Local 598 *Trust Plan Benefits*

Benefit Guide

2025

Updated June 2025

Welcome

We are pleased to provide you and your family this Benefits Guide to help you understand the benefits that are provided to our members. You have access to a very comprehensive and robust suite of benefits and we are committed to helping you understand what they are and how best to use them. The purpose of this guide is to do just that – give you an easy reference for all we offer and provide enough information so you know what you have, how to use it and where to go for more information.

Please keep in mind: This is a summary of your benefit offerings and is meant ***only*** as a brief description of the benefits under the various Benefits Funds to make the Funds' terms more understandable. Your rights as a participant are governed by the plan documents, consisting of the Trust Agreement together with all amendments, Plan Document and Summary Plan Descriptions. Please refer to and read all plan documents for more complete descriptions. The plan documents may be obtained by contacting the plan administrator for each Fund or United Association Local 598.

Our health plan is self insured, which means that the Trust fund covers the cost of care for you and your eligible family members out of the assets of the Trust. We do purchase insurance for those who have very large claims each year, but most care is paid for by the Trust. This means that the use of healthcare by our plan participants determines our future costs. We encourage you to be educated about how your benefits work and when and how to use them. We also encourage you to ask questions, use your resources, and be an overall smart consumer of healthcare.

Table of Contents

Eligibility and Plan Funding

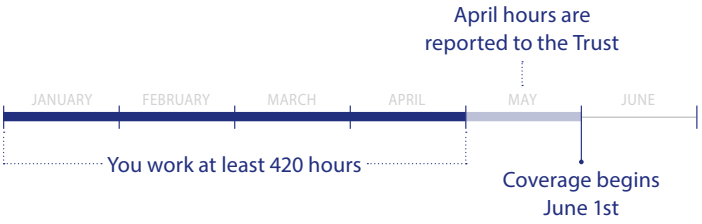
Plan Administration – BeneSys

BeneSys administers your plan eligibility, reserve accounts, the health reimbursement accounts (HRA), vacation account, and your medical plan. They are also known as the "Trust Office." They are responsible for collecting the employer contributions, establishing and maintaining your various accounts (reserve account, HRA, vacation savings) and processing your claims. They take your phone calls when you have questions or issues with eligibility or coverage, and are there to help you navigate our various plan benefits.

Eligibility

Every covered plan member has a reserve account that is established when you begin working and receiving employer contributions towards benefits. This is where all the health coverage employer contributions are accounted for you to then use for your medical, dental, vision and life insurance coverage premiums. Funds go into the account for every hour you work based on the amount determined by the Board of Trustees and the negotiated contribution rate.

When you are new to the plan, to get coverage for the first time you must have 420 hours of contributions accumulated over 4 consecutive months, or sooner. Your hours are recorded at the Trust Office for the month worked. Once your employer has reported 420 hours of contributions, your coverage will start the first day of the following month. Here is an example of how it works:



Example:

For each month of coverage, a set amount will come out of your account to pay your premiums for that month. Here's an example, using the 2025–26 monthly premium of $1,408.26. The amount is calculated as 147 hours times $9.58 (the current contribution rate for medical, dental, vision and life coverage). Coverage continues so long as you have at least $1,408.26 in your account.

You will continue to add to your account with every hour worked and as long as you have at least $1,408.26 in your account you will continue to have coverage. You can accumulate up to nine (9) months worth of premiums in your account.

If you don't have enough in your account for a month of coverage, and you had coverage in the prior month, you are allowed to maintain your insurance by self paying the shortage, either directly or by using your HRA funds.

Who are the family members you can cover for benefits?

In addition to yourself, your premium covers:

- Your legally married spouse (no domestic partners, no common law spouses), and
- Your children, including your birth children, step-children, adopted children (or placed for adoption), foster children for whom you are legally responsible, or any you are required to provide coverage through court order. You can cover these children until the end of the month when they turn age 26. They do not have to be financially dependent on you or be claimed on your income taxes, they just have to be yours!

Enrollment

When you meet the requirements for coverage, you will receive a packet from the Trust Office with the paperwork needed to get you and your family members signed up. You must complete and return the paperwork to BeneSys within 30 days. If you don't enroll your eligible family members when they are first eligible, you won't be able to enroll them until our annual open enrollment which typically occurs in November for coverage that will start at the beginning of January. Remember to include marriage and birth certificates with your enrollment paperwork.

When you have new family members through marriage, birth or adoption/foster care, they can be covered so long as you enroll them within 90 days of the date of the marriage, birth or placement. Otherwise you will have to wait for open enrollment to add them to the Plan.

When does coverage terminate?

Your coverage will end the last day of the month when there are not enough funds in your account to cover the cost of coverage and you are unable or ineligible to make self payments. You may be eligible to continue your coverage through COBRA; please see the summary plan description or contact the Trust Office for more information.

In addition to losing coverage when your account balance dips, your family members will lose coverage when they are no longer eligible such as if you divorce or legally separate, or when your children turn age 26.

Medical Benefits

Your medical plan provides coverage for expenses that are medically necessary and not experimental or investigational. We have partnered with Aetna for both our preferred provider (PPO) network and our medical management. This means that in order to make the most of your benefit dollar, and get the highest level of benefits, you should use a provider who is in the Aetna PPO network. There are also some services that will require authorization ***before*** you receive treatment or care. We will explain this more on page 4.

