INLANDBOATMEN'S UNION
OF THE PACIFIC
NATIONAL HEALTH BENEFIT TRUST

PPO Plan

Summary Plan Description

January 1, 2024

Important Contacts

Contact:	For Questions About:
BeneSys, Inc. www.ibubenefits.org (503) 224-0048 (800) 547-4457	• Eligibility • Payment of Claims • Identification Cards • General Questions • Medical claims • Dental claims • Vision claims • Time loss benefits • Benefit appeals • Supplemental Accounts
Premera Blue Cross www.premera.com/sharedadmin (800) 810-2583	Preferred Provider network for Providers, Hospitals, and clinics.
Moda Health Plan, Inc. www.modahealth.com (800) 913-4311	Retail prescription drug benefits and claims
Postal Prescription Services www.ppsrx.com (800) 552-6694 **Costco Mail Order Pharmacy** www.costco.com/home-delivery (800) 607-6861	Home delivery of prescription drugs
Ardon Health LLC www.ardonhealth.com (855) 425-4085	Specialty prescription drugs for complex health conditions
Innovative Care Management, Inc. (800) 862-3338	Prior authorization for certain services; pre-admission review for Hospital and facility admissions; and case management
Standard Insurance Company www.standard.com (800) 628-8600	Life insurance benefits for Employees

Introduction

This Benefit Booklet is effective January 1, 2024. The Benefit Booklet and the Trust Agreement are intended to meet the requirements of Section 402(b) of the Employee Retirement Income Security Act for the PPO Plan.

This Benefit Booklet summarizes the following:

- Eligibility to enroll in and remain enrolled in one of the health and welfare plans offered by the Board of Trustees;
- The circumstances that may result in termination of enrollment in the health and welfare plan you elected;
- The benefits provided by the PPO Plan;
- Appeal rights if your claim for eligibility to enroll in a health and welfare plan or your claim for benefits provided by the PPO Plan is denied; and
- Your rights under the Employee Retirement Income Security Act of 1974.

The Board of Trustees offers several health and welfare plans depending on the area where you live. The options are:

Alaska
PPO Plan

Washington
PPO Plan

Oregon
PPO Plan

Northern California
PPO Plan or Kaiser Permanente Health Plan

Southern California
PPO Plan

Hawaii
PPO Plan, Kaiser Permanente Health Plan, or HMSA Hawaii PPO Plan

The health and welfare plan options are described in more detail starting on page 17.

You are initially enrolled into the PPO Plan; however, you may elect a health and welfare plan at the time of initial enrollment if you live in a region that has another plan option. You may change health and welfare plans during the open enrollment period which is normally held in November with a change in health and welfare plans effective January 1. (Consult your Collective Bargaining Agreement if you have an option to disenroll from Trust provided health and welfare coverage.)

The health and welfare plans provided by the Board of Trustees and the benefits provided by the health and welfare plans are not vested. The Board of Trustees reserves the right to amend, change or terminate one or more of the health and welfare plans including the right to change eligibility rules, change or reduce benefits, and require or increase contributions or self-payments to maintain coverage.

The Board of Trustees has the discretionary authority to interpret all provisions of this Benefit Booklet including, but not limited to, eligibility to enroll in a health and welfare plan and the benefits, if any, to be paid by the PPO Plan. No individual Trustee, Union representative, Employer representative, or employee of the Trust Office is authorized to interpret this Benefit Booklet for the Board of Trustees. The Board of Trustees has authorized employees of the Trust Office to respond to written and oral inquiries on an informal basis. However, the written and oral answers are not binding on the Board of Trustees.

The PPO Plan has a website. The website provides online access to eligibility status, paid claims information, enrollment applications, claim forms, a copy of this Benefit Booklet, including updates, and links to the Trust's providers such as the PPO Providers, Kaiser Permanente, and HMSA Hawaii PPO Plan. The website address is www.ibubenefits.org.

Terms and phrases that start with capital letters are defined terms. See the **Definitions** section starting on page 139.

If you would like further information or assistance, please call or write the Trust Office:

Inlandboatmen's Union of the Pacific
National Health Benefit Trust
PMB #116
5331 S. Macadam Avenue, Suite 258
Portland, OR 97239
(503) 224-0048
(800) 547-4457
Email: ibu@benesys.com
Web: www.ibubenefits.org

Receipt of this booklet does not guarantee benefits or provide current enrollment for you and/or your dependents. Please review the terms and conditions for details of eligibility requirements, covered benefits and exclusions.

Table of Contents

Eligibility for Health and Welfare Plan Coverage

For Employees

You are eligible for coverage under one of the health and welfare plans offered by the Board of Trustees if you are or were an Employee of an Employer or the Union and have sufficient credits in your Individual Reserve Account to qualify for a month of health and welfare plan coverage.

For Dependents

To be eligible for coverage as a Dependent under one of the health and welfare plans offered by the Board of Trustees, your family member must be:

- Your lawful spouse. Your spouse is not eligible if you are legally separated.
- Your Domestic Partner.
- Your children until the end of the month they reach age 26 who are:
  - A natural child of you, your spouse or Domestic Partner;
  - A legally adopted child of you, your spouse or Domestic Partner;
  - The child of a deceased Employee or retired Employee;
  - A child placed with you for legal adoption in accordance with state law. "Placed with you for legal adoption" means you have assumed a legal obligation for the primary support of the child in anticipation of adoption. However, if adoption is not finalized, the Trust reserves the right to require repayment of benefits paid for the child; and
  - A child for whom you are required to provide health coverage under a qualified medical child support order.
- Unmarried children who continue to depend on you for support may continue coverage after reaching age 26 if:
  - The child cannot be self-supporting because of a developmental or physical disability;
  - The child became disabled before reaching age 26;
  - The child qualifies as your Dependent for purposes of your federal income tax return;

  - Within 31 days of the child reaching the limiting age, proof of disability is provided to the PPO Plan, Kaiser Permanente, or HMSA Hawaii PPO Plan and the PPO Plan, Kaiser Permanente, or HMSA Hawaii PPO Plan approves the request for coverage to continue; and
  - Upon request, continued proof of disability is provided to the PPO Plan, Kaiser Permanente, or HMSA Hawaii PPO Plan.
- An unmarried child under age 19 whose relationship with you meets the following criteria:
  - You have been named legal guardian of the child by a court of competent jurisdiction;
  - You provide the majority amount of support for the child; and
  - The child resides with you.

For Early Retirees

See **Early Retiree Eligibility – Who may be Covered** on page 62.

When Health and Welfare Plan Coverage Begins

For Employees and Dependents

Employers who have a collective bargaining agreement with the Union or a Joinder Agreement with the Trust and the Union are required to pay a contribution to the Trust on behalf of an Employee covered by the collective bargaining agreement or the Joinder Agreement at the contribution rate set by the collective bargaining agreement or the Joinder Agreement. All contributions will be credited to the Employee's Individual Reserve Account.

When there are sufficient credits in your Individual Reserve Account to pay for the health and welfare plan you have elected, you and your Dependents will have health and welfare plan coverage starting the first day of the next month and for as long as there continues to be sufficient credits in your Individual Reserve Account to continue to pay for the health and welfare plan you have elected. You may contact the Trust Office to determine the amount of credits in your Individual Reserve Account and your eligibility effective date. If the contribution is more than the cost of the health and welfare plan coverage, the excess is allowed to accumulate in your Individual Reserve Account. There is no limit to the credits an Employee may accumulate in their Individual Reserve Account. Health and welfare plan coverage will continue as long as you have sufficient credits in your Individual Reserve Account to pay for the cost of the health and welfare plan coverage you elected.

For New Dependents

A child is eligible for health and welfare plan benefits from birth or the time of placement with you for adoption. A new spouse is eligible for health and welfare plan benefits from the date of marriage. **You must complete an enrollment form to add your new dependent to your health and welfare plan coverage within 120 days of the event or you must wait until the next open enrollment period to add your newly acquired dependent.** See the Special Enrollment Rights section for more information. Contact the Trust Office for enrollment forms.

For Domestic Partners and their Children

A Domestic Partner and their children are eligible for health and welfare plan benefits beginning on the first day of the month following receipt of all enrollment documents, payment of any required federal income taxes for the health and welfare plan coverage, and acceptance of the enrollment forms. See the **Domestic Partner Coverage, Rules, and Procedures** section on page 14 for more information.

Paying for Health and Welfare Plan Coverage

The number of credits your Employer or Union contribute to the Trust for you is determined by the collective bargaining agreement or Joinder Agreement. All contributions are deposited in your Individual Reserve Account. When the credits in your Individual Reserve Account equals or exceeds the cost of the health and welfare plan coverage you have elected, you will have health and welfare plan coverage starting the first day of the next month and for as long as there continues to be sufficient credits in your Individual Reserve Account to pay for the health and welfare plan coverage you have elected.

Examples of How the Individual Reserve Account Works

The rates shown in the charts are **examples only**. The actual cost of health and welfare plan coverage and Employer contributions vary from year to year and from bargaining unit to bargaining unit. Check with the Trust Office for the most up-to-date cost information.

These examples are based on an Employer contribution of $1,894 per month and $3,788 bimonthly, and a monthly cost of health and welfare plan coverage of $1,844 per month.

Examples of Monthly Contributions and Plan Costs					
Month of Work	Month Employer Contributions Are Paid to the Trust	Amount Employer Contributes	Cost of One Month's Premium	Coverage Month	What is Left in Your Individual Reserve Account
January	February	$1,894	$1,844	March	$50
February	March	$1,894	$1,844	April	$100
March	April	$1,894	$1,844	May	$150
April	May	$1,894	$1,844	June	$200

Examples of Bi-Monthly Contributions and Plan Costs					
Months of Work	Month Employer Contributions Are Paid to the Trust	Amount Employer Contributes	Cost of Two Month's Premium	Coverage Months	What is Left in Your Individual Reserve Account
January and February	March	$3,788	$3,688	April May	$100
March and April	May	$3,788	$3,688	June July	$200
May and June	July	$3,788	$3,688	August September	$300

Inactive Individual Reserve Account

Your Individual Reserve Account will be "inactive" if there are credits in it that are not sufficient to pay one month of the health and welfare plan coverage you have selected and there have been no contributions made to your Individual Reserve Account for 24 consecutive months. After 24 months, whatever credits remain will be forfeited from your Individual Reserve Account to the unallocated reserves of the Trust. You may not transfer or liquidate your Individual Reserve Account outside of the Trust.

You may freeze your Individual Reserve Account and avoid forfeiture of credits in your Individual Reserve Account in two instances:

- Extended Coverage for Disabled Employees. See page 8; and

- Rights Under the Uniformed Services Employment and Re-Employment Rights Act. See page 9.

You should notify the Trust Office in writing if you want to freeze your Individual Reserve Account under one of these circumstances.

Flexible Benefits Plan

The Board of Trustees sponsors the Inlandboatmen's Union of the Pacific Flexible Benefits Plan (Flex Plan or Flexible Benefits Plan), which is a plan under Section 125 of the Internal Revenue Code. The Flex Plan gives an Employee the opportunity to use pre-tax dollars to pay the difference between the Trust's charge for health and welfare plan coverage and the Employer's contribution. The Employee may enter into a wage reduction arrangement with their Employer to pay the additional contribution on a pre-tax basis.

Eligibility

Those eligible to participate in the Flex Plan are Employees of an Employer who has adopted the Flex Plan in its collective bargaining agreement with the Union. Each Employee of an Employer who adopts the Flex Plan is eligible to participate if they are eligible for an Employer contribution to Trust and the Employer contribution, as provided in the collective bargaining agreement, is insufficient to pay for the health and welfare plan coverage selected by the Employee.

Enrollment

If your Employer's collective bargaining agreement includes the Flex Plan, you have the following opportunities to submit an election form to your Employer's personnel office:

- Initial Enrollment. For newly hired Employees, enrollment is allowed during the 60-day period after the Employee becomes eligible for an Employer contribution to the Trust.
- Automatic Renewal of Election Form. An election to participate in the Flex Plan will be automatically renewed for the next calendar year unless the Employee opts out of the Flex Plan during the annual open enrollment period. The amount of money deducted from the Employee's salary will be automatically adjusted to reflect the difference between the Employer contribution to the Trust and the cost of the health and welfare plan coverage the Employee has elected. Opt out of the Flex Plan by notifying your Employer's personnel office. It is your responsibility to check with your Employer to be sure the proper updates are reflected on your paycheck.
- Annual Enrollment Period. During the month of December, the Employer shall conduct an open enrollment during which an Employee may make a new election or change an existing election for the next calendar year. If you fail to timely notify your Employer of

a premium increase and your Individual Reserve Account is insufficient to maintain coverage, you would be required to make a partial self-payment to maintain coverage, until your Flex Plan deduction would be credited subsequently.

Changing your Flexible Benefits Plan Election Form Outside the Annual Enrollment Period

As a general rule, any Flex Plan election you made remains in force during the calendar year. However, changes to an election can be made during a calendar year under the following circumstances:

- The Employee's marriage, divorce, legal separation, or annulment;
- The birth, adoption, placement for adoption, or change in dependency or custody of an Employee's child;
- The death of the Employee's spouse or dependent child;
- A change in employment status by the Employee, spouse, or dependent child including commencement or termination of employment, a reduction or increase in hours of employment, changing from part-time status to full-time status or vice-versa;
- A change in legal custody (including the issuance of a qualified medical child support order) that affects a child's eligibility for coverage;
- A dependent child reaching the maximum age for health and welfare plan coverage;
- A special enrollment right (see page 11); and
- A change in Employer which does not allow or require Flex Plan deductions.

The Employee must inform their Employer within 30 days of one of the aforementioned events. Failure to do so will result in the original election remaining in force until the next annual enrollment period.

Information about the Flexible Benefits Plan

The Board of Trustees has the right to modify or terminate the Flex Plan at any time. It is also possible that future changes in state or federal tax laws may require the Flex Plan to be amended. Flex Plan participation may also terminate if the Flex Plan is not included in your collective bargaining agreement.

The Flex Plan is intended to meet certain requirements of federal tax law and the benefits you receive under the Flex Plan are not taxable to you under current law. However, the Board of Trustees cannot guarantee the favorable tax treatment to all Employees. In case of doubt, you should consult your tax advisor. In addition, the Flex Plan is designed to avoid the "use it or

lose it" rule that does not allow carryover of unused contributions to your account from year to year.

If an Employee's eligibility to participate in the Flex Plan is denied, you have the right to appeal as you would any other decision. Refer to the **Claims and Appeals Procedures** on page 70.

Please note, you may not fund your Individual Reserve Account by electing a Flex Plan deduction that exceeds the difference between the cost of monthly coverage and the contracted Employer contribution.

If you would like a complete copy of the Flexible Benefits Plan, contact the Trust Office.

Supplemental Account

If your Individual Reserve Account is not sufficient to pay for a month of health and welfare plan coverage, credits from your Supplemental Account will be used to make up the shortage unless you instruct the Trust Office in writing otherwise.

See page 58 for more information about your Supplemental Account.

Self-Payments

There are two types of self-payments you can make in order to maintain health and welfare plan coverage when there are insufficient credits in your Individual Reserve Account.

1. A partial self-payment is equal to the difference between the credits in your Individual Reserve Account and the required cost of health and welfare plan coverage for one month. There is no limit to the number of partial self-payments you can make. However, you must have had health and welfare plan coverage in the previous month to make a partial self-payment.
2. A full self-payment for the entire cost of health and welfare plan you have selected. This payment is a COBRA payment. For an explanation of the COBRA rules, see COBRA – Continuation Coverage on page 89.

The rules that apply to both types of self-payments are:

- There must be no lapse in health and welfare plan coverage;
- You must make the required partial self-payment by the 20th day of the month for which you are paying the cost of health and welfare plan coverage. For example, if you are making a partial self-payment for April coverage, the partial self-payment must be received by the Trust Office by April 20; and
- If your Individual Reserve Account is not sufficient to pay one month of health and welfare plan coverage, your Supplemental Plan Account is not sufficient to make up the

shortage, and you do not make a self-payment to continue health and welfare plan coverage, you will not be eligible to make future self-payments until your Individual Reserve Account has sufficient money to pay for one month of health and welfare plan coverage. You may not regain eligibility by self-payment after a lapse in coverage.

Benefits Available when Self-Paying

When making a COBRA full self-payment, no time loss or life insurance benefits are available and you are ineligible for disability waivers. Months of COBRA coverage do not count for the purpose of computing disability waivers.

Extended Coverage for Disabled Employees

Eligibility

If an Employee becomes disabled, their Individual Reserve Account may be frozen and health and welfare plan coverage may be continued using disability waivers if you meet the following eligibility requirements:

- You must be wholly and continuously disabled so that you are prevented from performing the functions pertaining to your job, and you must be under the care of a legally qualified physician;
- Your disability must continue for at least 30 days;
- You must have had health and welfare plan coverage from your Individual Reserve Account at the time the disability began. If you have health and welfare plan coverage based on a partial self-payment or COBRA payment at the time the disability began, you are not eligible for disability waivers;
- Health and welfare plan coverage must be continuous from the time the disability began even if a partial or full self-payment is required; and
- You must apply for this benefit within 12 months of the date you become disabled by completing the necessary Disability Waiver Form, available from the Trust Office.

If you qualify for disability waivers, your Individual Reserve Account will be frozen and you will not have to make self-payments, effective the first of the month following the initial 30 days of disability.

If you are eligible for disability waivers, you may also be eligible for time loss benefits. See **Time Loss Benefits** on page 56.

How to Earn Disability Waivers

When you have your first month of health and welfare plan coverage, you earn six months of disability waivers. Each January 1st thereafter, if you have nine months of health and welfare plan coverage during the previous year, you earn one additional month of disability waiver. You can be granted a maximum of 12 months of disability waivers. No month of disability waiver will be earned due to health and welfare plan coverage resulting from a partial or full self-payment.

If you lose health and welfare plan coverage and later regain health and welfare plan coverage, your lifetime maximum will not re-start or increase.

When all your disability waivers are exhausted, any credits left in your Individual Reserve Account and Supplemental Account may be used to continue health and welfare plan coverage. After these credits have been exhausted, you may be eligible for additional coverage under COBRA. See **COBRA – Continuation Coverage** on page 89.

Rights under Personal, Family, or Medical Leave Laws

Your Employer is required to fulfill its legal responsibilities to you under applicable laws relating to personal, family, and medical leave. It is your responsibility, not the Trust's, to determine the extent to which any of those laws might apply to you and the extent to which your Employer is obligated to continue to make contributions on your behalf to the Trust while you are away from work. If you have questions concerning your rights under the personal, family, and medical leave laws, contact your Employer or the Trust Office.

Rights under the Uniformed Services Employment and Re-Employment Rights Act

If an Employee or Dependent joins the Armed Forces of the United States or is called for active duty for more than 30 days, health and welfare plan coverage for the Employee or Dependent will end on the date the Employee or Dependent enters full-time active duty.

The Uniformed Services Employment and Re-Employment Rights Act (USERRA) provides certain rights that include:

- Your Individual Reserve Account will be preserved for a maximum of five years. However, you may use your Individual Reserve Account to provide coverage for your Dependents.
- There is a COBRA-type continuation coverage right for your Dependents to extend health and welfare coverage for a maximum of 24 months from the date military leave began. See COBRA – Continuation Coverage on page 89 or contact the Trust Office for

more information. The right only applies to Dependents covered by a health and welfare plan at the time of military service.

- When an Employee's military leave is expected to last 31 days or less, the Employer may be required to pay the required contribution to the Trust for this limited period of time. You must notify your Employer of the expected military leave and you must return to employment within the timeframe established by USERRA.
- When your military service ends, any eligibility waiting period cannot be applied to you and your Dependents unless the waiting period was established after you left for military service and the new waiting period applies to all Employees.

If you have any questions concerning your rights under USERRA, contact your Employer or the Trust Office.

When Coverage Ends for Employees

Once an Employee has established coverage under one of the health and welfare plans offered by the Trust, coverage will continue on a month-to-month basis. Coverage will automatically end on the last day of the month in which any of the following events occur:

- The last day of the month following the month in which the credits in your Individual Reserve Account are insufficient to pay for your health and welfare plan coverage and you do not make a timely self-payment;
- The date you enter full-time service in the United States Armed Forces; or
- The Board of Trustees terminates the health and welfare plan coverage in which you are enrolled or change the eligibility rules and you no longer meet the eligibility rules.

Employees should refer to the **COBRA – Continuation Coverage** section starting on page 89 to determine if coverage may be continued on a full self-pay basis.

When Coverage Ends for Dependents

Health and welfare plan coverage for Dependents will automatically end when any of the following events occur:

- The date the Employee's coverage terminates;
- The date coverage is lost because a required self-payment is not made within the time limits established by the Board of Trustees;
- The last day of the month in which a divorce or legal separation occurs and they no longer meet the definition of a Dependent;

- The last day of the month in which a dissolution of a Domestic Partnership occurs;
- The last day of the month in which a child ceases to meet the definition of Dependent;
- A Domestic Partner's coverage or a Domestic Partner's child's coverage is allowed to lapse (for example, a timely payment of federal income taxes associated with the Domestic Partner's health and welfare plan coverage is not paid by the due date);
- The date a Dependent enters full-time service in the United States Armed Services; or
- The date a Dependent fails to provide documentation to establish to the satisfaction of the Trust Office, the Board of Trustees, or their designee, that an individual meets the definition of Dependent.

Dependents should refer to the **COBRA – Continuation Coverage** section starting on page 89 to determine if coverage may be continued on a full self-pay basis.

Coverage for Surviving Spouses

Continued health and welfare plan coverage is available for an Employee's spouse if the Employee dies while covered for health and welfare plan coverage as described below.

Immediately upon the Employee's death, your spouse will be allowed to continue health and welfare plan coverage until your Individual Reserve Account has been exhausted, as long as your spouse:

- Is eligible for a benefit from the IBU National Pension Plan or from a reciprocal pension plan acknowledged by the IBU National Pension Plan; and
- Was enrolled for health and welfare plan coverage at the time of your death; and
- Does not remarry.

After your Individual Reserve Account is exhausted, your spouse may be able to continue coverage as outlined in the **COBRA – Continuation Coverage** section starting on page 89. When COBRA coverage ends, your spouse may then be able to continue coverage under one of the retiree medical plans offered by the Trust, if they meet the requirements. See page 61.

Special Enrollment Rights

Employees, Early Retirees and their Dependents may have special enrollment rights if they did not enroll for coverage when first eligible and meet the criteria described below.

Late Enrollees. An individual who did not enroll for health and welfare plan coverage when first eligible and who does not qualify as a special enrollee. A late enrollee may enroll for health and welfare plan coverage during the next open enrollment period.

Special Enrollee. An individual who can enroll for health and welfare plan coverage after initial eligibility ends and before the next open enrollment period because they experienced a loss of other group health coverage, change in family status or eligibility under the **Children's Health Insurance Program** as described on page 13.

Loss of Other Group Health Coverage

If an Employee did not enroll themself or a Dependent for health and welfare plan coverage because other group health coverage was in effect, the Employee may enroll themself or a Dependent for health and welfare plan coverage no later than 120 days after the other group health coverage ends, so long as the following conditions are met:

- The person to be enrolled was covered under another group health plan at the time for health and welfare plan coverage from the Trust was offered; and
- COBRA continuation coverage under another group health plan was exhausted. Failure to pay the premium or early termination of COBRA continuation coverage does not satisfy this requirement; or
- Coverage under another group health plan ended as the result of loss of eligibility for reasons such as legal separation, divorce, death, termination of employment or reduction in the number of hours of employment. Failure to pay the premium does not satisfy this requirement; or
- Employer contributions toward the premium for other group health plan coverage ended.

Health and welfare plan coverage offered by the Trust will become effective on the first day of the month following the Trust Office's receipt of a completed enrollment form. If the Trust Office does not receive a completed enrollment form within 120 days after the date the other group health plan coverage ended, the individual will be considered a late enrollee.

Change in Family Status

If an Employee did not enroll themself or a Dependent for health and welfare plan coverage when first eligible and later has a change in family status, the Employee or Dependent may be eligible to enroll as a special enrollee. If an Early Retiree enrolled for coverage has a change in family status, the Dependent may be eligible to enroll as a special enrollee. Marriage, establishment of a Domestic Partnership, adoption, placement for adoption, or birth of a child are considered changes in family status.

You must request enrollment within 120 days of the marriage or establishment of a Domestic Partnership, adoption, placement for adoption, or birth of a child. If the Trust Office does not

receive the enrollment form within 120 days of the date of the change in family status, the individual will be considered a Late Enrollee. Coverage will be effective as follows:

Change in Family Status	When Coverage Is Effective
Marriage	Date of marriage
Domestic partnership	First day of the month following Trust Office receipt of all documents, payment of the first month's premium (if required), and acceptance of documents
Birth of a child	Date of birth
Adoption or placement of a child for adoption	Date of adoption or placement for adoption

If you have health and welfare plan coverage under a Kaiser Permanente or HMSA Hawaii PPO Plan, it may have a different coverage effective date for a new spouse or Domestic Partner. Contact the Trust Office for more information and enrollment forms.

Children's Health Insurance Program (CHIP)

A federal law known as the Children's Health Insurance Program Reauthorization Act allows an Employee and/or a Dependent who is eligible to enroll for health and welfare plan coverage, but who is not enrolled, a special enrollment opportunity under the following circumstances:

- An Employee's or Dependent's Medicaid or CHIP coverage is terminated as a result of loss of eligibility and the Employee or Dependent requests health and welfare plan coverage within 120 days of the loss of coverage; or
- An Employee or Dependent becomes eligible for a premium assistance subsidy from Medicaid or a state's children's health insurance program to help pay for the cost of health and welfare plan coverage and the Employee or Dependent requests health and welfare plan coverage within 120 days after the date the Employee or Dependent is eligible for premium assistance.

To request health and welfare plan coverage based on either of these circumstances, contact the Trust Office for an enrollment form and information about how to enroll. Coverage will start on the first day of the month the Employee or Dependent qualifies for premium assistance or loses coverage under Medicare or CHIP. If the Trust Office does not receive the enrollment form within 120 days, the individual will be considered a late enrollee.

Domestic Partner Coverage, Rules, and Procedures

The PPO Plan, the Kaiser Permanente Plans, and the HMSA Hawaii PPO Plan allow an Employee to enroll their Domestic Partner and the Domestic Partner's Dependent children subject to the rules set forth below, in other sections of this Benefit Booklet, and in the Kaiser Permanente and HMSA Hawaii PPO Plan booklets.

See the **Definitions** section on page 139 for the definition of "Domestic Partner."

Coverage for a Domestic Partner and a Domestic Partner's Dependent children is not automatic. You must apply for coverage by completing the following forms that are available from the Trust Office:

- Affidavit of Domestic Partnership;
- Enrollment form; and
- Auto-Pay Authorization form (if applicable).

An Employee or Early Retiree may enroll a Domestic Partner and the Domestic Partner's Dependent children for health and welfare plan coverage during the following time periods:

- Within 30 days after the Employee becomes eligible for Employer paid health and welfare plan coverage;
- Within Special Enrollment Rights periods described on page 11; and
- During the open enrollment period established by the Board of Trustees.

Contact the Trust Office for enrollment forms.

If an Employee enrolls a Domestic Partner and a Domestic Partner's Dependent child for health and welfare plan coverage and allows the health and welfare plan coverage for the Domestic Partner and a Domestic Partner's Dependent child to lapse (for example does not pay the federal and, if applicable, state taxes) while health and welfare plan coverage is maintained for the Employee, the Employee will not be allowed to re-enroll their Domestic Partner and Domestic Partner's Dependent child for health and welfare plan coverage until the next open enrollment period unless there is an enrollment right under the **Special Enrollment Rights** section on page 11.

Federal law requires that the value of Employer paid health and welfare plan coverage provided to a Domestic Partner and the Domestic Partner's Dependent children are taxable income to the Employee unless the Employee certifies that the Domestic Partner and/or the Domestic Partner's Dependent children are claimed as "dependents" of the Employee for federal income tax purposes under 26 U.S.C. § 152 of the Internal Revenue Code. An Employee who elects to provide health and welfare plan coverage for a Domestic Partner and the

Domestic Partner's Dependent children as a result of Employer paid health and welfare plan coverage, absent a certification of dependent status satisfactory to the Board of Trustees, will be required to pay the federal and, if applicable, state income taxes associated with the value of Employer paid health and welfare plan coverage for the Domestic Partner and the Domestic Partner's Dependent children by the date established by the Board of Trustees or the coverage for the Domestic Partner and the Domestic Partner's children will terminate. The Board of Trustees determine the value of the health and welfare plan coverage for the Domestic Partner and, if applicable, the Domestic Partner's Dependent children. Contact the Trust Office for the current information. The Employee will receive a W-2 form from the Trust at the end of each year for the value of the Employer paid health and welfare plan coverage provided to the Domestic Partner and, if applicable, the Domestic Partner's Dependent children.

A payment to the Trust to cover the federal taxes must be paid by the 20th day of the month preceding the coverage month. For example, payment of federal taxes must be made by June 20 in order for your Domestic Partner to have July health and welfare plan coverage. If the Employee fails to make a timely payment, health and welfare plan coverage for the Domestic Partner and, if applicable, the Domestic Partner's Dependent children will end and the Employee will not be allowed to re-enroll the Domestic Partner and, if applicable, the Domestic Partner's Dependent children until the next open enrollment period unless there is an enrollment right under the **Special Enrollment Rights** section on page 11. Applicable required payments are based on plan premiums which will be adjusted annually, so that payments due in December will reflect the following year's rate.

