selecting a personal physician or changing from one personal physician to another can be accomplished by contacting Kaiser Permanente customer service, or accessing the Kaiser Permanente website at **www.kp.org/wa**. The change will be made within 24 hours of the receipt of the request, if the selected physician's caseload permits.

Specialty Care

Unless otherwise indicated, referrals are required for specialty care and specialists inside the MHCN network.

MHCN-Designated Self-Referral Specialist

Participants may make appointments directly with MHCN-Designated self-referral specialists at Kaiser Permanente owned or operated medical centers without a referral from their personal physician. Self-referrals are available for most specialty care areas.

Women's Health Care Direct Access Providers

Female participants may see a participating general and family practitioner, physician's assistant, gynecologist, certified nurse midwife, licensed midwife, doctor of osteopathy, pediatrician, obstetrician or advanced registered nurse practitioner who is contracted by Kaiser Permanente to provide women's health care services directly, without a referral from their personal physician, for maternity care, covered reproductive health services, preventive care (well care) and general examinations, gynecological care as well as follow-up visits for the above services. Within the MHCN, women's health care services are covered as if the participant's personal physician had been consulted, subject to the MHCN provider benefit level. Women's health care services obtained from a community provider are covered at the community provider benefit level.

If the participant's women's health care provider diagnoses a condition that requires referral to other specialists or hospitalization, the participant or her chosen provider must obtain preauthorization and care coordination in accordance with applicable Kaiser Permanente requirements.

Second Opinions

The participant may access a second opinion regarding a medical diagnosis or treatment plan from a MHCN provider, or a community provider, subject to the applicable deductible and/or coinsurance level.

Emergency and Urgent Care

Emergency care is available at MHCN facilities. If participants cannot get to a MHCN facility, participants may obtain emergency services from the nearest hospital. Participants, or persons assuming responsibility for a participant, must notify Kaiser Permanente by way of the Kaiser Permanente emergency notification line within 24 hours of any admission, or as soon thereafter as medically possible. The emergency notification line telephone number is (888) 457-9516.

Under the MHCN option, urgent care is covered only at MHCN medical centers, MHCN urgent care clinics or MHCN provider's offices. Urgent care received at any hospital emergency department is not covered unless authorized in advance by a MHCN provider.

Under the community provider option, urgent care is covered at any medical facility.

HEALTH REIMBURSEMENT ARRANGEMENT (HRA)

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

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

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

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

The HRA cannot be used for community provider medical expenses, prescription drug, dental and vision benefits.

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

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

- *Medical deductible and coinsurance amounts.*
- *Emergency room copayment amounts.*

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

DEDUCTIBLE

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

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

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

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

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

Once the family deductible is met, no further deductible amounts are required for any family member for the rest of that year. Non-covered charges do not apply to the deductible.

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

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

REIMBURSEMENT PROVISIONS (COINSURANCE)
Once you have met the deductible, the plan covers 85% of the MHCN provider charges for covered services or 60% of the preferred community provider contracted rate or community provider UCR charges for covered services.

MHCN providers	**80%**
Community providers	**60%**

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

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

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

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

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

PER CALENDAR YEAR EMPLOYEE-ONLY COVERAGE	MHCN PROVIDERS	COMMUNITY* PROVIDERS
With maximum HRA funding (base OOP max)	**$2,750**	**$5,500**
With no HRA funding (maximum OOP max)	**$3,250**	**$6,000**
FAMILY COVERAGE		
With maximum HRA funding (base deductible)	**$5,500**	**$16,500**
With no HRA funding (maximum deductible)	**$6,500**	**$17,500**

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

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

ANNUAL OUT-OF-POCKET MAXIMUM FOR ESSENTIAL HEALTH BENEFITS

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

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

Per Person	**$7,150**
Per Family	**$14,300**

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

- *The $100 emergency room copayment*
- *The 9th through 12th acupuncture visits*
- *Pediatric vision copayments*
- *Prescription drug copayments, but not any processing fees, cost differentials or non-covered prescription drug expenses*

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

HEALTH & WELLNESS PROGRAM – LIVEWELL

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

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

The LiveWell programs include:

Health Profile

The Kaiser Permanente Health Profile is a confidential annual questionnaire that gives you an immediate snapshot of your current health and health risks, and gives you a personal plan for healthy living.

Each year, you and your spouse have a limited period of time to take the confidential Health Profile to earn Health Reimbursement Arrangement (HRA) funding. You can take the Health Profile at other times of the year as well, but without the credit in your HRA. Information you provide on the Health Profile may qualify you for other LiveWell programs.

This confidential questionnaire can be taken online at **www.kp.org/wa** by clicking “Health Profile”. Alternatively, you can go online at **www.soundhealthwellness.com**, log into your secure account and then click on “Get Started”. From there click on “Take Your Health Profile”. With that you will be directed to the Kaiser Permanente website and guided through the process for completing your Health Profile. You can also complete the Health Profile on paper by contacting Kaiser Permanente at (866) 458-5277. Be sure to have your Kaiser Permanente ID card in hand when you call.

Healthwise Knowledgebase

This online database might be the next best thing to having a doctor in the house. It's a convenient, professional, reliable source for making better health care decisions. From what ails you to what confuses you, you are sure to find advice and resources based on the latest scientific research and reviewed by Kaiser Permanente doctors.
Visit **www.kp.org/wa**.

Consulting Nurse Helpline

24 hours a day, 7 days a week, you can call toll free (800) 297-6877 and knowledgeable registered nurses will confidentially help you find the information you need to make informed decisions.

LiveWell Online

You can log on to **www.kp.org/wa** to find health information, tools and services that make healthcare accessible and convenient, 24/7.

There are two levels of service on **www.kp.org/wa**: basic and enhanced. To get access to the basic online services, you'll need to register online and complete a one-time ID verification. If you do not answer the ID verification questions correctly, you will need to complete an additional one-time process to verify your identity to use the enhanced online services.

Basic services include:

- *Choose a doctor*
- *Access the Healthwise® Knowledgebase*
- *Access health tools and quizzes*
- *Living well with chronic conditions online classes*

Enhanced services include:

- *Refill prescriptions*
- *E-mail your healthcare team*
- *Request appointments*
- *Your online medical record*
- *Take your Health Profile*

Quit For Life® Program

You are eligible for the nationally recognized Quit for Life® Program to help you quit tobacco. You'll get a proven, personalized program that is simple, convenient and available at no cost. People who use the Quit for

Life® Program are up to five times more likely to stay quit at one-year than those who quit cold turkey. For more information:

- *Call (866) 784-8454 – whether you want to start the program today or you'd just like to talk about getting ready to quit.*
- *If you or your family or friends don't have coverage for Quit for Life®, you can call the Washington State QuitLine at (800) QUIT-NOW (800-784-8669).*

LiveWell Fit

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

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

COVERED MEDICAL EXPENSES

The Plan provides benefits for the following services and supplies, provided they are medically necessary and performed by a physician or other covered provider. All covered services are subject to case management and utilization review at the discretion of Kaiser Permanente.

Unless otherwise specified, if treatment/services are provided by a MHCN provider, the covered benefit will be paid at 80% after the deductible is met. If the treatment/services are provided by a community provider, the covered benefit will be paid at 60% of charges (not to exceed UCR) after the deductible is met.

Also, please refer to the medical exclusions and limitations as listed, beginning on page 65.

Acupuncture

The Plan covers treatment by an acupuncturist up to a maximum of eight visits per medical diagnosis per calendar year. When approved by Kaiser Permanente, additional MHCN provider visits are covered. Preventive care visits and any service not within the scope of their license are not covered.

Ambulance (local and air)

- *Emergency ground/air transport is covered at 80% after the annual deductible is satisfied for transport to a MHCN facility or non-MHCN facility. See page 131 for a definition of an emergency.*
- *Non-emergency ground/air interfacility transfer for MHCN-initiated transfers and community provider transfers are covered at 80% after the annual deductible is satisfied for transport from one medical facility to the nearest facility equipped to render further medically necessary treatment when prescribed by the attending physician. MHCN initiated hospital to hospital ground transfers are covered in full.*

Applied Behavior Analysis (ABA)

Applied Behavior Analysis (ABA) therapy is a covered service, limited to outpatient treatment of an autism spectrum disorder as diagnosed and prescribed by a neurologist, pediatric neurologist, developmental pediatrician, psychologist or psychiatrist experienced in the diagnosis and treatment of autism spectrum disorders as defined in the most current version of the Diagnostic and Statistical Manual of Mental Disorders (DSM). Documented diagnostic assessments, individualized treatment plans and progress evaluations are required.

Prior authorization is needed for development of initial treatment plan and ongoing ABA treatment. A copy of the ABA Coverage Policy and details of the authorization and assessment can be obtained by calling the Kaiser Permanente Customer Service center (206) 901-4636 or toll free (888) 901-4636.

Blood Transfusions

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

Chemical Dependency Treatment

Chemical dependency treatment services are covered under the MHCN option when provided at a MHCN facility or MHCN-approved treatment program, or under the community provider option when provided at an approved treatment facility.

Chemical dependency treatment may include the following services received on an inpatient or outpatient basis: diagnostic evaluation and education, organized individual and group counseling and/or prescription drugs and medicines.

Court-ordered treatment shall be covered only if determined to be medically necessary.

Clinical Trials

Notwithstanding any other provisions of this Plan, benefits for routine patient costs of qualified individuals in approved clinical trials will be covered, to the extent benefits for these costs are required by law.

Dental Services

Dental care services due to an injury requiring emergency care are covered, limited to accidental injury to sound natural teeth or fractured jaw. Benefits under the medical Plan will not be considered until dental plan benefits are exhausted. Routine dental treatment is not covered.

Services must be authorized by Kaiser Permanente, and dental work must be completed within 6 months of injury unless the participant's documented medical condition prohibits such dental work or Kaiser Permanente has approved such a delay in advance.

General anesthesia services and related facility charges for dental procedures will be covered for participants who are under 7 years of age, or are physically or developmentally disabled or have a medical condition where the participant's health would be put at risk if the dental procedure were performed in a dentist's office. Such services must be authorized in advance by Kaiser Permanente.

Excluded: dentist's or oral surgeon's fees.

Devices, Equipment and Supplies (for home use)

Devices, equipment and supplies, which restore or replace functions that are common and necessary to perform basic activities of daily living, are covered as set forth below. Examples of basic activities of daily living are dressing and feeding oneself, maintaining personal hygiene, lifting and gripping in order to prepare meals and carrying groceries.

- *Durable medical equipment - equipment which can withstand repeated use, is primarily and customarily used to serve a medical purpose, is useful only in the presence of an illness or injury and used in the participant's home. Examples of durable medical equipment include: hospital beds, wheelchairs, walkers, crutches, canes, glucose monitors, external insulin pumps, testing reagents and supplies, oxygen and oxygen equipment. Kaiser Permanente, in its sole discretion, will determine if equipment is made available on a rental or purchase basis.*
- *Orthopedic appliances which are attached to an impaired body segment for the purpose of protecting the segment or assisting in restoration or improvement of its function.*

  Excluded: arch supports, including custom shoe modifications or inserts and their fittings except for therapeutic shoes, modifications and shoe inserts for severe diabetic foot disease; and orthopedic shoes that are not attached to an appliance.

- *Ostomy supplies for the removal of bodily secretions or waste through an artificial opening.*
- *Prosthetic devices which replace all or part of an external body part, or function thereof.*

When authorized in advance, repair, adjustment or replacement of appliances and equipment is covered.

Excluded: items which are not necessary to restore or replace functions of basic activities of daily living; replacement or repair of appliances, devices and supplies due to loss, breakage from willful damage, neglect or wrongful use, or due to personal preference; and devices, equipment and supplies not requiring a prescription under state law or regulations.

Under the MHCN option, devices, equipment and supplies must be prescribed by a MHCN provider for conditions covered by the Plan and obtained at a MHCN pharmacy.