There are a few terms you should know to better understand how your plan works:

Deductible

The amount in a calendar year that you pay before the plan pays anything is called the deductible. Once you have had paid medical charges that are more than the deductible the plan will pay a benefit. We call the action of meeting your deductible, "satisfying" your deductible. Your plan has a calendar year individual deductible of $750 and a calendar year family deductible of $2,250. Each calendar year, no one person in your family will have a deductible of more than $750, but once the whole family has paid $2,250 towards the deductible it will be met for the whole family for the year.

Examples:

Family of two
Each has a deductible of $750 and once they have each met that amount their individual deductibles have been met.

Family of four
Two family members meet $750 each or $1,500 total.

The other two family members each meet $375, or $750 total, and the family deductible has been met.

Family of six
If each family member meets $375 the family has met the entire $2,250 for the year ($375x6=$2,250).

Coinsurance

Once you have incurred healthcare expenses beyond the deductible, the plan then pays a percentage of the cost of the treatment. This is known as "coinsurance" meaning that we co-insure: you pay some and the plan pays some. On our plan, for PPO providers the plan pays 80% and you pay 20%.

Copayment

A set dollar amount you pay towards the cost of a particular type of service. The deductible generally does not apply to benefits that have a copayment. As an example in our plan, you would pay a $25 copayment for an office visit and the plan would pay the rest.

Out-of-Pocket Maximum

The most you will pay out of your pocket in a calendar year for covered expenses before the plan then pays 100% for the rest of the calendar year. Medical plan out-of-pocket maximum includes any amount you pay towards the deductible, medical copayments and coinsurance. It does not include non-covered benefits or amounts over usual and customary.

Aetna network (PPO) providers

Our plan uses the Aetna PPO network for our PPO network benefits. Providers in the Aetna network have been credentialed by Aetna and have agreed to a set discounted rate for the services they provide. This is known as the negotiated rate. When you use a PPO provider, the plan will pay benefits based on the negotiated rate, regardless of what the provider bills.

The Aetna PPO network has a very large list of PPO providers that you can use when you need care. To find an Aetna PPO provider, or check to see if your provider is in the Aetna network, you can:

1. **Visit the Aetna.com website**
   - » Under Member Support select Account Management and Find a Doctor
   - » You can then either log in or continue as a guest
   - » You will provide the location where you want to look for a provider and the distance from that location you are willing to travel
   - » Pick our network: Under "Aetna Open Access," it's the "Aetna Choice II (Open Access)"
   - » Type in the provider name, or choose the tile with the provider type you are looking for
   - » Review your results
2. **Call the Trust Office** and ask them to help you determine if the doctor is in the network, or if a doctor you are considering is in the network.
3. **Ask your provider** if they are in the Aetna Choice II (Open Access) network – this is the least reliable option, as most will tell you that they "accept Aetna" but that may not mean they are in the Aetna Choice II network.

Out-of-Network Providers – Balance Billing

If you choose to use an out-of-network provider, the plan will pay based on Aetna's usual and customary charge. If the provider charges more than usual and customary, you may have to pay for any amount over, plus any cost sharing from the plan (like deductible and coinsurance). This amount over usual and customary is known as balance billing.

Your Medical Benefits – Summary

Benefit	Aetna PPO Provider	Out-of-Network Provider
Medical Calendar Year Deductible Individual Family	$750 $2,250	
Medical Calendar Year Out-of-Pocket Maximum Individual Family	Includes medical deductible, coinsurance and copayments $3,000 $6,000	
Pharmacy Calendar Year Out-of-Pocket Maximum Individual Family	Includes pharmacy coinsurance and copayments only $1,500 $3,000	
Preventive Care Services Routine Physical Exam Routine Cancer screenings Immunizations	100% no deductible	60% after the deductible
Vaccines at the Pharmacy	100% no deductible	N/A
Office and Urgent Care Visits	The plan pays 100% after $25 copay per visit. No deductible.	60% after the deductible
Telemedicine Visits		
From Teladoc Providers	Plan pays 100%, no deductible	N/A
Other Providers	Plan pays 100% after $25 copay per visit. No deductible.	60% after the deductible
Diagnostic X-ray, Lab and Tests	80% after the deductible	60% after the deductible
Hospital In and Outpatient	80% after the deductible	60% after the deductible
Emergency Room	$75 copay, then 80% after the deductible Copay waived if admitted	
Physician Surgery Services	80% after the deductible	60% after the deductible
Outpatient Rehabilitation-PT, OT and Speech Therapy Limited to a combined 60 visits per calendar year	80% after the deductible	60% after the deductible
Chiropractic Limited to a combined 12 visits per calendar year	80% after the deductible	60% after the deductible
Alternative Care – acupuncture, massage, naturopathy Limited to a combined 12 visits per calendar year	80% after the deductible	60% after the deductible
Infertility Testing Limited to Testing and Medications only	80% after the deductible Limited to plan payment of $7,000 lifetime for medical and $3,000 lifetime for pharmacy	60% after the deductible Benefit limits combined with in network
Mental Health and Chemical Dependency		
Inpatient and Residential	80% after the deductible	60% after the deductible
Outpatient Visits	100% after $25 copay per visit, no deductible	60% after the deductible
Pre-certification or Prior Authorization Requirements	Based on Aetna's requirements. Includes but is not limited to: inpatient hospital, skilled nursing facility, inpatient rehabilitation, hospice, inpatient and residential behavioral health care, home health care, surgery and some high cost screenings (MRI, CT, PET Scans).	