If an Employee elects to provide health and welfare plan coverage for a Domestic Partner and, if applicable, the Domestic Partner's Dependent children, and certifies that the Domestic Partner and/or the Domestic Partner's Dependent children are claimed as "dependents" of the Employee for federal income tax purposes under 26 U.S.C. § 152 of the Internal Revenue Code, the Employee will not receive a W-2 form from the Trust for the value of the Employer paid health and welfare plan coverage and will not be subject to the pre-payment of federal taxes detailed in the preceding paragraph. To avoid receipt of a W-2 form and the pre-payment of federal taxes, the Employee must sign a certificate regarding "dependent" status of the Domestic Partner and, if applicable, the Domestic Partner's Dependent children prior to the first month in which health and welfare plan coverage is provided to the Domestic Partner and, if applicable, the Domestic Partner's Dependent children and before January 1 of each subsequent year. Contact the Trust Office for the certification.

If a Domestic Partner has health and welfare plan coverage through the PPO Plan and their own health and welfare coverage, the benefits provided by the PPO Plan will be secondary with respect to payment of the Domestic Partner's health and welfare claims. If the Domestic Partner has health and welfare coverage through the PPO Plan and their own health and welfare coverage and the Domestic Partner has Dependent children that the Employee does not claim as

"dependents" on their federal income tax return, the PPO Plan will be secondary with respect to payment of the Dependent children's health and welfare claims.

The Employee and Domestic Partner have an obligation to notify the Trust Office in writing within 30 days after they are no longer Domestic Partners. The address of the Trust Office is:

Inlandboatmen's Union of the Pacific
National Health Benefit Trust
c/o BeneSys, Inc.
PMB #116
5331 S. Macadam Avenue, Suite 258
Portland, OR 97239

If the Employee or Domestic Partner makes a false statement or representation regarding their status as Domestic Partners in the enrollment form or fails to notify the Trust Office in writing within 30 days after they are no longer Domestic Partners and the Trust suffers any financial loss as a result thereof (for example, continued health and welfare coverage for the Domestic Partner), the Trust or the Board of Trustees may bring a civil action against the Employee and the Domestic Partner to recover any losses incurred by the Trust including reasonable attorney fees and court costs. The Board of Trustees may also offset prospective benefits payable to the Employee, Domestic Partner or their Dependent children in order to recover the Trust's loss. The Board of Trustees may also withdraw credits from the Employee's Individual Reserve Account to recover the Trust's loss.

Health and Welfare Plan Options

An Employee eligible for health and welfare plan coverage through the Trust has the option of enrolling in several health and welfare plans described below. An Employee will have the opportunity to elect a health and welfare plan at the time of initial eligibility and once each year during the open enrollment period usually in November with a change in health and welfare plan coverage effective January 1. If you do not elect a health and welfare plan, you and your Dependents will be enrolled in the PPO Plan. Because the cost of each health and welfare plan is different, check with the Trust Office to determine the monthly cost.

All Employees, regardless of where you reside, are eligible to elect the PPO Plan. The PPO Plan's benefits are described in this Benefit Booklet.

Northern California Employees who reside in the Kaiser Permanente service area have the option to elect Kaiser Permanente coverage. If Kaiser Permanente coverage is elected, you and your Dependents will have medical, prescription drug, and vision benefits provided by Kaiser Permanente. You and your Dependents will have the dental benefits described in this Benefit Booklet. The Employee will have the life insurance benefit described in this Benefit Booklet.

Hawaii Employees who reside in the Kaiser Permanente service area have the option to elect Kaiser Permanente coverage. If Kaiser Permanente coverage is elected, you and your Dependents will have medical, prescription drug, dental, and vision benefits provided by Kaiser Permanente. The Employee will have the life insurance benefit described in this Benefit Booklet.

Hawaii Employees who reside in the HMSA Hawaii PPO Plan service area have the option to elect HMSA Hawaii PPO Plan coverage. If HMSA Hawaii PPO Plan coverage is elected, you and your Dependents will have medical, prescription drug, dental, and vision benefits provided by HMSA Hawaii PPO Plan. The Employee will have the life insurance benefit described in this Benefit Booklet.

If you would like a copy of the Kaiser Permanente benefit booklet or HMSA Hawaii PPO Plan benefit booklet, please contact the Trust Office.

Highlights of the PPO Plan's Medical and Prescription Drug Benefits

The PPO Plan gives you the option to choose your Provider, Hospital, and clinic for all aspects of your medical care. You will encounter less paperwork and normally pay lower out-of-pocket costs if your medical services are provided by a PPO Provider.

PPO Providers. When you seek medical care from a Provider, Hospital, or clinic that is a PPO Provider and the medical care is a Covered Charge that is Medically Necessary (except preventive care services) and not subject to any exclusions or limitations, you will normally have lower out-of-pocket costs because Providers, Hospitals, and clinics that are PPO Providers have agreed to provide services at negotiated rates and the Covered Charges are normally payable at 80% of the negotiated rate after the Deductible has been met.

Non-PPO Providers. When you seek medical care from a Provider, Hospital, or clinic that is a Non-PPO Provider and the medical care is a Covered Charge that is Medically Necessary (except preventive care services) and not subject to any exclusions or limitations, the PPO Plan will normally pay 60% of the Maximum Allowable Charge after the Deductible has been met. You will normally have a larger out-of-pocket cost when you receive medical care from a Non-PPO Provider.

How the PPO Provider Network Works. The Trust has contracted with Premera Blue Cross to provide a network of PPO Providers throughout the United States.

The PPO Network is voluntary. You are free to choose any Provider, Hospital, or clinic you wish regardless of whether the Provider, Hospital, or clinic is or is not a PPO Provider.

Any time you need to see a Provider or are admitted to a Hospital or clinic, consult the PPO Network for a list of Providers, Hospitals, and clinics. You can obtain information about PPO Providers by telephoning BlueCard Access at (800) 810-2583 or using the Premera website. If you use the Premera website, follow these directions:

Step 1: Go to www.premera.com/sharedadmin and click the "Find a Doctor" link.

Step 2: Enter your search criteria, including location and Provider name or specialty.
Enter zip code, search radius, or city and state.
Search for people, places or medical specialists using the search bar or browse by category using the tiles at the bottom of the page.

Step 3: Review the search results to see the PPO Providers that match your criteria. You can also view more information about the PPO Providers and print a map and directions.

Benefit Summary

The following highlights are not a complete description of the PPO Plan's medical and prescription drug benefits, limitations and exclusions. More detail is provided in the pages following this chart.

Benefit Features	If You use a PPO Provider	If You use a Non-PPO Provider
Deductible (per calendar year) Individual	$200	$500
Family	$600	$1,000
Out-of-pocket maximum (per calendar year including Co-Payments and Deductible) Individual	**Medical excluding prescription drugs** $1,700	**Medical excluding prescription drugs** $5,000
Family	$3,600	$10,000
Hospital Services Inpatient or Outpatient	80% of negotiated rate after Deductible	60% of Maximum Allowable Charge after Deductible
Hospital Emergency Medical Services	Generally 80% of negotiated rate after Deductible. See page 30 for specifics.	Generally 80% of Maximum Allowable Charge after Deductible. See page 30 for specifics.
Maternity Care – Prenatal Prenatal Office Visits	Covered as Preventive Care Service (100% of Negotiated Rate, no Deductible or Co-Payment)	60% of Maximum Allowable Charge after Deductible
Radiology Services (ultrasound), Delivery and Postpartum Care	80% of negotiated rate after Deductible	60% of Maximum Allowable Charge after Deductible
Mental Health Inpatient and Partial Hospital Treatment	80% of negotiated rate after Deductible. See page 30 for specifics.	60% of Maximum Allowable Charge after Deductible. See page 30 for specifics.
Hospital Emergency Medical Services	Generally 80% of negotiated rate after Deductible. See page 30 for specifics.	Generally 80% of Maximum Allowable Charge after Deductible. See page 30 for specifics.

Benefit Features	If You use a PPO Provider	If You use a Non-PPO Provider
Outpatient	80% of negotiated rate after Deductible	60% of Maximum Allowable Charge after Deductible
Office visit	$20 Co-Payment per visit	60% of Maximum Allowable Charge after Deductible
Physician Services Allergy Testing/Treatment	100% of negotiated rate or $20 Co-Payment per visit*	60% of Maximum Allowable Charge after Deductible
Office Visit (for Injury or Illness)	$20 Co-Payment per visit	60% of Maximum Allowable Charge after Deductible
Surgery	80% of negotiated rate after Deductible	60% of Maximum Allowable Charge after Deductible
Acupuncture	80% of negotiated rate, no Deductible	60% of Maximum Allowable Charge, no Deductible
	Limited to 12 visits per calendar year**	
Chiropractic	80% of negotiated rate, no Deductible	60% of Maximum Allowable Charge, no Deductible
	Limited to 30 visits per calendar year**	
Naturopathic	80% of the negotiated rate, no Deductible	60% of Maximum Allowable Charge, no Deductible
	Limited to 30 visits per calendar year**	
Cochlear Implants (but not hearing aids)	80% of negotiated rate after Deductible	60% of Maximum Allowable Charge after Deductible
Diabetic Instruction (one outpatient instruction course per lifetime)	80% of negotiated rate, no Deductible	60% of Maximum Allowable Charge, no Deductible

* Allergy testing is paid at 100% of the negotiated rate only if an office visit is not billed by the Provider. If an office visit is part of the bill, the $20 Co-Payment applies.

* * Combined PPO Provider and Non-PPO Provider visit limits. Examples: The acupuncture benefit is limited to 12 visits per calendar year whether you use PPO Providers, Non-PPO Providers or both. Chiropractic benefits are limited to 30 visits per calendar year whether you use PPO Providers, Non-PPO Providers or both. Home health care benefits are limited to 100 visits per calendar year whether you use PPO Providers, Non-PPO Providers or both. Naturopathic benefits are limited to 30 visits per calendar year whether you use PPO Providers, Non-PPO Providers, or both.

Benefit Features	If You use a PPO Provider	If You use a Non-PPO Provider
Diagnostic X-ray and Lab	80% of negotiated rate after Deductible	60% of Maximum Allowable Charge after Deductible
Home Health Care	80% of negotiated rate after Deductible	60% of Maximum Allowable Charge after Deductible
	Limited to 100 visits per calendar year**	
Hospice Care Inpatient	80% of negotiated rate after Deductible	60% of Maximum Allowable Charge after Deductible
Outpatient	80% of negotiated rate after Deductible	60% of Maximum Allowable Charge after Deductible
Organ and Bone Marrow Transplants (Prior Authorization Required – See page 26**)**	80% of negotiated rate after Deductible	60% of Maximum Allowable Charge after Deductible
Outpatient Short-Term Rehabilitation	80% of negotiated rate after Deductible	60% of Maximum Allowable Charge after Deductible
Out of Area Treatment (for those traveling or living outside the PPO service area)	Covered Charges will be paid at preferred benefit level when the PPO Network is not accessible; you may use any eligible licensed Provider.	
Physical Therapy	80% of negotiated rate after Deductible	60% of Maximum Allowable Charge after Deductible
Preventive Care Services	100% of negotiated rate, no Deductible or Co-Payment	60% of Maximum Allowable Charge after Deductible
Skilled Nursing Facility	80% of negotiated rate after Deductible	60% of Maximum Allowable Charge after Deductible
	Limited to 30 days per calendar year***	
Speech Therapy	80% of negotiated rate after Deductible	60% of Maximum Allowable Charge after Deductible

*** *Skilled nursing facility benefits are limited to thirty (30) days per calendar year whether you use PPO Providers, Non-PPO Providers or both.*

Benefit Features	If You use a PPO Provider	If You use a Non-PPO Provider
Temporomandibular Joint Dysfunction (TMJ) and Myofascial Pain Dysfunction Inpatient	80% of negotiated rate after Deductible	60% of Maximum Allowable Charge after Deductible
	\$5,000 lifetime maximum****	
Outpatient	80% of negotiated rate after Deductible	60% of Maximum Allowable Charge after Deductible
	\$1,000 lifetime maximum****	
Weight Loss Surgery, Gastric Bypass, and Lap Band Surgery **(Prior Authorization Required – See page 26)**	80% of negotiated rate after Deductible	60% of Maximum Allowable Charge after Deductible
Substance Use Disorder Inpatient and Partial Hospital Treatment	80% of negotiated rate after Deductible	60% of Maximum Allowable Charge after Deductible
Hospital/Emergency Medical Services	Generally 80% of negotiated rate after Deductible. See page 30 for specifics.	Generally 80% of Maximum Allowable Charge after Deductible. See page 30 for specifics.
Outpatient	80% of negotiated rate after Deductible	60% of Maximum Allowable Charge after Deductible
Office visit	\$20 Co-Payment per visit	60% of Maximum Allowable Charge after Deductible
Alternative Housing Benefit	When special treatment is required away from your home, the PPO Plan pays the lesser of the single occupancy hotel rate or \$60 per day to cover living expenses away from your home. The maximum benefit is 70 days per period of confinement.	

**** *The TMJ and Myofascial Pain Dysfunction benefit is limited to \$5,000 for inpatient and \$1,000 for outpatient regardless of whether you use PPO Providers, Non-PPO Providers or both.*

Benefit Features	
Prescription Drugs	**Generics required unless brand use approved by Provider**
Retail Pharmacy Drug Program and Specialty Drug Program (up to 30-day supply)	• Generic: $10 Co-Payment • Formulary Brand: $20 Co-Payment • Non-Formulary Brand: $40 Co-Payment
Home Delivery Drug Program (up to 90-day supply)	• Generic: $20 Co-Payment • Formulary Brand: $40 Co-Payment • Non-Formulary Brand: $80 Co-Payment
Prescription Drug Out-of-Pocket Maximum (per calendar year including Co-Payments)	• Individual $4,900 • Family $9,600

Telemedicine

Telemedicine benefits are available to participants enrolled in the Premera PPO plan for a $0 Co-payment through Teladoc. Teladoc offers general medicine, dermatology, and behavioral health services. Contact Teladoc at www.teladoc.com/premera or by calling 855-332-4059.

For participants enrolled in the Premera PPO plan, telemedicine services received through your provider are also covered, subject to the same cost sharing as in person office visits.

If you are a participant in a Kaiser Permanente HMO or HMSA Hawaii PPO, please contact them for details on coverage of telemedicine services.

Payment of Medical Claims

Subject to all provisions in this Benefit Booklet including the Prior Authorization requirements, the Limits on Medical Benefits, Medical Exclusions, and Exclusions Applicable to All Benefits except Life Insurance, if a Covered Individual incurs Covered Charges and the service or treatment is Medically Necessary (except in the case of allowable preventive care services), the Trust will pay a percentage of the Covered Charges as described in the chart starting on page 19 after the Deductible, if applicable, is satisfied. Once the out-of-pocket maximum for the calendar year has been met, the Trust will pay 100% of the negotiated rate for a PPO Provider or 100% of the Maximum Allowable Charge for a Non-PPO Provider for the remainder of the calendar year for Essential Health Benefits unless a benefit has lower maximums or other limitations. The Percentage Payable, Deductible, Co-Payment and Out-of-Pocket Maximum are described below.

Percentage Payable. If you use a PPO Provider, the Trust will pay for Covered Charges at a percentage of the negotiated rate (for example, 80%) after a Covered Individual or family have satisfied the Deductible except for those benefits that have lower maximums or other limitations until the Out-of-Pocket Maximum has been met. If you use a Non-PPO Provider, the Trust will pay for Covered Charges at the Maximum Allowable Charge (for example, 60%) after a Covered Individual or family have satisfied the Deductible except for those benefits that have lower maximums or other limitations until the Out-of-Pocket Maximum has been met. If a Covered Individual or family has satisfied the Out-of-Pocket Maximum for a calendar year, the remainder of the Covered Charges will be paid at 100% of the negotiated rate for a PPO Provider or 100% of the Maximum Allowable Charge for a Non-PPO Provider for the remainder of the calendar year for Essential Health Benefits unless a benefit has lower maximums or other limitations.

Deductible. Most medical benefits provided by the PPO Plan are subject to a calendar year Deductible. See the chart starting on page 19. For PPO Providers, the per-person Deductible is $200 of Covered Charges in a calendar year and the family Deductible is $600 of Covered Charges in a calendar year. For Non-PPO Providers, the per-person Deductible is $500 of Covered Charges in a calendar year and the family Deductible is $1,000 of Covered Charges in a calendar year. Once the family Deductible has been met, no other family member must satisfy the Deductible for the remainder of the calendar year.

Any Covered Charges incurred during the last three months of the calendar year and applied to the Deductible will also apply toward the Deductible in the next calendar year.

Co-Payment. Co-Payment means the money a Covered Individual must pay for a Covered Charge during a calendar year in accordance with the percentage payable for the benefit after you have satisfied the Deductible. Co-Payments do not include expenses paid to satisfy the Deductible, non-covered charges, charges above the PPO Plan's allowed limits, charges above the Maximum Allowable Charge, or Co-Payments for prescription drugs, dental benefits, or vision benefits.

Out-of-Pocket Maximum. After the Co-Payments and Deductible paid to PPO Providers by a Covered Individual for medical charges (excluding prescription drug charges) reach $1,700 in a calendar year or after the Co-Payments and Deductibles paid to PPO Providers by a family for medical charges (excluding prescription drug charges) reach $3,600 in a calendar year, the Trust will pay 100% of the negotiated rate for PPO Providers for the remainder of the calendar year except for those medical benefits that have lower maximums or other limitations.

After the Co-Payments and Deductibles paid to Non-PPO Providers by a Covered Individual for medical charges (excluding prescription drug charges) reach $5,000 in a calendar year or after the Co-Payments and Deductibles paid to Non-PPO Providers by a family for medical charges (excluding prescription drug charges) exceed $10,000 in a calendar year, the Trust will

pay 100% of the Maximum Allowable Charge for the remainder of the calendar year except for those medical benefits that have lower maximums or other limitations.

During a calendar year, the maximum amount of money a Covered Individual will have to pay for Co-Payments for prescription drugs covered by the Prescription Drug Program is $4,900 and the maximum amount of money a family will have to pay for Co-Payments for prescription drugs covered by the Prescription Drug Program is $9,600.

Prior Authorization, Preadmission Review Program, and Case Management Services

Prior Authorization

The following benefits offered by the PPO Plan require prior authorization before services are authorized:

- Chemotherapy/radiation therapy
- Dialysis
- Genetic testing
- Infusion therapy
- Organ and bone marrow transplants (see page 36 for more information)
- Skilled nursing facility; and
- Weight loss surgery, gastric bypass, and lap band surgery (see page 37 for more information).

This means that you must receive authorization in writing from Innovative Care Management before you receive the services. If an emergency exists that prevents you from obtaining prior authorization, Innovative Care Management must be notified within 48 hours, following the start of treatment, or as soon as reasonably possible, to continue coverage of the services.

It is your responsibility to make sure that prior authorization is received. You or your Provider can call Innovative Care Management at (800) 862-3338. You or your Provider will be directed to the Prior Authorization Department which will guide you through the process.

If you do not receive prior authorization when required, the charges incurred will not be covered by the PPO Plan.

Preadmission Review Program

Preadmission Review is a program that reviews the necessity and quality of inpatient hospitalization for medical, surgical, Mental or Nervous Conditions and Substance Use Disorders. This program is provided by Innovative Care Management.

Authorization given by Innovative Care Management, for an inpatient stay for hospitalization, Mental or Nervous Conditions and Substance Use Disorders is only for the purpose of reviewing whether the admission is Medically Necessary for the care and treatment of an Illness or Injury. It does not guarantee that all charges are covered by the PPO Plan. All charges

submitted for payment are subject to all terms and conditions of the PPO Plan, regardless if preadmission authorization is received from Innovative Care Management.

You and your Provider have the final decision regarding Hospitalization and medical treatment.

For all inpatient Hospital stays, except childbirth, and including inpatient stays for Mental or Nervous Conditions or Substance Use Disorders, you, a family member, your Provider or Hospital should contact Innovative Care Management prior to admission. The telephone number is (800) 862-3338. The information you will need to provide is:

- Trust Name: IBU National Health Benefit Trust;
- Employee's or Early Retiree's name and identification number;
- Name, date of birth and address of person being admitted;
- Family contact and telephone numbers;
- Admitting Provider's name and telephone number;
- Hospital name, address and telephone number;
- Date of admission; and
- Diagnosis, surgery or procedure to be performed.

Innovative Care Management provides a preadmission evaluation for all inpatient Hospitalization, except childbirth, and including inpatient stays for Mental or Nervous Conditions or Substance Use Disorders.

- **Non-Emergency Hospitalization and Inpatient Stays**: Before admission, you, a family member, your Provider or Hospital should call Innovative Care Management at least 10 days prior to the scheduled Hospitalization or inpatient stay to determine whether the Hospital stay or inpatient stay is Medically Necessary.

- **Urgent Hospitalization and Inpatient Stays**. An urgent Hospital admission or inpatient stay occurs when the condition is not life threatening but requires an admission of less than 10 days' notice. In this situation, you, a family member, your Provider or Hospital should call Innovative Care Management prior to the scheduled Hospitalization or inpatient stay to determine whether the Hospital stay or inpatient stay is Medically Necessary. If you, a family member, your Provider or Hospital do not have time to call Innovative Care Management, Inc. before admission, call Innovative Care Management within 48 hours of the admission.

- **Emergency Hospitalization and Inpatient Stays.** An emergency Hospital admission or inpatient stay occurs as the result of an unforeseen condition requiring immediate medical attention and does not require preadmission certification. However, Innovative Care Management should be called by you, a family member, your Provider or Hospital within 48 hours of the admission.

Concurrent Review

After admission to a Hospital or inpatient stay, Innovative Care Management will continue to evaluate your progress through concurrent review that monitors the length of stay. If Innovative Care Management disagrees with the length of stay recommended by your Provider, or determines the continued confinement is no longer Medically Necessary, your Provider will be consulted. You and your Provider have the final decision regarding Hospital or inpatient confinement and medical treatment. However, it may not be covered by the plan.

Hospital Discharge Planning

During your Hospital or inpatient stay, Innovative Care Management will monitor your progress. Timely discharge planning will help you return home at the earliest date.

Case Management Services

The PPO Plan offers case management service through Innovative Care Management ("ICM"). Case Management is a program designed to help you and your family cope with serious medical conditions. An ICM nurse works closely with you, your family, and your Providers to ensure that you have the information and support you need. Whether you need specialized equipment, referrals, or simply a sympathetic ear, the ICM nurse assigned to you can help you get what you need when you need it. This support can help you feel more in control and confident when dealing with the increasingly complicated healthcare system.

You may be contacted by an ICM case manager regarding your condition and treatment.

Case management services are voluntary. If you call for preadmission review or you have a number of claims that indicate you will need extensive care, the PPO Plan will refer you to ICM.

If you, the case manager and the Trust Office agree on care not covered by this Benefit Booklet that can reasonably be expected to offer a cost-effective result without a sacrifice to the quality of your care, the Board of Trustees has the right to allow the care even though the care is not covered by the PPO Plan.

Coverage when Traveling Outside the United States

The BlueCard Worldwide Program

If you are outside the United States, Puerto Rico, and the U.S. Virgin Islands (the "BlueCard service area"), you may be able to take advantage of BlueCard Worldwide. BlueCard Worldwide is unlike the BlueCard Program in the BlueCard service area in some ways. For instance, although BlueCard Worldwide helps you access a provider network, you will most likely have to pay the provider and submit the claim yourself in order for the plan to reimburse you. However, if you need hospital inpatient care, the BlueCard Worldwide Service Center can often direct you to hospitals that will not require you to pay in full at the time of service. In such cases, these hospitals also send in the claim for you.

If you need to find a doctor or hospital outside the BlueCard service area, need help submitting claims or have other questions, please call the BlueCard Worldwide Service Center at (800) 810-BLUE (2583). The center is open 24 hours a day, seven days a week. You can also call collect at (804) 673-1177.

Medical Benefit Descriptions

Hospital Emergency Medical Services

Emergency Medical Services in a Hospital emergency room will be paid at the greatest of the following amounts:

- The median amount that PPO Providers have agreed to accept for the same services after the Deductible;
- The amount Medicare would allow for the same services after the Deductible; or
- The Maximum Allowable Charge for the same services after the Deductible.

Emergency Medical Services in a Hospital emergency room do not require prior approval.

Mental Health Benefits

Covered mental health services are inpatient care, partial hospitalization, and outpatient therapeutic visits to manage or lessen the effects of a mental health condition.

Hospital, partial hospitalization, and outpatient Covered Charges for Mental or Nervous Conditions are payable at 80% of the negotiated rate for a PPO Provider after the Deductible has been met or 60% of the Maximum Allowable Charge for a Non-PPO Provider after the Deductible has been met. Emergency Medical Services in a Hospital emergency room for Mental or Nervous Conditions are payable as described on page 30, **Hospital Emergency Medical Services**. Benefits are limited to Covered Charges provided by a Provider or a Qualified Treatment Facility in the least costly treatment setting which is Medically Necessary for the Covered Individual's condition. Covered Charges must be provided by a Provider or a Qualified Treatment Facility that is professionally licensed by the appropriate state agency to diagnose or treat a Mental or Nervous Condition and who provides services for Covered Charges within the scope of that license.

Office visits for Mental or Nervous Conditions require a $20 Co-Payment per visit if you use a PPO Provider. If you use a Non-PPO Provider, the Trust pays 60% of the Maximum Allowable Charge after the Deductible has been met. Covered Charges must be provided by a Provider who is professionally licensed by the appropriate state agency to diagnose or treat a Mental or Nervous Condition and who provides services for Covered Charges within the scope of that license.

Mental or Nervous Conditions means disorders listed in the Diagnostics and Statistics DSM 5 and the International Classification of Diseases ICD-11. The following Mental Conditions are covered when medically necessary:

- Treatment of eating disorders (such as anorexia nervosa, bulimia, or any similar condition)
- Physical, speech or occupational therapy provided for treatment of psychiatric conditions, such as autism spectrum disorders
- Applied behavioral analysis (ABA) therapy for members with one of the following:
  - Autistic disorder
  - Autism spectrum disorder
  - Asperger's disorder
  - Childhood disintegrative disorder
  - Pervasive developmental disorder
  - Rett's disorder
- Covered ABA therapy includes treatment or direct therapy for identified members and/or family members. Also covered are an initial evaluation and assessment, treatment review and planning, supervision of therapy assistants, and communication and coordination with other providers or school staff as needed. Delivery of all ABA services for a member may be managed by a Board Certified Behavior Analyst (BCBA) or one of the licensed providers below, who is called a Program Manager. Covered ABA services are limited to activities that are considered to be behavior assessments or interventions using applied behavioral analysis techniques. ABA therapy must be provided by:
  - A licensed physician (MD or DO) who is a psychiatrist, developmental pediatrician or pediatric neurologist
  - A licensed psychiatric nurse practitioner (NP), advanced nurse practitioner (ANP) or advanced registered nurse practitioner (ARNP)
  - A licensed occupational or speech therapist
  - A licensed psychologist (PhD)
  - A licensed community mental health agency or behavioral health agency that is also state-certified to provide ABA therapy

- A Board-Certified Behavior Analyst (BCBA). This means a provider who is state-licensed if the State licenses behavior analysts (Washington does). If the state does not require a license, the provider must be certified by the Behavior Analyst Certification Board. BCBAs are only covered for ABA therapy that is within the scope of their license or board certification.
- A therapy assistant/behavioral technician/paraprofessional, when their services are supervised and billed by a licensed provider or a BCBA.

Mental health services other than ABA therapy must be furnished by one of the following types of providers to be covered:

- Hospital
- State-Licensed Community Mental Health Agency
- Licensed physician (MD or DO)
- Licensed psychologist (PhD)
- A state hospital operated and maintained by the state of Washington for the care of the mentally ill
- Any other provider listed under the definition of "provider" (see the ***Definitions*** section in this booklet) who is licensed or certified by the state in which the care is provided, and who is providing care within the scope of their license.
- Behavioral health facilities that are accredited by the Joint Commission, the Commission on Accreditation of Rehabilitation Facilities (CARF), or the Council on Accreditation (COA), only when the state does not require licensure for the specific level of care.
- Washington state-licensed Behavioral Health Agency

When medically appropriate, services may be provided in your home.

Mental or Nervous Conditions do not include:

- Intellectual disabilities;
- Learning disorders;
- Paraphilias; and
- Any expense or charge for care that is, after professional medical review, deemed not Medically Necessary.

Qualified Treatment Facility means a facility, institution, or clinic duly licensed by the appropriate state agency and is primarily established and operated within the scope of its license.

Diabetic Instruction

Covered Charges for diabetic instruction are limited to one per lifetime outpatient diabetes self-management program that consists of assessment and training after diagnosis. Benefits are limited as follows:

- An education program must be credentialed or accredited by a state or national entity accrediting such programs; or
- An educational program must be provided by a Provider, a registered nurse, a certified diabetes educator, or a licensed dietician with demonstrated expertise in diabetes management.

Home Health Care

Covered Charges for home health care are limited to 100 visits per calendar year for combined services of PPO Providers and Non-PPO Providers.

To be Covered Charges, the services must be:

- Part-time or intermittent nursing care by a licensed practical nurse (LPN) or registered nurse (RN);
- Part-time or intermittent care by a home health aide;
- Occupational therapy, speech therapy, and physical therapy (provided such therapy is medically necessary and performed by a licensed therapist if licensing is required by the state in which the therapy is performed);
- Social work (provided such services are performed by a licensed social worker if licensing is required by the state in which the social work is performed). If licensing is not required, the social worker must have at least a master's degree in social work with one or more years of clinical social work experience;
- Nutrition services (provided such services are performed by a licensed nutritionist if licensing is required by the state in which the nutrition services are performed); or
- Special meals.

