



November 8, 2013

SUMMARY OF MATERIAL MODIFICATION

TO: ALL SOUND HEALTH & WELLNESS TRUST SOUND PPO PLAN PARTICIPANTS

RE: SOUND PPO PLAN CHANGES INSERT

This insert to your January 2009 Sound Health & Wellness Trust Summary Plan Description (SPD) booklet describes changes that have occurred with your plan. Please read this information carefully and keep it with your plan booklet.

ELIGIBILITY

By way of clarification, the language for coverage of a newly acquired child on page 21 is replaced in its entirety with the following:

- 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 an adopted child is covered as of the date of placement for adoption, if earlier than the date of adoption.

MEDICAL BENEFITS

Effective April 1, 2013, the Lifetime Maximum benefit of \$1,500,000 on page 35 will no longer apply beginning with health care services incurred on or after April 1, 2011 but will be replaced with Annual Maximum benefits as follows:

ANNUAL MAXIMUM BENEFIT

The plan has implemented an Annual Maximum benefit of \$1,500,000 for health care services incurred on or after April 1, 2011 and through March 31, 2012 and April 1, 2012 through March 31, 2013. This limited Annual Maximum will increase to \$2,000,000 effective for health care services incurred on or after April 1, 2013 and through March 31, 2014. Beginning April 1, 2014 there will no longer be an Annual Maximum benefit.

COVERAGE REQUIRING PREAUTHORIZATION

Effective May 1, 2013, the following replaces this section on pages 38 and 39, in its entirety:

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

Preadmission Authorization is required from Aetna for all inpatient medical, surgical, mental health or substance abuse admissions to determine medical necessity. In addition, you should contact the Trust Office to confirm eligibility for coverage and that the requested service is a covered medical expense. If you do not follow Preadmission Authorization procedures for inpatient admissions, you will be responsible for paying the first \$250 in covered charges before the plan begins to pay benefits. This \$250 will not be paid by your HRA and is in addition to any coinsurance amounts you must pay. Admissions and services provided during an inpatient stay that are not preauthorized and that are subsequently considered to be not Medically Necessary will not be considered covered medical expenses.

Inpatient Admissions and Surgical Services

The plan requires that you obtain Preadmission Authorization at least 72 hours in advance whenever your physician recommends a non-emergency elective inpatient hospital stay of 23 hours or more at a hospital, licensed treatment facility, or skilled nursing facility. Please call Aetna at (888) 632-3862, option 3 to have your stay and any procedures preauthorized for benefits. Assuming that the proposed procedure/stay is a covered expense under the plan, you or your Physician will be asked to provide necessary information to establish the Medical Necessity for your proposed elective hospital stay and all associated treatment and services. Preauthorization Requests found to be not Medically Necessary may be subject to referral for an Independent Medical Evaluation (IME) by an appropriately credentialed treating Physician of the Trust's choosing in order to determine Medical Necessity and/or appropriateness. If an IME is performed and the IME Physician concludes that the admission and related services are Medically Necessary then coverage will be provided at the benefit level specified under the plan. Should the IME Physician conclude that the requested services are not Medically Necessary but agrees that an alternative treatment or level of care is appropriate, then coverage for that alternative treatment or level of care will be provided at the benefit level specified in the plan. If the IME Physician concurs with the original preauthorization determination that the services are not Medically Necessary, you will be advised that the services will not be considered covered expenses by the plan. Should you or a covered dependent choose not to undergo an IME, all expenses incurred in conjunction with an elective stay or procedure will not be considered covered medical expenses by the plan.

Surgical Services

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

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- Breast reduction surgery
- Eyelid surgery, such as blepharoplasty
- Organ transplants (see page 55)
- Reconstructive and/or cosmetic surgery
- Removal of breast implants
- Stereotactic radiosurgeries (Gamma knife)
- Surgical interventions for sleep apnea
- Unproven, investigational or experimental services (unless specifically and completely excluded)
- Varicose vein surgery/sclerotherapy
- Weight loss surgery (see page 56)

Other Services

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

- Growth hormones (preauthorization by WellDyneRx/US Specialty Care)
- Home healthcare (see page 42)
- Home infusion
- Hospice care (see page 43)
- Medical equipment and prostheses if the purchase price exceeds \$2,000 or the monthly rental fee exceeds \$500 (see page 47)
- Orthognathic surgery
- PET scans
- Rehabilitation services – inpatient
- Rehabilitation services – outpatient

Dental Treatment

Effective July 1, 2013, the following replaces this section on page 40 in its entirety:

Accidental injuries to natural teeth and treatment of a fractured jaw are covered. Benefits under the medical plan will not be considered until dental plan benefits are exhausted.