Your Medical Benefits – Summary (continued)

Prior Authorization

There are services that both you and the Plan want to know are medically necessary and covered before care is provided. The process works like this:

1. Your provider recommends care that needs prior authorization
2. Your provider sends information to Aetna that describes what they are recommending, why it is being recommended and what other care may have already been tried
3. Aetna's clinical team reviews the information, and if it meets their criteria, they approve the care
4. Notice of approval is sent to the provider and the patient
5. You schedule your services and receive the care

If the care is denied, Aetna will provide a detailed explanation as to why and include their criteria for approval. Before issuing a denial, a physician also reviews the case to provide an additional layer of oversight. If the care is not approved the next steps are:

1. Ask your physician to have a doctor to doctor (also known as Peer-to-Peer) conversation with Aetna's clinical team. This can clear up questions, allow your physician to explain why the care is needed and what else has been tried. You can do this prior to any appeals.
2. You have the right to appeal denials to Aetna twice. On appeal, you will need to provide any additional information that proves the care is needed and meets Aetna's criteria. You may need to get additional information from your provider or try other alternatives. Be sure to follow the instructions and timelines provided in the denial letter.
3. If after the second appeal the care is still denied, you have the right to a review by an independent medical reviewer who is a specialty matched physician, not affiliated with Aetna. Their decision is final.

Choosing Wisely

How to be a better healthcare consumer: Tips to Avoid Unnecessary Care

When your doctor recommends a test, treatment (including medications) or procedure here are 5 questions to ask to be as informed as possible:

1. Do I really need this test or procedure? Medical tests help you and your doctor or other healthcare provider decide how to treat a problem, and what medical procedures will actually help.
2. What are the risks? Will there be side effects? What are the chances of getting results that are not accurate? Could that lead to more testing or another procedure?
3. Are there simpler, safer options? Sometimes all you need to do is make some lifestyle changes, such as eating healthier food or exercising more.
4. What happens if I don't do anything? Ask if your condition might get worse or better if you don't have the test or procedure right away.
5. How much does it cost? Ask if there are less-expensive tests, treatments or procedures, what your insurance may cover and about generic drugs instead of brand-name drugs.

1. Some medical tests, treatments and procedures provide little real benefit. And in some cases they may even cause harm. Talk to your doctor to make sure you end up with the right amount of care – not too much and not too little. Learn more at **choosingwisely.org/patient-resources**.

Pharmacy Benefits

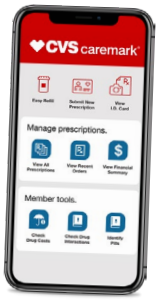
Our pharmacy benefits are managed by CVS Caremark (CVSC)

CVSC has a network of pharmacies you will use when you purchase your prescription medications. There are four options:

1. **CVSC Retail Pharmacy** – up to 30 days retail purchases from all major chains and most local pharmacies
2. **CVSC Retail 90** – up to 90 days retail purchase from most major chains
3. **CVSC Mail Order** – provides home delivery for any maintenance medications
4. **CVSC Specialty Pharmacy** – required home delivery of specialty medications

To find a network pharmacy near you, and to identify the Retail 90 providers:

1. Visit the CVS Caremark website at **Caremark.com** or download their **smartphone app**
   - » Register as a new user or sign in if you have already registered
   - » From there you can view pharmacies near you
2. Call customer service at **866-818-6911** and ask them if your pharmacy is in the network, or if a pharmacy you are considering is in the network. They can also do pharmacy searches for you and can tell you which pharmacies are part of the Retail 90 network
3. Ask your pharmacy if they are in the CVS Caremark network



There is no deductible for the pharmacy benefits.

Your pharmacy benefits - Summary

Benefit	Purchased at Retail	Purchased at Mail Order
Up to 30 Day Supply	CVSC Retail Pharmacy	N/A
Generic*	100% after $5 copay per script	N/A
Formulary or Preferred Brand	100% after $20 copay per brand	N/A
Non-Formulary or Non-Preferred Brand	100% after $40 copay per brand	N/A
Up to 90 Day Supply	CVSC Retail 90 Network	CVSC Mail Order Pharmacy
Generic*	100% after $10 copay per script	100% after $10 copay per script
Formulary or Preferred Brand	100% after $40 copay per brand	100% after $40 copay per brand
Non-Formulary or Non-Preferred Brand	100% after $80 copay per brand	100% after $80 copay per brand
Specialty Medications	Not available from Retail	Must be purchased from the CVSC Specialty Pharmacy Limited to 30 day supply You pay 10% of the cost of medication to the $1,500 out-of-pocket maximum per calendar year.

*Mandatory Generics. Our plan requires you to use a generic drug when one is available. Generics are therapeutically equivalent and are much less costly than brand drugs. If you choose to purchase a brand drug when there is an available generic you will be charged the brand copay and the difference in cost between the brand and the generic. If there is a medical reason you cannot take the generic version, your physician will need to request an authorization and be approved by CVSC to purchase the brand with no penalty.

Specialty Medication Program with PrudentRx

For those who use specialty medications, our plan includes the services of PrudentRx. This program allows you and our health plan to take advantage of discounts that the drug manufacturer gives through their payment coupon programs. This program will benefit both the patient and the plan, lowering your cost share and helping to keep our healthcare costs more affordable.

If you take a specialty medication it must be purchased through CVS Caremark Specialty pharmacy. During the set-up process, they will advise you if your medication is part of the PrudentRx program. In order to complete enrollment, you will be transferred to PrudentRx or they may call you directly at a different time. If you choose to participate, the cost of your medication will be zero. If you don't enroll with PrudentRx, your cost share will be significantly more – equal to 30% of the cost of the drug with no maximum. This program only applies to certain specialty medications, so if you take a medication not part of this program, regular specialty cost shares will apply. PrudentRx can be reached at 800-578-4403.