To be Covered Charges, the services must be:

- Medically Necessary for the treatment of a Covered Individual who is totally disabled and who, in the opinion of the attending physician, would otherwise have been confined as a registered bed patient in a Hospital or Skilled Nursing Facility;
- The Covered Individual is under the direct care of the attending physician;
- The plan of treatment covering home health care is established in writing by the attending physician prior to commencement of such treatment;
- The plan of treatment covering home health care is certified by the attending physician at least once every month; and
- The Covered Individual is examined by the attending physician not less than once every 60 days.
- To be Covered Charges the services must be provided by a home health care agency that meets the following requirements:
- It is primarily engaged in and is federally certified as a home health care agency and is duly licensed, if such licensing is required, by the appropriate licensing authority to provide the nursing or other therapeutic services listed above;
- Its professional service policies are established by a professional group associated with such agency or organization, including at least one physician, and at least one registered nurse (RN), to govern the services provided;
- It provides full-time supervision of such services by a legally qualified physician or by a registered nurse;
- It maintains a complete medical record of each patient; and
- It has an administrator.

To be Covered Charges, the services must not be otherwise excluded from coverage by the terms of this Benefit Booklet.

Hospice Care

Hospice care are services provided after the Covered Individual is, in the opinion of a physician, terminally ill with a life expectancy of not more than six months. To be eligible for this benefit, services must be provided by a covered hospice care provider (defined below) and be limited to the following:

- Part-time or intermittent care by an RN or LPN for up to eight hours in any one day;

- Psychological and dietary counseling;
- Consultation or case management services by a physician;
- Physical and occupational therapy;
- Part-time or intermittent home health aide services, which consist mainly of caring for the Covered Individual for up to eight hours in any one day; and
- Medical supplies, drugs, and medicines prescribed by a physician.

A covered hospice care provider is:

- A physician for consulting or case management services;
- A physical or occupational therapist; or
- A home health care agency for:
  - Physical or occupational therapy;
  - Part-time or intermittent home health aide services, which consist mainly of caring for the Covered Individual for up to eight hours in any one day; or
  - Psychological and dietary counseling.
- If you live in a remote area and there is no home health care agency readily available, the Plan will pay a person (who is not an immediate family member of the Covered Individual) or an agency with skills similar to a home health care agency to perform intermittent home health aide services which consist mainly of caring for the Covered Individual for up to eight hours in any one day.
- Eligible hospice care charges do not include:
- Bereavement counseling
- Funeral arrangements
- Pastoral counseling
- Care provided by family members
- Financial or legal counseling, including estate planning or the drafting of a will
- Homemaker or caretaker services, which are services not solely related to care of the Covered Individual, including:
  - Sitter or companion services for either the Covered Individual or other members of the family

  - Transportation
  - Housecleaning
  - Maintenance of the house
- Respite care that is furnished during a period of time when the Covered Individual's family or usual caretaker cannot, or will not, attend to the patient's needs.

Organ and Bone Marrow Transplant Benefit

The PPO Plan covers charges for human organ transplants that are Medically Necessary and appropriate treatment using prevailing standards of community medical practice and are not Experimental or Investigational Treatment. **Prior authorization by Innovative Care Management is required.** See page 26 for more information. The following types of transplants are covered by the PPO Plan if the aforementioned criteria are met:

Heart	Liver	Heart/lungs
Cornea	Kidney	Bone marrow
Kidney/pancreas (combined)	Pancreas	Lungs – single or bilateral

Preventive Care Services

Subject to the bulleted paragraphs below, the PPO Plan covers the following preventive care services at 100% of the negotiated rate for a PPO Provider (no Deductible or Co-Payment required) and at 60% of the Maximum Allowable Charge after the Deductible for a Non-PPO Provider:

- Items or services with a rating of "A" or "B" in the current recommendations of the U.S. Preventive Services Task Force. Examples of preventive care services include blood pressure and cholesterol screening, diabetes screening for individuals with hypertension, various cancer and sexually transmitted infection screenings, and counseling in defined medically appropriate areas.
- Immunizations for routine use in children, adolescents, and adults recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.
- For infants, children, and adolescents, preventive care and screening provided for in the comprehensive guidelines supported by the Health Resources and Services Administration (HRSA).

- With respect to women, such additional preventive care and screening provided for in binding comprehensive health plan coverage guidelines supported by HRSA. Examples of covered services include annual well-women visits, contraceptive methods and counseling, and breastfeeding support.
- The complete list of preventive services covered by the PPO Plan is available at www.hhs.gov/healthcare/about-the-aca/preventive-care and is subject to change. The PPO Plan covers a new guideline or recommendation effective with the Plan Year that begins on or after one year from the date the new recommendation or guideline is issued or adopted, as applicable. The PPO Plan does not cover any preventive care item or service after the date it is no longer included in the applicable recommendation or guideline, unless such coverage is provided for elsewhere in the PPO Plan.
- The PPO Plan only covers an item or service described in this section when it is provided in accordance with the applicable recommendation or guideline. The PPO Plan may use reasonable medical management techniques to determine the frequency, method, treatment, or setting for an item or service described in this section to the extent not specified in the applicable recommendation or guideline.
- The PPO Plan's coverage of preventive care services described in this section is subject to the following when provided within the PPO Provider network:
  - If the item or service is billed separately (or is tracked as individual encounter data separately) from an office visit, then the office visit is covered at the PPO Plan's PPO Provider network Deductible and coinsurance rate.
  - If the item or service is not billed separately (or is not tracked as individual encounter data separately) from the office visit and the primary purpose of the office visit was not the delivery of such item or service, then the office visit is covered at the PPO Plan's PPO Provider network rate and subject to the Deductible and coinsurance. If, however, the primary purpose of the office visit was the delivery of such item or service, the PPO Plan covers the PPO network office visit at 100%.

COVID-19 Testing and Vaccines

COVID-19 services are covered the same as other medical conditions as follows:

- COVID-19 testing, including any provider visit, lab work, or other related charges, is covered at standard plan cost sharing, which varies depending on whether or not providers are in-network or out-of-network.
- COVID-19 vaccines are covered the same as any other vaccine.

- Over-the-counter COVID-19 at home tests are not covered. These expenses may be reimbursed from your Supplemental Account (if have one; see page 58).

Weight Loss Surgery, Gastric Bypass, and Lap Band Surgery

The PPO Plan covers charges for weight loss surgery, gastric bypass, and lap band surgery that are Medically Necessary for the treatment of morbid obesity for adults age 18 and over. **Prior authorization by Innovative Care Management is required.**

To qualify for this benefit, you must also meet **all** of the following criteria:

- Age 18 or over
- Body mass index (BMI) of at least 40 or BMI of at least 35 with two or more of the following conditions:
  - Hypertension
  - Dyslipidemia (a blood lipid disorder that can contribute to many forms of disease including diabetes and cardiovascular disease)
  - Type 2 diabetes
  - Coronary heart disease
  - Sleep apnea
- Failure to achieve and maintain sufficient weight loss with nonsurgical treatment
- Evaluation by a licensed psychologist or psychiatrist documenting the following:
  - Absence of current substance abuse
  - Absence of serious untreated or uncontrolled medical, psychiatric, psychosocial, or cognitive condition that would interfere with postoperative adherence to treatment
  - Willingness to comply with preoperative and postoperative treatment plans
- Participation in a multidisciplinary program with the following:
  - Medical supervision by an MD, DO, NP, PA or a registered dietician under this medical supervision
  - At least four visits over 12 months, approximately every three months
  - Nutritional counseling
  - Exercise counseling
  - Behavior modification/support

- Weight loss or no further weight gain over 12 months

Substance Use Disorder

Hospital, partial hospitalization, and outpatient Covered Charges for Substance Use Disorders are payable at 80% of the negotiated rate for a PPO Provider after the Deductible has been met or 60% of the Maximum Allowable Charge for a Non-PPO Provider after the Deductible has been met. Emergency Medical Services in a Hospital emergency room for Substance Use Disorders are payable as described on page 30, **Hospital Emergency Medical Services**. Benefits are limited to Covered Charges provided by a Provider or a Substance Use Disorder Center in the least costly treatment setting which is Medically Necessary for the Covered Individual's condition. Covered Charges must be provided by a Provider or a Substance Use Disorder Center that is professionally licensed by the appropriate state agency to diagnose or treat Substance Use Disorders and who provides Covered Charges within the scope of that license.

Office visits for Substance Use Disorders require a $20 Co-Payment per visit if you use a PPO Provider. If you use a Non-PPO Provider, the Trust pays 60% of the Maximum Allowable Charge after the Deductible has been met. Covered Charges must be provided by a Provider who is professionally licensed by the appropriate state agency to diagnose or treat Substance Use Disorders and who provides Covered Charges within the scope of that license.

Substance Use Disorder means the addictive relationship with any drug or alcohol characterized by a physical or psychological relationship, or both, that interferes on a reoccurring basis with the Covered Individual's social, psychological, or physical adjustment to common problems. Covered Charges for Substance Use Disorders do not include services for addiction to tobacco or tobacco products and foods.

Substance Use Disorder Center means any facility for the treatment of Substance Use Disorder which is duly licensed by the appropriate state agency and is primarily established and operating within the scope of its license.

Alternative Housing Benefit

Alternative housing benefits are paid for housing for a Covered Individual receiving special treatment that is not available at a local facility. The alternative housing benefit is available if the Covered Individual's medical condition prohibits traveling between home and the site of treatment. A physician must certify that the medical condition requires hospitalization, and the alternative housing benefit must be approved in advance by the Trust Office. The PPO Plan will pay the lesser of the single occupancy hotel rate or $60 per day for up to 70 days for each period of confinement.

Benefit regarding Participation in Approved Clinical Trials

The PPO Plan covers routine patient costs for items and services furnished in connection with participation in approved clinical trials as required by 42 U.S.C. § 300gg-8 entitled "Coverage for Individuals Participating in Approved Clinical Trials" and any applicable regulations issued by the federal government.

Other Medical Benefits

The PPO Plan covers Covered Charges subject to the limitations and exclusions of this Benefit Booklet. Covered Charges include:

- Semi-private room and board and routine nursing for confinement in a Hospital.
- Up to the semi-private rate for room and board and routine nursing services for confinement in a Medicare-approved Skilled Nursing Facility. The Skilled Nursing Facility benefit does not cover routine custodial care, and you must be visited at least once each week by your physician. There is a 30-day limit per calendar year.
- Medical services and supplies furnished by the Hospital.
- Services by a Provider for medical or surgical care or treatment for covered Illnesses and Injuries.
- Anesthetics and their administration.
- Services of an RN for private duty nursing services in a Hospital.
- Services of an LPN for private duty nursing services in a Hospital.
- Services of a licensed physiotherapist, physical or occupational therapist.
- Charges by a physician or speech therapist for rehabilitative speech therapy due to an Illness (other than a functional nervous disorder), or for speech impairment (other than a functional nervous disorder) due to surgery as a result of an Illness or Injury.
- X-ray exams, lab tests and other diagnostic services.
- X-ray and radiation therapy; radiation therapy requires pre-authorization.
- Charges for the repair of sound, natural teeth (including their replacement) that are a result of an accidental bodily injury that occurs during the 24-month period following the accident. The 24-month limitation does not apply to Dependent children.
- Transportation within the United States and Canada of the Covered Individual by professional ambulance service, railroad, or scheduled airline to and from a Hospital or Skilled Nursing Facility. These will be Covered Charges if the Covered Individual's

Illness or Injury cannot be adequately treated at the location where the Illness or Injury occurs.

- Medical supplies as follows:
  - Blood and other fluids to be injected into the circulatory system;
  - Artificial limbs and eyes for the loss of natural limbs and eyes;
  - Lens for each eye (contacts or glasses) immediately following and because of cataract surgery only if vision cannot be corrected to 20/20 by use of conventional lenses (see **Vision Benefits** on page 55);
  - Casts, splints, braces, crutches, and surgical dressings; and
  - Rental of Durable Medical Equipment up to purchase price (for other than kidney dialysis). The purchase of Durable Medical Equipment, if approved, may be pro-rated over 12 months beginning with the date of purchase.
- Maternity expenses for Employees, Early Retirees, Dependent and Domestic Partners are covered on the same basis as for any other Illness, whether or not the pregnancy begins while the woman is covered under the PPO Plan. Coverage must be in effect at the time of delivery.
- Charges incurred for legally licensed midwives.
- Cochlear implants. This does not include routine hearing examinations and does not include hearing aids.
- Prescription drugs are covered under the prescription drug program. See **Prescription Drug Program** on page 45.
- Hemodialysis and peritoneal dialysis treatment when treated as an inpatient, in the outpatient department of a hospital or other facility, or in the home.
- Charges for male sterilization procedures. Benefits for all Food and Drug Administration (FDA) approved charges related to sterilization procedures for women are covered under Preventive Care, to the extent required by the Affordable Care Act (ACA).

Limits on Medical Benefits

The PPO Plan covers the following medical benefits subject to the following limitations.

Acupuncture – limited to 12 visits per calendar year.

Cardiac Rehabilitation – cardiac rehabilitation as deemed Medically Necessary is covered, provided services are rendered under the supervision of a Physician; in connection with a myocardial infarction, coronary occlusion or coronary bypass surgery; initiated within 12 weeks after other treatment for the medical condition ends; and in a Medical Care Facility. Charges for qualified cardiac/pulmonary rehabilitation programs are covered.

Casted Orthotics – limited to one pair per year. Excluded are corrective shoes, arch supports, and orthopedic appliances prescribed primarily for participation in sports, recreational or similar activities.

Chiropractic Treatment – limited to 30 visits per calendar year. X-rays are not included in the 30 visits per calendar year limit.

Home Health Care – limited to 100 visits per calendar year.

Jaw Treatment – treatment of TMJ (temporomandibular joint dysfunction) or MPD (myofascial pain dysfunction) is limited to a maximum benefit payment of $1,000 lifetime for outpatient care and $5,000 lifetime for inpatient care.

Naturopathic Care – treatment must be provided by a naturopathic physician who is licensed by the state in which care is rendered (if that state's laws license naturopathic physicians) and who practices within the scope of their license. Treatment is limited to 30 visits per calendar year. Benefits are limited to professional services only.

Skilled Nursing Facility – limited to 30 days per calendar year; requires pre-authorization.

Medical Benefit Exclusions

Any expenses or charges for the following medical items are not covered under the PPO Plan:

- Cosmetic or Reconstructive Surgery, except for reconstructive treatment or surgery due solely to:
  - An accidental bodily injury;
  - Surgical removal of all or a part of the breast tissue as the result of an Illness as required by the Women's Health and Cancer Rights Act; or
  - A birth defect.
- Custodial care.
- Dental services or supplies for treatment of the teeth, gums, or alveolar processes. However, Medical Coverage will be provided for Hospital charges if the Covered Individual is a bed patient or charges for the repair of sound, natural teeth (including their replacement) that are a result of an accidental bodily injury that occur during the

24-month period following the accident (see item 12 on page 50). The 24-month limitation does not apply to Dependent children.

- Education or training, except for support services related to Substance Use Disorders. The exclusion includes any expense and charge related to services or supplies for vocational assistance or counseling, rehabilitation or job training, outreach, lifestyle, and fitness.
- Fertility treatments, including diagnosis and treatment related to the restoration of fertility or the promotion of conception, including but not limited to tuboplasty, fertility drugs, artificial insemination, in vitro fertilization, embryo transplantation, and reversal of sterilization procedures.
- Gender affirmation surgery, except as required by Section 1557 of the Affordable Care Act.
- Hearing aids other than cochlear implants.
- Non-medical self-help or training, such as programs for weight control, general fitness, or exercise programs.
- Over-the-counter drugs or medication.
- Physical examinations, immunizations, (except as provided under Preventive Care Services), or medical care required as a condition of employment, except that Department of Transportation and Coast Guard physicals are covered. Drug screening is not covered under any circumstances except as provided under Preventive Care Services.
- Prescription drugs, except as covered under the **Prescription Drug Program** section beginning on page 45.
- Services or supplies prescribed or provided by non-eligible providers.
- Services or supplies provided by persons who usually live in the same household as the Covered Individual, or who is a member of their immediate family.
- Services or supplies that are Experimental or Investigational Treatment.
- Services or supplies that are for your convenience or that of your family or services of a personal nature, such as meals for guests, long distance telephone charges, radio or television charges, or barber or beautician charges.
- Sexual dysfunction treatment, except for those of organic origin and where the cause is documented by the attending physician.

- Shoes or arch supports except as allowed for casted orthotics as described on page 51, **Casted Orthotics**.
- Surgical procedures for correction of visual acuity, such as radial keratotomy or laser surgery.
- Treatment of learning disabilities, intellectual disabilities, marital, family or sexual counseling (unless it falls within Illness category) or sleeping disorders. However, the PPO Plan provides coverage for sleep apnea, sleep studies, and CPAP machines.
- Vision examinations, glasses, or the fitting of glasses (see **Vision Benefits** on page 55).
- Vitamins or nutritional or dietary supplements whether or not prescribed by a Provider with the exception of PKU formula and prenatal vitamins (see **Exclusions from the Prescription Drug Program** on page 49).
- Charges that are required as a result of complication from a service not covered under the Plan, unless expressly stated otherwise.
- General anesthesia, nursing and related hospital expenses in connection with an inpatient or outpatient dental procedure.
- Foot care, including treatment for weak, unstable or flat feet, bunions (unless an open cutting operation is performed), corns, calluses or toenails, unless at least part of the nail matrix is removed. This exclusion does not apply when treatment is medically necessary due to diabetes or peripheral vascular disease.
- Any expense or charge that falls within the **Exclusions Applicable to All Benefits except Life Insurance** as described on page 66.
- Any expense or charge for which a Covered Individual does not have to pay or is reimbursed.
- Any expense or charge that is, after professional medical review, deemed not Medically Necessary to the care or treatment of an Illness or Injury, except for preventive care services.
- Any expense or charge for a Non-PPO Provider that is in excess of the Maximum Allowable Charge for services and materials.
- Any expense or charge of a Provider for a service that is not within the scope of their license.
- Any expense or charge for which benefits are not provided by the PPO Plan.

Prescription Drug Program

The prescription drug program consists of the following three parts that work together to provide the best possible cost management opportunities for you and the Trust:

- A retail pharmacy network that includes a broad range of independent pharmacies and most major chain pharmacies.
- A specialty pharmacy network for certain prescription drugs used for treating complex health conditions.
- A home delivery pharmacy service for up to a 90-day supply of maintenance medication.

You have access to a "Member Dashboard" that is your personalized member website. This resource has information about your prescription drug benefits. You can locate a network pharmacy, access claims status and history, download authorization and claim forms, get a prescription drug price quote, and much more. To access the Member Dashboard, visit www.modahealth.com/memberdashboard/. Click on "Create an Account" and follow the instructions. You will need your IBU PPO ID card to set up your account. You may also call (800) 913-4311 with questions about the prescription drug program.

Co-Payment Obligations

Retail Pharmacy and Specialty Pharmacy Networks

There is no Deductible for retail and specialty prescriptions. Your financial obligation is as follows:

	Retail and Specialty Pharmacy Networks	**Non-Network Pharmacy**
Generic Drugs	$10 Co-Payment per prescription for a 30-day supply and $20 co-payment for a 90-day supply	Not covered
Preferred Brand Drugs	$20 Co-Payment per prescription for a 30-day supply and $40 co-payment for a 90-day supply	Not covered
Non-Preferred Brand Drugs	$40 Co-Payment per prescription for a 30-day supply and $80 co-payment for a 90-day supply	Not covered
Allowed Days' Supply	Up to a 90-day supply	N/A

Home Delivery Pharmacy Network

There is no Deductible for home delivery prescriptions. Your financial obligation is as follows:

Generic Drugs	$20 Co-Payment per prescription
Preferred Brand Drugs	$40 Co-Payment per prescription
Non-Preferred Barnd Drugs	$80 Co-Payment per prescription
Allowed Supply	Up to a 90-day supply

Generic Substitution Policy

For retail and home delivery prescription purchases, the purchase of generic drugs is required when available, unless your Provider authorizes the use of a preferred or non-preferred brand drug. If your Provider authorizes purchase of a generic and you request a preferred or non-preferred brand drug, you will be required to pay the difference in price in addition to the higher Co-Payment. See **Your Drug Formulary** on page 50.

The PPO Plan does not coordinate prescription drug benefits with other plans. Therefore, your PPO Plan prescription drug coverage is always primary.

Out-of-Pocket Maximum for Prescription Drugs

During a calendar year, the maximum amount of money a Covered Individual will have to pay for Co-Payments for prescription drugs covered by the Prescription Drug Program is $4,900 and the maximum amount of money a family will have to pay for Co-Payments for prescription drugs covered by the Prescription Drug Program is $9,600.

Using a Retail Pharmacy

You must obtain your prescription drugs from a retail network pharmacy. To find a retail network pharmacy, visit www.modahealth.com and click on "Find Care," then use "Search by network" to find a pharmacy in the "ArrayRx Broad Network." You may also call (800) 913-4311 to find a retail network pharmacy in your area.

When you visit a retail network pharmacy to fill a prescription, you will need to do the following:

- Present your identification card to the pharmacist each time you have a prescription filled.

- The pharmacist will enter the information from your identification card into the Moda Health Plan, Inc. computer system to check drug pricing and your eligibility.
- The pharmacist may recommend an alternative medication, such as a generic drug, after checking with your Provider.
- The pharmacist will fill the prescription and provide instructions on how to take the medication.
- You pay the pharmacy the Co-Payment.
- The pharmacy will submit the balance of the claim to the Trust for processing.

Using the Specialty Pharmacy

Certain prescription drugs used to treat complex health conditions must be obtained through the Specialty Pharmacy Program. The following is a partial list of medical conditions that may require prescription drugs that fall under the Specialty Pharmacy Program: oncology, Crohn's disease, rheumatoid arthritis, hepatitis, multiple sclerosis, HIV/AIDS, growth hormones, cirrhosis, and hemophilia. You may call Moda at (800) 913-4311 for a list of prescription drugs covered by the Specialty Pharmacy Program.

Prescription drugs covered by the Specialty Pharmacy Program must be ordered through Ardon Health. You and your Providers may contact Ardon Health by calling (855) 425-4085, by fax at (855) 425-4096, or at www.ardonhealth.com.

Using the Home Delivery Pharmacy

You can order medication through the home delivery pharmacy service. The program has been designed for people taking medications on an ongoing basis for the treatment of chronic and long-term conditions. These include, but are not limited to, diabetes, depression, asthma, heart conditions and high blood pressure. This program is not intended for medications needed immediately.

By using the home delivery pharmacy service, your prescription drugs are mailed to your home, and you are allowed to purchase up to a 90-day supply.

Ordering the First Time by Mail

- Ask your Provider to write the home delivery prescription for the maximum quantity the PPO Plan allows (a 90-day supply) and for one year of refills (if appropriate). Then mail the prescription to the home delivery pharmacy after you have registered with the pharmacy. To register with the pharmacy, call the pharmacy or register online (Postal Prescription Services (800) 552-6694 or www.ppsrx.com; Costco Mail Order Pharmacy

(800) 607-6861 or www.costco.com/home-delivery) or by completing a mail order service form (available online) and mailing it to the pharmacy with your prescription.

- On the front of each new prescription, clearly print the patient's name and their relationship to the Employee or Early Retiree (e.g., self, spouse, Domestic Partner, or child). Provide the patient's identification number from their IBU PPO ID card.
- Provide a street address for delivery. Some medications, such as narcotics, cannot be delivered to a post office box.

Refilling your Home Delivery Prescription

If your Provider has prescribed a refill, the home delivery pharmacy will send a refill slip with your prescription drug order. When you need the refill, detach the refill slip and mail it back to the pharmacy with your Co-Payment.

You may also order refills by phone or online (contact information below). Have your credit card information and the prescription number you would like to order ready.

Home Delivery Pharmacy – Important Contact Information

Postal Prescription Service	Phone: (800) 552-6694 (press #2 for Español) Monday-Friday: 6:00 a.m. to 6:00 Pacific Time Saturday: 9 a.m. to 2 p.m. Pacific Time Web: www.ppsrx.com Fax: (800) 723-9023 Mailing Address: PPS P.O. Box 2718 Portland, OR 97208
Costco Mail Order Pharmacy	Phone: (800) 607-6861 (press #2 for Español) Monday-Friday: 5 a.m. to 7 p.m. Pacific Time Saturday: 9:30 a.m. to 2 p.m. Pacific Time Web: www.costco.com/home-delivery Fax: (888) 545-4615 Mailing Address: Costco Mail Order 802 134th Street SW Ste 140 Everett, WA 98204

Covered Prescription Drugs

The prescription drug program covers the following:

- Prescription drugs (which are medical substances that by law require a prescription authorizing their dispense from a pharmacist to a patient and which can be filled only by a licensed pharmacist);
- Non-injectable legend drugs (see the list below for exclusions);
- Insulin;
- Prenatal vitamins;
- Oral contraceptives and contraceptive devices requiring a prescription;
- Diabetic supplies including disposable insulin syringes and needles, disposable blood testing agents (for example, Abbott and Bayer testing), lancets and lancet devices, alcohol swabs and glucose elevating agents (not to include adhesive tape, cotton balls, antiseptics or other common first aid supplies);
- Compound medications of which at least one ingredient is a legend drug; and
- Smoking deterrent medications prescribed by a Provider and used in combination with a smoking cessation program.

Exclusions from the Prescription Drug Program

- Vitamins, minerals, nutritional or dietary supplements, and calcium supplements, except prenatal vitamins taken during pregnancy.
- Drugs or medicines that can be obtained without a Provider's written prescription, including over the counter drugs.
- Injectable band syringes (other than insulin syringes).
- Drugs whose purpose is to measure or enhance fertility or treat infertility.
- Drugs prescribed for dermatological or cosmetic purposes or to promote hair growth (for example, Rogaine, Minoxidil, or Retin-A for patients over age 29).
- Therapeutic devices.
- Travel vaccines (for example, for yellow fever).
- Drugs dispensed by a Hospital while not confined to the facility, nursing home, clinic, ambulatory surgical center, physician or other institution.
- Drugs obtained after coverage has terminated.

- Drugs prescribed for weight loss or treatment of obesity.
- Drugs labeled "Caution: Limited by Federal Law to investigational use" or Experimental or Investigational Treatment drugs.
- Self-administered injectable drugs when supplied in a Provider's office, clinic or facility.

Limit on Quantities

There is a limit on the allowable number of tablets, patches, inhalers or nasal spray bottles each time a new or refill prescription is dispensed. These limits are based on the U.S. Food and Drug Administration's recommended dosage to encourage the safe and appropriate usage of prescription drugs. Limits apply to retail, home delivery, and specialty pharmacy prescriptions.

Your Drug Formulary

Your prescription drug program includes a formulary – a list of prescription drugs that are preferred by the PPO Plan. This list includes a wide selection of drugs and is preferred because it offers you choice while helping keep the cost of your prescription drug benefit affordable. Each drug has been reviewed by an independent group of physicians and pharmacists for safety and efficacy, and only Food and Drug Administration approved medications are included. Your PPO Plan encourages the use of formulary drugs to help control rising costs. Moda Health Plan, Inc. may remind your Provider when a formulary drug is available as a possible alternative for a drug that is not on the formulary, which may result in a change in your prescription. However, your Provider will always make the final decision on your medication.

For information on the formulary, visit www.modahealth.com/members or call (800) 913-4311.

Prior Authorization

Prescription drugs used to treat certain conditions require prior authorization from Moda Health Plan, Inc. If your medication requires prior authorization, your Provider will need to call Moda Health Plan, Inc. at (800) 913-4311 and complete and return a Pharmacy Prior Authorization Request Form.

You can also find out if a medication needs approval by logging in to your Member Dashboard at www.modahealth.com/members/ and looking for the prescription drug list. After your Provider submits a request, Moda Health Plan, Inc. will contact you, your Provider, and your pharmacy with a decision. If Moda Health Plan, Inc. approves the request, your medication will be covered by the PPO Plan. If Moda Health Plan, Inc. does not approve the request, your Provider will need to prescribe another medication. For your appeal rights, see **Claims and Appeals Procedures** on page 70.

Dental Benefits

The dental benefits are for Employees and Dependents enrolled in the PPO Plan and the Northern California Kaiser Permanente Plan. Employees and Dependents enrolled in the Hawaii Kaiser Permanente Plans or the HMSA Hawaii PPO Plan will have dental benefits provided by that plan.

Covered dental services are paid at 85% of Reasonable and Customary Charges for prophylaxis (dental cleanings), 80% of Reasonable and Customary Charges for preventive and basic services, and 50% of Reasonable and Customary Charges for other dental services. There is no Deductible. There is a calendar year maximum benefit payment of $2,000 per Covered Individual except the calendar year maximum benefit payment does not apply to Covered Individuals under age 19.

Covered Dental Services

For a dental service to be covered, it must be performed by a Dentist, a licensed denturist or a licensed dental hygienist working under the direction of a Dentist or licensed denturist providing services within the scope of their license.

The following preventive and basic services are covered dental services and paid at 80% of the Reasonable and Customary Charges except prophylaxis (dental cleanings) are paid at 85% of the Reasonable and Customary Charges:

- Oral examination, two times per calendar year.
- Prophylaxis (dental cleanings), are paid at 85% of the Reasonable and Customary Charge four times per calendar year.
- Topical application of fluoride for children under 19 years of age, two applications per person per calendar year.
- Dental sealant applied to permanent molar(s) for children under 19 years of age.
- Dental X-rays:
  - Full mouth set of X-rays, including panoramic (one set or panoramic per three consecutive years).
  - Bitewing X-rays, two sets per calendar year.
- Space maintainers for children 12 years of age and under.
- Extractions.
- Restorative type fillings.