Under the community provider option, devices, equipment and supplies must be obtained at a contracted network pharmacy, except when a contracted network pharmacy is not available within a 30 mile radius.

The participant will be charged for replacing lost or stolen devices, equipment and supplies.

Diabetic Supplies

Insulin, needles, syringes and lancets are covered as described in the Prescription Drugs section beginning on page 68.

External insulin pumps, blood glucose monitors, testing reagents and supplies – see Devices, Equipment and Supplies above.

Diagnostic Laboratory and Radiology Services

X-ray, ultrasound and laboratory service if medically necessary for diagnostic purposes are covered.

Emergency/Urgent Care Services

For emergency services (as defined on page 131) the Plan provides the following:

MHCN: Covered subject to a $100 copayment per participant per emergency visit at a MHCN facility, then covered at 80% after the annual deductible is satisfied. Copayment is waived if the participant is admitted as an inpatient to the hospital directly from the emergency department. Emergency admissions are covered at 80% after the annual deductible is satisfied.

Community Provider: Covered subject to a $100 copayment or total charge of services, whichever is less, at a non-MHCN facility, then covered at 60% after the annual deductible is satisfied. Emergency

admissions are covered at 60% after the annual deductible is satisfied. Emergency care copayment is waived if the participant is admitted as an inpatient to a non-MHCN hospital directly from the emergency department. The participant must notify Kaiser Permanente within 24 hours following admission and agree to have care managed by the MHCN in order to have inpatient services covered at the MHCN benefit level. If the participant does not notify Kaiser Permanente within 24 hours following admission, or declines to have care managed by the MHCN, all inpatient services the participant receives are covered at 60% after the annual deductible is satisfied.

Waiver for Multiple Injury Accident: If two or more participants in the same family require emergency care as a result of the same accident, coverage for all participants will be subject to only one emergency care copayment.

For urgent care services (as defined on page 136) the Plan provides the following:

MHCN: Care for urgent conditions is covered only at MHCN medical centers, MHCN urgent care clinics or MHCN providers' offices, subject to the applicable copayment, coinsurance and/or annual deductible. Urgent care received at any hospital emergency department is covered only if authorized in advance by a MHCN provider.

Community Provider: Charges for urgent conditions received at any medical facility are covered subject to the applicable copayment, coinsurance and/or annual deductible.

Gender Dysphoria Treatment

Treatment of gender dysphoria will be considered a covered expense, provided that the Trust Policy and other relevant terms of the Plan are met. A copy of the Trust Gender Dysphoria Coverage Policy may be obtained by calling the Trust Office or by visiting the Trust's website.

Preauthorization of all treatment services is required. Covered services may include supportive mental health counseling and treatment of any additional co-morbid mental health conditions, appropriate hormonal treatment interventions, orchiectomy, oophorectomy and hysterectomy, as well as genital reconstructive surgery, medically necessary medications and certain surgical procedures where those interventions and treatments comply with the Plan provisions. For services to be considered a covered expense, patients must coordinate care through Kaiser Permanente. Your physician can begin the process by calling the Kaiser Permanente Care Management Department at (866) 656-4183.

Covered services will not include any service considered to be cosmetic or not medically necessary as determined by the Plan.

Hearing Examinations and Hearing Aids

The Plan covers the following:

- *Hearing examinations to determine hearing loss*
- *Hearing aids, including hearing aid examinations and fittings when authorized by a physician up to a maximum of $400 per ear and limited to one aid per ear during a period of three consecutive years.*

The Plan does not cover:

- *Replacement costs of hearing aids due to loss, breakage or theft, unless at the time of such replacement the participant is eligible because it has been three consecutive years since the aid was received.*
- *Replacement parts, replacement batteries and maintenance costs.*

Home Health Care Services

Home health care services require preauthorization and are covered when the following criteria are met:

- *The participant is unable to leave home due to their health problem or illness. Unwillingness to travel and/or arrange for transportation does not constitute inability to leave the home.*
- *The participant requires intermittent skilled home health care services, as described below.*
- *Kaiser Permanente determines that such services are medically necessary and are most appropriately rendered in the participant's home.*

MHCN: Covered in full when provided by MHCN's home health services or when referred in advance by a MHCN personal physician to a MHCN-authorized home health agency.

Community Provider: Covered in full when prescribed by a provider and provided by a State-licensed home health agency.

Covered services for home health care may include the following when rendered pursuant to a Kaiser Permanente approved home health care plan of treatment: nursing care, restorative physical, occupational, respiratory, and speech therapy, durable medical equipment, medical social worker and limited home health aide services.

Home health services are covered on an intermittent basis in the participant's home. "Intermittent" means care that is to be rendered because of a medically predictable recurring need for skilled home health care services. "Skilled home health care" means reasonable and necessary care for the treatment of an illness or injury which requires the skill of a nurse or therapist, based on the complexity of the service and the condition of the patient and which is performed directly by an appropriately licensed professional provider.

Excluded: private duty nursing; housekeeping or meal services; any care provided by or for a family member; and any other services rendered in the home which do not meet the definition of skilled home health care above.

Hospice Care Services

Hospice care services require preauthorization and must be provided by a licensed hospice care program.

A hospice care program is a coordinated program of home and inpatient care, available 24 hours a day. This program uses an interdisciplinary team of personnel to provide comfort and supportive services to a participant, and any family members who are caring for the participant, who is experiencing a life-threatening disease with a limited prognosis. These services include acute respite and home care to meet the physical, psychosocial and special needs of the participant and their family during the final stages of illness. In order to qualify for hospice care, the participant's provider must certify that the participant is terminally ill and is eligible for hospice services.

Hospice services include:

- *Home services by an interdisciplinary team of personnel that provide comfort and supportive services.*
- *Inpatient services for short-term care; preauthorization is required.*
- *Respite care to provide continuous care of the participant and allow temporary relief to family members from the duties of caring for the participant, for a maximum of five consecutive days per occurrence.*
- *Other hospice services, when billed by a licensed hospice program, may include the following:*
  - *a. Inpatient and outpatient services and supplies for injury and illness.*
  - *b. Semi-private room and board, except when a private room is determined to be necessary.*
  - *c. Durable medical equipment.*

d. Counseling services for the participant and their primary care giver(s).

e. Bereavement counseling services for the family.

Hospice care, as set forth in this section, shall be covered as follows:

MHCN: Covered in full when provided by MHCN's hospice program or when referred in advance by a MHCN personal physician to a MHCN-approved hospice agency.

Community Provider: Covered in full when provided by a licensed non-MHCN hospice agency and preauthorized in advance by Kaiser Permanente.

Hospital Services

The following hospital services are covered under the MHCN option when provided or referred by the MHCN, or under the community provider option when authorized in advance by Kaiser Permanente:

- *Room and board, including private room when prescribed, and general nursing services.*
- *Hospital services (including use of operating room, anesthesia, oxygen, x-ray, laboratory and radiotherapy services).*
- *Drugs and medications administered during confinement.*
- *Special duty nursing, when prescribed as medically necessary.*

Except as specifically provided below, all inpatient admissions prescribed by a community provider must be authorized by Kaiser Permanente at least 72 hours in advance.

Participants receiving the following nonscheduled services are required to notify Kaiser Permanente by way of the Kaiser Permanente Notification Line within 24 hours following a nonscheduled admission, or as soon thereafter as medically possible: labor and delivery, emergency care services, and inpatient admissions needed for treatment of urgent conditions that cannot reasonably be delayed until preauthorization can be obtained.

Participants may not transfer to a MHCN hospital during a non-Emergency, scheduled admission to a non-MHCN hospital. Coverage for emergency care in a non-MHCN facility and subsequent transfer to a MHCN facility is set forth on page 53.

Also covered is outpatient hospital surgery (including ambulatory surgical centers).

See Emergency/Urgent Care Services on page 52 for emergency room coverage.

Manipulative Therapy

Self-referrals to a MHCN provider for manipulative therapy of the spine and extremities in accordance with Kaiser Permanente clinical criteria are covered up to a maximum of 10 visits per participant per calendar year. When approved by Kaiser Permanente, additional manipulation visits are covered.

Manipulative therapy of the spine or extremities by a community provider are covered up to a maximum of 10 visits per participant per calendar year.

Excluded: supportive care rendered primarily to maintain the level of correction already achieved; care rendered primarily for the convenience of the participant; care rendered on a non-acute, asymptomatic basis; and charges for any other services that do not meet Kaiser Permanente clinical criteria as medically necessary.

Maternity and Pregnancy Services

The Plan covers the following:

- *Delivery and associated hospital care.*
- *Routine prenatal and postpartum care.*
- *Care for complications of pregnancy.*
- *Pregnancy termination (involuntary/voluntary).*
- *Prenatal testing for the detection of congenital and heritable disorders when medically necessary as determined by Kaiser Permanente, and in accordance with Board of Health standards for screening and diagnostic tests during pregnancy.*
- *Home births for low risk pregnancies. Planned home births must be authorized in advance by Kaiser Permanente.*

The participant's physician, in consultation with the participant, will determine the participant's length of inpatient stay following delivery. Treatment for post-partum depression or psychosis is covered only under the mental health care benefit.

Excluded: birthing tubs and genetic testing of non-participants for the detection of congenital and heritable disorders.

Mental Health Care Services

- **Outpatient Services.** Outpatient mental health services place priority on restoring the participant to their level of functioning prior to the onset of acute symptoms or to achieve a clinically appropriate level of stability as determined by Kaiser Permanente. Treatment for clinical conditions may

utilize psychiatric, psychological and/or psychotherapy services to achieve these objectives.

Under the community provider option, outpatient mental health services are limited to the services rendered by a physician; a psychologist; a community mental health agency licensed by the Washington State Department of Social and Health Services; a master's level therapist; or advanced practice psychiatric nurse.

- **Inpatient Services.** Charges for inpatient services, including psychiatric emergencies resulting in inpatient services, shall be covered. The Plan includes coverage for acute treatment and stabilization of psychiatric emergencies provided in a MHCN approved hospital under the MHCN option, or, under the community provider option at a hospital or facility approved specifically for treatment of mental or nervous disorders. Under the community provider option, all inpatient mental health care must be authorized in advance by Kaiser Permanente.

  Services provided under involuntary commitment statutes shall be covered at facilities approved by Kaiser Permanente. Services for any involuntary court-ordered treatment program beyond 72 hours shall be covered only if determined to be medically necessary by Kaiser Permanente.

  Coverage for voluntary/involuntary emergency inpatient psychiatric services is subject to the emergency care benefit set forth on page 52, including the 24 hour notification and transfer provisions.

- **Exclusions and Limitations.** Covered services are limited to those authorized by (a) Kaiser Permanente under the MHCN option, or (b) the attending mental health provider and Kaiser Permanente, under the community provider option, for covered clinical conditions for which the reduction or removal of acute clinical symptoms or stabilization can be expected given the most clinically appropriate level of mental health care intervention.

Excluded: learning, communication and motor skills disorders; mental retardation; academic or career counseling; sexual and identity disorders, except as otherwise provided; personal growth or relationship enhancement; assessment and treatment services that are primarily vocational and academic; court-ordered or forensic treatment, including

reports and summaries, not considered medically necessary; work or school ordered assessment and treatment not considered medically necessary; counseling for overeating; nicotine related disorders; relationship counseling or phase of life problems (V code only diagnoses); and custodial care.

Any other services not specifically listed as covered in this section. All other provisions, exclusions and limitations under the Kaiser Permanente Plan also apply.

Naturopathy

The Plan covers up to a maximum of five visits per medical diagnosis per calendar year. When approved by Kaiser Permanente, additional MHCN provider visits are covered. Herbal supplements and service not within the scope of their license are not covered.

Nutritional Services

The Plan covers the following:

- *Phenylketonuria (PKU) supplements.*
- *Enteral therapy for elemental formulas when medically necessary. Necessary equipment and supplies are covered under Devices, Equipment and Supplies.*
- *Parenteral therapy (total parenteral nutrition) for parenteral formulas. Necessary equipment and supplies are covered under Devices, Equipment and Supplies.*

Excluded: any other dietary formulas, oral nutritional supplements, special diets, prepared foods/meals.