Other Healthcare Services

Teladoc - Virtual Doctor Visits

The Trust has contracted with Teladoc to provide you and your family access to virtual physician visits 24/7/365. Teladoc uses board certified physicians to provide care when and where you need it – from the privacy of your home, car or office. Teladoc providers can treat most urgent care needs like:

- Cough
- Headache
- Respiratory issues
- Urinary tract infections
- Rashes
- Eye infections
- Stomach aches
- Flu (non-COVID)

You can have a visit over the phone or by video conference (skype or facetime) and you can provide photos of rashes or eye infections. Simply download the **App** for your smartphone, visit their website at **teladoc.com** or call **1-800-Teladoc** (1-800-835-2362).

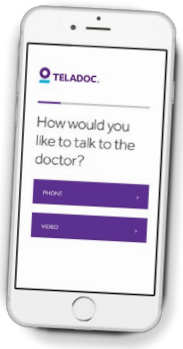
Dermatology

You can also have visits with a board certified dermatologist through Teladoc. For skin issues that are not urgent, such as acne or moles, you can schedule an appointment with a dermatologist who can help you develop a treatment plan, or determine if you need in-person care. These visits are generally within a few days of when you call. If your need is urgent, schedule your visit for immediate care with their primary care doctors.

Behavioral Health

Virtual visits extend to counseling sessions for mental health or substance abuse. You can select your counselor prior to your visit and that individual will be your therapist as long as you wish to have care. These visits are scheduled in advance and can be provided on a regular schedule. They are not 24/7, but are available on extended hours, including morning and evening appointments.

Having a visit is easy:



1. Register. You must register before your first visit. This is where Teladoc collects the information any provider would need before you get care – some medical history, current medications, allergies, plus your pharmacy of choice and your primary care physician. Registration can be done through the website or app, or you can call and do it over the phone.
2. Call or use the website or app to request a visit.

You can either have them call you back when the next available physician is ready, or you can set up an appointment time that works best for you. The average wait time is about 20 minutes. There is no cost to you for a Teladoc visit. For both dermatology and behavioral health, you will make an appointment at a time that works for you.

Aetna Nurseline

You have access to a registered nurse 24/7 who can answer your questions, provide guidance and help you care for yourself or a loved one. This is a great place to go when you are just not sure what's needed and you would like to talk it over with a medical professional. Think of it as having your own nurse who you can call anytime. Some common situations where people call Nurseline are:

- Questions about your health or how to use the healthcare system
- You or a family member are having symptoms that may need care, but you are just not sure where to go or what to do
- Your doctor has given you some home care instructions and you are not quite sure what to do

Call the nurseline anytime of the day or night

Have your ID card ready so you can give your group number

Simply Call **800-556-1555**

Coalition Health Center (CHC)

The Trust has partnered with Pacific Health Coalition and Marathon Health to provide NO COST primary care services for members and their families with health benefits covered by the Trust. The Coalition Health Center (CHC) offers a wide range of services for you, your spouse, and your children aged two and older who are enrolled on the health plan.

- Wellness and preventive care, such as annual exams, screenings, etc
- Chronic disease management, including medication management
- Treatment for illnesses, such as coughs, colds, sore throats, earaches and rashes
- Treatment for injuries, such as sprains, strains and minor lacerations
- Labs and testing, such as cholesterol, pregnancy, A1C, etc.
- Prescription dispensary. The CHC can provide some common prescription medications, for your convenience.
- Nearby imaging services

The CHC is located at 6818 W. Rio Grande Ave, Suite A, Kennewick, WA 99336. Call them at (509) 236-0649 to schedule your appointment. Hours of operation are Monday – Friday, 8:30am – 4:30pm. After hours care is available for established patients though the 24/7 Registered Nurse triage line to support urgent care needs.

Dental Benefits

Your dental plan is administered by Delta Dental and you are free to use any licensed dental provider for your dental care. Delta Dental maintains a network of dentists who have agreed to bill Delta Dental directly and accept a negotiated fee (discount). Allowable charges for out-of-network dentists are paid based on what 90% of the dentists in the area consider reasonable. If your dentist is outside the Delta Dental network you may be responsible for any additional amounts above the reasonable fee (also called balance billing).

We encourage you to have your routine and preventive dental care to maintain good oral health. If your dentist recommends major work that will cost more than $400, consider getting a "pre-determination." The dentist will send the treatment plan to Delta Dental and they will tell you and your dentist what the plan will pay before you have the work done, so there are no financial surprises.

Your dental benefits - Summary

Benefit Type	Plan Benefits
Calendar Year Deductible Individual Family	 $50 $150
Preventive Care Oral Exams (2 per calendar year) Cleanings (2 times per calendar year) Fluoride for children under age 19 (once every 6 months) Sealants	100% (deductible waived)
Basic Services Fillings Root canal therapy Periodontal work Extractions	80% after the deductible
Major Services Crowns Bridges Dentures Implants	80% after the deductible
Annual Benefit Maximum For those age 19 or over For those under age 19	 The play will pay up to $3,000 per covered person, per calendar year Unlimited Preventive care does not accumulate to the annual maximum
Orthodontia – for adults and children	50%, no deductible $2,000 lifetime maximum

Vision Benefits – Provided by Vision Service Plan

Vision Service Plan (VSP) is our provider for vision benefits. Their large nation-wide network is called the Signature Provider Network. We encourage you to use a VSP provider so you can receive the highest possible benefits. You don't have to, but if you don't your benefits will be very limited. To find a VSP provider simply visit **vsp.com** and click on the "find an in-network doctor" tile. Then put in your zip code or address and click Search. You will see a list of providers by distance from your address or zip code. You can also create an account, which will provide more personalized information.