- General and local anesthetic when administered with oral surgery (certain guidelines apply).
- Treatment of periodontal and other diseases of the gums and tissues supporting the teeth.
- Endodontic treatment, including root canal, if tooth is opened while covered.
- Injection of antibiotic drugs.
- Re-cementing of crowns, inlays and bridgework.
- Emergency palliative treatment.

The following major services are covered dental services and paid at 50% of the Reasonable and Customary Charges:

- Dental implants.
- Relining of dentures once every two years.
- Inlays, onlays, gold fillings and crowns.
- Initial installation of fixed bridgework including inlays and crowns, to replace one or more natural teeth extracted while the person was covered under the PPO Plan.
- Initial installation of partial or full dentures (excluding adjustments for the six-month period following installation), to replace one or more natural teeth extracted while the person was covered under the PPO Plan.
- Replacement of existing bridgework by new bridgework, or the addition of teeth to existing dentures or bridgework. However, only replacements and additions to existing dentures or bridgework will be covered if evidence satisfactory to the Board of Trustees or its designee is furnished that one of the following applies:
  - The replacement or addition of teeth is required to replace one or more teeth that were extracted while the person was covered under the PPO Plan; or
  - The existing denture or bridgework cannot be made serviceable and was installed at least two years prior to its replacement.

Orthodontic Treatment for Dependent Children

Coverage is provided for Dependent children at 50% of Reasonable and Customary Charges for orthodontic treatment, extractions, services and supplies up to a lifetime maximum benefit payment of $1,000. Charges for replacement of lost, missing or stolen prosthetic or orthodontic appliances are not covered.

Dental Limitations and Exclusions

No benefits will be paid for the following:

- Jaw treatment, including TMJ and MPD. (A limited benefit is available under the medical portion of the PPO Plan. See **Jaw Treatment** on page 41.
- Sealants, except as specifically provided under **Covered Dental Services** on page 51.
- Charges for any treatment, material or supplies not begun and completed while the person is covered under the PPO Plan except as allowed below.
- Charges for treatment, material or supplies furnished by other than a Dentist or licensed denturist except charges for scaling or cleaning performed by a hygienist under the direction of a Dentist or licensed denturist.
- Charges for treatment, materials or supplies for cosmetic purposes, including, but not limited to, personalization or characterization of dentures except when required due to an accidental bodily injury or surgical procedure for removal of a tumor.
- Charges for dentures, crowns, inlays, onlays, bridgework or other treatment, materials or supplies provided to alter vertical dimension or alter occlusion.
- Charges for prosthetic appliances (including, but not limited to bridges and crowns) and the fitting of them, which were ordered while the person was not covered by the PPO Plan, or which were ordered while the person was covered by the PPO Plan, but were not delivered and installed while so covered except as allowed below.
- Charges for installation of a dental appliance, a crown, a bridge or gold restoration furnished within 30 days after the date of termination of an person's coverage for dental benefits under the PPO Plan, will be Covered Dental Services if:
  - An impression for such appliance is taken prior to the date of termination of coverage;
  - The tooth was prepared for the crown, bridge or gold restoration prior to the date of termination of coverage, and
  - The person is not entitled to payment for such installation under health or dental coverage of any type or source.
- Charges for replacements or additions to existing dentures or bridgework will be covered only if evidence satisfactory to the Board of Trustees or its designee is furnished that one of the following applies:
  - The replacement or addition of teeth is required to replace one or more teeth extracted while the person was covered under the PPO Plan; or

- The existing denture or bridgework cannot be made serviceable and was installed at least two years prior to its replacement.
- Replacement crowns, inlays or onlays on the same teeth are covered only once in a five-year period.
- Charges for failure to keep a scheduled appointment with the dental provider.
- Charges for treatments, materials, or supplies that are experimental in nature.
- Charges that are not dentally necessary and/or are not recognized by the American Dental Association.
- Charges in excess of the Reasonable and Customary Charges for the treatment, materials, or supplies.
- Any expense or charge that falls within the **Exclusions Applicable to All Benefits except Life Insurance Claims** on page 66.

Vision Benefits

The vision benefits are for Employees and Dependents enrolled in the PPO Plan. Employees and Dependents enrolled in the Northern California and Hawaii Kaiser Permanente Plans and the HMSA Hawaii PPO Plan will have vision benefits provided by that plan.

Covered vision services are paid at 80% of Reasonable and Customary Charges. There is no Deductible. There is a calendar year maximum benefit payment of $300 per Covered Individual except the calendar year maximum benefit payment does not apply to Covered Individuals under age 19.

Covered Vision Services

The following charges for materials and vision-related services are covered when performed by a legally qualified ophthalmologist (M.D.) or optometrist (O.D.):

- Routine eye examination
- Lenses for eyeglasses
- Contact lenses
- Eyeglass frames

Vision Limitations and Exclusions

No benefits will be paid for the following:

- Special procedures, such as orthoptics, non-prescription glasses or contact lenses, vision training, subnormal vision aids, warranties, cleaning solutions, and cleaning kits.
- Treatment of medical conditions of the eye such as cataracts, retinopathy, etc. (may be covered by the medical portion of the PPO Plan).
- Any expense or charge that falls within the **Exclusions Applicable to All Benefits except Life Insurance Claims** on page 66.

Time Loss Benefits

This benefit is designed to partially replace an Employee's income while disabled. Dependents and COBRA participants are not eligible to receive time loss benefits.

If you are unable to work due to Illness or Injury, and you meet the required waiting period prior to benefit payment, you may receive a benefit of $300 per week, up to a maximum of 26 weeks for each disability. You must be enrolled in Trust-provided health and welfare plan coverage at the time the disability begins and remain enrolled in Trust-provided health and welfare plan coverage during your period of disability. If you become disabled during any month in which your eligibility is provided by COBRA self-payment, you are not entitled to weekly time loss benefits for that disability. Benefits will end if you lose coverage.

Time loss benefits start as follows:

If Disability Results From:	**Benefits Begin:**
An Injury	On the first day of disability
An Illness	On the eighth consecutive day of disability
An Inpatient Hospital Confinement	On the first day of disability

Time loss payments are subject to federal income tax and, if applicable, state income tax. By January 31st of the following year, the Trust Office will mail a W-2 form for time loss payments paid to you during the previous year.

A period of disability will begin only when you have been seen and treated by a physician.

Definition of Disability

To qualify for time loss benefits, you must be wholly and continuously prevented from performing each and every function pertaining to your employment, and you must be under the direct care of a physician. Prior to the payment of benefits, the Board of Trustees reserves the right to have an independent medical exam performed.

Maximum Period of Time Loss Benefits

The maximum period of time loss benefits is 26 weeks for each disability. A new period of disability will start when you again become disabled after you have returned to active employment:

- For two weeks or more if the cause or causes are related in any way to the prior disability; or

For one day or more if the cause or causes are not related to the prior disability.

Exclusions

Time loss benefits will not be paid in any of the following situations:

- For the same period you are collecting or entitled to accumulated time off, vacation pay, sick leave, Workers' Compensation benefits, Longshore & Harbor Workers Act benefits, unearned wages or pension benefits;
- If you are eligible for state or other governmental program that is intended to replace income when an Employee cannot work (for a program that is not described in the preceding sub-paragraph). You must apply for and use such state benefits before time loss benefits will be paid under this Plan. If the time loss benefits under this Plan are greater than the state provided benefit, the Plan will pay the difference to an eligible employee. If the time loss benefits under this Plan are payable for a longer period of time than the state provided benefit, then the Plan will pay time loss benefits to an eligible Employee for the time after the state program benefits cease until the Plan's time loss benefit period ends.

Other Benefits for Disabled Employees

You may also be eligible for a disability waiver of health and welfare premiums. See the Extended Coverage for Disabled Employees section on page 8.

Supplemental Account

If you have a Supplemental Account, it is a vital part of the health and welfare plans offered by the Board of Trustees because it allows you to determine how your out-of-pocket medical expenses are paid.

The Supplemental Account is a supplement to your health and welfare plan coverage. If sufficient contributions are made by your Employer to the Trust, a separate Supplemental Account will be established in your name. This account is separate from your Individual Reserve Account.

How to Accumulate Credits in your Supplemental Account

On an annual basis, a transfer of credits may be made from your Individual Reserve Account to your Supplemental Account. This transfer normally takes place after the cost of January health and welfare plan coverage has been deducted from your Individual Reserve Account.

In order for credits to be transferred from your Individual Reserve Account to your Supplemental Account, you must have at least one month of health and welfare coverage credits left in your Individual Reserve Account and you must have health and welfare plan coverage through a plan offered by the Board of Trustees in the month the transfer from your Individual Reserve Account to your Supplemental Account occurs. If these criteria are met, the excess will be transferred to your Supplemental Account. Under no circumstance can your Supplemental Account exceed $5,000. Any credits in excess of $5,000 will remain in your Individual Reserve Account to provide you continued health and welfare plan coverage. See pages 2-4 for an explanation of your Individual Reserve Account.

Uses for the Credits in your Supplemental Account

If your Individual Reserve Account is insufficient to pay for your Trust health and welfare plan coverage, your Supplemental Account is automatically used to pay for the cost of the Trust health and welfare plan coverage you elected. The only time the Trust Office will not make the deduction from your Supplemental Account to pay the cost of Trust health and welfare plan coverage is when you have stated in writing that you do not want your Supplemental Account used for this purpose, in which you have 12 months to request and provide documentation to receive reimbursement If sufficient documentation is not received within 12 months, the money will be transferred back to your Individual Reserve and is subject to forfeiture provisions as noted in **Inactive Individual Reserve Account** on page 4.

You may also use the credits in your Supplemental Account to reimburse you for out-of-pocket expenses incurred by you or a Dependent for "medical expenses" as defined below. Medical expenses may be reimbursed from your Supplemental Account if:

- The expense qualifies as a "medical expense," which is:
  - An expense incurred for medical care as defined in Section 213(d) of the Internal Revenue Code to the extent that such medical care is not reimbursed or reimbursable by an employer provided accident or health plan or any other group or individual accident or health plan;
  - You have not claimed the expense as a deduction on your or your Dependent's federal income tax return;
  - Non-prescription drugs and over the counter medications do not qualify as medical expenses; and
  - The credits in your Supplemental Account cannot be used to reimburse you for the cost of purchasing an individual health plan through a state or federal marketplace exchange or from an insurance carrier.

    See IRS Publication 502 for a description of eligible medical expenses.
- There are sufficient credits in your Supplemental Account to reimburse you for the medical expense at the time the claim is filed;
- The medical expense is incurred by an Employee, Early Retiree or a Dependent;
- The Employee, Early Retiree or Dependent was enrolled for Medical Coverage through the PPO Plan or another medical plan sponsored by the Board of Trustees at the time the medical expense was incurred; and
- The request for reimbursement is submitted to the Trust Office within the time frame described below the next heading.

Payment from the Supplemental Account will be paid to the Employee or Early Retiree.

How to Access the Credits in your Supplemental Account

You can obtain the credits in your Supplemental Account in one of the following ways:

- If you are enrolled in the PPO Plan, once a month (if medical expenses have been submitted), a letter will be sent to you summarizing the claims processed for you and your Dependents. This "monthly recap" letter will indicate the amount of charges processed and the amount eligible to be paid from your Supplemental Account. To obtain the credits from your Supplemental Account, this letter must be signed and returned to the Trust Office by the date specified. If the letter is not signed and returned to the Trust Office by the date specified, you will not be issued a check from your Supplemental Account.

- If you are enrolled in the PPO Plan, you may enroll in the "Automatic Supplemental Account Reimbursement Program." Upon enrollment, credits in your Supplemental Account will automatically be sent to you at the time the Trust Office receives documentation of a medical expense for which you are entitled to reimbursement. Enrollment in this Automatic Program occurs once per year. If you elect not to enroll, you will not be able to enroll until the next enrollment period.
- If you are not enrolled in the PPO Plan (but are enrolled in one of the other plans offered by the Trust) and you want to obtain reimbursement for an out-of-pocket medical expense, you must obtain a reimbursement form from the Trust Office and submit the completed reimbursement form with all required documentation to the Trust Office within 12 months after the expense was incurred. Supplemental Account reimbursement forms may be found at www.ibubenefits.org.

How and When an Employee or Early Retiree can Opt Out of and Forfeit the Credits in Their Supplemental Account

An Employee or Early Retiree with credits in a Supplemental Account may opt out of the Supplemental Account and forfeit the credits in the Supplemental Account at any time by completing a "Supplemental Account opt-out form" and submitting it to the Trust Office. Supplemental Account opt-out forms may be obtained by calling the Trust Office at one of the telephone numbers on page iii or by obtaining the form at www.ibubenefits.org. The forfeited credits will go to the Trust and not the Employee or Early Retiree.

The reason an Employee or Early Retiree may want to opt out of and forfeit the credits in the Supplemental Account is so you may qualify for a premium tax credit if you or a family member purchase medical and prescription drug coverage through an Affordable Care Act exchange marketplace. If you no longer have health and welfare coverage provided by the Trust and have credits remaining in your Supplemental Account, you can obtain an individual medical and prescription drug plan through the Affordable Care Act exchange marketplace but you will be ineligible for premium assistance that is available to some individuals who purchase a medical and prescription drug plan through an Affordable Care Act exchange marketplace.

Early Retiree Medical and Prescription Drug Options

Options for Early Retirees and their Dependents not Eligible for Medicare

The Board of Trustees offer medical and prescription drug plans for Early Retirees and their non-Medicare-eligible Dependents. **Domestic Partners and the children of a Domestic Partner are not eligible for the Early Retiree medical and prescription drug options described below.** The options are:

- For Early Retirees and their Dependents who reside in the Kaiser Permanente service area in Hawaii, the Kaiser Permanente Medical and Prescription Drug Plan.
- For Early Retirees and their Dependents who do not reside in the Kaiser Permanente service areas of Hawaii the medical and prescription drug benefits described in this Benefit Booklet.

The Board of Trustees establishes the monthly premium for medical and prescription drug coverage as well as the amount of the monthly subsidy, if any, the Trust will provide toward the cost of medical and prescription drug coverage for Early Retirees and their non-Medicare-eligible Dependents.

Required payments by Early Retirees and their non-Medicare-eligible Dependents must be received at the Trust Office by the 20th day of the month preceding the month of medical and prescription drug coverage. For example, the self-payment for March medical and prescription drug coverage must be received at the Trust Office on or before February 20. If you are receiving a pension from the Inlandboatmen's Union of the Pacific National Pension Plan, you can make arrangements to have your monthly self-payment deducted automatically from your monthly pension check. Monthly self-payments should be mailed to the following address:

Inlandboatmen's Union of the Pacific
National Health Benefit Trust
c/o Benesys, Inc.
PMB #116
5331 S. Macadam Avenue, Suite 258
Portland, OR 97239

Options for Medicare-Eligible Retirees and Medicare-Eligible Dependents. The Board of Trustees made arrangements with Via Benefits. to assist Medicare-eligible retirees and Medicare-eligible Spouse who enrolls in an individual Medicare Supplement Plan which is affordable and meets your medical and prescription drug needs. There is a separate booklet entitled "Retiree Health Reimbursement Arrangement" which describes the Medical Reimbursement Plan the Board of Trustees has established for Medicare-eligible retirees and

their Medicare-eligible Spouses. For a copy of the booklet, you may call or write the Trust Office or log into the benefits website. The Trust Office's contact information is listed on page iii. The Trust currently deposits a specified amount of money in a Health Reimbursement Account for a Medicare-eligible retiree and Medicare-eligible Spouse to help offset the cost of an individual Medicare Supplement Plan and to help pay for other out-of-pocket medical expenses.

The benefits currently offered by the Board of Trustees and the payments currently made toward the cost of medical and prescription drug coverage for Early Retirees, Medicare-eligible retirees and their Dependents are not vested. The Board of Trustees, in its sole discretion, may authorize the use of Trust money to help offset the cost of medical and prescription drug coverage. The Board of Trustees cannot guarantee that the medical and prescription drug benefits described in this Benefit Booklet will be available in the future. The Board of Trustees retains the right to reduce or eliminate the benefits or increase the cost to the retiree.

Early Retiree Eligibility – Who May Be Covered

To be eligible for coverage in a medical and prescription drug plan described earlier in this section, the Early Retiree must:

- Complete, sign and submit an application for Early Retiree medical and prescription drug coverage on a form provided by the Trust Office;
- Have the application accepted by the Board of Trustees or its designee;
- Have had at least five years of coverage in one of the health and welfare plans offered by the Board of Trustees;
- Have had coverage in one of the health and welfare plans offered by the Board of Trustees for at least 24 of the 36 months prior to the last month of Employer paid health and welfare coverage. For example, if the last month of employer paid health and welfare coverage was December 2023, the retired employee must have had at least 24 months of health and welfare coverage through the Trust in the 36 months preceding January 1, 2024;
- Be retired from the industry in which you were an active Employee;
- Be receiving benefits from a retirement plan recognized by the Board of Trustees;
- Not working in the industry from which you retired, unless such work is permitted pursuant to the Inlandboatmen's Union of the Pacific National Pension Plan;
- Make a monthly self-payment in the amount and within the time required by the Board of Trustees for medical and prescription drug coverage;

- Provide proof that you have maintained continuous medical and prescription drug coverage from the time your health and welfare coverage through the Trust terminated until you enroll in an Early Retiree medical and prescription drug plan offered by the Board of Trustees. For example, Employee A retires on December 31, 2023, at age 60. Employee A's health and welfare coverage provided through the Trust terminated on February 28, 2024. Employee A maintains medical and prescription drug coverage effective March 1, 2024, from a source other than the Trust, such as an individual medical and prescription drug plan, or a spouse's group medical and prescription drug plan. On January 1, 2025, Employee A could enroll in one of the Trust's Early Retiree medical and prescription drug plans, because they maintained continuous medical and prescription drug coverage from March 1, 2024, through December 31, 2024, and meets the other enrollment criteria in this section;
- An Early Retiree enrolled for medical and prescription drug coverage provided by the Trust can disenroll and re-enroll once so long as the Early Retiree maintains continuous medical and prescription drug coverage during the time they have disenrolled from medical and prescription drug coverage provided by the Trust;
- The options available to an Early Retiree after retirement are:
  - Continue under the PPO Plan (medical, prescription drug, dental and vision coverage), the Kaiser Permanente Plan, or HMSA Hawaii PPO Plan until your Individual Reserve Account is depleted, then elect to enroll in COBRA continuation coverage for 18 months before transferring to an Early Retiree medical and prescription drug plan;
  - Continue under the PPO Plan (medical, prescription drug, dental and vision coverage), the Kaiser Permanente Plan, or HMSA Hawaii PPO Plan until your Individual Reserve Account is depleted, then terminate your coverage, and maintain continuous medical and prescription drug coverage from another source. Prior to Medicare entitlement, submit an application for Early Retiree medical and prescription drug coverage provided by the Trust;
  - Immediately enroll in an Early Retiree medical and prescription drug plan offered by the Trust, and use the money in your Individual Reserve Account to pay for the monthly premium; or
  - When your Employer provided Trust coverage ends, enroll in a medical and prescription drug plan of your choice. So long as you maintain continuous medical and prescription drug coverage, you can enroll in an Early Retiree medical and prescription drug plan offered by the Board of Trustees prior to Medicare entitlement, as long as the eligibility criteria are met.

Termination of Early Retiree Benefits

Medical and prescription drug coverage will automatically terminate for the Early Retiree on the earliest of the following dates:

- The date the Board of Trustees change the eligibility rules and the Early Retiree no longer meets the eligibility rules;
- The date the Board of Trustees terminates the medical and prescription drug plan elected by the Early Retiree;
- The date the Early Retiree fails to make the monthly self-payment by the due date established by the Board of Trustees;
- The date the Early Retiree returns to work in the industry (see **Returning to Covered Employment** on page 64); or
- The date the Early Retiree becomes eligible for Medicare.

Medical and prescription drug coverage will automatically terminate for an Early Retiree's Dependent on the earliest of the following dates:

- The date the Board of Trustees changed the eligibility rules and the Dependent no longer meets the eligibility rules;
- The date the Board of Trustees terminates the medical and prescription drug plan elected by the Dependent;
- The date the Dependent fails to make a monthly self-payment by the date established by the Board of Trustees;
- The date the Early Retiree's coverage ends for any reason except for death or eligibility for Medicare;
- The date the Dependent no longer meets the PPO Plan requirements as a Dependent;
- The date the Dependent becomes eligible for Medicare; or
- For a surviving spouse, the last day of the month in which remarriage or establishment of a Domestic Partner relationship occurs.

Returning to Covered Employment

If an Early Retiree returns to covered employment with an Employer and retires again, they will be eligible to re-enroll for benefits by making application within 30 days of their retirement so long as they meet the criteria under the heading **Early Retiree Eligibility – Who may be Covered**.

If an Early Retiree has returned to work for a non-contributing employer in the maritime industry and retires once again, they will not be eligible to re-enroll for benefits unless they meet the criteria under the heading **Early Retiree Eligibility – Who may be Covered** on page 62.

If an Early Retiree returns to work for an Employer who is obligated to contribute to the Trust for them per a collective bargaining agreement or a Joinder Agreement, they will return to the same health and welfare plan in which they were covered prior to retirement as soon as there is sufficient credits in their Individual Reserve Account to qualify for a month of health and welfare coverage.

Exclusions Applicable to All Benefits except Life Insurance

All benefits described in this Benefit Booklet, except the Life Insurance Benefit, are subject to the following exclusions. Benefits are not payable for:

- Any medical expense or charge which does not meet the definition of Medical Necessity except preventive care services.
- Any medical expense or charge not provided by a Provider except as specifically allowed by this Benefit Booklet.
- Any expense or charge provided by a Provider if the expense or charge is outside the scope of the Provider's license.
- Services and supplies received while not covered by the PPO Plan except for specific exceptions allowed by the Dental Benefits section of the PPO Plan.
- Any medical expense in excess of the Maximum Allowable Charge for a Non-PPO Provider or the negotiated rate for a PPO Provider.
- For dental and vision benefits, any expense in excess of Reasonable and Customary Charges.
- Any expense or charge for which a Covered Individual does not have to pay or is reimbursed.
- Any Injury or Illness for which the Covered Individual has received or would be entitled to receive compensation for that particular Injury or Illness under any Workers' Compensation, Longshore and Harborworker occupational disease policy or agreement or other similar legislation, whether or not the Covered Individual elects such coverage or meets the claim filing deadline, except the Trust may advance payment per the Subrogation and Reimbursement Obligations section.
- Any expense or charge for services or supplies that are paid for or otherwise provided under any law of a government (including Medicare), except where the payments are provided under a plan specifically established by a government for its own civilian participating employees and their dependents.
- Any expense or charge incurred while in service in the armed forces.
- Any expense or charge which arises out of or is caused or contributed to by war or an act of war. War means declared or undeclared war, whether civil or international, and any substantive armed conflict between organized forces of a military nature.

- Any expense or charge incurred while legally confined for participation in criminal activities and any expense or charge incurred as a result of participation (other than as a victim) in violent criminal activity.
- Any expense or charge for a service or supply provided to you, or a Dependent by any member of your immediate family.
- Claims that are not submitted within one year of the date of the service or supply or, in the case of time loss benefits, a claim which is not submitted within one year from the date of disability.
- Any expense or charge for services or supplies that are considered Experimental or Investigational Treatment.
- Any expense or charge for the cost of drugs, procedures, services, supplies, or treatment rendered or received in person, by mail, or otherwise outside the United States if the purpose of such travel or communication is to obtain or receive such drug, procedure, service, supply, or treatment.

How to File Claims except Life Insurance Claims

Claims should be submitted to the Trust Office for payment within 90 days after the expense is incurred. If a claim is not submitted for payment within one year after the expense is incurred, the claim will be denied. Contact the Trust Office with questions regarding claims submission and benefits. See page 123 for the procedure for submitting a claim for life insurance benefits.

For Medical Claims

Be sure to present your identification card when receiving services. This card identifies you as a PPO Plan participant and tells the Provider, Hospital, facility, or clinic where to send the bill for payment.

Premera and the Trust Office will determine the benefits and pay the Provider, Hospital, facility, or clinic directly, in accordance with the reimbursement schedule for the PPO Plan. You will receive an explanation of benefits which specifies the amount paid. If you receive a bill from the Provider, Hospital, facility, or clinic, be sure to verify that it has been submitted to Premera.

If another benefit plan is primary, Premera or the Trust Office may request you provide an explanation of benefits indicating what the other plan paid prior to processing the claim.

For Dental and Vision Claims

To request payment:

- Complete the patient information section of the appropriate claim form available at www.ibubenefits.org or from the Trust Office.
- Have your Provider complete the rest of the form.
- Send the completed form along with your bill to the Trust Office at the address listed on the form.

For Time Loss and Disability Waiver Claims

If you are unable to work due to an Illness or Injury, follow these steps:

- Obtain a claim form from the Trust Office available at www.ibubenefits.org or your Union office.
- Complete Part 1 of the claim form, marking your selection of time loss benefits, disability waiver of premium, or both. Have your physician complete Part 2, providing the dates you are unable to work, and have your Employer complete Part 3. If you are applying for a disability waiver of premium only, you do not need to complete Part 3.

- Send the completed form to the Trust Office at the address on the form.

Right to Request Examination

The Board of Trustees, at the expense of the Trust, has the right to have a Covered Individual examined, as often as it may require, whenever their Illness or Injury is the basis of a claim. The Board of Trustees also has the right to require an autopsy, if not prohibited by law. A disputed Illness or Injury is a basis for this requirement.

How Medical Claims Will Be Paid

Claims will be paid in the following manner:

- Upon presentation of the completed claim form and itemized bill for Covered Charges, Premera will issue a check payable to the Provider, Hospital, facility, or clinic on behalf of the Trust for the amount of the Covered Charges eligible for payment.
- In the event the Covered Individual assigns payment in writing to a Non-PPO Provider, Hospital, facility, or clinic, the check will be made payable to the assignee.
- Written notice of a claim must be given to Premera or the Trust Office or appropriate claims administrator as soon as reasonably possible. No claim will be paid if received by Premera, the Trust Office or appropriate claims administrator more than one year after the date of service.

Separate claim forms are used for medical, vision, prescription drug, dental and time loss claims.

Claims and Appeals Procedures

The procedures below are the sole and exclusive procedures available to a Covered Individual or any other person (claimant) who is dissatisfied with:

- An eligibility determination, including a rescission of coverage, i.e. discontinuation of coverage that has a retroactive effect for a reason other than failure to make a timely payment;
- A benefit determination, including the denial, reduction, or failure to provide or make payment (in whole or in part) for a benefit that is based on the PPO Plan; or
- An action or decision by Premera, the Trust Office, the Appeal Review Committee, or the Board of Trustees.

If you have a claim or issue concerning a benefit provided or denied by Kaiser Permanente, the HMSA Hawaii PPO Plan, or Standard Insurance Company, the claim should be filed with that organization according to its claims and appeals procedures. Call the Trust Office if you need assistance with the claims and appeals procedures.

Time Frame for Initial Decision by Trust Office

The time frame in which an initial decision concerning a claim will be made depends on the type of claim submitted. There are different time frames for different types of claims as follows:

Medical and prescription drugs (post-service claims)	30 days
Dental and vision	30 days
Disability waiver and time loss	45 days
Eligibility, a self-payment, coverage for a Dependent or Domestic Partner, a COBRA issue, or a rescission of coverage issue	90 days

Medical, Prescription Drug, Dental and Vision Claims

The Trust Office is responsible for reviewing medical and prescription drug claims. You will be notified in writing whether your claim is approved or denied. The time frame in which a denial notice will be provided is based on the type of claim you have submitted.

Urgent Care Claim

An urgent care claim is a claim where the terms of the PPO Plan require prior authorization before medical care or treatment can be obtained and a delay in obtaining the medical care or treatment could:

- Seriously jeopardize the life or health of the Covered Individual to regain maximum function; or
- In the opinion of a Provider with knowledge of the Covered Individual's medical condition, subject the Covered Individual to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

In the event there is an urgent care claim, the Trust Office or its designee will provide notice of the benefit determination (whether approved or denied) within 72 hours after receipt of the urgent care claim unless insufficient information is provided to determine whether, or to what extent, benefits are covered or payable by the PPO Plan. In such a case, the Trust Office or its designee shall notify the Covered Individual as soon as possible but not later than 24 hours after receipt of the urgent care claim and identify the specific information necessary to complete review of the urgent care claim. The Covered Individual shall have at least 48 hours to provide the requested information. The Covered Individual will be notified of the decision as soon as possible but not later than 48 hours after either receipt of the information or the end of the additional time period, whichever is earlier. The Covered Individual may appeal an adverse benefit determination to the Appeal Review Committee/Board of Trustees and they or their designee will act on the appeal within 72 hours after receipt.