Obesity Related Services

Services not covered unless the employee has been employed for at least 12 months with an employer. Bariatric surgery and related hospitalizations are covered when Kaiser Permanente criteria are met.

If a community provider is utilized, the bariatric surgery must be provided through a Center of Excellence.

Excluded: pre and post surgical nutritional counseling and related weight loss programs; prescribing and monitoring of drugs; structured weight loss and/or exercise programs; and specialized nutritional counseling.

Optical Services for Eye Pathology

The Plan covers the following:

- *Routine eye examinations and refractions to monitor medical conditions as often as medically necessary.*
- *Contact lenses for eye pathology, including following cataract surgery, as follows:*

  MHCN: Covered in full.

  Community Provider: Covered at 60% after the annual deductible is satisfied.

  - *One contact lens per diseased eye, in lieu of intraocular lenses, including exam and fitting, is covered for participants following cataract surgery provided the participant has been continuously covered by Kaiser Permanente since such surgery.*
  - *Replacement of lenses for eye pathology, including following cataract surgery will be covered only once within a 12 month period and only when needed due to a change in the participant's medical condition.*

Routine eye examinations, lenses and frames are covered under the Vision Care benefits as described on page 71.

Organ Transplants

Transplant services, including heart, heart-lung, single lung, double lung, kidney, pancreas, cornea, intestinal/multi-visceral, bone marrow, liver transplants and stem cell support (obtained from allogeneic or autologous peripheral blood or marrow) with associated high dose chemotherapy. Services are limited to the following:

- *Evaluation testing to determine recipient candidacy,*
- *Matching tests,*
- *Inpatient and outpatient medical expenses listed below for transplantation procedures. Covered services must be directly associated with, and occur at the time of, the transplant. The following transplantation expenses are covered:*

  a. Hospital charges,

  b. Procurement center fees,

  c. Professional fees,

  d. Excision fees, and

  e. Donor costs for a covered organ recipient are limited to procurement center fees, travel costs for a surgical team and excision fees.

- *Follow-up services for specialty visits,*
- *Rehospitalization, and*
- *Maintenance medications.*

Under the community provider option, transplant services must be authorized in advance by Kaiser Permanente.

Excluded: donor costs to the extent that they are reimbursable by the organ donor's insurance; treatment of donor complications; living expenses; and transportation expenses.

Physician Visits
The Plan covers the following:

- *Covered medical and surgical services, including consultations, in the hospital or provider's office.*
- *Allergy testing.*

Plastic and Reconstructive Services (Cosmetic Surgery)
Plastic and reconstructive services are covered as set forth below:

- *Correction of a congenital disease or congenital anomaly. A congenital anomaly will be considered to exist if the participant's appearance resulting from such condition is not within the range of normal human variation.*
- *Correction of a medical condition following an injury or resulting from surgery covered while enrolled under the Kaiser Permanente Plan which has produced a major effect on the participant's appearance, when in the opinion of Kaiser Permanente, such services can reasonably be expected to correct the condition.*
- *The Women's Health and Cancer Rights Act of 1998 requires that the Plan provide benefits for mastectomy-related services due to disease or cancer if you have had or are going to have a mastectomy. For individuals receiving mastectomy related benefits, coverage will be provided in a manner determined in consultation with the attending physician and patient for: all stages of reconstruction of the breast on which the mastectomy was performed, reconstruction and surgery to produce a symmetrical appearance, and prostheses and physical complications of all stages of mastectomy, including lymphedema.*

The Plan does not provide benefits for prophylactic mastectomies except as may be required under the Women's Health and Cancer Rights Act.

Podiatric Services

Medically necessary foot care is covered. Routine foot care is not covered, except in the presence of a non-related medical condition affecting the lower limbs.

Preventive Services

Included under this benefit are well adult and well child physicals, immunizations, pap smears, mammograms and prostate/colorectal cancer screening in accordance with the well care schedule established by Kaiser Permanente. The well care schedule is available at Kaiser Permanente clinics, by accessing Kaiser Permanente's website at www.kp.org/wa, or by calling Kaiser Permanente customer service at (888) 941-4636.

MHCN: Covered in full. Services provided during a preventive care visit which are not in accordance with the well care schedule are covered at 80% after the annual deductible is satisfied.

Community Provider: Covered at 60% after the annual deductible is satisfied.

Excluded: eye refractions; physicals for travel, employment, insurance or license.

Rehabilitation Services

The Plan covers the following:

- *Inpatient physical, occupational, speech, pulmonary and cardiac therapy to restore function following illness, injury or surgery, including services for neurodevelopmentally disabled children age 6 and under, are covered for up to 30 days combined per condition per calendar year. Preauthorization is required if a community provider is utilized.*
- *Outpatient physical, occupational, speech, pulmonary and cardiac therapy to restore function following illness, injury or surgery, including services for neurodevelopmentaly disabled children age 6 and under, are covered for up to 45 visits combined per condition per calendar year.*
- *Services are subject to all terms, conditions and limitations of the Kaiser Permanente Plan including the following:*

a. All services must be (1) prescribed and provided by a MHCN-approved rehabilitation team at a MHCN or MHCN-approved rehabilitation facility under the MHCN option, or (2) prescribed and provided by a rehabilitation team under the community provider option, that may include medical, nursing, physical therapy, occupational therapy, massage therapy, cardiac therapy, pulmonary therapy and speech therapy providers.

b. Services are limited to those necessary to restore or improve functional abilities when physical, sensori-perceptual and/or communication impairment exists due to injury, illness or surgery. Such services are provided only when significant, measurable improvement to the participant's condition can be expected within a 60 day period as a consequence of intervention by covered therapy services described in paragraph a., above.

Excluded: specialty rehabilitation programs; long-term rehabilitation programs; physical therapy, occupational therapy, speech therapy, pulmonary therapy and cardiac therapy services when such services are available (whether application is made or not) through programs offered by public school districts; therapy for degenerative or static conditions when the expected outcome is primarily to maintain the participant's level of functioning (except for neurodevelopmentally disabled children age 6 and under where significant deterioration in the child's health would result without the services); recreational, life-enhancing, relaxation or palliative therapy; implementation of home maintenance programs; programs for treatment of learning problems; any services not specifically included as covered in this section; and any services that are excluded in Medical Exclusions and Limitations as listed beginning on page 65.

Skilled Nursing Facility Care

Skilled nursing care in a MHCN skilled nursing facility when full-time skilled nursing care is necessary in the opinion of the attending physician, is covered for up to 60 days per participant per calendar year. Under the community provider option, skilled nursing care must be authorized in advance by Kaiser Permanente.

When prescribed by the participant's physician, such care may include room and board; general nursing care; drugs, biologicals, supplies and equipment ordinarily provided or arranged by a skilled nursing facility; and short-term physical therapy, occupational therapy and restorative speech therapy.

Excluded: personal comfort items such as telephone and television; rest cures; and custodial, domiciliary or convalescent care.

Surgical Services

Medically necessary surgeries resulting from an illness or injury are covered.

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

Sterilization (vasectomy, tubal ligation), circumcision and second surgical opinions are also covered.

Temporomandibular Joint (TMJ) Services

Medical and surgical services and related hospital charges, including orthognathic (jaw) surgery, for the treatment of temporomandibular joint (TMJ) disorders are covered. TMJ appliances are covered as set forth under Orthopedic Appliances, page 52.

Excluded: orthognathic (jaw) surgery in the absence of a TMJ or severe obstructive sleep apnea diagnosis except for congenital anomalies; treatment for cosmetic purposes; dental services, including orthodontic therapy; and any hospitalizations related to these exclusions.

Tobacco Cessation

If you want to quit tobacco, you should enroll in the Quit for Life Program, as described on page 48.

X-ray, Radiation and Chemo Therapy

Medically necessary treatments are covered.

MEDICAL EXCLUSIONS AND LIMITATIONS

In addition to exclusions listed throughout this medical benefits section and the General Plan Exclusions section (page 115), the following are not covered:

1. *Services or supplies not specifically listed as covered.*
2. *Cosmetic services, including treatment for complications resulting from cosmetic surgery.*
3. *Convalescent or custodial care.*
4. *Those parts of an examination and associated reports and immunizations required for employment, immigration, license, travel or insurance purposes that are not deemed medically necessary by Kaiser Permanente for early detection of disease.*
5. *Services and supplies related to sexual reassignment not covered under the Trust Gender Dysphoria Coverage Policy. See page 53 for a summary of the covered benefit and see the Trust website for the Policy.*
6. *Diagnostic testing and medical treatment of sterility, infertility and sexual dysfunction, regardless of origin or cause, unless specifically listed.*
7. *Any services to the extent benefits are "available" to the participant as defined herein under the terms of any vehicle, homeowner's, property or other insurance policy, except for individual or group health insurance, whether the participant asserts a claim or not, pursuant to medical coverage, medical "no fault" coverage, Personal Injury Protection coverage or similar medical coverage contained in said policy. For the purpose of this exclusion, benefits shall be deemed to be "available" to the participant if the participant is a named insured, comes within the policy definition of insured, or otherwise has the right to receive first party benefits under the policy.*
8. *The cost of services and supplies resulting from a participant's loss of or willful damage to appliances, devices, supplies and materials covered by Kaiser Permanente for the treatment of disease, injury or illness.*
9. *Orthoptic therapy (i.e., eye training).*
10. *Specialty treatment programs such as weight reduction, and "behavior modification" programs.*

11. *Services or care needed for injuries or conditions resulting from active or reserve military service, whether such injuries or conditions result from war or otherwise. This exclusion will not apply to conditions or injuries resulting from previous military service unless the condition has been determined by the U.S. Secretary of Veterans Affairs to be a condition or injury incurred during a period of active duty. Further, this exclusion will not be interpreted to interfere with or preclude coordination of benefits under Tri-Care.*
12. *Procedures and services to reverse a therapeutic or nontherapeutic sterilization.*
13. *Dental care, surgery, services and appliances, including: treatment of accidental injury to natural teeth, reconstructive surgery to the jaw in preparation for dental implants, dental implants, periodontal surgery and any other dental service not specifically listed as covered. Kaiser Permanente will determine whether the care or treatment required is within the category of dental care or service.*
14. *Drugs, medicines and injections, except as set forth in the Prescription Drug section beginning on page 68. Any exclusion of drugs, medicines and injections, including those not listed as covered in the Kaiser Permanente drug formulary (approved drug list), will also exclude their administration.*
15. *Experimental or investigational services, except for clinical trials specifically excepted from the Plan's definition of Experimental or Investigational (see definition on page 131), or trials required to be covered by applicable law.*
16. *Hypnotherapy, and all services related to hypnotherapy.*
17. *Genetic testing and related services, unless determined medically necessary by Kaiser Permanente, and in accordance with Board of Health standards for screening and diagnostic tests, or specifically provided in the Kaiser Permanente Plan. Testing for non-participants is also excluded..*
18. *Follow-up visits related to a non-covered service.*
19. *Fetal ultrasound in the absence of medical indications.*
20. *Routine foot care, except in the presence of a non-related medical condition affecting the lower limbs.*
21. *Complications of non-covered services.*
22. *Obesity treatment and treatment for morbid obesity, including any medical services, drugs, supplies or any bariatric surgery (such as gastroplasty, gastric banding or intestinal bypass), regardless of co-morbidities, complications of obesity or any other Medical Condition, except as set forth on page 59.*

23. *Services or supplies for which no charge is made, or for which a charge would not have been made if the participant had no health care coverage or for which the participant is not liable; services provided by a member of the participant's family.*
24. *Autopsy and associated expenses.*
25. *Services provided by government agencies, except as required by federal or state law.*
26. *Services related to temporomandibular joint disorder (TMJ) and/or associated facial pain or to correct congenital conditions, including bite blocks and occlusal equilibration, except as specified as covered on page 64.*
27. *Services covered by the national health plan of any other country.*
28. *Missed appointments, billing fees, late payment fees, interest charges or cancellation fees.*
29. *Take home drugs, dressings and supplies following hospitalization.*
30. *Services rendered as a result of work related injuries, illnesses, or conditions, including injuries, illnesses or conditions incurred as a result of self-employment, when not eligible for workers compensation coverage.*
31. *Internally implanted insulin pumps, artificial hearts, artificial larynx and any other implantable device that has not been approved by Kaiser Permanente.*

PRESCRIPTION DRUGS

Generic and brand name drugs and medicines must be listed as covered in the Kaiser Permanente drug formulary. The Kaiser Permanente drug formulary (approved drug list) is defined as a list of preferred drugs and medicines, supplies and devices developed and maintained by Kaiser Permanente.