Mastectomy

Effective June 1, 2013, the existing language “The plan does not provide benefits for prophylactic mastectomies” on page 46 is deleted and replaced with the following:

“The Plan does not provide benefits for prophylactic mastectomies except as may be required under the Women’s Health and Cancer Rights Act and for covered women who are determined by the Trust to be at an extraordinarily high risk of developing difficult to treat breast cancer, in accordance with the Trust’s current Prophylactic Mastectomy & BRCA Testing Policy (“Policy”). No benefits will be provided for prophylactic mastectomies for indications not specifically provided for under the Policy.

Preauthorization from the Trust is required for any prophylactic mastectomy. You may find the current Policy at www.soundhealthwellness.com under forms and documents or you may contact the Trust Office for a copy.”

The current Prophylactic Mastectomy & BRCA Testing Policy (“Policy”) is:

This Prophylactic Mastectomy & BRCA Testing Policy (the “Policy”) sets forth the circumstances under which the Sound Health & Wellness Trust (“Trust”) will determine that a covered woman is at an extraordinarily high risk of developing difficult to treat breast cancer, for purpose of eligibility for a prophylactic mastectomy. The plan does not provide benefits for prophylactic mastectomies except as may be required under the Women’s Health and Cancer Rights Act and for covered women the Trust determines to be at an extraordinarily high risk. The plan requires a covered woman to receive preauthorization from the Trust for a prophylactic mastectomy.

A covered woman with one or more of the following conditions will be considered by the Trust as having extraordinarily high risk of developing difficult to treat breast cancer, provided the woman submits sufficient information or evidence satisfactory to the Trust to establish the existence of the condition(s):

- Possess the BRCA1 or BRCA2 mutations, as confirmed by appropriate testing
- Have a documented past history of radiation therapy treatments to the chest for Hodgkin’s or other similar diseases between ages of 10 and 30 years
- Have documented evidence of genetic mutations in the TP53 or PTEN genes
- Have 2 or more first degree blood relatives (mother, sister, grandmother, daughter) on the same side of the family with a history of breast cancer or a combination of breast and ovarian cancer, without regard to genetic testing results
- Have a documented family history of one BRCA negative first degree relative with multiple primary or bilateral breast cancers
- Be diagnosed with breast cancer at 45 years of age or younger
- Have multiple primary or bilateral breast cancers

BRCA testing is covered in women who have a personal history of:

- Breast Cancer with an onset on or before the age of 45 or a personal history of breast cancer after the age of 45 with additional risk factors for developing a second primary breast cancer or ovarian cancer
- Ovarian Cancer
- A family history that would markedly increase the risk of developing breast and/or ovarian cancer and has received appropriate pre-test counseling to determine that the test results will influence ongoing screening and or treatment.

With respect to any genetic information, the Trust will request only the minimum amount of information necessary for the purpose of determining eligibility for coverage of a prophylactic mastectomy, in accordance with the Genetic Information Nondiscrimination Act of 2008 (“GINA”).

Genetic Testing

Plan exclusion “Genetic testing except when there are medically documented symptoms or signs presented indicating a possible disease presence and genetic testing is needed to identify the disease in order for the attending physician to prescribe appropriate treatment.” #22 on page 57 is deleted in its entirety and replaced with the following genetic testing benefit:

Genetic testing for the purposes of screening for the presence of occult disease, for the purposes of risk stratification for the development of clinically absent or unapparent disease, for the evaluation of possible prophylactic surgical treatment or any other purpose with the exception of the following:

- Governmentally mandated neonatal testing and testing performed in association with amniocentesis and other covered related or equivalent procedures
- Testing where a definitive diagnosis of breast cancer or other hematologic or oncologic diagnosis has been made to determine the medical appropriateness of therapy subject to all medical necessity, investigational/experimental, and all other relevant provisions of the Plan
- Testing of individuals with a high probability of possessing a BRCA mutation (as defined in the Trust’s current Prophylactic Mastectomy and BRCA Testing Policy) and who have undergone appropriate pre-testing evaluation and counseling, and where it has been determined that the results of testing will definitively determine future treatment or modify ongoing surveillance and treatment of the participant.

Substance Abuse Treatment

Effective April 1, 2011, the following replaces this section on page 53 in its entirety:

Substance Abuse Treatment

Treatment for Substance Abuse is a covered benefit. Covered expenses include treatment of alcoholism and/or drug abuse, at an approved treatment facility hospital or a Covered Provider’s office. Treatment is limited to short-term intensive inpatient care and/or outpatient counseling in a nonresidential setting, according to a Physician’s treatment plan.