Pre-Service Claim

A pre-service claim is a claim where the terms of the PPO Plan require prior authorization before medical care or treatment can be obtained. Unlike an urgent care claim, a Covered Individual's health is not in serious jeopardy at the time the pre-service claim is submitted. In the event there is a pre-service claim, the Trust Office or its designee shall provide notice of the benefit determination (whether approved or denied) within a reasonable period of time but not later than 15 days after receipt of the claim. The time period may be extended up to an additional 15 days for matters beyond the control of the Trust Office or its designee, but the Covered Individual will be notified of the extension before the end of the initial 15-day period. The notice will identify the circumstances requiring the extension and the date by which the Trust Office or its designee expects to issue a decision. If the extension is necessary because the Covered Individual did not submit necessary information, the notice will describe the information required and give the Covered Individual an additional period of at least 45 days to furnish the information. The Covered Individual may appeal an adverse benefit determination

to the Appeal Review Committee/Board of Trustees and they or their designee will act on the appeal within 30 days after receipt.

Concurrent Claim

A concurrent claim is a claim that is reconsidered after initial approval of an ongoing course of treatment and results in a reduction or termination of benefits before the end of the approved course of treatment. An example is an inpatient Hospital stay, originally approved for five days that is subsequently shortened to three days. In the event of reconsideration, the Covered Individual must be notified so that they can appeal the decision and obtain a decision on appeal before the course of treatment is reduced or terminated. An appeal to extend a course of treatment for a claim involving urgent care must be acted on within 24 hours after receipt of the appeal but only if the appeal is received at least 24 hours before the expiration of the approved course of treatment. Coverage for the ongoing course of treatment will be continued pending the outcome of the appeal.

Post-Service Claim

A post-service claim is a claim for payment of benefits after the care or treatment has been provided. An example is the amount of a Provider's bill that will be paid. The Trust Office will provide notice of the benefit determination (whether the claim is approved or denied) within a reasonable period of time but not later than 30 days after receipt of the claim. The time period may be extended up to an additional 15 days for matters beyond the Trust Office's or its designee's control but the Covered Individual will be notified of the extension before the end of the 30-day period. The notice will identify circumstances requiring an extension of time and the date by which the Trust Office expects to issue the decision. If the extension is necessary because the Covered Individual did not submit necessary information, the notice will describe the information needed and give the Covered Individual an additional period of at least 45 days to furnish the information. The Covered Individual may appeal an adverse benefit determination to the Appeal Review Committee/Board of Trustees and they or their designee will act on the appeal within the time limit specified in the **Review by the Appeal Review Committee/Board of Trustees** section.

Disability Waiver and Time Loss Claims

The Trust Office is responsible for reviewing disability waiver and time loss claims. You will be notified in writing whether your claim for disability waiver or time loss benefits is approved or denied within 45 days after receipt of an application for disability waiver or time loss benefits. If the Trust Office determines an extension of time is necessary to complete review of the claim because of matters beyond its control, the 45-day period may be extended up to 30 days provided the Trust Office notifies you of the extension of time for processing the claim during the initial 45-day period. If, prior to the end of the first 30-day extension, the Trust Office

determines that a further extension of time is necessary to complete review of the claim because of matters beyond its control, the 30-day extension may be extended up to an additional 30 days provided the Trust Office notifies you of the extension before the end of the first 30-day extension. If an extension of time is required, you will be notified in writing and the notice shall specify the reason(s) for the extension, the unresolved issue(s), if any, preventing a decision, additional information, if any, needed by the Trust Office and a date a decision is expected. The Covered Individual may appeal an adverse benefit determination to the Appeal Review Committee/Board of Trustees and they or their designee will act on the appeal within the time limits specified in the **Review by the Appeal Review Committee/Board of Trustees** section.

Eligibility Claims

The Trust Office is responsible for reviewing claims concerning eligibility-type issues such as ineligibility to enroll in a health and welfare plan, use of your Supplemental Account, a late self-payment, coverage for a Dependent, COBRA coverage issues and rescission of coverage issues. You will be notified in writing of an eligibility decision. The written decision will normally be provided within 90 days after receipt of your written notice concerning an eligibility issue. The Covered Individual may appeal an adverse eligibility decision to the Appeal Review Committee/Board of Trustees and they or their designee will act on the appeal within the time limits specified in the **Review by the Appeal Review Committee/Board of Trustees** section.

Independence of Decision Makers

Throughout the claims and appeals process, the PPO Plan will insure that all claims and appeals are adjudicated in a manner designed to insure the independence and impartiality of the persons involved in making the decision. The PPO Plan will not provide bonuses to individuals or organizations based on the number of denials made by the claims adjudicator or the entity employing the claims adjudicator. The PPO Plan will not contract with a medical expert based on the expert's reputation for outcomes in contested cases. Rather, the PPO Plan will contract with medical experts based on each expert's professional qualifications.

Content of Adverse Benefit Determination or Eligibility Determination

If your claim is denied by the Trust Office, or one of its designees, the adverse benefit determination will be in writing and will provide:

- Information sufficient to identify the claim including (to the extent applicable) the date of the service, the name of the Provider, Hospital, facility, or clinic, the claim amount, the diagnosis code and its meaning, the treatment code and its meaning and an explanation of the standard used in making the decision, e.g., Medical Necessity;

- The specific reason(s) for the adverse benefit determination which may include a denial code and its meaning;
- A description of any additional material or information necessary to perfect the claim and an explanation why the material or information is necessary;
- If the adverse benefit determination is based on an internal rule, guideline, protocol or similar criterion, the internal rule, guideline, protocol or similar criterion will be described or you will be notified of your right to receive the document free of charge upon request;
- If the adverse benefit determination is based on a decision involving Medical Necessity or because the service is Experimental or Investigational Treatment, you will be notified of your right to receive a statement of the scientific or clinical judgment for the decision free of charge upon request;
- A description of internal and external review procedures including information on how to initiate an appeal and the time limits for filing an appeal;
- A statement of your right to bring a civil action for the benefit under ERISA; and
- Contact information for any ombudsman/health insurance consumer assistance services available under the Public Service Health Act.

Procedure to Appeal an Adverse Benefit Determination or Eligibility Determination

If you disagree with the adverse benefit determination or eligibility determination issued by the Trust Office or its designee, you or your authorized representative may file a written appeal within 180 days after receipt of the adverse benefit determination or eligibility determination. The written appeal must be filed as follows:

IBU National Health Benefit Trust
ATTN: Appeal Review Committee
PMB #116
5331 S. Macadam Avenue, Suite 258
Portland, OR 97239

You or your authorized representative may request, in the appeal, to appear at a hearing before the Appeal Review Committee/Board of Trustees when your appeal is considered.

Upon written request to the Trust Office, you will be entitled to review or receive your entire claim file.

Scope of Review

If the Trust Office's decision is appealed, the appeal will be referred to the Appeal Review Committee and, if necessary, the Board of Trustees as described in the **Review by the Appeal Review Committee/Board of Trustees** section. In either case, the claim will be reviewed *de novo* (meaning without deference to the initial decision). All relevant information will be reviewed regardless of whether the information was previously submitted.

If the Appeal Review Committee or Board of Trustees intends to issue an adverse benefit determination based on new or additional evidence or a new rationale, it will provide the new or additional evidence or new rationale to you free of charge as soon as possible and in advance of the date the decision will be made to give you a reasonable opportunity to respond prior to the decision being made.

If the claim involves issues of medical judgment, such as whether a particular treatment, drug or other item is Experimental or Investigational Treatment or Medically Necessary, a health care professional who has appropriate medical training and experience will be consulted. If a health care professional is consulted, that person will be different from any health care professional previously consulted involving your claim and will not be the subordinate of the health care professional previously consulted. If a health care professional is consulted, they will be identified regardless of whether the advice is relied on.

Review by the Appeal Review Committee / Board of Trustees

The Co-Chairs of the Board of Trustees appoint the Appeal Review Committee which consists of an equal number of Employer Trustees and Union Trustees. The Co-Chairs may be the Appeal Review Committee.

Upon receipt of an appeal, the Trust Office will submit the appeal and all relevant information to the Appeal Review Committee. If a timely request to appear at the meeting of the Appeal Review Committee is made by the claimant, the claimant may appear at the meeting or the claimant may be represented at the meeting by an attorney or other representative of their choosing at their own cost and expense.

The appeal will be considered by the Appeal Review Committee no later than the next regularly scheduled meeting of the Board of Trustees following receipt of the appeal unless the appeal is received less than 30 days prior to the meeting. In that event, the Appeal Review Committee will consider the appeal no later than the date of the subsequent Board of Trustees' meeting. If due to special circumstances, the Appeal Review Committee requires an extension of time to review the appeal, you will be notified in writing of the special circumstances necessitating the extension and when the decision will be made.

If the Appeal Review Committee deadlocks or has not reached a unanimous decision prior within the timeframe described above, the appeal will be submitted to the Board of Trustees at their next regularly scheduled meeting.

If a timely request to appear at a meeting is made, the claimant may appear at the meeting or the claimant may be represented at the meeting by an attorney or other representative at their choosing and at their cost and expense.

A decision by the Appeal Review Committee or the Board of Trustees will be in writing and sent to you within five days after the decision is made.

Content of an Adverse Benefit Determination on Appeal

If either the Appeal Review Committee or the Board of Trustees denies your appeal, the adverse benefit determination will be in writing and include the same type of information described under the heading **Content of Adverse Benefit Determination or Eligibility Determination** on page 73 and will also include a discussion of the reason(s) for the decision and reference to the specific PPO Plan provision(s) on which the adverse benefit determination is based.

Authority of the Appeal Review Committee/Board of Trustees

The Appeal Review Committee and the Board of Trustees, whichever decides the appeal, has the full and exclusive authority to administer the Trust and PPO Plan, interpret all Trust and PPO Plan documents including this Benefit Booklet and resolve all questions arising in the administration, interpretation and application of the Trust and the PPO Plan to specific situations. The Appeal Review Committee and the Board of Trustees' authority include but are not limited to:

- The right to resolve all matters when review has been requested;
- The right to establish and enforce rules and procedures for the administration of claims so long as the rules and procedures are consistent with ERISA; and
- The right to construe and interpret all Trust documents including but not limited to the PPO Plan and this Benefit Booklet.

External Review Process

The external review process is not available for disability waiver, time loss and eligibility claims.

If you disagree with the adverse benefit determination issued by the Appeal Review Committee or Board of Trustees and the decision involves a medical, prescription drug, dental, vision, a rescission of coverage claim, or an adverse benefit determination based on compliance with the

surprise billing protections under the No Surprises Act, you or your authorized representative may file a written appeal within four months after the date of receipt of the adverse benefit determination. The written appeal must be filed as follows:

IBU National Health Benefit Trust
Attention: Appeal Review Committee
PMB #116
5331 S. Macadam Avenue, Suite 258
Portland, OR 97239

The written appeal must describe the adverse benefit determination that is being appealed.

Preliminary Review

Within five business days after receipt of the appeal, the Trust Office will make a preliminary review of the appeal which will include:

- A determination whether the claimant is covered by the PPO Plan at the time the health care item or service was requested or in the case of a post-service claim was covered by the PPO Plan at the time the health care item or service was provided;
- A determination whether the appeal involves a medical, prescription drug, dental, vision, or a rescission of coverage claim, as opposed to eligibility requirements (e.g., worker classification or similar determination). Eligibility, disability waiver, and time loss appeals are not subject to the External Review Process;
- A determination whether the claimant has exhausted the internal claims review procedures or whether exhaustion is not required; and
- A determination whether the claimant has provided all forms and information required to process the appeal.

Within one business day after completing the preliminary review, the Trust Office will notify the claimant in writing whether the appeal is eligible for external review. If the appeal is not complete, the claimant will be notified of the additional information or materials that are required and that it must be received within the four-month period for requesting external review or, if later, 48 hours after receipt of the notice that the submission is incomplete. If the Trust Office determines the appeal is complete but not eligible for external review, the reasons will be provided and the claimant will be provided contact information for the Employee Benefits Security Administration, (866) 444-3272.

The PPO Plan or its designee will contract with at least three independent review organizations (IROs) that are accredited by URAC or a similar nationally-recognized accrediting organization. The IRO will decide the appeal. The appeal will be submitted to an IRO on a random or rotating

basis. The IRO will not receive a financial incentive for determinations that uphold adverse benefit determinations.

Referral to IRO

The PPO Plan or its designee will provide the IRO with all documents and information considered by the Appeal Review Committee/Board of Trustees related to the appeal within five business days of the referral of the appeal to the IRO. If the PPO Plan or its designee fails to timely provide documents and information to the IRO, the IRO can terminate the external review and make a decision to reverse the adverse benefit determination. Within one business day after making the decision, the IRO must notify the claimant and PPO Plan.

If the IRO receives new information or documentation from the claimant, the IRO must notify the PPO Plan within one business day of receipt. Thereafter, the Appeal Review Committee/Board of Trustees may, but is not required to, reconsider the adverse benefit determination in light of the new information or documentation. Reconsideration by the Appeal Review Committee/Board of Trustees will not delay the IRO review. If the Appeal Review Committee/Board of Trustees decides to reverse the prior adverse benefit determination, the claimant and the IRO will be notified within one business day after the decision is made.

The IRO will review all information and documents timely received. The IRO will decide the appeal on a *de novo* basis, meaning without regarding to any decisions or conclusions reach by the Appeal Review Committee/Board of Trustees. In addition to the documents and information provided by the PPO Plan or its designee and claimant, the IRO may consider the following in reaching its decision:

- The claimant's medical records;
- The claimant's health care professional's recommendation;
- Reports from health care professionals and other documents submitted by the PPO Plan, claimant or the claimant's Provider;
- The terms of the PPO Plan;
- Appropriate practice guidelines, which must include applicable evidence-based standards and may include other practice guidelines developed by the federal government, national or professional medical societies, boards and associations;
- Any applicable clinical review criteria developed and used by the PPO Plan unless the criteria are inconsistent with the terms of the PPO Plan or applicable law; and
- The opinion of the IRO's clinical reviewer after considering relevant information and documents.

Decision by the IRO

The IRO must provide a written decision to the claimant and PPO Plan within 45 days after receipt of the request for review. The decision of the IRO should include, to the extent relevant, the following:

- A general description of the reason for the appeal, including information sufficient to identify the claim, the diagnosis code and its meaning, the treatment code and its meaning and the reason for the denial that is subject to appeal;
- The date the IRO received the appeal and the date of decision;
- Reference to documents and information considered in reaching the decision including, if applicable, the claimant's medical records, the recommendations and reports of the claimant's health care professional, clinical review criteria developed and used by the PPO Plan, the applicable terms of the PPO Plan and appropriate practice guidelines, including the applicable evidence-based standards;
- A discussion of the principal reasons for the decision, including any evidence-based standards relied upon;
- 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 claimant or the PPO Plan;
- A statement that judicial review may be available to the claimant; and
- Contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman established under the Public Service Health Act.

If the IRO reverses the decision of the Appeal Review Committee/Board of Trustees, the PPO Plan must immediately provide coverage or payment as directed by the IRO.

Expedited Review by the IRO

The PPO Plan will allow a claimant to make a request for expedited external review at the time the claimant receives:

- An adverse benefit determination that involves a medical condition for which the time frame for completion of the expedited internal appeal would seriously jeopardize the life or health of the claimant or would jeopardize the claimant's ability to regain maximum function and a request for expedited internal review has been filed; or
- The claimant has received an adverse benefit determination from the Appeal Review Committee/Board of Trustees and the claimant has a medical condition where the time frame for completion of the appeal process to the IRO would seriously jeopardize the

claimant's life or health or would jeopardize the claimant's ability to regain maximum function or the appeal concerns an admission, availability of care, continued stay or health care item or service for which the claimant received emergency services but has not been discharged from a facility.

Upon receipt of a request for expedited external review, the Trust Office or its designee will immediately make a preliminary determination if the appeal is eligible for the expedited external review under the standards detailed above. The Trust Office or its designee will notify the claimant in writing whether the appeal is eligible for an expedited decision by the IRO.

Upon a determination that a request is eligible for expedited external review, the Trust Office will transmit all necessary documents and information to the IRO electronically or by any other available expeditious method.

The IRO must consider the information and documents provided to it, to the extent it considers them appropriate. In reaching a decision, the IRO will review the appeal on a *de novo* basis, meaning without regard to any decisions or conclusions reached during the earlier stages of the PPO Plan's review procedures.

The IRO will issue a decision as expeditiously as possible but in no event more than 72 hours after the IRO receives the request for expedited external review. If the decision of the IRO is verbal, it must, within 48 hours of providing the verbal decision, provide written confirmation of the decision to the claimant and the PPO Plan.

Coordination of Benefits

Overview

The Coordination of Benefits (COB) provision applies when a Covered Individual has health and welfare coverage under more than one Plan as defined below. All of the benefits of the PPO Plan are subject to COB except prescription drug, life insurance and time loss. The PPO Plan will coordinate the benefits of the PPO Plan with those of your other health and welfare plans to make certain the total payments from all health and welfare plans are not more than the total Allowable Expense as defined below. The PPO Plan has adopted the National Association of Insurance Commissioners Guidelines for COB for any issue not addressed by the PPO Plan.

The COB rules govern the order in which each Plan will pay a claim for benefits. The Plan that pays first is the Primary Plan. The Primary Plan must pay benefits in accordance with its policy terms without regard to the possibility that another Plan may cover some expenses. The Plan that pays after the Primary Plan is the Secondary Plan. The Secondary Plan may reduce the benefits it pays so that payments from all Plans do not exceed 100% of the total Allowable Expense.

Definitions

Allowable Expense – except as set forth below, means a health care expense, including deductibles, coinsurance and copayments that are covered at least in part by any Plan covering the Covered Individual. When a Plan provides benefits in the form of services, the reasonable cash value of each service will be considered an Allowable Expense and a benefit paid. An expense that is not covered by any Plan covering the Covered Individual is not an Allowable Expense. In addition, any expense that a provider by law or in accordance with a contractual agreement is prohibited from charging a Covered Individual is not an Allowable Expense.

The following are examples of expenses that are not Allowable Expenses:

- If a Covered Individual is confined in a private Hospital room, the difference between the cost of a semi-private hospital room and a private hospital room is not an Allowable Expense unless one of the Plans provides for coverage for private hospital room expenses.
- If a Covered Individual is covered by two or more Plans that compute their benefit payments on a basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology, any amount billed in excess of the highest reimbursement amount for a specific benefit is not an Allowable Expense.

- If a Covered Individual is covered by two or more Plans that provide benefits or services on the basis of negotiated fees, any amount in excess of the highest of the negotiated fees is not an Allowable Expense.
- If a Covered Individual is covered by one Plan that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology and another Plan that provides its benefits or services on the basis of negotiated fees, the Primary Plan's payment arrangement shall be the Allowable Expense for all Plans. However, if the provider has contracted with the Secondary Plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the Primary Plan's payment arrangement and if the provider's contract permits, the negotiated fee or payment shall be the Allowable Expense used by the Secondary Plan to determine benefits.
- The amount of any benefit reduction by the Primary Plan because a Covered Individual has failed to comply with the Plan provisions is not an Allowable Expense. Examples of these types of Plan provisions include second surgery opinions, precertification of admissions, and preferred provider arrangements.
- An expense or a portion of an expense that is not covered by any of the Plans is not an Allowable Expense.

Any expense that a provider by law or in accordance with a contractual agreement is prohibited from charging a Covered Individual is not an Allowable Expense.

Claim – means a request that benefits of a Plan be provided or paid. The benefits claimed may be in the form of:

- Services (including supplies);
- Payment for all or a portion of the expenses incurred;
- A combination of the previous two paragraphs; or
- An indemnification.

Closed Panel Plan – means a Plan that provides health care benefits to Covered Individuals primarily in the form of services through a panel of providers that have contracted with or are employed by the Plan and that excludes coverage for services provided by other providers, except in cases of emergency or referral by a Plan member.

Custodial Parent – means the parent awarded custody by a court decree or, in the absence of a court decree, the parent with whom the child resides more than one-half of the calendar year excluding any temporary visitation.

Plan – means any of the following that provides benefits or services for medical, dental, or vision care or treatment. If separate contracts are used to provide coordinated coverage for Covered Individuals of a group, the separate contracts are considered parts of the same Plan and there is no COB among those separate contracts.

Plan includes:

- Group and non-group insurance, contracts, health maintenance organization contracts, Closed Panel Plans, or other forms of group or group-type coverage (whether insured or uninsured);
- Medical care components of long-term care contracts, such as skilled nursing care (with pre-authoization);
- Medical benefits under group or individual automobile contracts; and
- Medicare or other federal governmental plans, as permitted by law.

Plan does not include:

- Hospital indemnity coverage benefits or other fixed indemnity coverage;
- Accident only coverage;
- Specific disease or specified accident coverage;
- Limited benefit health coverage, as defined by state law;
- School accident-type coverage that covers students for accidents only, including athletic injuries, either on a 24-hour basis or on a "to and from school" basis;
- Benefits provided in long-term care insurance policies for non-medical services such as personal care, adult daycare, homemaker services, assistance with activities of daily living, respite care and custodial care, or for contracts that pay a fixed daily benefit without regard to expenses incurred or the receipt of services;
- Medicare supplement policies;
- A state plan under Medicare; and
- A government plan which by law provides benefits that are in excess of those of any private insurance plan or other non-governmental plan.

Primary Plan – means a Plan whose benefits for a Covered Individual's healthcare coverage must be determined without taking the existence of any other plan into consideration.

Secondary Plan – means a Plan that is not a Primary Plan.

This Plan – means, in the COB context, the part of the PPO Plan providing health care benefits to which the COB provision applies and which may be reduced because of the benefits of other Plans.

Order of Benefit Determination Rules

When a Covered Individual is covered by two or more Plans, the rules for determining the order of benefit payments are as follows:

1. The Primary Plan pays or provides its benefits according to its terms of coverage and without regard to the benefits of any other Plan.
2. Except as provided in subparagraph 2(b) below:
    a. A Plan that does not contain a COB provision that is consistent with the National Association of Insurance Commissioners Guidelines is always primary unless the provisions of both Plans state that the complying Plan is primary.
    b. Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage shall be excess to any other parts of the Plan provided by the contract holder. Examples of these types of situations are major medical coverage that are superimposed over base plan hospital and surgical benefits and insurance-type coverages that are written in connection with a Closed Panel Plan to provide out-of-network benefits.
3. A Plan may consider the benefits paid or provided by another Plan in calculating payment of its benefits only when it is secondary to the other Plan.
4. Each Plan determines its order of benefits using the first of the following rules that apply:
    a. *Non-Dependent or Dependent*. The Plan that covers the Covered Individual other than as a Dependent, for example as an Employee, member, policyholder, subscriber, or retiree is the Primary Plan and the Plan that covers the Covered Individual as a Dependent is the Secondary Plan. However, if the Covered Individual is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the Plan covering the Covered Individual as a Dependent; and primary to the Plan covering the Covered Individual as other than a Dependent (e.g., a retired employee); then the order of benefits between the two Plans is reversed so that the Plan covering the Covered Individual as an Employee, member, policyholder, subscriber, or retiree is the Secondary Plan and the other Plan is the Primary Plan.

b. *Dependent Child Covered under More than One Plan*. Unless there is a court order stating otherwise, when a dependent child is covered by more than one Plan, the order of benefits is determined as follows:

i. For a dependent child whose parents are married or are living together whether or not they have ever been married:

- The Plan of the parent whose birthday falls earlier in the calendar year is the Primary Plan; or
- If both parents have the same birthday, the Plan that has covered the parent the longest is the Primary Plan.

ii. For a dependent child whose parents are divorced or separated or are not living together, whether or not they have ever been married:

- If a court decree states that one of the parents is responsible for the dependent child's health care expenses or health care coverage and the Plan of that parent has actual knowledge of those terms, that Plan is primary. This rule applies to plan years commencing after the Plan is given notice of the court decree;
- If a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of subparagraph 4(b)(i) above shall determine the order of benefits;
- If a court decree states the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of subparagraph 4(b)(i) above shall determine the order of benefits; or
- If there is no court decree allocating responsibility for the dependent child's health care expenses or health care coverage, the order of benefits for the child are as follows:
    - The Plan covering the Custodial Parent;
    - The Plan covering the Custodial Parent's spouse;
    - The Plan covering the non-custodial parent; and then
    - The Plan covering the non-custodial parent's spouse.

iii. For a dependent child covered under more than one Plan of individuals who are the parents of the child, the provisions of subparagraph 4(b)(i) or 4(b)(ii)

above shall determine the order of benefits as if those individuals were the parents of the child.

c. *Dependent Child with Multiple Coverage*. For a Dependent Child who has coverage under either or both parents' plans and also has their own coverage as a dependent under a spouse's plan, the rules in paragraph (f) apply. In the event the Dependent Child's coverage under the spouse's plan began on the same date as the Dependent Child's coverage under either or both parents' plans, the order of benefits shall be determined by applying the birthday rule in paragraph 4(b)(i) to the Dependent Child's parent(s) and the Dependent Child's spouse.

d. *Active Employee or Retired or Laid-Off Employee.* The Plan that covers a person as an active employee (an employee who is not laid off or retired), is the Primary Plan. The Plan covering the same person as a retired or laid-off employee is the Secondary Plan. The same would hold true if a person is a dependent of an active employee and the same person is a dependent of a retired or laid-off employee. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule in subparagraph 4(a) can determine the order of benefits.

e. *COBRA or State Continuation Coverage*. If a person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another Plan, the Plan covering the person as an employee, member, subscriber, or retiree or covering the person as a dependent of an employee, member, subscriber, or retiree is the Primary Plan and the COBRA or state or other federal continuation coverage is the Secondary Plan. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule in subparagraph 4(a) can determine the order of benefits.

f. *Longer or Shorter Length of Coverage*. The Plan that covered the Covered Individual as an employee, member, policyholder, subscriber, or retiree for the longer period of time is the Primary Plan and the Plan that covers the Covered Individual the shorter period of time is the Secondary Plan. To determine the length of time a Covered Individual has been covered under a Plan, two successive plans shall be treated as one if the Covered Individual was eligible under the second Plan within 24 hours after coverage under the first plan ended. The start of a new Plan does not include a change in the amount or scope of a Plan's benefits; a change in the entity that pays, provides or administers the Plan's benefits; or a change from one type of plan to another, such as from a single employer plan to multiple employer plan. The Covered Individual's length of time covered under a plan is measured from the

Covered Individual's first date of coverage under that Plan. If that date is not readily available, the date the Covered Individual first became a member of the group shall be used as the date from which to determine the length of time the Covered Individual's coverage under the present plan has been in force.

g. If none of the preceding rules determine the order of benefits, the Allowable Expenses shall be shared equally between the Plans meeting the definition of Plan.

h. For all purposes in this section, if the PPO Plan is not the Primary Plan, it will not pay more than it would have paid had it been the Primary Plan.

Procedure to be Followed by Secondary Plan to Calculate Benefits and Pay a Claim

When the PPO Plan is the Secondary Plan, it may reduce its payment obligation so that the total benefits paid or provided by all Plans during a plan year are not more than the total Allowable Expenses. In determining the amount to be paid for any claim, the Secondary Plan will calculate the benefits it would have paid in the absence of other health care coverage and apply that calculated amount to any Allowable Expense under its Plan that is unpaid by the Primary Plan. The Secondary Plan may reduce its payment by the amount so that when combined with the amount paid by the Primary Plan, the total benefits paid or provided by all Plans for the claim do not exceed the total Allowable Expense for that claim. In addition, the Secondary Plan shall credit to its Plan deductible any amounts it would have credited to its deductible in the absence of other health care coverage.

Right to Receive and Release Needed Information

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under the PPO Plan and other Plans. The organization responsible for COB administration may get the facts it needs from or give them to other organizations or persons for the purpose of applying these rules and determining benefits payable under the PPO Plan and the other Plans covering the person claiming benefits. Organizations responsible for COB administration need not tell, or get the consent of, any person to do this. Each person claiming benefits under the PPO Plan must give the Trust Office any facts it needs to apply these rules and determine benefits payable.

Facility of Payment

A payment made under another Plan may include an amount that should have been paid under the PPO Plan. If this occurs, the Trust Office may pay that amount to the organization that made that payment. That amount will then be treated as though it was a benefit under the PPO Plan. The Trust Office will not have to pay that amount again. The term "payment made" includes

providing benefits in the form of services, in which case "payment made" means the reasonable cash value of the benefits provided in the form of services.

Right of Recovery

If the amount of the payment made by the PPO Plan is more than it should have paid under this COB provision, it may recover the excess from one or more of the persons it has paid or for whom it has paid; or any other person or organization that may be responsible for the benefits or services provided for the Covered Individual. The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

COBRA – Continuation Coverage

This section is applicable to all Employees, Early Retirees and their Dependents regardless of whether you are enrolled in the PPO Plan, a Kaiser Permanente Plan, or the HMSA Hawaii PPO Plan.

Introduction

This section contains important information about your right to COBRA continuation coverage, which is a temporary extension of medical and prescription drug coverage or medical, prescription drug, dental and vision coverage. COBRA continuation coverage is available when you or your Dependents who are covered under the PPO Plan or an insured Plan (Kaiser Permanente or HMSA Hawaii PPO Plan) would otherwise lose your group health and welfare plan coverage. This section explains COBRA continuation coverage, when it becomes available and what you and your Dependents need to do to preserve your right to COBRA continuation coverage.

What is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of health and welfare plan coverage that would otherwise end because of a life event known as a qualifying event. The qualifying events are listed later in this section.

After a qualifying event occurs, COBRA continuation coverage must be offered to each person who is a qualified beneficiary. A qualified beneficiary is someone who will lose health and welfare plan coverage because of a qualifying event. Depending on the type of qualifying event, Employees, Early Retirees, spouses and Dependent children may be qualified beneficiaries. Certain newborns, newly adopted children and alternate recipients under Qualified Medical Child Support Orders may also be qualified beneficiaries. Qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

Who is Entitled to Elect COBRA Continuation Coverage?