COVERED EXPENSES

Generic drugs will be dispensed whenever available. Brand name drugs will be dispensed if there is not a generic equivalent. In the event the participant elects to purchase brand-name drugs instead of the generic equivalent (if available), or if the participant elects to purchase a different brand-name or generic drug than that prescribed by the participant's provider, and it is not determined to be medically necessary, the participant will also be subject to payment of the additional amount above the applicable pharmacy copayment set forth below.

The Plan covers legend medications, contraceptive drugs and devices and their fittings, diabetic supplies, including insulin syringes, lancets, urine-testing reagents, blood-glucose monitoring reagents, and insulin.

Under the MHCN option, all drugs, supplies, medicines and devices must be prescribed by a MHCN provider for conditions covered by the Plan and obtained at a MHCN pharmacy.

Under the community provider option, all drugs, supplies, medicines and devices must be obtained at a contracted network pharmacy, except when a contracted network pharmacy is not available within a 30 mile radius or for drugs dispensed by a provider for emergency care.

Growth hormones are covered if preauthorized in advance by Kaiser Permanente.

Excluded: over-the-counter drugs, medicines, supplies and devices not requiring a prescription under state law or regulations, except as covered under Tier 0; drugs used in the treatment of sexual dysfunction disorders (except as provided under the Trust's Policy); medicines and injections for anticipated illness while traveling; and vitamins, including Legend (prescription) vitamins.

The participant will be charged for replacing lost or stolen drugs, medicines or devices.

COPAYMENTS

The following copayments will apply to outpatient prescription drugs:.

- *Prescription drugs and medicines, for a supply of 30 days or less when listed in the Kaiser Permanente drug formulary*

  ***Tier 0** – Some selected highly cost effective medications when prescribed by a provider are covered in full with no copayment.*

  ***Tier 1** – Generic drugs listed in the Kaiser Permanente drug formulary are covered subject to the lesser of the charge or a $6 copayment.*

  ***Tier 2** – Brand name drugs listed in the Kaiser Permanente drug formulary are covered subject to the lesser of the charge or a $22 copayment.*
- *Over-the-counter drugs and medicines*
  Not covered, except as set forth above in Tier 0.
- *Allergy serum*
  Covered subject to the applicable prescription drug copayment (as set forth above) for each 30-day supply.
- *Injectables*
  Injections that can be self-administered are subject to the applicable prescription drug copayment (as set forth above).
- *Mail order drugs and medicines*
  MHCN: Covered subject to the applicable prescription drug copayment (as set forth above) for each 30 day supply or less.
  Community Provider: Not covered.

Copayments for single or multiple 30 day supplies of a given prescription are payable at the time of delivery.

EXTENDED MEDICAL BENEFITS WHEN DISABLED

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

- *Medical*
- *Prescription drugs*

As used in this section, totally disabled means the person is unable, because of an injury or illness, to perform any normal activities they were performing on or before the date the person's) coverage ends.

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

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

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

VISION CARE

This benefit is available only to employees (and their enrolled dependents) who have worked for an employer for 12 months and met the other eligibility rules described on page 14.

COVERED VISION EXPENSES

The following table summarizes your vision care benefits:

COVERED EXPENSE	MHCN PROVIDERS	COMMUNITY PROVIDERS
Exams (once every 12 months)	**80%**	**60%**
Lenses/Frames/Contacts (once every 12 months)*	**100%, up to $150****	**100%, up to $150****

! ***Including contact lens evaluations and examinations associated with their fitting***

! ****A maximum of $150 is payable for MHCN providers and community providers combined.***

The lenses/frames/contacts benefit may be used toward the following in any combination, over the benefit period, until the benefit maximum is exhausted:

- *Eyeglass frames*
- *Eyeglass lenses (any type) including tinting and coating*
- *Corrective industrial (safety) lenses*
- *Sunglass lenses and frames when prescribed by an eye care provider for eye protection or light sensitivity*
- *Corrective contact lenses in the absence of eye pathology, including associated fitting and evaluation examinations.*
- *Replacement frames, for any reason, including loss or breakage*
- *Replacement contact lenses or eyeglass lenses*

This Plan does not cover evaluations and surgical procedures to correct refractions and complications related to such procedures.

DENTAL BENEFITS

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

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

- ***DDWA Preferred Option (#09136).*** *This option allows you to see any licensed provider. However, if you use a DDWA dentist, reimbursement will be based on their pre-approved filed fees. If you do not use a DDWA dentist, reimbursement will be based on the maximum allowable fee and you may have greater out-of-pocket expenses. Nearly 90% of dentists in Washington are DDWA dentists. Ask your dentist if they are a DDWA dentist. Also, if you use a DDWA preferred dentist, your benefits will be greater than if you use a DDWA non-preferred dentist or a non-DDWA dentist. See page 74 for more details about this option.*
- ***DeltaCare Option (#00405).*** *DeltaCare is a dental HMO plan administered by DDWA. This option requires you to choose from a smaller list of approved dentists and clinics. You choose a DeltaCare primary care dentist who coordinates all of your care, including any referrals to specialists. Dental benefits are paid according to DeltaCare benefit schedules. See page 86 for more details.*
- ***Schedule Plan Option.*** *This option allows you to see any licensed dentist. However, if you use a DDWA dentist, they will not charge more than their pre-approved filed fees. Benefits will be paid according to the schedule of allowances. Dental charges in excess of the schedule will be your responsibility. See page 87 for more details about the Dental Schedule.*

The following definitions apply to these dental benefits:

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

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

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

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

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

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

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

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

DDWA PREFERRED DENTAL OPTION(#09136)

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

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

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

DEDUCTIBLE

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

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

Non-covered charges do not apply to the deductible.

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

REIMBURSEMENT PROVISIONS (COINSURANCE)

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

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

MAXIMUM BENEFITS

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

COVERED DENTAL EXPENSES

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

The amounts payable by DDWA for Class I, II and III covered dental benefits are described above. Also, refer to the General Limitations and Exclusions sections as shown on page 84.

CLASS I

Class 1: Diagnostic

Covered Dental Benefits

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

Limitations

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

Exclusions

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

Class 1: Preventive
Covered Dental Benefits

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

Limitations

- *Prophylaxis cleaning and/or periodontal maintenance procedures will be limited to two in a calendar year*
- *Topical application of fluoride or preventive therapies (but not both) is covered twice in a calendar year through age 18*
- *Fissure sealants are available for children through age 15. If eruption of permanent molars is delayed, sealants will be*

allowed if applied within 12 months of eruption with documentation from the attending dentist. Payment for application of sealants will be for permanent maxillary (upper) or mandibular (lower) molars with incipient or no caries (decay) on an intact occlusal surface. The application of fissure sealants is a covered benefit once in a lifetime per tooth

- *Space maintainers are covered once in a patient's lifetime for the same missing tooth or teeth through age 13*

Exclusions

1. *Consultations or elective second opinions.*
2. *Cleaning of a prosthetic device.*
3. *Oral hygiene and/or dietary instruction or for a plaque control program (a series of instructions on the care of the teeth).*

CLASS II

Class 2: General Anesthesia

Covered Dental Benefits

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

Limitations

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

Class 2: Intravenous Sedation

Covered Dental Benefits

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

Limitations

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

Class 2: Palliative Treatment

Covered Dental Benefits

Palliative treatment for pain.

Limitations

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

Class 2: Restorative

Covered Dental Benefits

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

Limitations

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

Exclusions

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

Class 2: Oral Surgery

Covered Dental Benefits

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

Exclusions

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

Class 2: Periodontics (Treatment of Gum Diseases)

Covered Dental Benefits

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

- *Periodontal scaling/root planing is covered once in a 24 month period from the date of service*
- *Limited occlusal adjustments are covered once in a 12 month period from the date of service*
- *Periodontal surgery (per site) is covered once in a three year period from the date of service*

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

Exclusions

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

Class 2: Endodontics (Treatment to Tooth Pulp)

Covered Dental Benefits

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

Limitations

- *Root canal treatment on the same tooth is covered only once in a two-year period from the date of service*
- *Re-treatment of the same tooth is allowed when performed by a different dental office*

- *Refer to Class III Prosthodontics if the root canals are placed in conjunction with a prosthetic appliance.*

Exclusions

1. *Bleaching of teeth.*

CLASS III

Class 3: Restorative
Covered Dental Benefits

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

Limitations

- *Crowns, veneers, or onlays on the same teeth are covered once in a five-year period from the seat date*
- *An inlay (as a single tooth restoration) will be considered as elective treatment and an amalgam allowance will be made once in a two-year period, with any difference in cost being the responsibility of the eligible person*
- *Crown buildups are a covered benefit when more than 50% of the visible portion of the tooth structure is missing or there is less than 2mm of vertical height remaining for one-half or more of the tooth circumference and there is evidence of decay or other significant breakdown*
- *Crown buildups are covered once in a two-year period from the date of service*

- *Crown buildups or post and cores are not a covered benefit within two years of a restoration on the same tooth from the date of service*
- *A crown used for purposes of re-contouring or repositioning a tooth to provide additional retention for a removable partial denture is not a covered benefit unless the tooth is decayed to the extent that a crown would be required to restore the tooth whether or not a removable partial denture is part of the treatment*
- *Crowns or onlays are not a covered benefit when used to repair micro-fractures of tooth structure when the tooth displays no symptoms or there are existing restorations with defective margins when there is no decay*
- *Crowns and/or onlays placed because of weakened cusps or existing large restorations without overt pathology are not a covered benefit*
- *Crown and bridgework in conjunction with periodontal splinting or other periodontal therapy and periodontal appliances are not a covered benefit*
- *Post and core are covered once in a five-year period from the date of service on the same tooth*
- *Ceramic substrate/porcelain or cast metal crowns and onlays are not covered for children under 12 years of age.*

Exclusions

1. *Copings.*

Class 3: Prosthodontics (Dentures and Bridges)

Covered Dental Benefits

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

Limitations

- *Replacement of an existing prosthetic device is covered only once every five years from the delivery date and only then if it is unserviceable and cannot be made serviceable*
- *Inlays are a covered benefit on the same teeth once in a five-year period from the date of service only when used as an abutment for a fixed bridge*

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

Exclusions

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

ACCIDENTAL INJURY

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

GENERAL LIMITATIONS

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

GENERAL EXCLUSIONS

1. *Care for any dental condition, ailment, or injury for which you or your dependent are entitled to receive benefits in whole or in part under occupational coverage voluntarily obtained by the employer or required by Workers' Compensation of the United States or services rendered in a hospital owned or operated by a State or United States Government Agency or any care for which benefits are available under any State or Federal Act, even though the member and/or their dependent waives their right to such benefits.*
2. *Application of desensitizing agents.*
3. *Experimental services or supplies.*
    - *Experimental services or supplies are those whose use and acceptance as a course of dental treatment for a specific condition is still under investigation/observation. In determining whether services are experimental, DDWA, in conjunction with the American Dental Association, will consider if:*
        a. *The services are in general use in the dental community in the State of Washington;*
        b. *The services are under continued scientific testing and research;*
        c. *The services show a demonstrable benefit for a particular dental condition; and*
        d. *They are proven to be safe and effective.*
    - *Any individual whose claim is denied due to this experimental exclusions clause will be notified of the denial within 20 working days of receipt of a fully documented request.*