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

Coverage for Substance Abuse Treatment will consist of:

- Up to 3 inpatient days for supervised inpatient detoxification (Detox) per Acute Occurrence. Acute Occurrence is defined as Treatment required for a medically supervised detoxification program where inpatient hospitalization is deemed to be Medically Appropriate and sufficient clinical documentation is present to substantiate the chronic ingestion via any route of any substance taken for recreational purposes or where clinical documentation of dependency has been established. An Acute Occurrence (Substance) will not be considered to have ended unless and until the patient has maintained sobriety without exception (relapse free) and is free of all supportive treatment (excepting Alcoholics Anonymous and similar peer programs) for a period of not less than 366 days.

- In addition to the “Detox Benefit”, coverage for treatment of an Acute Occurrence of substance abuse will consist of up to 12 days of inpatient therapy or its’ outpatient equivalent or combination thereof. Outpatient treatment will be calculated as the greater of up to 3 outpatient sessions or 3 hours of outpatient therapy being equivalent to 1 in patient day.
- Eligibility for all inpatient and outpatient therapy will be subject to all additional relevant plan provisions including but not limited to Medical Necessity.

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

To ensure coverage, call Aetna Health at (888) 632-3862, option 3 to preauthorize any inpatient admission. If you do not obtain preauthorization, you will be responsible for paying the first \$250 in covered charges before the plan begins to pay benefits. More information about preauthorization is on page 33. In addition to authorizing the appropriate length of stay before an admission, the care you receive is reviewed to ensure the need for continuation of the inpatient stay. Benefits may be reduced or denied if an inpatient stay is determined to be no longer Medically Necessary.

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

- Detox (unless followed immediately by inpatient or outpatient covered treatment)
- Information or referral services
- Residential care in recovery houses

Nutritional Counseling

Effective October 1, 2011 the following new benefit is added:

Nutritional Counseling

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

PRESCRIPTION DRUG BENEFITS

Effective April 1, 2011, exclusion #16 on page 64 is revised to read as follows:

16. Prescription drugs utilized for the treatment of substance abuse will be included under the Trust’s Prescription Drug benefit with a Tier 3 co-payment if they are pre-certified and prescribed by a Trust credentialed provider as part of an eligible comprehensive treatment program.

Prior authorization criteria are compound specific and require that the medications are being prescribed for an FDA approved usage in amounts not to exceed manufacturer's recommended dosages and in compliance with Trust Medical Necessity and appropriateness requirements. Medications must be prescribed by an appropriately licensed American Board of Addictions Medicine (ABAM) credentialed specialist, or board certified psychiatrist as part of a comprehensive treatment program. In the alternative, the Trust may provide coverage for medications on a case by case basis when prescribed by appropriately licensed Physicians certified through a non-ABAM continuing education program when given as part of a comprehensive treatment program acceptable to the Trust which must include an evaluation and appropriate concurrent care provided by a psychiatrist, psychologist, or masters level therapist experienced in the treatment of substance abuse patients.

SUBROGATION (RIGHT OF RECOVERY)

Effective November 2, 2012, the Subrogation (Right of Recovery) language on pages 102 and 103 is replaced in its entirety with the following:

RIGHT TO REIMBURSEMENT

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

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

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.

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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. The plan shall have a constructive trust, lien and/or an equitable lien by agreement in favor of the plan on any overpaid or advanced benefits received by the participant, dependent, or a representative of the participant or dependent (including an attorney) that is due to the plan, and any such amount shall be deemed to be held in trust by the participant or dependent for the benefit of the plan until paid to the plan. By accepting benefits from the plan, the participant and dependent consent and agree that a constructive trust, lien, and/or equitable lien by agreement in favor of the plan exists with regard to any overpayment or advancement of benefits, and in accordance with that constructive trust, lien, and/or equitable lien by agreement, the participant and dependent agree to cooperate with the plan in reimbursing it for all of its costs and expenses related to the collection of those benefits.
10. 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, sickness, accident or condition.

11. 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.

DEFINITIONS

Effective December 6, 2012, the definition of Spouse on page 129 is revised in its entirety to read:

"Spouse" is defined as the individual who is legally married to the participant, as recognized under the laws of the state or jurisdiction in which the marriage was performed.

Effective March 28, 2013, the definition of Domestic Partner on page 124 is revised in its entirety to read:

"Domestic Partner" means a person of the same sex as an employee participant who is legally registered with the State of Washington as a domestic partner of such employee participant. Beginning June 30, 2014, either the employee participant or such individual's domestic partner must be at least age 62 at the time such domestic partnership is established.