If you are an Employee or Early Retiree, you will become a qualified beneficiary if you lose your coverage under the PPO Plan, a Kaiser Permanente Plan, or HMSA Hawaii PPO Plan because either of the following qualifying events happen:

- Your hours of employment are reduced; or
- Your employment ends for any reason.

If you are the spouse of an Employee or Early Retiree, you will become a qualified beneficiary if you lose your coverage under the PPO Plan, a Kaiser Permanente Plan, or HMSA Hawaii PPO Plan because any of the following qualifying events happen:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason;
- Your spouse becomes entitled to Medicare (Part A, Part B, or both); or
- You become divorced or legally separated from your spouse. If an Employee or Early Retiree cancels coverage for their spouse in anticipation of a divorce or legal separation and a divorce or legal separation later occurs, then the divorce or legal separation will be considered a qualifying event even though the ex-spouse lost coverage earlier. If the ex-spouse provides written notice to the Trust Office within 120 days after the divorce or legal separation and can establish that the Employee or Early Retiree canceled the coverage earlier in anticipation of the divorce or legal separation, then COBRA continuation coverage may be available for the period after the divorce or legal separation.

Domestic Partners and children of Domestic Partners are not qualified beneficiaries and do not have a right to elect COBRA continuation coverage. However, if an Employee or Early Retiree has a qualifying event, they are allowed to elect COBRA continuation coverage for themself as well as their Domestic Partner and the Domestic Partner's children who will lose health and welfare coverage as a result of the Employee's or Early Retiree's qualifying event.

Dependent children will become qualified beneficiaries if they lose coverage under the PPO Plan, a Kaiser Permanente Plan, or HMSA Hawaii PPO Plan because any of the following qualifying events happen:

- The parent-Employee or Early Retiree dies;
- The parent-Employee's or Early Retiree's hours of employment are reduced;
- The parent-Employee's or Early Retiree's employment ends for any reason;
- The parent-Employee or Early Retiree becomes entitled to Medicare (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child is no longer eligible for coverage because they no longer qualify as a "Dependent child."

A child of a Domestic Partner is not a qualified beneficiary and does not have the right to elect COBRA continuation coverage if any one of the above events occurs.

Special Second Election Period. Certain former Employees who are eligible for federal trade adjustment assistance or alternative trade adjustment assistance are entitled to a second opportunity to elect COBRA continuation coverage for themselves and certain family members (if they did not already elect COBRA) during a special second election period of 60 days or less (but only if the election is made within six months after coverage under the PPO Plan, a Kaiser Permanente Plan, or HMSA Hawaii PPO Plan is lost). If you are an Employee, former Employee, or Early Retiree and you qualify for federal trade adjustment assistance or alternative trade adjustment assistance, contact the Trust Office after qualifying for federal trade assistance or alternative trade adjustment assistance or you will lose any right that you may have to elect COBRA during a special second election period. Contact the Trust Office for more information about this special second election period.

Notices and Elections of COBRA Continuation Coverage

Your spouse's or Domestic Partner's coverage ends on the last day of the month in which a divorce, legal separation or dissolution of the Domestic Partner relationship occurs and a Dependent child's coverage ends on the last day of the month in which the Dependent child no longer qualifies as a Dependent.

When the qualifying event is the termination of employment, reduction of hours of employment, or death of the Employee or Early Retiree, the Plan will offer COBRA continuation coverage to qualified beneficiaries. You do not need to notify the Trust Office of any of these qualifying events.

For the other qualifying events (divorce or legal separation, or a Dependent child losing eligibility for coverage as a Dependent child, a COBRA election will be available only if you notify the Trust Office in writing within 60 days after the later of:

- The date of the qualifying event; or
- The date on which the qualified beneficiary loses (or would lose) coverage under the terms of the Plan as a result of the qualifying event.

Follow the notice procedures in the next section.

Notice Procedures

Any notice that you provide must be in writing. Oral notice, including notice by telephone, is not acceptable. You must mail or deliver your written notice to the Trust Office at this address:

Inlandboatmen's Union of the Pacific
National Health Benefit Trust
c/o Benesys, Inc.
PMB #116
5331 S. Macadam Avenue, Suite 258
Portland, OR 97239

If mailed, your notice must be postmarked no later than the last day of the required notice period. Any notice you provide must state the Trust name (Inlandboatmen's Union of the Pacific National Health Benefit Trust), the name and address of the Employee or Early Retiree covered by the Trust and the name(s) and address(es) of the qualified beneficiary(ies) who will lose coverage due to a qualifying event. The notice must also state the qualifying event (divorce, legal separation, or a child who no longer qualifies as a Dependent) and the date the qualifying event happened. If the qualifying event is a divorce or legal separation, your notice must include a copy of the divorce decree or legal separation agreement.

If the Trust Office receives timely written notice that one of the three qualifying events (divorce, legal separation, or a child losing Dependent status) has happened, the Trust Office will notify the family member of the right to elect COBRA continuation coverage. You, your spouse, or Dependent child will also be notified of the right to elect COBRA continuation coverage automatically (without any action required) when coverage is lost because your employment ends, hours of employment are reduced, you die or become entitled to Medicare (Part A, Part B or both).

A qualified beneficiary must elect COBRA continuation coverage within 60 days of receiving the COBRA election form or, if later, 60 days after coverage ends by completing and returning the election form to the Trust Office. Each qualified beneficiary has a right to elect COBRA continuation coverage. If the qualified beneficiary does not elect COBRA continuation coverage within the 60-day election period, the qualified beneficiary(ies) will lose the right to elect COBRA continuation coverage. The decision to accept COBRA continuation coverage is effective on the date the election is mailed to the Trust Office. A qualified beneficiary may change a prior rejection of COBRA continuation coverage to acceptance at any time until the election period expires.

In considering whether to elect COBRA continuation coverage, the qualified beneficiary should take into account that they have special enrollment rights under federal law. A qualified beneficiary has the right to request special enrollment in another group health plan for which they are otherwise eligible (such as a plan sponsored by your spouse's employer) within 30

days after Plan coverage ends because of one of the qualifying events listed above. You will also have the same special enrollment rights at the end of the COBRA continuation coverage if you get COBRA continuation coverage for the maximum period of time available.

Benefits Available under COBRA Continuation Coverage

A qualified beneficiary has the right to elect COBRA continuation coverage for medical and prescription drug coverage, or for medical, prescription drug, dental and vision coverage. Any other benefits provided to you or your family such as time loss benefits, disability waivers, and life insurance are not available by electing COBRA continuation coverage. COBRA continuation coverage is identical to the medical, prescription drug, dental and vision coverage available to similarly situated Employees or Early Retirees and Dependents. If the medical, prescription drug, dental and/or vision coverage is modified, COBRA continuation coverage will be modified in the same way. All family members must select the same coverage.

How Long COBRA Continuation Coverage Lasts

COBRA continuation coverage is a temporary continuation of health and welfare plan coverage. The COBRA continuation coverage periods described below are maximum coverage periods. COBRA continuation coverage can end before the end of the maximum coverage period for the reasons described in the section entitled **Termination of COBRA Continuation Coverage before the End of the Maximum Period**.

When the qualifying event is the death of the Employee or Early Retiree, the Employee or Early Retiree becoming entitled to Medicare benefits (Part A, Part B or both), divorce, legal separation, or a Dependent child losing eligibility as a Dependent child, COBRA continuation coverage lasts for up to 36 months.

When the qualifying event is the Employee's or Early Retiree's termination of employment or reduction of the Employee's or Early Retiree's hours of employment, COBRA continuation coverage lasts for up to 18 months. There are several ways the 18 months of COBRA continuation coverage can be extended.

Medicare Extension of Eighteen-Month Period of COBRA Continuation Coverage. When the qualifying event is the Employee's or Early Retiree's termination of employment or reduction of the Employee's or Early Retiree's hours of employment, and the Employee or Early Retiree becomes entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the Employee or Early Retiree can last for 36 months after the date of Medicare entitlement. For example, if an Employee became entitled to Medicare eight months before the date their health and welfare coverage terminates because of a reduction of hours of employment, COBRA continuation coverage for their spouse and Dependent children can last up to 36 months after the date of Medicare entitlement, which

is equal to 28 months after the date of the qualifying event (36 months minus eight months). Otherwise, when the qualifying event is the Employee's or Early Retiree's termination of employment or reduction of hours of employment, COBRA continuation coverage generally lasts for up to 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

Disability Extension of 18-Month Period of COBRA Continuation Coverage. If a qualified beneficiary is determined by the Social Security Administration to be disabled and you notify the Trust Office in a timely fashion, all qualified beneficiaries may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. This extension is available only for qualified beneficiaries who are receiving COBRA continuation coverage because of a qualifying event that was the Employee's or Early Retiree's termination of employment or reduction of hours of employment. The disability must have started at a time before the 61st day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage. You must make sure that the Trust Office is notified in writing of the Social Security Administration's disability determination within 60 days after the date of the determination and before the end of the 18-month period of COBRA continuation coverage. You must follow the procedures under the heading **Notice Procedures**. In addition, your written notice must include the name of the disabled qualified beneficiary, the date that they became disabled, the date that the Social Security Administration made its determination and include a copy of the Social Security Administration's disability determination. If these procedures are not followed or if the notice is not provided in writing to the Trust Office within the required time, there will be no disability extension of COBRA continuation coverage. If the qualified beneficiary is determined by the Social Security Administration to no longer be disabled, you must notify the Trust Office in writing within 30 days after the Social Security Administration's determination.

Second Qualifying Event Extension of 18-Month Period of COBRA Continuation Coverage. If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, the spouse and Dependent children can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months. This extension is available to the spouse and any Dependent children receiving COBRA continuation coverage if the Employee or Early Retiree dies, becomes entitled to Medicare benefits (Part A, Part B, or both), gets divorced, legally separated, or if the Dependent child no longer qualifies as a Dependent child but only if the event would have caused the spouse, or Dependent child to lose coverage under the PPO Plan, a Kaiser Permanente Plan, or the HMSA Hawaii PPO Plan had the first qualifying event not occurred. In all these cases, the spouse or Dependent child must make sure that the Trust Office is notified in writing of the second qualifying event within 60 days of the second qualifying event. The spouse or Dependent child must follow the procedures under the heading **Notice Procedures**. Your written notice must describe the second qualifying event and

the date it happened. If the second qualifying event is a divorce or legal separation, your notice must include a copy of the divorce decree or legal separation agreement. If these procedures are not followed or if the notice is not provided in writing to the Trust Office within the required 60-day period, there will be no extension of COBRA continuation coverage due to a second qualifying event.

How Much COBRA Continuation Coverage Costs

A qualified beneficiary who elects COBRA continuation coverage will be required to pay the cost of COBRA continuation coverage. The cost may not exceed 102% (or, in the case of an extension of COBRA continuation coverage due to a disability, 150%) of the cost to the group health plan for coverage of a similarly situated Employee, Early Retiree, or Dependent who is not receiving COBRA continuation coverage. The amount of your COBRA premiums may change from time to time during your period of COBRA coverage and you will be notified if the COBRA premium charges.

When and How Payment for COBRA Continuation Coverage must be Made

First Payment for COBRA Continuation Coverage. If you elect COBRA continuation coverage, you do not have to send payment with the election form. However, you must make your first payment for COBRA continuation coverage no later than 45 days after the date of your election. This is the date the election form is postmarked, if mailed. If you do not make your first payment for COBRA continuation coverage in full no later than 45 days after the date of your election, you will lose all COBRA continuation coverage rights.

Your first payment must cover the cost of COBRA continuation coverage from the time your coverage under the PPO Plan, a Kaiser Permanente Plan, or the HMSA Hawaii PPO Plan would have otherwise terminated up to the time you make the first payment. You are responsible for making sure that the first payment is enough to cover the entire cost. You may contact the Trust Office to confirm the correct amount of your first payment.

All payments for COBRA continuation coverage should be sent to:

Inlandboatmen's Union of the Pacific
National Health Benefit Trust
c/o Benesys, Inc.
PMB #116
5331 S. Macadam Avenue, Suite 258
Portland, OR 97239

Monthly Payments for COBRA Continuation Coverage. After you make your first payment for COBRA continuation coverage, you are required to pay for COBRA continuation coverage for each subsequent month of coverage. The monthly payments are due by the first day of the

month. If you make a monthly payment by the first day of the month, your coverage will continue for that coverage period without any break. **The Trust Office will not send notices of payments due for these coverage periods**.

Monthly payments for COBRA continuation coverage should be sent to:

Inlandboatmen's Union of the Pacific
National Health Benefit Trust
c/o Benesys, Inc.
PMB #116
5331 S. Macadam Avenue, Suite 258
Portland, OR 97239

Grace Period for Monthly Payments. Although monthly payments are due by the first day of the month, you have a grace period of 30 days to make each monthly payment. Your COBRA continuation coverage will be provided for each coverage period as long as payment for that coverage period is made before the end of the grace period. However, if you pay a monthly payment later than the first day of the month but before the end of the grace period, your coverage under the PPO Plan, a Kaiser Permanente Plan, or HMSA Hawaii PPO Plan will be suspended as of the first day of the month and then retroactively reinstated (going back to the first day of the month) when the monthly payment is received. This means that any claim you submit for benefits while your coverage is suspended may be denied and may have to be resubmitted once your coverage is reinstated. If you fail to make a monthly payment by the end of the grace period, you will lose all COBRA continuation coverage rights.

Termination of COBRA Continuation Coverage before the End of the Maximum Period

COBRA continuation coverage will automatically end (even before the end of the maximum coverage period) if:

- The premium is not paid by the end of the grace period;
- After electing COBRA continuation coverage, a qualified beneficiary becomes entitled to Medicare (Part A, Part B, or both);
- After electing COBRA continuation coverage, a qualified beneficiary becomes covered under another group health plan;
- The Trust no longer provides group health coverage for any of its participants;
- The Employee's last Employer stops contributing to the Trust and makes a group health plan available for its employees formerly covered under the Trust. In this situation, the group health plan maintained by your last employer has the obligation to make COBRA

continuation coverage available to any qualified beneficiary who was receiving COBRA continuation coverage from the Trust on the day before the cessation of contributions by the Employer and whose last employment prior to the qualifying event was with the Employer; or

- During a disability extension period, the disabled person is determined by the Social Security Administration to no longer be disabled. In this circumstance, COBRA continuation coverage will be terminated for any qualified beneficiary who is receiving extended COBRA continuation coverage under the disability extension at the later of (a) the first day of the month that is more than 30 days after the final determination by the Social Security Administration that the qualified beneficiary is no longer disabled; or (b) the end of the coverage period that applies without regard to the disability extension.

A qualified beneficiary must notify the Trust Office in writing within 30 days if, after electing COBRA continuation coverage, they become entitled to Medicare (Part A, Part B or both), is covered under another group health plan or is determined by the Social Security Administration to no longer be disabled. Follow the **Notice Procedures** on page 92.

Automatic COBRA Continuation Coverage for your Spouse or Domestic Partner and Dependent Children in Certain Circumstances

When an Employee or Early Retiree elects COBRA continuation coverage, coverage for their spouse or Domestic Partner (if they had coverage immediately before the qualifying event) and Dependent children will continue automatically unless your spouse or Domestic Partner or Dependent children independently declines COBRA continuation coverage. If the Employee or Early Retiree chooses not to elect COBRA continuation coverage, your spouse (if they had coverage immediately before the qualifying event) and Dependent children may still elect COBRA continuation coverage. Of course, in all circumstances, anyone electing COBRA continuation coverage must pay the required premium.

Transfer Rights

If you are covered by a Kaiser Permanente Plan or the HMSA Hawaii PPO Plan that covers a limited geographic area and move to another area where employers contributing to the Trust have an active workforce, you may be entitled to elect coverage available to other Employees working in that area. If you find yourself in this situation, call or write the Trust Office. Under no circumstance would such a transfer prolong your maximum COBRA continuation coverage.

More Information about Individuals who may be Qualified Beneficiaries

A child born to, adopted by or placed for adoption with an Employee or Early Retiree during a period of COBRA continuation coverage is considered a qualified beneficiary provided the

Employee or Early Retiree has elected COBRA continuation coverage. The child's COBRA continuation coverage begins when the child is born and it lasts as long as COBRA continuation coverage lasts for other family members of the Employee or Early Retiree. To be enrolled, the child must satisfy the otherwise applicable eligibility requirements (for example, age).

A child of an Employee or Early Retiree who is receiving benefits under the PPO Plan, a Kaiser Permanente Plan, or the HMSA Hawaii PPO Plan pursuant to a Qualified Medical Child Support Order is entitled to the same rights under COBRA as a Dependent child of the Employee or Early Retiree, regardless of whether that child would otherwise be considered a Dependent.

Are there Coverage Options Besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for qualified beneficiaries through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

Health Insurance Marketplace. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. Through the Marketplace, you could be eligible for a tax credit that lowers your monthly premiums and cost-sharing reductions that lower your out-of-pocket costs for Deductibles, co-insurance and Co-Payments. You have a 60-day special enrollment period following the time you lose your Plan coverage in which to enroll in the Marketplace. After 60 days, your special enrollment period will end and you may not be able to enroll until the Marketplace's next annual open enrollment period. To find out more about the Marketplace, visit www.healthcare.gov.

Enrollment in Another Group Health Plan. You may be eligible to enroll in coverage under another group health plan (such as your spouse's plan) if you request enrollment within 30 days of the loss of coverage. If you or your Dependent chooses to elect COBRA coverage instead of enrolling in another group health plan for which you are eligible, you may have another opportunity to enroll in the other group health plan within 30 days of losing your COBRA continuation coverage.

More Information about COBRA Continuation Coverage

Questions concerning the PPO Plan, a Kaiser Permanente Plan, or the HMSA Hawaii PPO Plan or your COBRA continuation coverage rights should be addressed to the Trust Office. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District office of the US

Department of Labor's Employee Benefits Security Administration (EBSA) or visit the EBSA website at www.dol.gov/agencies/ebsa. Addresses and phone numbers of Regional and District EBSA offices are available through the website. For more information about options available through the Health Insurance Marketplace, visit www.healthcare.gov.

Keep the Trust Office Informed of Address Changes

To protect your family's rights, you should keep the Trust Office informed of any changes in the addresses of family members. You should keep a copy of any notice you send to the Trust Office.

Subrogation and Reimbursement Obligations

The following definitions apply to this section:

- **Covered Individual** – means an individual covered by the PPO Plan as well as the estate, heirs, guardian and/or conservator of a Covered Individual. Covered Individual also includes any trust established for the purpose of receiving Recovery Funds and/or paying future income, care or medical expenses to or for a Covered Individual as the result of a Third Party Claim.
- **Recovery Funds** – means any amount recovered by or for a Covered Individual from a Third Party as the result of a Third Party Claim.
- **Third Party Claim** – means any claim, lawsuit, settlement, award, verdict, judgment, arbitration decision or other action by a Covered Individual against a Third Party (or any right to assert the foregoing) alleging or claiming the Third Party may be responsible (from a liability and/or financial standpoint) for the Injury or Illness of a Covered Individual for which Covered Charges are paid or may be paid by the Trust.
- **Third Party** – means any individual or entity who may be fully or partially responsible (from a liability and/or financial standpoint) for the Injury or Illness of a Covered Individual for which Covered Charges are paid or may be paid by the Trust. Third Party includes any insurer of such individual or entity and includes, but is not limited to, all types of liability insurance as well as other forms of insurance that may pay money to or on behalf of a Covered Individual including uninsured motorist coverage, under-insured motorist coverage, premises med-pay coverage, personal injury protection coverage, worker's compensation coverage, and longshore and harborworker coverage.

Subrogation Rights

Upon payment of Covered Charges in excess of $10,000 for an Injury or Illness of a Covered Individual that are related to a Third Party Claim, the Trust shall be subrogated to all a Covered Individual's rights of recovery against a Third Party and the Covered Individual shall do whatever is necessary to secure such rights and do nothing to prejudice them.

The Trust, PPO Plan, or Board of Trustees may pursue a Third Party to recover the Covered Charges for an Injury or Illness that are paid or may be paid by the Trust that are related to the Third Party Claim in the Trust's name, PPO Plan's name, Board of Trustees' name, or in the name of a Covered Individual. The Trust, PPO Plan, and Board of Trustees are entitled to all subrogation rights and remedies of a Covered Individual under common law and statutory law as well as under this Benefit Booklet.

Right of Recovery

In addition to the Trust's subrogation rights, the following rules apply:

- A Covered Individual and their attorney, if any, shall hold any Recovery Funds in a trust or escrow account for the Trust up to the amount of Covered Charges the Trust paid or may pay for the Injury or Illness of a Covered Individual that are related to the Third Party Claim. The Trust shall be paid first from the Recovery Funds.
- A Covered Individual grants the Trust an equitable lien and/or constructive trust to all Recovery Funds up to the amount of Covered Charges the Trust paid or may pay for the Injury or Illness of a Covered Individual that are related to the Third Party Claim. If the Covered Individual is represented by an attorney, all Recovery Funds shall be deposited in the attorney's trust account. No portion of the Recovery Funds shall be paid to the Covered Individual, the attorney or anyone other than the Trust until the Trust's right to reimbursement in the following paragraph has been fully satisfied.
- The Trust is entitled to a first priority recovery from the Recovery Funds for the full amount of Covered Charges it has paid or may pay for the Injury or Illness of a Covered Individual that are related to the Third Party Claim. However, if the Covered Individual has employed an attorney who assisted in obtaining the Recovery Funds, the Plan will allow no more than a 25% reduction in the repayment of Covered Charges; provided the Board of Trustees may allow a greater reduction in the repayment of Covered Charges in an amount thee Trustees have determined is a reasonable attorney fee (but not to exceed the percentage amount of such legal fees). A reduction in Covered Charges will be allowed only for reasonable and necessary out-of-pocket costs incurred in obtaining the Recovery Funds. There will be no reduction in Covered Charges to the extent that the Recovery Funds are attributable to personal injury protection insurance coverage. The repayment obligation exists regardless of whether: (1) a Covered Individual has been made whole; (2) the Third Party admits liability or asserts that a Covered Individual is also at fault; (3) the Covered Individual only sought the recovery of non-economic damages; or (4) a claim has been resolved through a disputed claims settlement where the parties agree the Injury or Illness is not work-related or caused by the Third Party. The Board of Trustees reject the make whole, collateral source and common fund theories and the Trust's rights shall not be affected by similar doctrines or rules, whether established at common law or statute, that would reduce the Trust's right to full recovery under this **Subrogation and Reimbursement Obligations** section of the Benefit Booklet.
- The Trust, PPO Plan, and Board of Trustees may require a Covered Individual and their attorney, if any, to sign a reimbursement agreement to abide by this **Subrogation and**

Reimbursement Obligations section as a prerequisite to paying for Covered Charges related to a Third Party Claim.

- A Covered Individual and their attorney, if any, shall do nothing to prejudice the Trust's right of recovery under this **Subrogation and Reimbursement Obligations** section.
- The Trust and PPO Plan may, at the discretion of the Board of Trustees, suspend payment or deny payment of Covered Charges for an Injury or Illness of a Covered Individual related to the Third Party Claim if a Covered Individual and/or their attorney fail to cooperate and/or perform all acts required by this **Subrogation and Reimbursement Obligations** section or the Board of Trustees has a reasonable basis to believe a Covered Individual will not honor all of their obligations under this **Subrogation and Reimbursement Obligations** section.

Additional Obligations of a Covered Individual and Rights of the Trust, PPO Plan and the Board of Trustees

In connection with the Trust's, the PPO Plan's and the Board of Trustees' right to subrogation and reimbursement, a Covered Individual shall do the following as applicable and agrees that the Trust, the PPO Plan, and the Board of Trustees may do one or more of the following at the Board of Trustees' discretion:

- If a Covered Individual seeks payment for Covered Charges for an Injury or Illness for which there may be a Third Party Claim, a Covered Individual shall notify the Trust Office of the potential Third Party Claim. A Covered Individual has this responsibility even if the first request for payment of Covered Charges is a bill or invoice submitted by a Provider or Hospital.
- Upon request from the Trust Office, a Covered Individual shall provide the Trust Office with all available information relating to the potential Third Party Claim.
- A Covered Individual shall immediately disclose to the Trust Office all Recovery Funds and all settlements of any kind that have been obtained that are related to the Third Party Claim.
- By accepting payment of Covered Charges relating to an Injury or Illness for which there may be a Third Party Claim, a Covered Individual agrees that the Trust, the PPO Plan and the Board of Trustees have the right to intervene in any lawsuit, mediation or arbitration filed by or on behalf of a Covered Individual seeking Recovery Funds from a Third Party.

- A Covered Individual agrees that the Trust Office, Trust, PPO Plan and/or Board of Trustees may notify any Third Party or Third Party's representative or insurer of the recovery rights set forth in this **Subrogation and Reimbursement Obligations** section.
- This **Subrogation and Reimbursement Obligations** section applies regardless of whether a Covered Individual's Injury or Illness for which there may be a Third Party Claim occurred before the Covered Individual became enrolled in the PPO Plan.
- If any term, provision, agreement or condition of this **Subrogation and Reimbursement Obligations** section is held by a Court to be invalid or unenforceable, the remainder of the section shall remain in full force and effect and shall in no way be affected, impaired or invalidated.
- The Board of Trustees has the authority to compromise subrogation and reimbursement claims on a case by case basis depending on the facts and circumstances.

Return of Overpayment

If the Trust, PPO Plan, Premera, Moda Health Plan, Inc., the Trust Office, the Board of Trustees or any of their designees mistakenly pay a claim for a Covered Individual for which they are not entitled to payment, or if payment is made to or for a person who no longer qualifies as a Dependent (for example, a former spouse or former Domestic Partner), or if a payment is made to a person or entity who is not entitled to payment, or if payment is made in the wrong amount, the Board of Trustees or its designee has the right to recover the payment from the person or entity paid or anyone else who benefited from it, including a provider of services. The Board of Trustees' or its designee's right to recover includes the right to deduct the amount paid by mistake from future benefits payable for an Employee, Early Retiree, or any Dependent of the Employee or Early Retiree even if the mistaken payment was not made on that person's behalf.

Legal Rights, Notices and Disclosures

Newborns' and Mothers' Health Protection Act

Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child for less than 48 hours following a vaginal delivery or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending Provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours, as applicable). In any case, plans and issuers may not, under federal law, require a Provider to obtain authorization from the plan or the issuer for prescribing length of stay not in excess of 48 hours (or 96 hours). The PPO Plan complies with the Newborns' and Mothers' Health Protection Act.

Women's Health and Cancer Rights Act

If following a mastectomy you elect breast reconstruction in connection with such mastectomy, the following charges will be covered:

- Reconstruction of the breast on which the mastectomy has been performed;
- Surgery and reconstruction of the other breast to produce symmetric appearance; and
- Coverage for prostheses and physical complications of all stages of mastectomy, including lymphedemas, in a manner determined in consultation between you and your attending physician.

This benefit is subject to the Deductible, Co-Payments, and percentage payable provisions in the PPO Plan.

Qualified Medical Child Support Orders

The Board of Trustees will recognize and be bound by Qualified Medical Child Support Orders. You may contact the Trust Office to obtain, without charge, the procedure the Board of Trustees will follow when a Medical Child Support Order is received.

Disclosure of Grandfather Plan Status

The PPO Plan, the Kaiser Permanente Plans, and the HMSA Hawaii PPO Plan are not "grandfathered health plans" under the Patient Protection and Affordable Care Act.

No Suprises Act

Beginning January 1, 2022, the Plan implemented changes as required by the No Surprises Act, which is a federal law that protects healthcare consumers from receiving surprise bills from out-of-network Providers in certain situations.

In-Network Cost Sharing and No Balance Billing for Services Covered under the No Surprises Act

Typically, under the Plan, if you receive medical services from an out-of-network provider, you are responsible for out-of-network cost sharing amounts (including any Co-payments, Coinsurance and Deductible). You are also responsible for any amount that exceeds the Plan's Maximum Allowance for the covered services (which is called "balance billing").

Starting January 1, 2022, if you receive covered services that are covered under the No Surprises Act (see below for description of the limited covered services covered by the No Surprises Act), your cost sharing will be the same as if you had received those services from an in-network provider. This means that:

- You will not have to satisfy the out-of-network deductible, copayment or coinsurance for these services.
- You will not have to pay the amount billed by the out-of-network provider that exceeds the Plan's Maximum Allowance for the covered service.
- You will only pay the in-network cost sharing.
- When there is in-network coinsurance, your coinsurance will be based on a percentage of the amount required by the No Surprises Act, which will usually be the qualifying payment amount. The qualifying payment amount is generally the median contracted rate for the item or service in the same geographic region, as adjusted under Department of Labor Regulations.

Furthermore, your share of costs for out-of-network services that are covered under the No Surprises Act will apply to your in-network out-of-pocket maximum. (Typically, cost sharing for out-of-network services other than Emergency services would not apply to your in-network out-of-pocket maximum under the Plan.)

In addition, if you receive covered services covered by the No Surprises Act, the Plan will pay the out-of-network provider directly, based on the terms of the No Surprises Act. In that case, the out-of-network provider is generally prohibited from sending you a "balance bill" for charges billed for otherwise covered services in excess of the amount on which the Plan based its payment.

Services Covered by the No Surprises Act

The following services are covered under the No Surprises Act:

- Emergency Services at an out-of-network health care facility or provided by an out-of-network provider (unless you consent to be treated by the out-of-network provider for certain post-stabilization services – see "Consent Requirements" below)
- Non-emergency services provided by an out-of-network provider at an in-network health care facility (unless you consent to be treated by the out-of-network provider, if applicable – see "Consent Requirements" below)
- Out-of-network air ambulance services

Keep in mind that the special rules described above only apply to covered services covered by the No Surprises Act. Other out-of-network covered services remain subject to the normal rules of the Plan.