4. *Analgesics such as nitrous oxide, conscious sedation, euphoric drugs or injections.*
5. *Prescription drugs.*
6. *In the event you fail to obtain a required examination from a DDWA-appointed consultant dentist for certain treatments, no benefits shall be provided for such treatment.*
7. *Hospitalization charges and any additional fees charged by the dentist for hospital treatment.*
8. *Broken appointments.*
9. *Patient management problems.*
10. *Completing insurance forms.*
11. *Habit-breaking appliances.*
12. *Orthodontic services or supplies.*
13. *TMJ services or supplies.*
14. *This Plan does not provide benefits for services or supplies to the extent that benefits are payable for them under any motor vehicle medical, motor vehicle no-fault, uninsured motorist, under-insured motorist, personal injury protection (PIP), commercial liability, homeowner's policy or other similar type of coverage.*
15. *Claims received after the 12-month filing limit.*
16. *Charges made after coverage ends, except for the completion within 30 days of single procedures commenced while this coverage was in effect.*
17. *Charges that exceed the maximum benefits.*
18. *Conditions caused by or arising from an act of war, armed invasion or aggression.*
19. *Expenses incurred before you became eligible.*
20. *Phone or other consultants when a dentist does not physically see a patient.*
21. *Replacement of prosthodontic device or orthodontic appliance that is lost, stolen or damaged by neglect.*
22. *Separate asepsis or sterilization charges.*
23. *Services primarily for patient or provider convenience.*
24. *All other services not specifically included in this program as covered dental benefits.*
25. *Bleaching of teeth.*
26. *Sleep apnea supplies, such as mandibular advancement devices.*

DELTACARE DENTAL OPTION (#00405)

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

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

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

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

SCHEDULE PLAN OPTION

The Schedule Plan option covers services by any licensed dentist, denturist or dental hygienist (under dentist's supervision). Once you pay the deductible, benefits for basic services are paid according to the Schedule of Dental Allowances on page 89.

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

DEDUCTIBLE

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

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

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

MAXIMUM BENEFITS

Basic Services – The annual maximum benefit for each covered person is $2,500 per calendar year. The lifetime maximum benefit for implants is $3,477.60.

COVERED BASIC SERVICES

Benefits include necessary dental treatment listed in the Schedule of Dental Allowances and received while you or your dependents are covered. After you pay the deductible, the Plan pays the amount charged by your licensed dentist, denturist or dental hygienist (under

dentist's supervision) up to the allowance shown in the schedule for that procedure and annual maximum benefit.

Covered basic dental services include the following:

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

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

Restorative Dentistry: Amalgam, composite resin and plastic fillings, as well as gold restoration and crowns, are covered.

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

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

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

Prosthodontics (Dentures and Bridges): Benefits include full or partial dentures and bridges once per five years. Replacement dentures and bridges are covered only if the existing denture or bridge is unserviceable and the Plan hasn't paid for it within the last five years. The five-year period begins on the date the original denture or bridge was placed.

EXTENSION OF COVERAGE

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

CONFIRMATION OF TREATMENT AND COSTS

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

The confirmation process is highly recommended for the following services:

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

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

If the procedures shown on the dental treatment plan do not begin within 12 months or if the treatment plan changes, you must submit a new dental treatment plan to DDWA.

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

SCHEDULE OF DENTAL ALLOWANCES FOR BASIC SERVICES

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

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

DENTAL SCHEDULE

ADA CODE	PROCEDURE	MAXIMUM BENEFIT ALLOWANCE $
Diagnostic		
	Exams	
0120	Periodic oral exam	**34.00**
0140	Limited, problem-focused oral exam	**46.70**
0150	Comprehensive/initial oral exam	**54.10**
Radiographs (x-rays)		
	Complete mouth	

ADA CODE	PROCEDURE	MAXIMUM BENEFIT ALLOWANCE $
0210	Intraoral (including bitewings)	**82.30**
0330	Panoramic	**71.70**
	Intraoral periapical	
0220	First film	**17.60**
0230	Each additional film	**16.30**
	Bitewings	
0270	Single film	**17.60**
0272	2 films	**27.80**
0274	3 to 4 films	**39.40**
0240	Occlusal single film	**27.00**
0340	Cephalometric (other than TMJ or orthodontia)	**82.20**
0470	Study models/diagnostic casts	**68.30**
Preventive		
	Prophylaxis (cleaning and scaling)	
1110	Age 14 and over (adult)	**69.40**
1120	To age 14 (child)	**44.40**
	Fluoride Application (excluding prophylaxis)	
1206	Topical fluoride varnish	**24.50**
1208	Topical application of fluoride	**26.40**
1351	Sealant, each tooth	**34.10**
Minor Restorations		
	Amalgam Restorations	
2140	Primary, permanent – 1 surface	**79.00**
2150	Primary, permanent – 2 surfaces	**107.70**
2160	Primary, permanent – 3 surfaces	**132.90**

ADA CODE	PROCEDURE	MAXIMUM BENEFIT ALLOWANCE $
2161	Primary, permanent – 4 or more surfaces	**159.20**
Other Minor Restorations		
2330	Composite resin – 1 surface, anterior	**96.10**
2331	Composite resin – 2 surfaces, anterior	**125.70**
2332	Composite resin – 3 surfaces, anterior	**158.10**
2335	Composite resin – 4 or more surfaces, anterior	**184.80**
Major Restorations (predetermination required)		
	Inlays/Onlays	
2510	Inlay-metallic – 1 surface	**356.00**
2520	Inlay-metallic – 2 surfaces	**396.90**
2530	Inlay-metallic – 3 or more surfaces	**425.30**
2542	Onlay-metallic – 2 surfaces	**401.10**
2543	Onlay-metallic – 3 or more surfaces	**438.90**
	Crowns	
2740	Porcelain	**435.80**
2750	Porcelain with metal (gold)	**435.80**
2780	Gold (3/4 cast)	**435.80**
2790	Gold (full cast)	**435.80**
2930	Stainless steel, primary	**107.10**
2931	Stainless steel, permanent	**136.50**
	Other Services	
2920	Recement crown	**62.20**
2940	Sedative filling/temporary crown (fractured tooth)	**65.10**
2950	Core buildup, including any pins	**133.40**

ADA CODE	PROCEDURE	MAXIMUM BENEFIT ALLOWANCE $
2951	Pin retention – each tooth	**27.30**
2952	Cast post/core – in addition to crown	**174.30**
Endodontics		
	Pulp Treatment	
3110	Pulp cap	**52.50**
3220	Vital pulpotomy	**121.80**
	Root Canal Therapy (includes treatment plan, clinical procedures and follow-up care; excludes final restoration)	
3310	1 root (anterior)	**427.40**
3320	2 roots (bicuspid)	**528.70**
3330	3 or more roots (molar)	**747.30**
3410	Apicoectomy (performed as a separate surgical procedure, including curettage) – first root, anterior	**588.10**
3421	Apicoectomy (performed as a separate surgical procedure, including curettage) – first root, bicuspid	**690.90**
3425	Apicoectomy (performed as a separate surgical procedure, including curettage) – first root, molar	**634.20**
3426	Apicoectomy (performed as a separate surgical procedure, including curettage) – each additional root	**246.80**
3430	Retrograde filling, each root	**176.40**
3450	Root amputation, each root	**335.90**
Periodontics		
9310	Periodontal exam	**86.40**
4910	Periodontal maintenance (prophylaxis)	**113.60**
4210	Gingivectomy – each quadrant	**420.00**

ADA CODE	PROCEDURE	MAXIMUM BENEFIT ALLOWANCE $
4211	Gingivectomy – each tooth	**149.10**
4260	Osseous surgery – each quadrant	**908.40**
4277	Free soft tissue grafts – each site	**529.20**
Oral Surgery		
Extractions (includes local anesthesia and routine postoperative care)		
7111	Extraction, coronal remnants: deciduous tooth	**90.80**
7140	Extraction, erupted tooth or exposed root	**90.80**
7210	Erupted tooth (surgically removed)	**178.70**
7240	Impacted tooth – completely bony	**320.30**
7250	Surgical removal of residual tooth roots	**196.40**
Related Oral Surgical Procedures		
7270	Reimplantation of tooth	**315.00**
7286	Biopsy of oral tissue (soft)	**211.10**
7310	Alveoloplasty – each quadrant	**188.00**
7471	Removal of exostosis – maxilla or mandible	**377.00**
7510	Incision and drainage of abscess (intraoral)	**147.00**
7960	Frenulectomy (separate procedure)	**284.10**
Prosthodontics (predetermination required)		
Dentures		
5110, 5120	Complete upper or lower	**661.50**
5211, 5212	Partial upper or lower – resin base (including conventional clasps, rests and teeth)	**404.30**
5213, 5214	Partial upper or lower – cast base (including conventional clasps, rests and teeth)	**682.50**

ADA CODE	PROCEDURE	MAXIMUM BENEFIT ALLOWANCE $
5410, 5411	Denture adjustment, upper or lower	**39.90**
5610	Repair broken denture (no teeth involved)	**87.40**
5640	Replace broken tooth (per tooth)	**83.10**
5650	Add tooth to denture	**102.10**
5710, 5711	Denture rebase, upper or lower	**283.50**
5750, 5751	Reline denture, upper or lower	**286.20**
	Dental Implants	
6010	Each implant	**869.40**
	Maximum – each arch	**1738.80**
	Lifetime maximum	**3477.60**
	Bridgework	
6210	Cast gold pontic	**420.00**
6240	Porcelain – fused to gold pontic	**420.00**
6545	Retainer – cast metal for resin-bonded fixed prosthesis	**262.50**
6750	Porcelain – fused to gold abutment crown	**430.50**
6790	Cast gold abutment crown	**430.50**
6930	Recement bridge	**92.10**
Other Dental Procedures		
9110	Emergency care for pain	**83.50**
9220	General anesthesia*	**320.30**
9243	Intravenous moderate (conscious) sedation/analgesia – each 15 minute increment	**53.75**
9310	Professional consultation	**86.40**

ADA CODE	PROCEDURE	MAXIMUM BENEFIT ALLOWANCE $
	Space Maintainers	
1510	Fixed space maintainer (fixed, unilateral)	**212.10**
1515	Fixed space maintainer (fixed, bilateral)	**305.60**
9940	Night guard	**408.50**
	TMJ/TMD Therapy	
9310	Exam	**86.40**
0330	X-rays	**71.70**
0470	Models	**68.30**
7880	Device/appliance	**408.50**
	Appliance adjustment (maximum of 4)	**39.90**
9951	Occlusal adjustment (limited; maximum of 4)	**84.00**
9952	Occlusal adjustment (complete)	**378.00**

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

EXCLUSIONS

The Dental Schedule option does not cover:

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

4. *Charges made after coverage ends, except:*
    - *Dental procedures requiring multiple visits that were started while coverage was in effect, and completed within 30 days after dental coverage ends.*
5. *Charges that exceed the maximum allowance for the procedure.*
6. *Claims received after the 12-month filing limit.*
7. *Conditions caused by or arising from an act of war, armed invasion or aggression.*
8. *Cosmetic services (unless performed as part of treating a covered functional disorder or an accidental injury).*
9. *Crown buildups are a covered benefit when more than 50% of the visible portion of the tooth structure is missing or there is less than 2mm of vertical height remaining for one-half or more of the tooth circumference and there is evidence of decay or other significant breakdown.*
10. *Crown buildups for the purpose of improving tooth form, filling in undercuts, or reducing bulk in castings are considered basing materials and are not a covered benefit.*
11. *Crowns or onlays are not a covered benefit when used to repair micro-fractures of tooth structure when the tooth displays no symptoms or there are existing restorations with defective margins when there is no decay.*
12. *Crowns and/or onlays placed because of weakened cusps or existing large restorations without overt pathology are not a covered benefit.*
13. *Dental procedures not recommended and approved by a dentist.*
14. *Duplicate dentures or dental services.*
15. *Expenses incurred before the patient becomes eligible, including prosthodontic devices or crowns prepared before the effective date but placed afterward.*
16. *Experimental or investigational services or supplies.*
17. *Home use supplies such as toothpaste, toothbrush, water-pick, fluoride, mouthwash, dental floss, etc.*
18. *Hospital facility charges for treating a dental condition.*
19. *If a patient seeks care from more than one dentist during the course of any treatment, or if more than one dentist renders services for the same dental procedure, the Plan will not be liable for more than the amount that it would have been liable from one dentist; nor will the Plan be liable for duplication of services.*
20. *Implants are covered once in a lifetime, with a maximum of two implants per arch.*
21. *Nitrous oxide.*