When you want to schedule a vision care visit, simply:

1. Choose your VSP provider and schedule an appointment
   - » They will need the employee's name, birth date and last four digits of the employee's social security number as well as the patient name and DOB.
2. The provider will file the claim and take care of all the paperwork
3. You pay any out of pocket costs to them and you are done!

If you choose to use an out-of-network provider, you will need to pay for the service and submit for reimbursement. To do so, simply download a claim form from the VSP website, complete and send it along with your itemized receipt directly to VSP. They will send you a reimbursement check. You can also submit your out-of-network claim through the VSP member portal on their website. Once you log into your account click on "View Your Benefits" then "My Benefits" and scroll down to click "Submit an Out-of-Network Claim." You can use VSP providers for just lenses and frame if you have had an exam with an out-of-network provider.

Eyeconic program

VSP also has online shopping available through their online Eyeconic program. You can integrate your VSP benefits with this online site to purchase your glasses and/or contact lenses with additional available discounts. Using their virtual try-on services, you can determine what you look like in any of their frame options so you can choose the best frames based on your face shape and lifestyle. They have most brands of contact lenses, and free shipping and returns. This is an easy, affordable option for those with busy lives.

Your vision benefits - Summary

You and your covered family members can have one routine eye exam plus lenses and frames, or contact lenses, every 12 months.

Benefit	VSP Provider	Out-of-Network Provider
Well Vision Exam	Paid in Full	$50 allowance
Frames	$150 allowance $170 allowance for featured frame brands 20% savings on any amount over the allowance $80 allowance at Costco	$70 allowance
Lenses		
Single Vision	Paid in full	$50 allowance
Bifocals	Paid in full	$75 allowance
Trifocals	Paid in full	$100 allowance
Lens Enhancements		
Progressive Lenses	Paid in full	$75 allowance
Anti-reflective coating	Paid in full	Not covered
Polycarbonate lenses	Paid in full	Not covered
Contact Lenses (instead of glasses)		
Lens exam (fitting and evaluation)	Copay of no more than $60	Not covered
Lenses	$150 allowance	$105 allowance
Extra Savings Glasses & Sunglasses	30% savings on additional glasses and sunglasses from the same VSP provider on the same day as your well vision exam. 20% discount from any VSP provider within 12 months of your last well vision exam.	None
Retinal Screenings	No more than $39 copay on routine retinal screenings as an enhancement to your well vision exam.	Not covered
Laser Vision Correction	Average 15% discount off regular price or 5% off promotional price from VSP contracted facilities.	None

Health Reimbursement Arrangement (HRA)

Your HRA account provides funds to pay for out-of-pocket healthcare expenses not covered by insurance and premiums for months when you don't have enough in your reserve account. For every hour you work, a set amount goes into your HRA. The funds in your individual account are held for you to pay covered out-of-pocket expenses for you and your eligible family members. The list of what you can use the funds for is large and governed by the IRS. To review the entire list, visit: **https://www.irs.gov/publications/p502**.

Here's a short summary of *some* of the things you can use your HRA funds to pay for:

- Medical or dental plan deductible
- Copays for medical or pharmacy expenses
- Coinsurance for medical, pharmacy or dental expenses
- Dental expenses in excess of your annual plan maximum
- Orthodontia not paid by our dental plan
- Glasses or contacts not paid by our vision plan
- Laser eye surgery
- Chiropractic or medically necessary massage therapy not covered by the plan
- Over the counter medications (like allergy, acid reflux or pain medications)
- Contact lens solution
- Bandaids and other first aid supplies
- Reading glasses
- Pregnancy tests
- Menstrual products
- Thermometer
- Vitamins and supplements with a prescription from your doctor

How do I access my HRA funds?

You have two ways to access your HRA funds; you can use your Benny Card or you can file a claim for reimbursement. The method you use will depend on what type of services you are paying for.

The Benny Card is issued to you when the account is opened. It can only be used at a pharmacy for prescriptions or any allowable pharmacy items. You may swipe your card for retail prescriptions, at a participating pharmacy, or supermarket pharmacy that can identify HRA eligible items at checkout. You may also provide your card number for mail-order prescriptions. Your HRA account will be debited the amount of the pharmacy expense, as long as you have a sufficient balance.

For all non-pharmacy expenses, you will need to pay out of pocket and then file a claim for reimbursement. This process can be used to reimburse for any eligible expense including, medical, dental, vision and pharmacy. Because the use of the plan is governed by the IRS, we have to have documentation to support the use of the HRA funds. Keep your receipts, explanation of benefits or paperwork from your providers to include with your claim submission. They need to include:

- The name of the patient
- The name of the provider
- A description of the service or items purchased
- The date the services were provided or items were purchased
- The charge and/or out-of-pocket expense that was not paid by the Plan or other insurance

You have four ways to submit your HRA claim for reimbursement:

1. File a claim through the secure portal by uploading receipts from there
2. Use the App to photograph and submit claims
3. Download a claim form, scan your paperwork, and send via email
4. Download a claim form and send in paper through the USPS

The mobile application and secure online portal gives you 24/7 access to view information and manage your HRA. Here's how you access the Portal and App:

BeneSys HRA

- Use the secure online portal by visiting **www.ua598benefits.org**. Select Health Care and click on the "WEX Health" (HRA) link under "Useful Health Care Links."
- Search "Benesys Inc. HRA App" from the App Store or Google Play to download and use the App. Your login for the App will be the same that you used to set up your WEX Health HRA access.

Employee Assistance Plan – Canopy

Our EAP is a free and confidential program that helps you and your family members address issues that are distracting you from work and life. There are two parts to our EAP: Wellbeing and Work/Family/Life programs.