Also note that regardless of whether a covered service is also covered under the No Surprises Act, you are always responsible for any expenses or charges billed by any provider or facility that are not medically necessary or are otherwise not covered services under the Plan.

Definition of Emergency Services

The Plan covers Emergency Services for the treatment of an Emergency condition. Effective January 1, 2022, the special rules for the No Surprises Act apply as described above. Emergency Services and Emergency condition are defined as follows:

Emergency condition means a medical condition, including a mental health condition or substance use disorder, manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in serious medical complications, loss of life, serious impairment of bodily functions, or serious dysfunction of a body part.

Emergency Services means, with respect to an Emergency condition:

- An appropriate medical screening examination that is within the capability of an emergency room of a hospital or independent freestanding emergency department, as applicable, including ancillary services routinely available to the emergency department to evaluate such Emergency condition;
- Such further medical examination and treatment as are required to stabilize the patient within the capabilities of the staff and facilities available at the hospital or the independent freestanding emergency department, as applicable (regardless of the

department of the hospital in which such further examination or treatment is furnished); and

- Post-stabilization services, which are services furnished by out-of-network providers or out-of-network facilities after the patient is stabilized as part of outpatient observation or an inpatient/outpatient stay related to the Emergency condition (regardless of the department of the hospital in which such further examination or treatment is furnished), until: (1) the treating provider or facility determines that the individual is able to travel using non-medical transportation or non-emergency medical transportation; and (2) the individual is provided with appropriate written notice to consent to out-of-network treatment (see below) and gives informed consent to such out-of-network treatment.

Ground ambulance services are not Emergency Services for the purposes of the No Surprises Act and will be covered under the normal terms set forth in this booklet.

Remember: If you go to the emergency room for medical services or treatment for a condition that is not an Emergency condition (as defined above), it may not be covered by the Plan.

Consent Requirements

The special rules for services covered under the No Surprises Act will not apply if you consent to receiving treatment from an out-of-network provider. These consent rules apply to (i) non-emergency services provided at an in-network facility other than ancillary services (described below) or (ii) Emergency Services that are post-stabilization services. If you consent to out-of-network services, you will be responsible for payment of the applicable out-of-network cost sharing, as well as any balance bills for amounts in excess of the Plan's Maximum Allowance for those services.

You are considered to consent to out of network service if:

- You are provided with written notice: (1) that the provider is an out-of-network provider; (2) of any estimated charges for treatment; (3) of any applicable advance limitations under the Plan; (4) that consent to receive treatment by such out-of-network provider is voluntary; and (5) that you may instead seek care from an in-network provider. In the case of non-Emergency Services this notice must be provided at least 72 hours before the appointment (or 3 hours in advance of services rendered in the case of a same-day appointment), and on the day of the appointment.
- You give signed consent to treatment by the out-of-network provider, acknowledging that you understand that treatment by the out-of-network provider may result in greater out-of-pocket costs compared to treatment by an in-network provider.

The consent rules described above do not apply to ancillary services or to items or services furnished as a result of unforeseen, urgent medical needs that arise at the time you are being

treated. For this purpose, ancillary services include (i) items and services related to emergency medicine, anesthesiology, pathology, radiology, and neonatology (whether provided by a physician or nonphysician practitioner); (ii) items and services provided by assistant surgeons, hospitalists, and intensivists; (iii) diagnostic services, including radiology and laboratory services; and (iv) items and services provided by an out-of-network provider if there is no in-network provider who can furnish such items or services at the facility.

Claim Determinations for Claims Subject to Surprise Billing Protections

The Claims Administrator will make an initial payment or notice of denial of payment for Emergency Services at out-of-network health care facilities, non-emergency services provided by out-of-network providers at in-network facilities, and out-of-network air ambulance services within 30 calendar days of receiving a claim from the out-of-network provider or facility that includes all necessary information to decide the claim.

External Review of Adverse Determinations Based on No Surprises Act Protections

External review is available for adverse benefit determinations based on compliance with the surprise billing protections under the No Surprises Act or its implementing regulations. See the section titled External Review Process starting on page 76 for details.

Provider Directory Updates

To help you find care from in-network providers and facilities, Premera maintains a provider directory. Premera updates its provider directory every 90 days, and the Plan office will respond to your inquiry about the network status of a provider or facility within one business day. If you receive inaccurate information from Premera or the Plan office about a provider or facility's network status, you will be liable only for in-network cost sharing for the services underlying your inquiry. However, it is your responsibility to confirm that the provider or facility that you have selected is in-network at the time you receive services.

Continuity of Coverage

The Plan will provide "continuity of coverage" in certain situations where a provider or facility go from being in-network to out-of-network.

Specifically, if you are a "Continuing Care Patient," you will be notified of the change in the network status of a provider or facility, and your right to elect continued transitional care from the provider or facility; and, you will be allowed 90 days of transitional care from the provider or facility at in-network cost sharing to allow you time to transition to a new in-network provider or facility (provided you remain eligible for Plan coverage).

A Continuing Care Patient is an individual, who, with respect to a provider or facility, (i) is undergoing a course of treatment for an acute illness (serious enough to require specialized

medical treatment to avoid the reasonable possibility of death or permanent harm) or chronic illness or condition (life-threatening, degenerative, potentially disabling, or congenital; and requires specialized medical care over a prolonged period of time); (2) is undergoing a course of institutional or inpatient care from the provider or facility; (3) is scheduled to undergo non-elective surgery from the provider, including receipt of postoperative care from such provider or facility; (4) is pregnant or undergoing a course of treatment for the pregnancy from the provider or facility; or (5) is or was determined to be terminally ill (under Social Security Act § 1862(dd)(3)(A)) and is receiving treatment for such illness from such provider or facility.

State Benchmark Plan for Determining Essential Health Benefits

The Board of Trustees has adopted the Utah benchmark plan for determining Essential Health Benefits for the PPO Plan.

Notice of Privacy Practices of the Trust and PPO Plan

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW THIS SECTION CAREFULLY.

If you have health and welfare plan coverage provided by Kaiser Permanente or the HMSA Hawaii PPO Plan, these plans have their own privacy practices to protect your medical information.

Policy regarding your Protected Health Information

This section describes the legal obligations of the PPO Plan and your legal rights regarding your Protected Health Information held by the PPO Plan under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the Health Information Technology for Economic and Clinical Health Act (HITECH). Among other things, this section describes how your Protected Health Information may be used or disclosed to carry out treatment, payment, or health care operations, or for any other purposes that are permitted or required by law.

The HIPAA Privacy Rule protects only certain medical information known as Protected Health Information. Generally, Protected Health Information is health information, including demographic information, collected from you or created or received by a health care provider, a health care clearinghouse, a health plan, or the PPO Plan, from which it is possible to individually identify you and that relates to:

- Your past, present, or future physical or mental health condition;
- The provision of health care to you; or
- The past, present, or future payment for health care services provided to you.

If you have any questions about this notice or about the Trust's and PPO Plan's privacy practices, please contact the PPO Plan's HIPAA client service representative whose address and telephone number are listed on page 120.

The PPO Plan's Responsibilities

The PPO Plan is required by law to:

- Maintain the privacy of your Protected Health Information;
- Provide you with certain rights with respect to your Protected Health Information;
- Give you this section which describes the PPO Plan's legal duties and privacy policies regarding your Protected Health Information; and
- Follow the terms of this section until modified.

The Board of Trustees reserves the right to change the terms of this section and to make new provisions regarding the use and disclosure of your Protected Health Information that the PPO Plan maintains, as allowed or required by law. If there are material changes to this section, you will be provided with a revised notice mailed to your last known address.

How the PPO Plan may Use and Disclose Protected Health Information about You

Under the law, the PPO Plan may use and disclose your Protected Health Information under certain circumstances without your permission. The following paragraphs describe different ways the PPO Plan may use and disclose your Protected Health Information. Each paragraph will explain what is meant and may present examples. Not every use or disclosure in a paragraph will be listed. However, all of the ways the PPO Plan is permitted to use and disclose your Protected Health Information will fall within one of these paragraphs.

- *To Make or Obtain Payment*. The PPO Plan may use and disclose your Protected Health Information to determine your eligibility for PPO Plan benefits, to facilitate payment for the treatment and services you receive from your Providers, to determine benefit responsibility under the PPO Plan, or to coordinate PPO Plan coverage. For example, the PPO Plan may tell your Provider about your medical history to determine whether a particular treatment is experimental, investigational, or Medically Necessary, or to determine whether the PPO Plan will cover the treatment. The PPO Plan may also share your Protected Health Information with a utilization review or precertification service organization. The PPO Plan may also share your Protected Health Information with another entity to assist with the adjudication or subrogation of health claims or to another health plan to coordinate benefit payments.
- *To Facilitate Treatment*. The PPO Plan may use and disclose your Protected Health Information to facilitate treatment or services by Providers. The PPO Plan may provide

medical information about you to Providers, including doctors, nurses, and hospital personnel who are involved in your care. For example, the PPO Plan may disclose Protected Health Information about you to Providers who are treating you.

- *For Health Care Operations*. The PPO Plan may use and disclose your Protected Health Information to facilitate the administration of the PPO Plan. These uses and disclosures are necessary to run the PPO Plan. For example, health care operations include activities such as:
  - Quality assessment and improvement activities;
  - Activities designed to improve health or reduce health care costs;
  - Clinical guideline and protocol development, case management and care coordination;
  - Contacting Providers and participants with information about treatment alternatives and other related functions;
  - Health care professional competence or qualification review and performance evaluation;
  - Accreditation, certification, licensing and credentialing activities;
  - Underwriting, including stop-loss underwriting, premium rating and related functions to create, renew or replace health insurance or health benefits. However, your genetic information will not be used for underwriting purposes;
  - Review and auditing, including compliance reviews, medical reviews, legal services, fraud and abuse detection and compliance programs;
  - Submitting claims for stop-loss reimbursement;
  - Business planning and development, including cost management and planning related to analyses and formulary development; and
  - Business management and general administration activities of the PPO Plan, including customer service and resolution of appeals and grievances.
- *When Required by Law*. The PPO Plan will disclose Protected Health Information about you when required to do so by federal, state or local law. For example, the PPO Plan may disclose Protected Health Information when required by a court order in a lawsuit such as a medical malpractice case.
- *To Avert a Serious Threat to Health or Safety*. The PPO Plan may use and disclose Protected Health Information about you when necessary to prevent a serious threat to your health

and safety, to the health and safety of the public or another person. Any disclosure, however, will only be made to someone able to help prevent the threat. For example, the PPO Plan may disclose Protected Health Information about you in a proceeding regarding the licensure of a physician.

- *Military.* If you are a member of the armed forces, the PPO Plan may disclose Protected Health Information about you as required by military command authorities. The PPO Plan may also release Protected Health Information about foreign military personnel to the appropriate foreign military authority.

- *For Treatment Alternatives*. The PPO Plan may use and disclose your Protected Health Information to send you information about or recommend possible treatment options or alternatives that may be of interest to you.

- *For Disclosure to the Board of Trustees*. The PPO Plan may disclose your Protected Health Information to another health plan maintained by the Trust or to the Board of Trustees for plan administration functions performed by the Board of Trustees on behalf of the PPO Plan. In addition, the PPO Plan may provide summary health information to the Board of Trustees so that the Board of Trustees may solicit premium bids from health insurers or modify, amend or terminate the PPO Plan. The PPO Plan may also disclose to the Board of Trustees information whether you are participating in the PPO Plan. Your Protected Health Information cannot be used for employment purposes without your specific authorization.

- *Spouses, Family Members, and Close Personal Friends.* The PPO Plan may make your Protected Health Information known to a spouse, family member, or close personal friend. Disclosure of your Protected Health Information will be based on how involved the person is in your health care or payment of your health claims. For example, the PPO Plan will normally provide information to a spouse or family member confirming eligibility for health coverage or if a health claim was paid but not the specific treatment or diagnosis or the reason the health care provider was consulted. The PPO Plan may also release Protected Health Information to parents or guardians, if allowed by law. If you are not present or able to agree to these disclosures of your Protected Health Information, the PPO Plan, through the Trust Office or Board of Trustees, may use professional judgment to determine whether the disclosure is in your best interest. If you do not want your Protected Health Information disclosed to a spouse, family member, or close personal friend as outlined in this paragraph, you must notify the PPO Plan as described in the **Right to Request Restrictions** section on page 117.

  With only limited exceptions, the PPO Plan will send all mail to the employee or early retiree. This includes mail related to the employee's or early retiree's spouse and other family members who are covered under the PPO Plan and includes mail with

information on the use of PPO Plan benefits by the employee or early retiree, spouse, and other family members and information on the denial of any PPO Plan benefits to the employee or early retiree, spouse, and other family members. If a person covered by the PPO Plan has requested Restrictions or Confidential Communications and the PPO Plan has agreed to the request, the PPO Plan will send mail as provided by the request for Restrictions or Confidential Communications.

- *Personal Representative*. The PPO Plan will disclose your Protected Health Information to individuals authorized by you, or to an individual designated as your personal representative, attorney-in-fact, etc., so long as you provide written notice/authorization and any supporting documents (for example, power of attorney). Even if you designate a personal representative, federal law permits the PPO Plan to elect not to treat the person as your personal representative if the PPO Plan has a reasonable belief that:
  - You have been, or may be, subject to domestic violence, abuse or neglect by such person;
  - Treating such a person as your personal representative could endanger you; or
  - Plan representatives determine, in their professional judgment, that it is not in your best interest to treat the person as your personal representative.
- *Business Associates*. The PPO Plan contracts with business associates who perform various services for the PPO Plan. For example, the Trust Office handles many functions in connection with the operation of the PPO Plan. To perform these functions, or provide the services, the PPO Plan's business associates may receive, create, maintain, transmit, use or disclose your Protected Health Information, but only after agreeing, in writing, to implement appropriate safeguards concerning your Protected Health Information. For example, the PPO Plan may disclose your Protected Health Information to a business associate to process your medical claims for payment or to provide utilization management or pharmacy benefit management services but only after the business associate enters into a business associate contract with the Trust.
- *Other Covered Entities*. The PPO Plan may use or disclose your Protected Health Information to assist Providers in connection with their treatment or payment activities or to assist other covered entities in connection with payment activities and certain health care operations. For example, the PPO Plan may disclose your Protected Health Information to a Provider when needed by the Provider to render treatment to you or the PPO Plan may disclose Protected Health Information to another covered entity to conduct health care operations in the area of quality assurance.
- *To Conduct Health Oversight Activities*. The PPO Plan may disclose your Protected Health Information to a health oversight agency for authorized activities, including audits, civil,

administrative or criminal investigations, inspections, licensure or disciplinary action. These activities are necessary for the government to monitor the health care system, government programs and compliance with civil rights laws.

- *Legal Proceedings*. If you are involved in a lawsuit or a dispute, the PPO Plan may disclose your Protected Health Information in response to a court or administrative order. The PPO Plan may also disclose your Protected Health Information in response to a subpoena, discovery request or other lawful process by someone else involved in the legal dispute, but only if efforts have been made to tell you about the request or to obtain a court or administrative order protecting the information requested.
- *Law Enforcement*. The PPO Plan may disclose your Protected Health Information to law enforcement officials if asked to do so. Some of the reasons for such a disclosure include, but are not limited to:
  - It is required by law or some other legal process;
  - Locate or identify a suspect, fugitive, material witness or missing person;
  - A death believed to be the result of criminal conduct; or
  - It is necessary to provide evidence of a crime that occurred.
- *National Security and Intelligence*. The PPO Plan may disclose your Protected Health Information to authorized federal officials to facilitate specified government functions related to national security, intelligence activities and other national security activities authorized by law.
- *Research*. The PPO Plan may disclose your Protected Health Information to researchers when:
  - The individual identifiers have been removed; or
  - When the institutional review board or privacy board has reviewed the research proposal and established protocols to ensure the privacy of the requested information, and approved the research.
- *Inmates*. If you are an inmate in a correctional institution, the PPO Plan may disclose your Protected Health Information to the correctional institution or to a law enforcement official for:
  - The institution to provide health care to you;
  - Your health and safety and the health and safety of others; or
  - The safety and security of the correctional institution.

- *Coroners, Medical Examiners, and Funeral Directors.* The PPO Plan may disclose your Protected Health Information to a coroner or medical examiner for purposes of identifying a deceased person, determining a cause of death, or for the coroner or medical examiner to perform other duties authorized by law. The PPO Plan may disclose information to funeral directors so they may carry out their duties.
- *Organ and Tissue Donation.* If you are an organ or tissue donor, the PPO Plan may disclose Protected Health Information after your death to organizations that handle organ, eye or tissue donation and transplantation or to an organ or tissue donation bank.
- *Workers' Compensation*. The PPO Plan may disclose your Protected Health Information for workers' compensation or similar programs but only as authorized by and to the extent necessary to comply with workers' compensation laws and other similar programs that provide benefits for work-related Injuries or Illnesses.
- *Disclosures to the Secretary of the U.S. Department of Health and Human Services*. The PPO Plan is required to disclose your Protected Health Information to the Secretary of the U.S. Department of Health and Human Services when the Secretary is investigating or determining the PPO Plan's compliance with the HIPAA Privacy Rule.
- *Public Health Risks*. The PPO Plan may disclose your Protected Health Information for public health activities. These activities generally include the following:
  - To prevent or control disease, Injury or disability;
  - To report births and deaths;
  - To report child abuse or neglect;
  - To report reactions to medications or problems with products;
  - To notify people of recalls of products they may be using;
  - To notify a person who may have been exposed to a disease or may be at risk of contracting or spreading a disease or condition; and
  - To notify the appropriate governmental authority if the PPO Plan believe that a person has been the victim of abuse, neglect, or domestic violence. The PPO Plan will only make this disclosure if you agree, or when required or authorized by law.
- *Disclosures to the Centers for Medicaid and Medicare Services.* The PPO Plan may disclose your Protected Health Information, as permitted by federal regulations, to the Centers for Medicaid and Medicare Services, in order to comply with mandatory Medicare coordination of benefit requirements. The PPO Plan may share required data, including

health information, with the Centers for Medicaid and Medicare Services and state Medicaid agencies.

- *Disclosures to You*. At your request, the PPO Plan is required to disclose the portion of your Protected Health Information that contains medical records, billing records and other records used to make decisions regarding your health care benefits. The PPO Plan is also required, when requested, to provide you with an accounting of most disclosures of your Protected Health Information if the disclosure was for reasons other than for payment, treatment, or health care operations and if the Protected Health Information was not disclosed pursuant to your authorization.

Authorization to Use or Disclose Your Protected Health Information

Other uses or disclosures of your Protected Health Information not disclosed above will only be made with your written authorization. For example, in general and subject to specific conditions, the PPO Plan will not use or disclose your psychiatric notes; will not use or disclose your Protected Health Information for marketing purposes; and will not sell your Protected Health Information, unless you give the PPO Plan written authorization. You may revoke written authorization at any time so long as the revocation is in writing. Once the PPO Plan receives your written revocation, it will only be effective for further uses and disclosures. It will not be effective for any Protected Health Information that may have been used or disclosed in reliance upon the written authorization prior to receiving your written revocation.

Minimum Necessary Disclosure of Protected Health Information

The amount of Protected Health Information the PPO Plan will use or disclose will be limited to the "minimum necessary" as defined in the HIPAA Privacy Rule.

Potential Impact of State Laws

The HIPAA Privacy Rule generally does not take precedence over state privacy or other applicable laws that provide individuals greater privacy protections. As a result, to the extent state law applies, the privacy laws of a particular state, or other federal laws, rather than the HIPAA Privacy Rule, might impose a privacy standard under which the PPO Plan will be required to operate. For example, the PPO Plan will follow more stringent state privacy laws that relate to use and disclosure of Protected Health Information concerning HIV or AIDS, mental health, substance use disorder/chemical dependency, genetic testing, reproduction rights, and so on.

Your Rights with Respect to your Protected Health Information

You have the following rights regarding your Protected Health Information that the PPO Plan maintains:

- *Right to Request Restrictions*. You have the right to request restrictions or limitations on the Protected Health Information the PPO Plan uses or discloses about you for treatment, payment or health care operations. You also have the right to request a limit on your Protected Health Information that the PPO Plan discloses to someone involved in your care or the payment for your care such as a family member or friend. For example, you could ask that the PPO Plan not use or disclose information about a surgery you had.

  Except as provided in the next paragraph, the PPO Plan is not required to agree to your request. However, if the PPO Plan does agree to the request, it will honor the restriction until you revoke it or the PPO Plan notifies you.

  The PPO Plan will comply with any restriction request if: except as otherwise required by law, the disclosure is to a health plan for purposes of carrying out payment or health care operations (and is not for the purpose of carrying out treatment); and the Protected Health Information pertains solely to a health care item or service for which the Provider involved has been paid in full by you or someone else.

  To request restrictions, you must make your request in writing to the HIPAA Client Service Representative for the Trust at the address on page 120. In your written request, you must tell the PPO Plan:

  - What Protected Health Information you want to limit;
  - Whether you want to limit the PPO Plan's use, disclosure or both; and
  - To whom you want the limits to apply, for example, non-disclosure to your spouse.

- *Right to Request Confidential Communications*. You have the right to request that the PPO Plan communicate with you about health matters in a certain way or in a certain location. For example, you may ask that the PPO Plan communicate with you only at a certain post office box, telephone number or by email.

  To request confidential communications, you must make your request in writing to the HIPAA Client Service Representative for the Trust at the address on page 120. The PPO Plan will not ask you the reason for the request. Your written request must specify how or where you wish to receive confidential communications. The PPO Plan will accommodate all reasonable requests.

- *Right to Inspect and Copy your Protected Health Information*. You have the right to inspect and copy your Protected Health Information that may be used to make decisions about your PPO Plan benefits. If the Protected Health Information you request is maintained electronically, and you request an electronic copy, the PPO Plan will provide a copy in the electronic form and format you request, if the Protected Health Information can be

readily produced in that form and format. If the Protected Health Information cannot be readily produced in that form and format, the PPO Plan will work with you to come to an agreement on form and format. If the PPO Plan cannot agree on an electronic form and format, it will provide you with a paper copy. A request to inspect and copy records containing your Protected Health Information must be made in writing to the HIPAA Client Service Representative for the Trust at the address on page 120. If you request a copy of your Protected Health Information, the PPO Plan may charge a reasonable fee for copying, mailing, or other supplies associated with the request.

- Right to Amend your Protected Health Information. If you believe that your Protected Health Information maintained by the PPO Plan is inaccurate or incomplete, you may request that the PPO Plan amend your Protected Health Information. The request may be made as long as the Protected Health Information is maintained by the PPO Plan.

- A request for an amendment of Protected Health Information must be made in writing to the HIPAA Client Service Representative for the Trust at the address on page 120 and must provide a reason for the request.

  The PPO Plan may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, the PPO Plan may deny your request if you ask the PPO Plan to amend Protected Health Information that: is not part of the Protected Health Information kept by or for the PPO Plan; was not created by the PPO Plan, unless the person or entity that created the Protected Health Information is no longer available to make the amendment; is not part of the Protected Health Information that you would be permitted to inspect and copy; or is already accurate and complete. If the PPO Plan denies your request, you have the right to file a statement of disagreement with the PPO Plan and any future disclosures of the disputed Protected Health Information will include your statement.

- Right to an Accounting of Disclosures. You have the right to request an accounting of certain disclosures of your Protected Health Information that were made contrary to the Notice of Privacy Practices and/or the HIPAA Privacy Rule. The accounting will not include: disclosures for purposes of treatment, payment or health care operations; disclosures made to you; disclosures made pursuant to your authorization; disclosures made to friends or family members in your presence or because of an emergency; disclosures for national security purposes; and disclosures incidental to otherwise permissible disclosures.

  The request for an accounting must be made in writing to the HIPAA Client Service Representative for the Trust at the address on page 120. The accounting request should specify the time period for which you are requesting the accounting. Accounting requests may not be made for periods of time going back more than six (6) years from

the date of the request. Your request should state the form you want the list of disclosures (for example, paper or electronic). The PPO Plan 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 PPO Plan will inform you of the fee in advance.

- *Right to be Notified of a Breach.* You have the right to be notified in the event that the PPO Plan, or a business associate, discovers a breach of your unsecured Protected Health Information.
- *Right to a Paper Copy of the PPO Plan's Privacy Notice*. You have a right to a paper copy of the PPO Plan's Privacy Notice. You may ask the PPO Plan to give you a copy of this notice at any time. To receive a paper copy, please contact the HIPAA Client Service Representative for the Trust at the address on page 120.

Complaints

If you believe that your privacy rights have been violated, you may file a complaint with the PPO Plan or with the Office for Civil Rights of the United States Department of Health and Human Services. To file a complaint with the PPO Plan, you should notify the HIPAA Client Service Representative for the Trust, in writing, at the address on page 120. You will not be penalized, or in any other way retaliated against, for filing a complaint with the Office for Civil Rights or with the PPO Plan.

HIPAA Client Service Representative

The PPO Plan has designated the Trust's Client Service Representative to answer all questions and respond to all issues regarding this section and your privacy rights. You may contact this person at:

Inlandboatmen's Union of the Pacific
National Health Benefit Trust
Attention: HIPAA Client Service Representative
PMB #116
5331 S. Macadam Avenue, Suite 258
Portland, OR 97239
(503) 224-0048
(800) 547-4457

If you have any questions regarding this section, please contact the Trust's HIPAA Client Service Representative.

Life Insurance Benefits

For Employees Only

Life insurance benefits are available to Employees and retired All Alaska Longshore members who are covered under the Active PPO members only. Employees enrolled in the PPO Plan, a Kaiser Permanente Plan, or HMSA Hawaii PPO Plan have this benefit. Employees making COBRA payments are not eligible for life insurance benefits. The life insurance benefits are provided through a group policy with Standard Insurance Company.

Amount of Life Insurance

The group policy provides a $15,000 life insurance benefit. The group policy also pays expenses incurred to transport your body to a mortuary near your primary place of residence up to $1,500.

When Life Insurance Begins

Your life insurance automatically begins on the date an Employee qualifies for Trust provided health and welfare plan coverage.

When Life Insurance Ends

Your life insurance automatically ends at the earliest of:

- The date the Trust's group policy with Standard Insurance Company terminates;
- The date the last period ends for which a required premium is made on your behalf to Standard Insurance Company by the Trust;
- The date you cease to be eligible for Trust provided health and welfare plan coverage due to a lack of Employer contributions or a combination of Employer and Employee contributions or retirement as an IBU Employee. A self-payment under COBRA does not extend life insurance; or
- The date you become a full-time member of the Armed Forces of any country (except as provided under the Uniformed Services Employment and Reemployment Rights Act).

Benefit Payment and Beneficiary Provisions

- **Payment of Benefits.** Benefits payable because of your death will be paid to your beneficiary.
- **Naming a Beneficiary.** Beneficiary means the person(s) you name to receive your life insurance benefit. You may name more than one beneficiary. Two or more surviving

beneficiaries will share equally unless you specify otherwise. You may name a beneficiary or change a beneficiary at any time without the consent of the beneficiary.

You must name or change beneficiaries in writing. Your beneficiary designation must:

- Be signed by you and dated;
- Delivered to the Trust Office during your lifetime;
- Relate to the life insurance provided under the group policy; and
- Will take effect on the date it is received by the Trust Office.

You may obtain a beneficiary designation form by calling the Trust Office at (800) 547-4457 or (503) 224-0048 or on the benefits website www.ibubenefits.org.

- **Simultaneous Death Provision.** If a beneficiary dies on the same day you die or within 15 days thereafter, benefits will be paid as if that beneficiary died before you unless proof of loss is delivered to Standard Insurance Company before the beneficiary's death.
- **No Surviving Beneficiary.** If you do not name a beneficiary or if you are not survived by a beneficiary, benefits will be paid in equal shares to the first surviving class below:
  - Your spouse or Domestic Partner. Spouse means the person to whom you are legally married. Domestic Partner means an individual recognized as such under applicable law;
  - Your child or children;
  - Your parents;
  - Your brothers and sisters;
  - Your estate.
- **Method of Payment.** Benefits will be paid in a lump sum. To the extent permitted by law, the amount payable to the recipient will not be subject to any legal process or to the claims of any creditor.

How to File a Claim for Life Insurance Benefits

- **Filing a Claim.** Claims should be filed on Standard Insurance Company forms. You may obtain a claim form by writing to or calling the Trust Office as follows:

  BeneSys, Inc.
  PMB #116
  5331 S. Macadam Avenue, Suite 258
  Portland, OR 97239
  (503) 224-0048
  (800) 547-4457
  Email: ibu@benesys.com

- **Time Limits for Filing a Claim.** A claim should be filed within 90 days after the date of loss. If that is not possible, a claim must be filed as soon as reasonably possible, but not later than one year after that 90-day period. If a claim is filed outside this time limit, the claim will be denied. This time limit will not apply if your beneficiary lacks legal capacity.

- **Proof of Loss.** Proof of loss means written proof that a loss occurred:

  - For which the group policy provides benefits;
  - That is not subject to any exclusions; and
  - That meets all other conditions for the benefit.

  Proof of loss includes any additional information Standard Insurance Company may reasonable require in support of a claim.

- **Investigation of a Claim.** Standard Insurance Company may have you examined at its expense at reasonable intervals. Standard Insurance Company may have an autopsy performed at its expense, except where prohibited by law.

- **Time of Payment.** Benefits will be paid within 60 days after proof of loss is satisfied.