22. *Oral exam or prophylaxis (cleaning of teeth) more often than twice per calendar year.*
23. *Oral hygiene or dietary instruction for plaque control or care of the teeth.*
24. *Orthodontia or orthodontic retainer adjustment charges.*
25. *Payment for full-mouth x-rays or fluoride treatments more than once per calendar year.*
26. *Phone or other consultations when a dentist does not physically see a patient.*
27. *Precision attachments.*
28. *Prescription drugs (see page 68 for prescription drug coverage).*
29. *Replacement of a prosthodontic device or orthodontic appliance that is lost, stolen or damaged by neglect.*
30. *Replacement of dentures (full or partial) or bridges more often than once per five years.*
31. *Separate asepsis or sterilization charges.*
32. *Services for which no charge is made or services that would not have been received in the absence of these benefits.*
33. *Services or supplies provided by a dentist, denturist or dental hygienist who usually lives in your home or is related by blood or marriage.*
34. *Services or supplies the patient has not actually received (e.g., a crown that's ordered but not placed).*
35. *Services primarily for patient or provider convenience.*
36. *Temporary services.*
37. *Treatment (other than scheduled benefits) of jaw joint problems including temporomandibular joint (TMJ) dysfunction, disorder or syndrome, or any other craniomandibular disorders or conditions of the joint linking the jawbone and skull or muscles, nerves and other tissues relating to that joint.*
38. *Sleep apnea supplies, such as mandibular advancement devices.*

COORDINATION OF BENEFITS

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

The plan that pays benefits first is considered the primary plan and pays benefits without regard to those payable under other plans. When another plan is primary, the Trust pays an amount that, when added to other plan benefits, does not exceed 100% of allowable expenses under this Plan. This provision applies whether or not a claim is filed under Medicare or another plan. The Trust is authorized to obtain information about benefits and services available from Medicare or other plans to implement this rule.

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

The following rules determine which group plan is primary:

- *A plan that has no coordination of benefit provisions pays before a plan that includes such provisions*
- *A plan that covers a person as an active employee pays before an active employer health plan that covers the person as a dependent*
- *Benefits of the plan covering the person as an active employee or dependent of an active employee is primary before benefits of the plan covering the person as a retired, COBRA, terminated or laid-off employee or dependent of a retired, COBRA, terminated or laid-off employee*
- *If a dependent child is covered under both married parents' plans, the child's primary coverage is through the parent whose birthday comes first in the calendar year, with secondary coverage through the parent whose birthday comes later. If the other plan relies on gender instead of this "birthday rule" to coordinate benefits, the "gender rule" is*

used. However, for a child who is a child under this Plan and the spouse of an active employee under another plan, the plan that covers that person for the longest is primary

- *If a dependent child's parents are not married, and a court decree and/or parenting plan establishes financial responsibility for the child's healthcare coverage, the plan of the parent with responsibility is primary. If the divorce decree is silent, the following guidelines apply:*
  - *The plan of the parent with custody pays benefits first if that parent has not remarried. The plan of the parent without custody pays second*
  - *If the parent with custody has remarried, the plans pay in this order: plan of the parent with custody, plan of the spouse of the parent with custody, plan of the parent without custody and plan of the spouse of the parent without custody*
- *For children whose parents were never married, the same rules apply as for divorced parents*
- *If none of the above rules establishes which group plan would pay first, then the plan that has covered the person longer is considered primary*

The Trust excludes coverage for services or charges that would be provided or covered by a health maintenance organization (HMO) or other prepaid arrangement if such HMO or other prepaid arrangement were the only source of coverage. The reason for this exclusion is that an HMO will not coordinate benefits with the Trust for services provided by a non-HMO provider.

This Plan coordinates with:

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

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

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

MEDICARE

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

Disabled Employees or Disabled Dependents Under 65

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

End Stage Renal Disease (ESRD)

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

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

SUBROGATION (RIGHT OF RECOVERY)

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

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

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

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

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

expenses are covered under the surrogacy agreement between the surrogate mother and ultimate parent(s). The Plan is subrogated to the rights of the surrogate mother for payment of medical expenses against the ultimate parent(s) for the recovery of any amount, the payment of which was the ultimate parent(s) responsibility pursuant to the surrogacy agreement. The surrogate mother is required to notify the Trust within 20 days of entering into such a surrogacy agreement.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

EMPLOYEE LIFE INSURANCE BENEFIT

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

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

BENEFIT

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

An accelerated benefit option is available if you are terminally ill with less than 24 months to live. This option allows 50% of the life benefit to be paid to you. The remaining 50% of the benefit will be paid to your beneficiary at your death.

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

Contact the Trust Office for more information.

DESIGNATION OF BENEFICIARY

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

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

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

EXTENDED LIFE BENEFITS WHEN DISABLED

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

In this section, totally disabled means, because of illness or injury, you cannot do the important duties of your job and cannot do any other job for which you're suited by education, training or experience.

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

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

CONVERSION PRIVILEGE

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

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

DEPENDENT LIFE INSURANCE BENEFIT

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

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

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

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

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

EMPLOYEE ACCIDENTAL DEATH OR DISMEMBERMENT BENEFIT

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

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

BENEFIT

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

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

Paraplegia (total paralysis of both lower limbs)	**$7,500**
Hemiplegia (total paralysis of upper and lower limbs on the same side of the body)	**$7,500**

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

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

ACCIDENTAL DEATH OR DISMEMBERMENT EXCLUSIONS

No accidental death or dismemberment benefits are paid for any loss caused or contributed to by:

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

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

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

EMPLOYEE WEEKLY DISABILITY (TIME LOSS) BENEFIT

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

BENEFIT

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

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

WEEKLY DISABILITY PAYMENT

HOURS EMPLOYED IN ELIGIBILITY DETERMINATION MONTH	MAXIMUM WEEKLY BENEFIT
Less than 80	**$ 0**
80 but less than 120	**$180**
120 but less than 150	**$240**
150 or more	**$300**

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

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

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

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

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

Disability periods are counted in this way:

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

WEEKLY DISABILITY EXCLUSIONS

Weekly disability benefits do not cover:

1. *Any disability that starts prior to the effective date of your coverage for this benefit.*
2. *Both an injury and an illness during any concurrent period.*
3. *Disability due to environmental conditions.*
4. *Disability due to intentionally self-inflicted injuries that do not result from a physical or mental health condition.*
5. *Disability resulting from participation in a riot.*

6. *Injury or illness caused directly or indirectly by war or any act of war, declared or undeclared.*
7. *Injury sustained in the course of employment for wages or profit.*
8. *Period of disability covered in whole or in part under occupational coverage voluntarily obtained by your employer or required by workers' compensation laws.*
9. *Period of disability when you are not following a treatment plan.*
10. *Period of disability when you are not regularly attended to and seen by a physician or certain covered providers.*
11. *Period of time that is not substantiated by objective medical evidence.*
12. *Period of time when you are not considered continually totally disabled.*
13. *Both a work related and non-work related injury concurrently.*
14. *Any disability while incarcerated.*

TAXATION OF BENEFITS

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

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

WEEKLY DISABILITY DEFINITIONS

The following definitions apply to the weekly disability benefits described in this section.

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

Average Weekly Wage means the eligible employee's average weekly gross wages, including commissions, overtime and other pay at premium rates, as reported to the Trust by the employer. Please see the Employee Weekly Disability Benefit section (page 111) for the calculation of the average weekly wage.

Covered Provider means:

- *A physician as defined below*
- *For podiatry (foot care) benefits – podiatrist*
- *For pregnancy benefits – midwife*
- *For mental and nervous as well as alcoholism and/or drug abuse treatment benefits – psychologist*
- *For various benefits:*
  - *Physician's assistant*
  - *Advance Registered Nurse Practitioner (ARNP)*
  - *Dentist*

All covered providers must be licensed in the state which services are performed and the services must be within the scope of the provider's license.

Only these covered providers can certify disability for Employee Weekly Disability (see page 111), Extended Medical Benefits (see page 70) and eligibility Premium Waivers (see page 23).

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

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

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

GENERAL PLAN EXCLUSIONS

With respect to all benefits, unless otherwise specifically provided, this Plan does not cover.

1. *Any expense incurred before your date of coverage. An expense is considered incurred on the date you receive the service or supply for which the charge is made.*
2. *Any expense incurred after the termination of your coverage under this Plan, except as specifically indicated.*
3. *Any illness, disease or injury for which an employer is required to furnish hospital care or other benefits in whole or in part by state or federal Workers' Compensation laws or other legislation, including Employee's Compensation or Liability Laws of the United States, or a program which provides equivalent coverage, even though the employee or dependent waives his or her rights to such benefits.*
4. *Any service or supply for which no charge is made or no payment is required.*
5. *Services performed by a provider not licensed in the state where services are performed and not within the scope of the provider's license.*
6. *Any services or supplies not specifically covered under the Plan.*
7. *Claims received after the 12-month filing limit.*
8. *Conditions or injuries caused by or arising from war or any act of war, declared or undeclared, armed invasion or aggression.*
9. *Court-appointed treatment not covered by the Plan.*
10. *Late fees, finance charges or collection charges imposed by the provider.*
11. *Services or supplies received from a physician or other provider who usually lives in your home or is related by blood or marriage.*
12. *Treatment for injuries sustained while committing or attempting to commit a felony.*

SUBMITTING A CLAIM

HOW TO FILE A CLAIM

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

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

Unless you or your dependent can establish to the Trustees' satisfaction that it wasn't possible to file within this time, your benefit will be denied. Subject to special provisions for urgent care claims (see page 119), claims must be submitted in writing and to the proper address.

The Plan may require more details to process claims. These may involve eligibility, the nature of services or supplies received, coordination of benefits, other insurance, third-party reimbursement or other Plan provisions. Not providing required information to the Plan within 12 months of the original request may result in the denial of your claim for untimely filing.

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

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

KAISER PERMANENTE MEDICAL, PRESCRIPTION DRUG AND VISION BENEFITS

If you receive a bill for services you believe are covered under the Kaiser Permanente Plan, you must, within 90 days of the date of service, or as soon thereafter as reasonably possible, either:

1. *Contact Kaiser Permanente customer service to make a claim, or*
2. *Pay the bill and submit a claim for reimbursement of covered services to:*

   Kaiser Permanente
   P.O. Box 34585
   Seattle, WA 98124-1585

No claim will be accepted unless filed within 12 months from the date the service or supply was received.

DDWA PREFERRED, SCHEDULE AND DELTACARE DENTAL BENEFITS

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

When you choose a non-participating provider, submit an American Dental Association-approved claim form (available on the Trust's website) directly to:

Delta Dental of Washington
P.O. Box 75983
Seattle, WA 98175-0983

LIFE INSURANCE AND ACCIDENTAL DEATH OR DISMEMBERMENT BENEFITS

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

WEEKLY DISABILITY BENEFITS (TIME LOSS)

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

PROCEDURES FOR PROCESSING CLAIMS

For other than life insurance, accidental death or dismemberment and DeltaCare benefits properly filed claims are processed according to these guidelines:

Post-Service Claims

Any properly filed claim for health benefits that is not a pre-service, urgent care or concurrent care claim (as defined on the following pages) is processed as a post-service claim. If more information is needed, you (or your dependent) are notified via an explanation of benefits. A post service claim ordinarily is processed within 30 days of receipt.