Wellbeing Services

These benefits are here to support you and your family members when you are experiencing life stress and need to talk to someone to help you through. This includes behavioral, mental health or substance abuse issues, or help with setting life goals or advancing in your career. Masters Level counselors are available to you 24/7/365.

Individual Counseling Sessions

You can receive up to 6 free counseling sessions per unrelated incident for each employee/family unit to help you with areas such as:

- Marital & Family Relationships
- Depression and Anxiety
- Alcohol and Substance Abuse
- Job Related Problems
- Stress Management
- Conflict Resolution
- Domestic Violence
- Grieving a Loss
- Parenting Stressors

These visits can be in person, over the phone or through video chat. Simply contact Canopy and they will help you find the right counselor for your needs.

Life Coaching

Life coaching consists of up to three telephone sessions with a Master's level life coach. The sessions focus on setting achievable goals, identifying barriers and planning to help achieve your goals.

Scheduling an Appointment

- Call Canopy at 800-433-2320 to schedule over the phone
- Log in at **my.canopywell.com** and schedule online
  - » Under My EAP Benefits, select **Counseling Sessions**

WholeLife Directions

Would you like help figuring out areas of your life that could use some extra support? Take the WholeLife Directions assessment! It will show you where you could use some help and provides resources to do so. The assessment focuses on things like anxiety, depression, sleep (or lack of), stress, substance use and relationship conflict. After completing the on-line questionnaire, you get immediate feedback and recommendations, which may include EAP services, or self-guided modules depending on your risk level. To get started, log into the Canopy member website, or search WholeLife Directions in the App Store or Google Play. Your access code is **Local 598**.

LifeBalance

LifeBalance provides you discounts for healthy, fun and family-friendly activities. These discounts range from tickets to events and movies, travel and shopping, to cooking classes and outdoor adventures and Dell computers. This is also where you will find the discounted pet insurance options. Log into the Canopy member website or visit **LifeBalanceProgram.com/login**. Your activation code is **CAS2948**.

Employee Assistance Plan – Canopy (continued)

Work/Family/Life Services

This provides additional support and services when you have specific needs for legal, financial, housing, and more.

Legal Services

Each employee is entitled to one, no cost, initial 30-minute office or telephone consultation with a network attorney or mediator (up to 3 issues per year). If you decide to retain the attorney for additional services, services will be discounted 25%. You also have access to a legal resource center where you can create and print legal forms and documents, including a will questionnaire.

Financial Services

Each covered member can have 30 days of no cost, unlimited access to a financial coach. The coach can help you with financial concerns like managing debt, preparing for retirement, budgeting, improving your credit score and more. You will work with experienced financial professionals who will help you with a needs analysis and create a written action plan.

Housing Support, Relocation and Home Ownership Program

You have available a variety of services to help with housing:

- Resources for buying, selling and refinancing a home
- Down payment resources
- Rental property alert notifications
- Credit score review
- Resources for housing assistance, temporary accommodations and emergency housing
- Options for housing in your area

Concierge Services

Canopy EAP provides information and resource retrieval services for today's busy people. They find the needed information within 3-5 business days of your call. Your time is saved as the legwork is done for you. No issue is too small, from helping you locate the perfect anniversary or birthday gift, to finding a dry cleaner or pet-sitter.

Identity Theft Services

This service provides you with a free 60-minute consultation with a highly-trained Fraud Resolution Specialist. They will conduct emergency response activities and help you to restore your identity and good credit as well as assist with the costly steps to dispute fraudulent debts, etc.

Eldercare Services

Canopy provides help in finding solutions for the needs of older adults and the family members caring for them, such as housing, alterative living, home health, community services, legal concerns and medical issues.

Childcare and Education Services

This service provides assistance finding qualified childcare, and can help with education, behavioral and developmental concerns. They can also help with adoption information from newborns through age 18.

Pet Parent Resources

There are times when we need some help with our furry friends for:

- Pet Insurance – Discounts Available through LifeBalance
- Concierge support for boarding, sitting, day care, walking services and more
- New pet parent resources
- Bereavement support
- Emergency Preparedness for Pets

*To access **any** of the services provided by Canopy simply:*

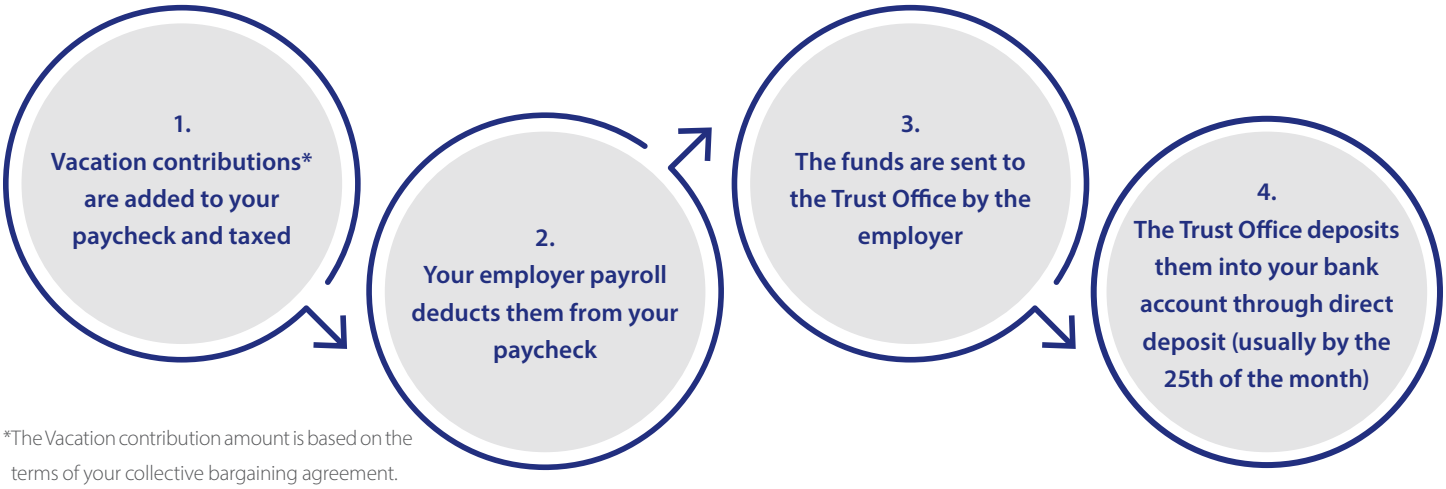
Call: **800-433-2320** Text: **503-850-7721** Email: **info@canopywell.com**