- **Notice of Decision Regarding a Claim.** Standard Insurance Company will evaluate a claim for benefits promptly after it is received. Within 90 days after receipt of a claim, Standard Insurance Company will send the claimant:

  - A written decision about the claim; or
  - A written notice that Standard Insurance Company is extending the time to decide the claim for an additional 90 days.

  If Standard Insurance Company extends the time to decide a claim, it will notify the claimant of the following:

- The reason(s) for the extension;
- When it expects to decide the claim;
- An explanation of the standards on which entitlement to benefits is based;
- The unresolved issue(s) preventing a decision; and
- Any additional information Standard Insurance Company needs to resolve the issue(s).

If Standard Insurance Company requests additional information, the claimant will have 45 days to provide the information. If the claimant does not provide the requested information within 45 days, Standard Insurance Company may decide the claim based on the information it has received.

If Standard Insurance Company denies any part of the claim, it will send the claimant a written notice of denial containing:

- The reason(s) for the decision;
- Reference to the part(s) of the group policy on which the decision is based;
- A description of any additional information needed to support the claim;
- Information concerning the claimant's right to review Standard Insurance Company's decision; and
- Information concerning the claimant's right to bring a civil action for benefits under Section 502(a) of the Employee Retirement Income Security Act if the claim is denied on review.

- Review Procedures. If all or part of a claim is denied, the claimant may request review in writing addressed to Standard Insurance Company within 60 days after receiving notice of denial of the claim. The address and telephone number for Standard Insurance Company are on page 136.

  The claimant may send Standard Insurance Company written comments or other information to support the claim. The claimant may review and receive copies of any non-privileged information that is relevant to the request for review. There will be no charge for the copies. Standard Insurance Company's review will include any written comments or other information the claimant submits.

  Within 60 days after Standard Insurance Company receives the request for review, it will send the claimant:

  - A written decision regarding the appeal; or

- A notice that Standard Insurance Company is extending the review period for 60 days.

If Standard Insurance Company extends the review period, it will notify the claimant of the following:

- The reason(s) for the extension;
- When it expects to decide the claim on review; and
- Any additional information it needs to decide the claim.
- If Standard Insurance Company requests additional information, the claimant will have 45 days to provide the information. If the claimant does not provide the requested information within 45 days, Standard Insurance Company may conclude its review of the claim based on the information it has received.
- If Standard Insurance Company denies any part of the claim on review, the claimant will receive a written notice of denial containing:
- The reason(s) for the decision;
- Reference to the part(s) of the group policy on which the decision is based;
- Information concerning the claimant's right to receive, free of charge, copies of non-privileged documents and records relevant to the claim; and
- Information concerning the claimant's right to bring a civil action for benefits under Section 502(a) of the Employee Retirement Income Security Act.
- The group policy does not provide voluntary alternative dispute resolution options. The claimant may contact the local office of the United States Department of Labor or the state insurance commissioner for assistance.

Authority of Standard Insurance Company

Standard Insurance Company has full and exclusive authority to control and manage the group policy, to administer claims, to interpret the group policy, and to resolve all questions arising in the administration, interpretation, and application of the group policy.

Standard Insurance Company's authority includes, but is not limited to:

- The right to resolve all matters when review has been requested;
- The right to establish and enforce rules and procedures for the administration of the group policy and any claim made under it; and

- The right to determine eligibility for life insurance, the amount of benefits payable, and the sufficiency of the information provided to establish eligibility for life insurance benefits and the amount of your life insurance benefit.

Subject to the review procedures in the group policy and legal action, any decision Standard Insurance Company makes in the exercise of its authority is conclusive and binding.

Time Limits for Legal Actions

No lawsuit at law or in equity may be brought until 60 days after Standard Insurance Company has been given proof of loss. No action may be brought more than three years after the earlier of:

- The date Standard Insurance Company receives proof of loss; or
- The time within which proof of loss is required to be given.

Ability to Purchase an Individual Portability Insurance Policy

If your life insurance under the group policy ends because your employment terminates, you may be eligible to buy portable group insurance coverage from Standard Insurance Company without submitting evidence of insurability. To be eligible you must satisfy the following requirements:

- On the date your employment terminates, you must be able to perform with reasonable continuity the material duties of at least one gainful occupation for which you are reasonably fit by education, training, and experience;
- On the date your employment terminates, you are under age 65;
- On the date your employment terminates, you must have been continuously insured under the group policy for at least 12 consecutive months; and
- You must apply in writing and pay the first premium directly to Standard Insurance Company within 31 days after the date your employment terminates.

The portable group insurance will be provided under a Master Group Life Portability Insurance Policy Standard Insurance Company has issued to the Standard Insurance Company Group Insurance Trust. Your individual life insurance policy will be governed under the terms of the Group Life Portability Insurance Policy and will contain different provisions than this group policy.

The amount of insurance that you are eligible to buy under the Group Life Portability Insurance Policy is:

Minimum: $10,000

Maximum: $15,000

You may buy less than the maximum amount in increments of $1,000.

Portable group insurance will become effective the day after your employment terminates if you apply within 31 days after the date your employment terminates. If death occurs within 31 days after the date insurance ends under the group polity, life insurance benefits, if any, will be paid according to the terms of the group policy in effect on the date your employment terminates and not the terms of the Group Life Portability Insurance Policy.

Right to Convert to an Individual Life Insurance Policy

You may buy an individual life insurance policy from Standard Insurance Company without submitting evidence of insurability if:

- Your life insurance ends for any reason except failure to make a required premium; and
- You apply in writing and pay Standard Insurance Company the first premium during the 31-day period after your life insurance ends.

If your life insurance ends or is reduced because of termination or amendment of the group policy, the following will apply:

- You may not convert insurance which has been in effect for less than five years; and
- The maximum amount of life insurance you have a right to convert is the amount of your life insurance immediately prior to your termination of coverage under the group policy minus any other group life insurance for which you become eligible during the 31 days after termination of this group policy.

You may select any form of individual life insurance policy Standard Insurance Company issues to persons of your age except:

- A term insurance policy;
- A universal insurance policy;
- A policy with disability, accidental death, or other additional benefits; or
- A policy that is in an amount less than the minimum amount Standard Insurance Company issues for the form of life insurance you select.

The individual life insurance policy will become effective 31 days after the date group life insurance ends. Standard Insurance Company will use its published rates for standard risks to determine the premium.

If you die during the 31 day period following termination of your group insurance, Standard Insurance Company will pay a death benefit equal to $15,000 whether or not you applied for an individual policy. The benefit will be paid according to the **Benefit Payment and Beneficiary Provisions** section on page 121.

Address and Telephone Number for Standard Insurance Company

The address and toll-free telephone number of Standard Insurance Company are:

Standard Insurance Company
PO Box 2800
Portland, OR 97208
(800) 628-8600

Amendment and Termination

Plan Amendments and Restatements

The Benefit Booklet may be amended or restated from time to time by the Board of Trustees in accordance with the voting procedures in the Trust Agreement for the Trust. None of the provisions in the Benefit Booklet are vested.

Plan Termination

The Board of Trustees may terminate the Plan in accordance with the substantive provisions and the voting procedures in the Trust Agreement for the Trust.

Administrative Facts

This section is a general explanation of certain terms of the PPO Plan and the Flexible Benefits Plan and other legal instruments and is not intended to modify or change them in any manner. The rights and duties of all persons connected with the PPO Plan and the Flexible Benefits Plan are set forth in those instruments, which may be inspected at the Trust Office.

Names of the Plans

Inlandboatmen's Union of the Pacific National Health Benefit Trust – PPO Plan

Inlandboatmen's Union of the Pacific National Health Benefit Trust – Flexible Benefits Plan

Effective Date of Summary Plan Description

January 1, 2024

Plan Sponsor

The Plans are sponsored by:

Board of Trustees of the
Inlandboatmen's Union of the Pacific National Health Benefit Trust
c/o BeneSys, Inc.
PMB #116
5331 S. Macadam Avenue, Suite 258
Portland, OR 97239
(503) 224-0048
(800) 547-4457

Employer and Plan Identification Numbers

The employer identification numbers assigned by the Internal Revenue Service are:

PPO Plan:	93-0864012
Plan Identification Number:	501

Plan Year

The plan year begins each January 1 and ends the following December 31.

Type of Plan

The PPO Plan is a health and welfare benefit plan.

The Flexible Benefits Plan is a plan under Section 125 of the Internal Revenue Code that allows Employees the opportunity to use pre-tax dollars to pay for the cost of health and welfare plan coverage in instances where an Employer's required contribution is insufficient. The Flexible Benefits Plan is funded by Employee wage reductions.

Plan Administrator

The PPO Plan and Flexible Benefits Plan are administered by the Board of Trustees of the Inlandboatmen's Union of the Pacific National Health Benefit Trust with the assistance of BeneSys, Inc., a contract administration organization whose address and telephone number are:

BeneSys, Inc.
PMB #116
5331 S. Macadam Avenue, Suite 258
Portland, OR 97239
(503) 224-0048
(800) 547-4457

Agent for Legal Service

Mike Jokela
BeneSys, Inc.
5331 S. Macadam Avenue, Suite 220
Portland, OR 97239

Service of legal process may also be made upon a member of the Board of Trustees or the Trust Office.

Board of Trustees

Employee Trustees	
Robert Estrada, Co-Chair IBU Puget Sound 5215 Ballard Ave NW #3 Seattle, WA 98107	Marina V. Secchitano IBU San Francisco 450 Harrison St., #103 San Francisco, CA 94105-2640
Brian Dodge IBU Columbia River 2435 NW Front Avenue Portland, OR 97209	Cris Sogliuzzo IBU So. California 1911 N. Gaffey Street, Suites A&B San Pedro, CA 90731

Employee Trustees	
Palani Simon IBU Hawaii 451 Atkinson Drive Honolulu, HI 96814	Christoper Simmons IBU Puget Sound 5215 Ballard Ave NW #3 Seattle, WA 98107

Employer Trustees	
Matt Hainley, Co-Chair Sause Brothers Ocean Towing 3710 NW Front Avenue Portland, OR 97210	Patrick Murphy Blue & Gold Fleet Inc. Pier 41, Marine Terminal San Francisco, CA 94133
Dan Lowry Crowley Marine Services 1102 SW Massachusetts Street Seattle, WA 98104	Chris Mack Jr. Foss Maritime Company 450 Alaskan Way South Seattle, WA 98104

Description of Collective Bargaining Agreements and Joinder Agreements

The Plans are maintained pursuant to the terms of collective bargaining agreements between Employers and the Union and pursuant to the terms of Joinder Agreements between Employers, the Union, and the Trust. The collective bargaining agreements and Joinder Agreements generally provide that Employers and the Union will make required contributions to the Trust for the purpose of enabling Employees working under the collective bargaining agreements and Joinder Agreements to participate in one of the health and welfare benefit plans offered by the Board of Trustees. The contribution rates are specified in each collective bargaining agreement and Joinder Agreement. An Employee's rights, if any, to participate in the Flexible Benefits Plan are set forth in the collective bargaining agreements. Copies of the collective bargaining agreements and Joinder Agreements may be obtained from the Trust Office.

A complete list of Employers including the Union that contribute to the Trust pursuant to a collective bargaining agreement and/or Joinder Agreement may be obtained upon written request to the Trust Office and is available for examination during regular office hours at the Trust Office.

Plan Benefits

The PPO Plan provides time loss benefits and life insurance benefits for Employees only, and medical, prescription, dental, and vision benefits for Employees and their Dependents. The PPO Plan provides medical and prescription drug benefits for some Early Retirees and their Dependents.

The Board of Trustees also offers medical, prescription drug, dental, and vision coverage from Kaiser Permanente and HMSA Hawaii PPO.

Benefits, Eligibility and Termination of Eligibility

This Benefit Booklet describes eligibility and termination of eligibility requirements for the health and welfare plans offered by the Board of Trustees. This Benefit Booklet describes benefits provided by the PPO Plan. If at any time you are unable to locate your Benefit Booklet, an additional copy may be obtained from the Trust Office:

BeneSys, Inc.
5331 S. Macadam Avenue, Suite 220
Portland, OR 97239
(503) 224-0048
(800) 547-4457

Source of Contributions

The health and welfare plans offered by the Board of Trustees are funded through Employer contributions and Union contributions (for its Employees only), the amount of which is specified in the collective bargaining agreements and Joinder Agreements. The health and welfare plans may also be partially funded through Employee contributions made under the Flexible Benefits Plan. Credits accumulated in an Employee's Individual Reserve Account may be used to extend health and welfare plan coverage. Self-payments by Employees, Early Retirees, and Dependents are permitted as outlined in this Benefit Booklet. The amount of self-payments is fixed from time to time by the Board of Trustees.

Organizations Providing Benefits, Funding Media and Type of Administration

The names and addresses of the organizations providing benefits and their roles (i.e., whether they are responsible for the administration of the benefit and whether the benefit is payable under an insurance policy) are set forth below.

Medical, Prescription Drug, Dental, Vision, and Time Loss Benefits under the PPO Plan

Claims arising from the PPO Plan for medical, prescription drug, dental, and vision benefits for Employees, Early Retirees, and Dependents and the time loss benefits for Employees are paid directly from the Trust's assets.

Preferred Provider Organizations

The Trust has entered into a contract with Premera Blue Cross to provide and maintain a network of PPO Providers that can be used by Employees, Early Retirees, and Dependents enrolled in the PPO Plan. The Trust is responsible for paying claims submitted by Providers, Hospitals, clinics, and facilities. Premera Blue Cross is responsible for the administration of the contracts with Providers, Hospitals, clinics, and facilities that are PPO Providers. The Trust pays a fee to Premera Blue Cross for providing and maintaining the PPO Provider network.

Premera Blue Cross

7001 220th Street SW, Building 3
Mountlake Terrace, WA 98043
(800) 810-2583

Prior Authorization and Case Management

The Trust has entered into a contract with Innovative Care Management, Inc. to provide prior authorization and case management services for Employees, Early Retirees, and Dependents enrolled in the PPO Plan. The Trust pays a fee to Innovative Care Management, Inc. for the services it provides.

Innovative Care Management, Inc.
12300 SE Mallard Way, Suite 265
Milwaukie, OR 97222
(800) 862-3338

Kaiser Permanente Foundation Health Plan and HMSA Hawaii PPO Plan

Employees, Early Retirees, and Dependents living in certain geographic areas have the option of selecting medical, prescription drug, dental, and vision coverage from Kaiser Permanente or HMSA Hawaii PPO Plan. The medical, prescription drug, dental, and vision benefits are insured and provided under contracts between the Trust and Kaiser Permanente Foundation Health Plan, or HMSA Hawaii PPO Plan. The Kaiser Permanente Foundation Health Plan and HMSA Hawaii PPO Plan are responsible for administering their plans and paying the claims.

Kaiser Permanente Foundation Health Plan (Hawaii)
6700 Kalanianaole Highway, Suite 111

Honolulu, HI 96825

Kaiser Permanente Foundation Health Plan (Northern California)
1950 Franklin Street
Oakland, CA 94612

HMSA Hawaii PPO Plan
P.O. Box 860
Honolulu, HI 96808

Prescription Drug Program

The PPO Plan's retail prescription drug program for Employees, Early Retirees, and Dependents is administered by Moda Health Plan, Inc. The Trust is responsible for paying the prescription drug claims. A fee is paid to Moda Health Plan, Inc. for administering the prescription drug program.

Moda Health Plan, Inc.
P.O. Box 40384
Portland, Oregon 97240
(800) 913-4311

The PPO Plan's Specialty Prescription Drug Program for Employees, Early Retirees, and Dependents is administered by Ardon Health LLC. The Trust is responsible for paying the specialty pharmacy prescription drug claims. A fee is paid to Ardon Health LLC for administering the program.

Ardon Health LLC
P.O. Box 20338
Portland, OR 97294
(855) 425-4085

The PPO Plan's home delivery prescription drug program for Employees, Early Retirees, and Dependents is administered by Postal Prescription Services and Costco Mail Order Pharmacy. The Trust is responsible for paying the home delivery pharmacy prescription drug claims. A fee is paid to Postal Prescription Services for administering the program.

Postal Prescription Services
P.O. Box 2718
Portland, OR 97208
(800) 552-6694

Costco Mail Order Pharmacy
802 134th Street SW Ste 140
Everett, WA 98204
(800) 607-6861

Life Insurance

The life insurance benefit for Employees is provided by Standard Insurance Company. The benefit is provided and insured under a group contract between the Trust and Standard Insurance Company. Standard Insurance Company is responsible for administering the program and paying the claims.

Standard Insurance Company
PO Box 2800
Portland, OR 97208
(800) 628-8600

Plan Termination

Should health and welfare plans offered by the Board of Trustees terminate for any reason, all money and assets remaining in the Trust, after the payment of expenses, will be used for the continuance of the benefits provided by the then existing health and welfare plans until such money and assets have been exhausted, unless some other disposition is required in regulations adopted by the U.S. Department of Labor. In no event will any of the remaining money or assets of the Trust be paid to or be recoverable by any Employer or the Union.

Liability of Third Parties and the Board of Trustees

No Employer or the Union has any liability, directly or indirectly, to provide for or pay for the benefits provided by the health and welfare plans offered by the Board of Trustees beyond the obligation to make contributions required by its collective bargaining agreement or Joinder Agreement. Likewise, there will be no liability upon the Board of Trustees, individually or collectively, to provide or pay for the benefits provided by the health and welfare plans offered by the Board of Trustees if Trust assets are not sufficient or available to pay such benefit obligations.

ERISA Statement of Rights

As a participant in one of the health and welfare plans offered by the Board of Trustees, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants will be entitled to:

- Examine, without charge, at the Plan administrator's office and at other specified locations, such as worksites and union halls, all documents governing operation of the health and welfare plans, 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.

- Obtain, upon written request to the Plan administrator, copies of documents governing the operation of the health and welfare plans, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. A reasonable charge may be made for the copies.
- Receive a summary of the Plan's annual financial report. The Plan administrator is required by law to furnish each participant with a copy of this annual financial report.
- Continue health care coverage if there is a loss of coverage under a health and welfare plan as a result of a qualifying event. You or your Dependents may have to pay for such coverage. See COBRA Continuation Coverage rights for more information.

In addition to creating rights for participants, ERISA imposes duties upon the people who are responsible for the operation of the health and welfare plans. The people who operate the health and welfare plans, called "fiduciaries," have a duty to do so prudently and in the interest of you and other 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 welfare benefit or exercising your rights under ERISA.

If your claim for a welfare benefit is denied in whole or in part, you must receive a written explanation of the reason for the denial. You have the right to have the health and welfare plan review and reconsider your claim. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan administrator. If you have a claim for benefits that 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 administrator's decision or lack of a decision concerning the qualified status of a medical child support order, you may file suit in federal court.

If it should happen that fiduciaries misuse the Trust'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 health and welfare plan, you should contact the Trust Office. If you have any questions about this Statement, about your rights under ERISA, or about

your rights under the Health Insurance Portability and Accountability Act of 1996 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. Alternatively, you may obtain assistance by calling the Employee Benefits Security Administration's toll-free number (866) 444-3272 or writing to the following address:

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. You may also find assistance for your questions and a list of Employee Benefits Security Administration field offices at www.dol.gov/agencies/ebsa.

Definitions

Benefit Booklet – this booklet, which is the Plan's Summary Plan Description as required under the Employee Retirement Income Security Act of 1974.

Board of Trustees – the individuals who govern the Inlandboatmen's Union of the Pacific National Health Benefit Trust and the health and welfare plans and their successors.

Co-Payment – the amount a Covered Individual must pay for certain Covered Charges after the Deductible has been satisfied and after the Trust has paid the Percentage Payable.

Cosmetic or Reconstructive Surgery – the surgical alteration of tissue for the improvement of the Covered Individual's appearance rather than improvement or restoration of bodily function.

Covered Charges – charges covered by the PPO Plan.

Covered Individual – a person enrolled in the PPO Plan.

Deductible – a set amount of Covered Charges that a Covered Individual is responsible to pay each calendar year before the Trust begins paying the Percentage Payable. See the **Benefit Summary** on page 19 for Deductible amounts.

Dentist – a doctor of dental surgery or a doctor of medical dentistry, licensed in the state in which treatment is rendered.

Dependent – see definition of Dependent on page 1.

Domestic Partner – the Employee or Early Retiree and another individual who meet the following criteria:

- They have a close personal relationship and are responsible for each other's common welfare;
- They are at least age 18 and mentally competent to contract;
- They are each other's sole domestic partner;
- They are not blood relatives to a degree that state law prohibits marriage in the state where they reside;
- Neither person is legally married or separated or in a domestic partnership with anyone else and neither person has been in another relationship for the last 12 months;
- They share the same permanent address with the intent to do so indefinitely; and
- They have agreed to be responsible for each other's basic living expenses such as the cost of food, shelter, and other necessary expenses.

Durable Medical Equipment – Medically Necessary items that are able to stand repeated use (except certain consumable medical supplies) and that are prescribed by a physician for therapeutic use in direct treatment of an Illness or Injury. Examples include trusses and crutches, pacemakers, diabetic equipment such as blood glucose monitors, insulin pumps, accessories to pumps, and insulin infusion devices, and (up to the purchase price) Hospital-type beds, traction equipment, wheelchairs, ventilators and respirators. Durable Medical Equipment does not include modifications to vehicles or residences, exercise equipment, ergonomic chairs, hot tubs or other household items, even if physician-recommended.

Early Retiree – a former Employee of an Employer or the Union who has submitted an application for Early Retiree medical and prescription drug benefits described in "Early Retiree Medical and Prescription Drug Options" and whose application has been accepted by the Trust Office or Board of Trustees and is not eligible for Medicare.

Emergency Medical Services – a medical condition with acute symptoms of sufficient severity (including severe pain) so that a prudent layperson that possesses an average knowledge of health and medicine, could reasonably expect the condition, in the absence of immediate medical attention, could result in:

- Placing the health of the individual or unborn child in serious jeopardy;
- Seriously impair the individual's bodily function; or
- Cause serious dysfunction to an individual's organ or body part.

Employee – an individual who is or has worked under a collective bargaining agreement or a Joinder Agreement for an Employer or the Union and is entitled to have health and welfare contributions made on their behalf to the Trust.

Employer – an entity which is obligated to make health and welfare contributions to the Trust on behalf of Employees pursuant to a collective bargaining agreement or a Joinder Agreement.

ERISA – the Employee Retirement Income Security Act of 1974, as amended, and its regulations.

Essential Health Benefits – ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services including oral and vision care as these terms are defined in Section 1302 of the Patient Protection and Affordable Care Act as amended by the Health Care and Education Reconciliation Act, applicable regulations and the Board of Trustees' good faith interpretation of these terms.

Experimental or Investigational Treatment –any services, including a treatment, procedure, facility, equipment, drug, drug usage, medical device, or supplies (the "Service"), that the Board of Trustees, its designee or medical consultant determines meets one or more of the following criteria:

- A Service that cannot be lawfully marketed without the approval of the FDA and has not been granted such approval on the date it is furnished.
- A facility or Provider who has not demonstrated proficiency in the Service, based on experience, outcome, or volume of cases.
- Reliable evidence shows the Service is the subject of ongoing clinical trials to determine its maximum tolerated dose, toxicity, safety, or efficacy.
- Reliable evidence shows the Service is not as safe and effective for a particular medical condition, as compared to other generally available services, and that it poses a significant risk to the patient's health or safety.

Reliable evidence means only published reports and articles in authoritative medical and scientific literature, scientific results of the provider of care's written protocols, or scientific data from another provider studying the same service.

Hospital – a facility legally operating as a Hospital in the state in which it operates and that meets the following requirements:

- It has facilities for the inpatient diagnosis, treatment, and acute care of injured and ill persons by or under the supervision of a staff of physicians; and
- It continuously provides 24-hour nursing services by or under the supervision of registered nurses.
- In no event will a Hospital be:
  - An institution or facility that is run mainly as a rest, nursing, or convalescent home, a , or a health resort;
  - An institution or facility to provide hospice care for terminally ill patients;
  - An institution or facility for the care of the elderly; or
  - An institution or facility for the treatment of tuberculosis.

Illness – a disorder or disease of your body or mind or pregnancy that requires treatment by a Provider. All Illnesses due to the same cause, or to a related cause, will be deemed to be one Illness.

Injury – an accidental bodily injury to you caused by an external force or element which requires treatment by a Provider. All Injuries due to the same cause, or due to a related cause, will be deemed to be one Injury.

Individual Reserve Account – a separate bookkeeping record maintained by the Trust Office that credits the monetary contributions that an Employer or the Union pays to the Trust on behalf of an Employee performing work under a collective bargaining agreement or a Joinder Agreement.

Joinder Agreement – a written agreement between the Board of Trustees, the Trust, or PPO Plan and an Employer or the Union that allows the Employer or the Union to make contributions to the Trust on behalf of its Employees who are covered by the Joinder Agreement.

Maximum Allowable Charge – the amount of a Covered Charge for Medical Benefits provided by a Non-PPO Provider that does not belong to a PPO network with Premera or a Blue Cross and/or Blue Shield licensee that is the least of the following three amounts:

- An amount that is no less than the lowest amount that Premera or a Blue Cross and/or Blue Shield licensee would pay for the same or similar service, treatment or material from a comparable Provider, Hospital, facility or clinic that has a preferred provider agreement with Premera or a Blue Cross and/or Blue Shield licensee;
- 125% of the fee schedule determined by the Centers for Medicare and Medicaid Services (Medicare) if available; or
- The Provider's, Hospital's, facility's or clinic's billed charges.

Medical Coverage or Medical Benefits – benefits other than dental, vision, time loss, life insurance benefits, the Flexible Benefits Plan, wellness benefits, and the Supplemental Plan.

Medical Necessity – those covered services and supplies for Medical Benefits that are determined to meet all of the following requirements:

- Essential to, consistent with, and provided for the diagnosis or the direct care and treatment of an Illness, Injury, or condition harmful or threatening to the Covered Individual's life or health, unless provided for preventive services when specified as covered under the PPO Plan;
- Appropriate and consistent with the diagnosis as specified in accordance with authoritative medical or scientific literature;
- Not primarily for the convenience of the patient, the patient's family, the patient's physician, or another Provider;

- The most cost effective of the alternative supplies or levels of service that can safely be provided to the patient; and
- Not primarily for research or data accumulation.

The fact that services or supplies were furnished, prescribed, or approved by a Provider does not in itself mean that the services or supplies were Medically Necessary.

Medicare – medical benefits provided by Title XVIII of the federal Social Security Act.

Non-PPO Provider – any Provider, Hospital, clinic, or facility that is not a PPO Provider.

Percentage Payable – the amount the Trust will pay for Covered Charges at the negotiated rate for a PPO Provider or the Maximum Allowable Charge for a Non-PPO Provider after the Deductible and/or Co-Payments have been satisfied.

Plan or **Plans** – the PPO Plan and the Flexible Benefits Plan.

PPO Plan – the medical, prescription drug, dental, vision, supplemental account, time loss, and life insurance benefits described in this booklet and any amendments, additions, or deletions subsequently made.

PPO Provider – any Provider, Hospital, facility, or clinic that belongs to the PPO network recognized by the Trust as a PPO Provider.

Premera – Premera Blue Cross.

Protected Health Information – individually identifiable health information that is not subject to specific exclusions. The definition of Protected Health Information in 45 C.F.R. § 164.501 is adopted for use by the Plan.

Providers – (must be duly licensed within the geographic area where services are rendered if the state requires a license):

- Medical Doctor (M.D.)
- Doctor of Osteopathy (D.O.)
- Chiropractic Physician (D.C.)
- Doctor of Medical Dentistry (D.M.D.)
- Doctor of Dental Surgery (D.D.S.)
- Optometrist (O.D.)
- Doctor of Podiatry Medicine (D.P.M.)
- Clinical Psychologist (Ph.D.)

- Clinical Social Worker or other mental health practitioner who is a PPO Provider
- Nurse Midwife who is licensed by the state
- Registered Physical or Occupational Therapist who is licensed by the state as a Physical Therapist or Occupational Therapist
- Speech Therapist who has a master's degree in speech pathology, has completed an internship, and is licensed by the state in which they performs their services (if that state requires licensing)
- Physician's Assistant who is certified by the National Commission on Certification of Physician's Assistants, or is a certified graduate of an approved training course accredited by the American Medical Association's Committee on Allied Health Education and works for a clinic or for a physician who is an M.D. or D.O.
- Nurse Practitioner (certified)
- Licensed Denturist
- Certified Licensed Acupuncturist
- PPO Providers acting within the scope of their license up to the negotiated rate in effect for the PPO Provider, excluding naturopaths.

Reasonable and Customary Charges – charges that do not exceed the fee usually charged by the person or institution and that are similar to charges made by other persons or institutions with similar training and experience in the same geographical area for comparable services and supplies. As to any particular service or supply, the term geographic area means a county or representative cross section of persons, groups, or other entities rendering or furnishing comparable services or supplies.

Skilled Nursing Facility – a facility qualified as such under Medicare.

Trust – the Inlandboatmen's Union of the Pacific National Health Benefit Trust.

Trust Agreement – The First Restated Trust Agreement Governing the Inlandboatmen's Union of the Pacific National Health Benefit Trust and amendments thereto and restatement thereto.

Trust Office – BeneSys, Inc., PMB #116, 5331 S. Macadam Avenue, Suite 258, Portland, OR 97239, (503) 224-0048 or (800) 547-4457 outside of Portland.

Union – Inlandboatmen's Union of the Pacific Marine Division of the International Longshoremen's and Warehousemen's Union.


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