Pre-Service Claims

These procedures apply only to processing treatment plans submitted for preauthorization. See each section for the preauthorization rules that apply to that benefit. For example, on page 56, a hospital preadmission authorization must be requested for all nonemergency inpatient hospital admissions prescribed by a community provider.

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

A decision on a pre-service claim ordinarily is made within 15 days. This period may be extended for an additional 15 days if the Trust Office determines that the extension is necessary due to matters beyond the control of the Plan and provides the reason for the extension – including a statement of the circumstances requiring the extension of time and the

date by which the Trust expects to render a decision – within the initial 15 days.

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

Urgent Care Claims

Urgent Care claims are for services where following the normal claims processing timing rules could seriously jeopardize the claimant's health or ability to regain maximum function, or in the opinion of a physician familiar with the claimant's medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim. Urgent care claims may be filed orally, or in writing, by the claimant, physician or covered provider with knowledge of the condition. The Trust will notify the claimant of its benefit determination (whether adverse or not) as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the claim by the Trust, unless the claimant fails to provide sufficient information to determine whether, or to what extent, benefits are covered or payable under the Plan.

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

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

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

Concurrent Care Claims

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

Any request to extend treatment that involves urgent care is decided as soon as possible, taking into account the medical exigencies. The claimant is notified of the determination within 24 hours of when the Plan receives the claim, if it is received at least 24 hours before the previously approved treatment ends.

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

NOTICE OF DENIAL

A benefit denial contains this information:

1. *The reason for the denial.*
2. *The denial code (if any) and its corresponding meaning.*
3. *A statement regarding the availability of the diagnosis and treatment codes upon request.*
4. *Information sufficient to identify the claim, including the date of service, health care provider and claim amount, if applicable.*
5. *Reference to the Plan provision(s) relied on.*
6. *Description of any additional material needed for the claim, with an explanation of why it is necessary.*
7. *Reference to any internal rule, guideline or protocol used in denying the claim, with a statement that a copy is available without charge upon request.*
8. *An explanation of the medical judgment – applying Plan terms to your circumstances – if the denial is based on the service or supply being medically necessary or experimental or investigational, or an equivalent exclusion.*
9. *An explanation of the Plan's appeal procedures and the available external review procedures, including applicable time limits.*
10. *The availability of and contact information for any applicable office of health insurance consumer assistance or ombudsman.*

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

FILING AN APPEAL

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

APPEAL OF BENEFIT DENIAL

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

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

APPEAL PROCEDURES

The procedures below and in the external review section are the exclusive procedures available to you if you are dissatisfied with an eligibility determination, benefit denial or partial benefit award by the Trust or its authorized claim payers. These procedures must be exhausted before you may request an external review or may file suit under Section 502(a) of ERISA.

Information To Be Provided Upon Request And Automatically (if applicable)

You or your authorized representative may, upon request and free of charge, have reasonable access to all documents relevant to the claim for benefits. Relevant documents include information relied upon, submitted, considered, or generated in making the benefit determination. They will also include internal guidelines, procedures or

protocols concerning the denied treatment, without regard to whether such document or advice was relied on in making the benefit determination.

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

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

Review by Appeals Committee

Except for urgent care and pre-service claims, an appeal is presented to the Trust's Appeals Committee at its next scheduled meeting after receiving the appeal. The Appeals Committee is appointed by the Trust's third party administrator and will not include any employee of the third party administrator who was involved in the initial processing of the claim. The Appeals Committee reviews the administrative file, taking into account all comments, documents, records, and other information submitted by the claimant relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination. The review is new and independent of the initial denial.

If the denial is based on a medical or dental judgment, the Appeals Committee consults a medical professional with appropriate training and experience in the applicable field of medicine. This professional will not be the individual who made the initial benefit determination or their subordinate. The Appeals Committee will identify by name any individuals consulted for medical or dental advice.

The claimant will be notified of the Committee's decision as soon as reasonably practical, but not later than five days after the decision is made.

Voluntary Review by Hearing Committee

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

Hearings are held at the next regularly scheduled meeting unless the claimant agrees to a different schedule. The claimant is notified of the Committee's decision as soon as practical, but not later than five days after the decision is made.

Appeal Procedures for Pre-Service and Urgent Care Claims

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

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

- *There is only one level of review, by the Hearing Committee at its next scheduled meeting after the claimant's appeal is received. The claimant is notified of the Committee's decision as soon as practical, but not later than five days after the decision is made.*
- *The claimant or his or her authorized representative may participate, as authorized by the Committee, to the extent the Committee deems necessary. If the claimant wishes to appear in person, the claimant may schedule a formal hearing for a later meeting of the Committee.*

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

- *An initial decision is made within 24 hours after the Plan receives the Urgent Care Claim appeal if the initial claim is complete when submitted. If more information is necessary to process the claim, the claim will be resolved no later than 48 hours after the Trust receives the additional information or the end of the 48 hours the claimant has to provide the additional information, whichever is earlier. In addition:*
  - *An urgent care appeal may be made orally or in writing*
  - *A medical or dental professional with knowledge of the claimant's condition may act as an authorized representative without prior written authorization*
  - *Information can be provided to the claimant or authorized representative by phone, fax or other expedited method, as long as written or electronic verification is furnished not more than 72 hours later*

Contents of Decision

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

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

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

Request for External Review

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

You may request external review for any denied appeals that involve (1) a question of medical judgment, which includes decisions about medical necessity, appropriateness, health care setting, level of care, effectiveness of a covered benefit, a determination that a treatment is experimental or investigational, or (2) a denial due to a rescission of coverage (meaning a retroactive termination of coverage). External review is not available for any other types of denials, including claims

related to eligibility or claims related to life/death benefits or disability benefits, or a legal or contractual interpretation of the Plan's terms.

Requests for external reviews must be sent to:

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

Preliminary Review of External Review Request

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

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

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

Review by Independent Review Organization

The assigned IRO will timely notify you in writing of the request's eligibility and acceptance for external review. This notice will include a statement that you may submit in writing to the assigned IRO within 10

business days following the date of receipt of the notice additional information that the IRO must consider when conducting the external review. The IRO is not required to, but may, accept and consider additional information submitted after 10 business days.

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

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

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

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

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

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

Expedited External Review

You may request an expedited external review if you receive:

- *An adverse benefit determination involving your medical condition for which the time frame for completion of the Trust's expedited internal review process would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function and you have filed a request for an expedited internal appeal; or*

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

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

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

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

Actions Following the Decision of the IRO

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

DEFINITIONS

The following definitions apply to the benefits described in this booklet. **Except where otherwise indicated, whenever the following terms are used in this booklet, they have the following meanings:**

I. The following definitions apply to all of the benefits described in the booklet.

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

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

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

Domestic Partner – see definition of spouse.

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

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

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

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

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

Plan means the plan of benefits described in this booklet.

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

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

II. The following definitions apply to the Kaiser Permanente medical, prescription drug and vision benefits described in this booklet.

Allowance means the maximum amount payable by the Kaiser Permanente Plan for certain covered services under the Kaiser Permanente Plan.

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.

Community Provider means licensed physicians, registered nurses, midwives, acupuncturists, and podiatrists to the extent they provide a service or treat participants within the scope of their licenses. For purposes of the Kaiser Permanente Plan, community providers do not include individuals employed by or under contract with the MHCN.

Contracted Network Pharmacy means a pharmacy that has contracted with Kaiser Permanente to provide covered legend (prescription) drugs and medicines for outpatient use under the Kaiser Permanente Plan.

Copayment means the specific dollar amount a participant is required to pay at the time of service for certain covered services under the Kaiser Permanente Plan.

Covered Services means the services for which a participant is entitled to coverage under the Kaiser Permanente Plan.

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

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

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

Exceptions

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

- *Category 1*
  - *The trial is a Phase III or Phase IV trial approved by the National Institutes of Health, the FDA, the Department of Veteran Affairs or an approved research center*
  - *The trial has been reviewed and approved by a qualified institutional review board*

- *The facility and personnel have sufficient experience or training to provide the treatment or use the supplies*

- *Category 2*
  - *The trial is to treat a condition too rare to qualify for approval under Category 1*
  - *The trial has been reviewed and approved by a qualified institutional review board*
  - *The facility and personnel have sufficient experience or training to provide the treatment or use the supplies*
  - *The available clinical or preclinical data provide a reasonable expectation that the trial treatment will be at least as effective as non-investigational therapy*
  - *There is no therapy that is clearly superior to the trial treatment*

Kaiser Permanente investigates each claim for benefits that might include experimental or investigational treatment in consultation with medical professionals, including its own staff, to determine whether the treatment is excluded as experimental or investigational, or whether it is covered as one of the exceptions stated above and whether it is medically necessary under the Plan.

Fee Schedule means a fee-for-service schedule adopted by the MHCN, setting forth the fees for the MHCN medical and hospital services.

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

Home Health Aide means an individual employed by an approved home health 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*

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

Hospital means an institution that:

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

This definition specifically excludes:

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

Hospital Care means those medically necessary services generally provided by acute general hospitals for admitted patients. Hospital care does not include convalescent or custodial care, which can, in the opinion of the provider, be provided by a nursing home or convalescent care center.

Managed Health Care Network (MHCN) means the participating provider with which Kaiser Permanente has entered into a written participating provider agreement for the provision of covered services. Kaiser Permanente's participating provider is Kaiser Foundation Health Plan of Washington Options, Inc.

Medical Condition means a disease, illness or injury.

Medically Necessary or Medical Necessity means a procedure, service or supply that meets all of 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.

Medicare means the federal health insurance program for the aged and disabled.

MHCN-Designated Self-Referral Specialist means a MHCN specialist specifically identified by Kaiser Permanente to whom participants may self-refer.

MHCN Facility means a facility (hospital, medical center or health care center) owned, operated or otherwise designated by the MHCN.

MHCN Personal Physician means a provider who is employed by or contracted with the MHCN to provide primary care services to participants and is selected by each participant to provide or arrange for the provision of all non-emergency covered services, except for services set forth in the Kaiser Permanente Plan which a participant can access without a referral. Personal physicians must be capable of and licensed to provide the majority of primary health care services required by each participant.

MHCN Provider means the medical staff, clinic associate staff and allied health professionals employed by the MHCN and any other health care professional or provider with whom the MHCN has contracted to provide health care services to participants enrolled under the Kaiser Permanente Plan, including, but not limited to, physicians, podiatrists, nurses, physician assistants, social workers, optometrists, psychologists, physical therapists and other professionals engaged in the delivery of healthcare services who are licensed or certified to practice in accordance with Title 18 Revised Code of Washington.

Out-of-Pocket Expenses means any applicable copayment, coinsurance and/or deductible paid by the participant for covered services, which are applied to the out-of-pocket limit.

Out-of-Pocket Limit means the maximum amount of out-of-pocket expenses incurred and paid, during the calendar year for covered services received by the employee and their dependents within the same calendar year. The out-of-pocket limit amount and expenses that apply are set forth in the Summary of Benefits. Charges in excess of UCR, services in excess of any benefit level and services not covered by the Kaiser Permanente Plan are not applied to the out-of-pocket limit.

Plan Coinsurance means the percentage amount the participant and the Kaiser Permanente Plan are required to pay for covered services received under the Kaiser Permanente Plan.

Preferred Community Provider means a community provider that has agreed to accept from Kaiser Permanente a contracted rate for covered services. Services received from a preferred community provider are subject to a discounted rate, less any applicable copayment, coinsurance and/or annual deductible.

Preferred Community Provider Contracted Rate means the discounted rate that the preferred community provider has agreed to accept from Kaiser Permanente for medical services received by participants.