Register and use the Website: **www.canopywell.com** to create a Member Log-in. Enter **Local598** for company name when you register.

Download and use the App: Search Canopy EAP from the App Store or Google Play

Vacation Plan

Taking time away from work is important for your physical and mental well being. As such, part of your benefits package includes funds that will allow you to afford to take needed time off. It works like this:



*The Vacation contribution amount is based on the terms of your collective bargaining agreement.

Death Benefits

In the event of your death, your beneficiary will receive the following benefits:

- Included with your medical coverage is a life insurance benefit of $10,000 from Reliance Standard Life. If you are on COBRA at the time of death the benefit reduces to $5,000.
- Burial benefit from the UA of $2,500 so long as you were a member in good standing for a minimum of six months prior to passing.
- Burial benefits from the Washington State Association of $1,000 for any member in good standing at the time of passing. You may also be eligible for a lump sum death benefit, depending upon your hours, years of credit, etc. Refer to your Plan Document and contact Zenith-American Solutions directly for details.
- A burial benefit from Local 598 based on $2 per each working member of Local 598 for the month prior to your death. This means members registered for work or currently working. It does not include lifetime members. The average amount is currently $1,500 to $1,600.

You should appoint a beneficiary for each of these policies. If you don't, the proceeds will be paid in this order:

- To your legal spouse; if none then
- Your surviving children in equal shares; if none then
- Your surviving parents in equal shares; if none then
- Your surviving siblings in equal shares; if none then
- Your estate

For coverage with your medical plan, visit **www.ua598benefits.org** to download a beneficiary form. Contact the retirement plan websites or administrators for information on how to appoint beneficiaries for the burial benefits. For the burial benefit from Local 598, contact the Union Hall to make a beneficiary designation.

Accidental Death and Dismemberment (AD&D)

You are covered for $4,000 of AD&D through American Income Life. This benefit would be paid if your death was due to an accident, or you lost a limb or eyesight due to an accident on or off the job.

Benefits at Your Retirement

Health and Welfare Benefits

Eligibility

You must be retired and submit an application for retiree health and welfare benefits within 120 days of your pension effective date with an Industry Pension Plan.* You must also be receiving your pension. In addition, you must:

- Have had health and welfare coverage in 36 of the 60 months prior to your pension effective date and have 15,000 or more employer contribution hours to the Trust, OR 25,000 or more of employer contribution hours. The 5 year limit does not apply to a spouse who was over age 55 at the time of your death.
- Have had continuous health and welfare coverage for 60 months prior to your pension effective date and have 25,000 or more of employer contribution hours to the Trust.

Non-bargaining employees and owners of employers participating in the Trust may also be eligible. Review the Retiree SPD for more details.

*There are other pathways to eligibility. For a complete description, please refer to the SPD, including all amendments addressing retiree eligibility.

Covered Family Members

You may also cover:

- Your legal spouse
- Your children until they turn age 26

If the retiree dies while covered, their surviving spouse can continue Plan coverage. Surviving children will be allowed to continue coverage for five years or until they reach age 26, whichever occurs first. Normal premiums apply. Contact the Trust Office for details.

Coverage Provided – Medicare and Early Retirees

$5,000 of life insurance – you will be automatically enrolled

You will need to choose and enroll for:

- Dental (same benefit as the Actives, described on page 7)
- Vision (same benefit as the Actives, described on page 8)
- Dental and vision
- Neither dental or vision