Referral means a written temporary agreement requested in advance by a MHCN personal physician and approved by Kaiser Permanente that entitles a participant to receive covered services from a specified health care provider at the MHCN benefit level, up to the limits of the referral and subject to all terms and conditions of the referral and the Kaiser Permanente Plan. Participants who have a complex or serious medical or psychiatric condition may receive a standing referral for specialist services. Any referral to a specialist that requires or results in an additional referral to another specialist or provider, must be approved by the participant's personal physician and the MHCN in order to be covered at the MHCN benefit level.

Self-Referred means covered services received by a participant from a community provider, designated women's health care specialist, or MHCN-Designated self-referral specialist that are not referred by a MHCN personal physician.

Service Area means Washington counties of Benton, Columbia, Franklin, Island, King, Kitsap, Kittitas, Lewis, Mason, Pierce, San Juan, Skagit, Snohomish, Spokane, Thurston, Walla Walla, Whatcom, Whitman and Yakima; Idaho counties of Kootenai and Latah; and any other areas designated by Kaiser Permanente.

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.

Urgent Condition means the sudden, unexpected onset of a medical condition requiring medical care or treatment within 24 hours which, if not received:

1. *Could seriously jeopardize the life or health of the participant or the ability of the participant to regain maximum function, or,*
2. *In the opinion of a physician with knowledge of the participant's medical condition, would subject the participant to severe pain that cannot be adequately managed without the care or treatment.*

Usual, Customary and Reasonable (UCR) is a term used to define the level of benefits which are payable by Kaiser Permanente when expenses are incurred from a non-MHCN provider. Expenses are considered Usual, Customary and Reasonable if the charges are consistent with those normally charged to others by the provider or organization for the same services or supplies; and the charges are within the general range of charges made by other providers in the same geographical area for the same services or supplies. Amounts charged by a community provider in excess of UCR rates are the responsibility of the employee and/or participant.

SUMMARY PLAN DESCRIPTION

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

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

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

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

EMPLOYER IDENTIFICATION NUMBER/PLAN NUMBER
The employer identification number assigned by the Internal Revenue Service is EIN 91-6058475. The plan number is 501.

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

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

PLAN DOCUMENTS
This booklet – together with the benefit description of DeltaCare coverage – summarizes major Plan provisions. The Trustees have the complete and exclusive discretionary authority to remedy any contradictions between this booklet and any other documents governing the Plan.

NAME AND ADDRESS OF AGENT FOR SERVICE OF PROCESS

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

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

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

NAMES, TITLES AND ADDRESSES OF TRUSTEES

EMPLOYER TRUSTEES	UNION TRUSTEES
Scott Klitzke Powers, Chairman Allied Employers, Inc. 811 Kirkland Ave Suite 100 Kirkland, WA 98033	**Todd Crosby, Secretary** UFCW Local No. 21 5030 First Ave. S. Suite 200 Seattle, WA 98134
Brent Bohn Albertsons, Inc. 1421 S. Manhattan Ave. Fullerton, CA 92831	**Emilia (Mia) Contreras** UFCW Local No. 21 5030 First Ave. S. Suite 200 Seattle, WA 98134
Frank Jorgensen Safeway, Inc. 1121 124th Ave. NE Bellevue, WA 98005	**James Crowe** UFCW Local No. 21 5030 First Ave. S Suite 200 Seattle, WA 98134
Yvonne Peters Allied Employers, Inc. 811 Kirkland Ave. Suite 100 Kirkland, WA 98033	**Faye Guenther** UFCW Local No. 21 5030 First Ave S. Suite 200 Seattle, WA 98134
Cynthia Thornton Fred Meyer, Inc. 3800 SE 22nd Ave. Portland, OR 97202	**Joe Mizrahi** UFCW Local No. 21 5030 First Ave. S. Suite 200 Seattle, WA 98134
	James To UFCW Local No. 21 5030 First Ave. S. Suite 200 Seattle, WA 98134

DESCRIPTION OF COLLECTIVE BARGAINING AGREEMENTS

This Plan is maintained under multiple collective bargaining agreements between employers and UFCW local unions, and the master health and welfare agreement. You may obtain copies by writing to the Trust Office. The agreements also are available at the Trust Office, and at local union offices. The Trustees may make a reasonable charge to cover the cost of furnishing the agreements. You may want to ask the amount up front.

PARTICIPATION, ELIGIBILITY AND BENEFITS

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

Certain employees not covered by a collective bargaining agreement also are eligible to participate through special agreements between their employers and the Board of Trustees.

Eligibility rules governing which employees and dependents are entitled to benefits begin on page 9. Descriptions of the benefits begin on page 40.

CIRCUMSTANCES THAT MAY RESULT IN INELIGIBILITY OR DENIAL OF BENEFITS

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

The Board of Trustees has the authority to terminate the Trust. The Trust will also terminate at the expiration of all collective bargaining agreements and special agreements requiring contributions to the Trust. If the Trust terminates, any and all monies and assets remaining in the Trust, after payment of expenses, will be used as permitted by the Trust, until the monies and assets are used up, unless some other disposition is required by law.

SOURCES OF CONTRIBUTIONS

This Plan is funded through employer and employee contributions, with the amount determined through collective bargaining between employers and labor organizations, as specified in the collective bargaining agreements and master health and welfare agreement. You can find out whether a particular employer is a participating employer and, if so, the employer's address, by writing to the Trust. The Trust may make a reasonable charge to cover the cost of providing this information. You may want to ask the amount up front.

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

TYPE OF FUNDING

- *Employer contributions, employee premiums and COBRA payments are received and held by the Board of Trustees in the Sound Health & Wellness Trust to pay benefits and administrative expenses.*
- *The Trust PPO medical and weekly disability benefits are self-funded.*
- *The Kaiser Permanente Washington Options, Inc. medical, prescription drug and vision coverage is self-funded and administered by Kaiser Permanente, 320 Westlake Ave. N., Suite 100, Seattle, WA 98109-5233.*
- *The Trust PPO prescription drug benefit is self-funded and administered by OptumRx PBM of Maryland, Inc., 1600 McConnor Parkway, Schaumburg, IL 60173*
- *The Trust PPO vision benefit is self-funded and administered by VSP, 3333 Quality Drive, Rancho Cordova, CA 95670.*
- *The Preferred Dental and Dental Schedule coverages are self-funded and administered by Delta Dental of Washington, P.O. Box 75983, Seattle, WA 98175-0983.*
- *DeltaCare dental coverage is fully insured by Delta Dental of Washington, P.O. Box 75983, Seattle, WA 98175-0983.*
- *Life and accidental death or dismemberment benefits are fully insured by Metropolitan Life Insurance Company, 200 Park Avenue, New York, NY 10166.*

PLAN YEAR

This Plan year is April 1 through March 31.

Right to Receive and Release Necessary Information

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

Facility of Payment

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

Overpayments

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

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

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

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

Disposition of Uncashed Claim Checks

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

YOUR ERISA RIGHTS

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

RECEIVE INFORMATION ABOUT YOUR PLAN AND BENEFITS

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

CONTINUE HEALTH PLAN COVERAGE

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

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

PRUDENT ACTIONS BY PLAN FIDUCIARIES

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

ENFORCE YOUR RIGHTS

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $147 a day until you receive them, unless the materials were not sent because of reasons beyond the Administrator's control. If your claim for benefits is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the Plan's decision or lack of decision concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in federal court.

If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

ASSISTANCE WITH YOUR QUESTIONS

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

NOTICE OF PRIVACY PRACTICES (HIPAA)

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

USE AND DISCLOSURE OF HEALTH INFORMATION

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

- ***To make or obtain payment:*** *The Trust may use or disclose your health information to make payment to or collect payment from third parties, such as other health plans or providers, for the care you receive.*

  For example, the Trust may provide information regarding your coverage or healthcare treatment to other health plans to coordinate payment of benefits.

- ***To facilitate treatment:*** *The Trust may disclose information to facilitate treatment which involves the provision, coordination or management of healthcare or related services.*

  For example, the Plan may disclose the name of your treating dentist to a treating orthodontist so that the orthodontist may ask for your dental x-rays.

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

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

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

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

AUTHORIZATION TO USE OR DISCLOSE HEALTH INFORMATION

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

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

YOUR RIGHTS WITH RESPECT TO YOUR HEALTH INFORMATION

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

- ***Right to request restrictions:*** *You may request restrictions on certain uses and disclosures of your health information. You have the right to request a limit on the Trust's disclosure of your health information to someone involved in the payment of your care. However, the Trust generally is not required to agree to your request. The Trust is required to agree to your request for restrictions in the case of a disclosure for payment purposes where you have paid the health care provider in full, out-of-pocket. If you wish to request restrictions, please make the request in writing to the Trust's Privacy Contact Person listed below.*
- ***Right to receive confidential communications:*** *You have the right to request that the Trust communicate with you in a certain way if you feel the disclosure of your health information could endanger you. For example, you may ask that the Trust only communicate with you at a certain phone*

number or by email. If you wish to receive confidential communications, please make your request in writing to the individual identified as the Trust's Privacy Contact Person below. The Trust will attempt to honor your reasonable requests for confidential communications.

- ***Right to inspect and copy your health information:*** *You have the right to inspect and copy your health information. A request to inspect and copy records containing your health information must be made in writing to the Privacy Contact Person listed below. If you request a copy of your health information, the Trust may charge a reasonable fee for copying, assembling costs and postage, if applicable, associated with your request.*
- ***Right to amend your health information:*** *If you believe that your health information records are inaccurate or incomplete, you may request that the Trust amend the records. That request may be made as long as the information is maintained by the Trust. A request for an amendment of records must be made in writing to the Trust's Privacy Contact Person listed below. The Trust may deny the request if it does not include a reasonable reason to support the amendment. The request also may be denied if your health information records were not created by the Trust, if the health information you are requesting be amended is not part of the Trust's records, if the health information you wish to amend falls within an exception to the health information you are permitted to inspect and copy, or if the Trust determines the records containing your health information are accurate and complete.*
- ***Right to an accounting:*** *You have the right to request a list of disclosures of your health information made by the Trust for any reason other than for treatment, payment or health operations. The request must be made in writing to the Privacy Contact Person listed below. The request should specify the period for which you are requesting the information, but may not start earlier than April 14, 2003, when the Privacy Rule became effective. Accounting requests may not be made for periods going back more than six years. The Trust will provide the first accounting you request during any 12-month period without charge. Subsequent accounting requests may be subject to a reasonable cost-based fee. The Trust will inform you in advance of the fee, if applicable.*

Right to a paper copy of this notice: *You have a right to request and receive a paper copy of this Notice at any time, even if you have received this Notice previously or agreed to receive the Notice electronically. To obtain a paper copy, please contact the Privacy Contact Person listed below. You also may obtain a copy of the current version of the Trust Notice at* ***www.soundhealthwellness.com.***

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

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

PRIVACY CONTACT PERSON/PRIVACY OFFICIAL

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

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

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

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

DUTIES OF THE TRUST

The Trust is required by law to maintain the privacy of your health information as set forth in this Notice and to provide to you this Notice of duties and privacy practices. The Trust is required to abide by the terms of this Notice, which may be amended from time to time. The Trust reserves the right to change the terms of this Notice and to make the new Notice provisions effective for all health information that it maintains. If the Trust changes its policies and procedures, the Trust will revise the Notice and will provide a copy of the revised Notice to you within 60 days of the change.

You have the right to express complaints to the Trust and to the Secretary of the Department of Health and Human Services if you believe that your privacy rights have been violated. Any complaints to the Trust should be made in writing to the Privacy Official identified above. The Trust encourages you to express any concerns you may have regarding the privacy of your health information. You will not be retaliated against in any way for filing a complaint.

www.soundhealthwellness.com

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

Eligibility, Weekly Disability, Life Insurance and Other Questions
(206) 282-4500 or (800) 225-7620

Kaiser Foundation Health Plan of Washington Options, Inc.
Medical, Prescription Drug and Vision Claims
(888) 901-4636

Kaiser Foundation Health Plan of Washington Options, Inc.
Health Profile
(888) 901-4636

Kaiser Foundation Health Plan of Washington Options, Inc.
Consulting Nurse Helpline
(800) 297-6877

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