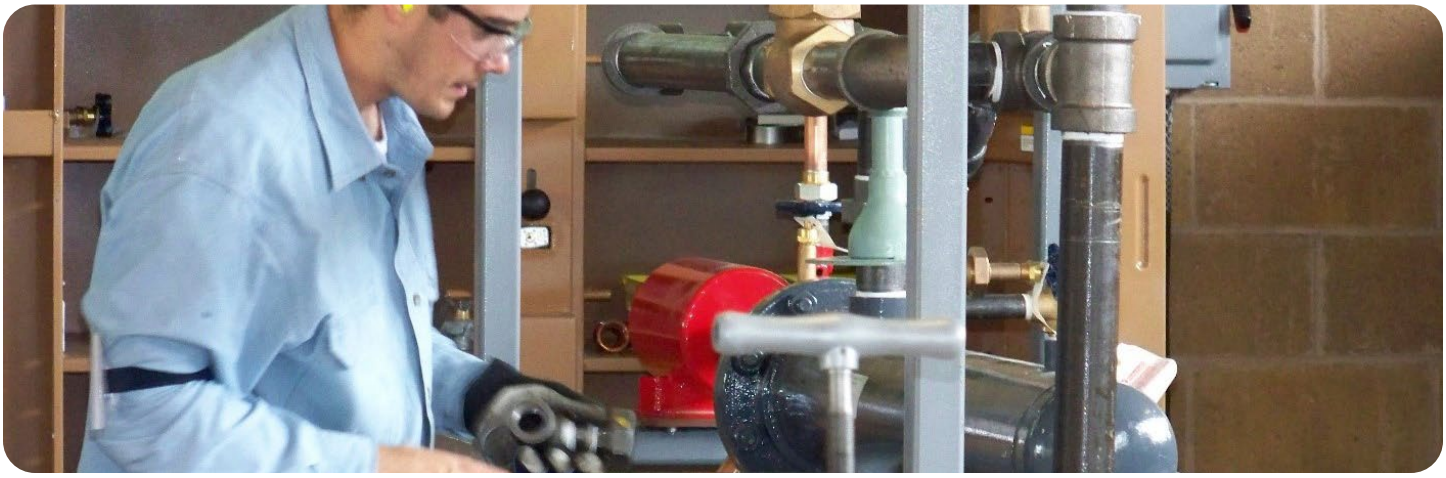
If you don't make an election, you will have neither dental or vision. If you don't enroll when you first retire, you can't enroll later. The exception is if you or your family members have been covered by another dental or vision plan. In that case, you can enroll when the other coverage stops.

You must self pay the cost of the dental and vision plans.

Medicare Retirees

You will be enrolled in the Humana Group Medicare Advantage PPO plan for medical and pharmacy coverage. The Trust pays a portion (roughly half) of the premiums for this coverage and you pay the rest. You have the choice to continue to be enrolled for dental or vision benefits.

The Trust has retained RetireeFirst, a retiree benefits management solutions and advocacy service provider. RetireeFirst Advocates are US-based and available to help you navigate the complex retiree healthcare landscape and troubleshoot any issues you may have with Humana, and your provider or pharmacy.



Benefits at Your Retirement (continued)

Early Retirees (Pre-65)

Each early retiree will have a Retiree Health Reimbursement Account (RHRA) opened at the time of retirement. Retiree HRA credits will be added to your account on or around the first of each month. In addition to these credits, the balance in your Reserve Account (Hours Bank) when you retire will be transferred into your Retiree HRA. You have the choice to enroll for dental or vision benefits.

Retiree HRA Credits

For those who retire after 12/31/2015, your monthly RHRA credit will depend on your hours of employer and reciprocity contributions on record at WSPPIPP while you were active. The RHRA contributions are:

Hours of Employer & Reciprocity Contributions	Monthly Benefit	
	Retiree Only	Retiree & Spouse
15,000 to 22,499	$125	$200
22,500 to 29,999	$250	$400
30,000 to 37,499	$375	$600
37,500 or more	$500	$800

What can you use the Retiree HRA funds for?

RHRA funds can be used to pay premiums for health insurance either through your spouse's employer or coverage you purchase individually. You can also use the funds to pay for out-of-pocket healthcare expenses not covered by insurance, just like you could when you were active. This includes out of pocket expenses for deductibles, copayments, coinsurance, dental, vision, or anything allowed by the IRS code section 213(d).

How do you access the Retiree HRA funds?

If you use the money to reimburse for monthly insurance premiums, once a year you must set up a recurring claim to direct deposit your monthly funds into your bank account. You will also be issued a Retiree HRA Benny Card (debit card) that you can use to pay your out of pocket healthcare expenses in the same way before you retired. See page 9 for details on how to submit claims or substantiate your Benny Card use.

If you should pass away while covered as an Early Retiree, your surviving family will continue to receive your RHRA credits for the earliest of:

- 5 years from your date of death or
- your spouse turns 65 or
- your child turns 26.

The five year limit will not apply to a spouse who was age 55 or older at the time of your death.

Pension Benefits

Your pension benefits are not provided by the Local 598 Health and Welfare Trust. You have access to three pension plans, each with their own eligibility and benefit schedules. These plans provide regular benefits once you meet the retirement eligibility rules. This is a high level overview of the three plans. Please refer to each Plan's Documents for detailed information.

Supplemental Pension Plan

Plan Type: Money purchase pension plan
Plan Administrator: BeneSys, Inc.
Recordkeeper: Northwest Plan Services (NWPS)

Eligibility

You become a participant in the plan when you are entitled to an employer contribution, and you continue in the plan as long as you have funds in your account.

Plan Funding

The plan is funded only by employer contributions that are deposited into your own account for each hour worked. The amount of the contribution is set out in your collective bargaining or participation agreement.

Prior to 8/1/2011, employees were also allowed to put funds into the account, so if you participated prior to that time, you may have a second account called the "After Tax Account" where these contributions are held. Disbursements from the After Tax Account are not taxed.

Funds are 100% vested at all times, even if you leave the plumbing and pipefitting industry before applying for retirement benefits.

Investments

You choose how your account is invested from options offered by the Supplemental Pension Board of Trustees. You can change your investments by contacting NWPS. If you don't direct your investments, they will be placed in a default investment until you decide how you would like to have them invested.

Benefit at retirement

The amount available to you at retirement will depend on:

Employer contributions into your account (based on hours worked) + Investment income on the accumulated funds − fees = Dollars at retirement

When can you collect the benefit?

You can access your funds at the normal retirement age which means you have reached age 62. You do not have to retire to receive benefits. You can collect early retirement benefits as early as age 55, and you can also defer your benefits after age 62 if you continue to work. You must start taking distributions by age 72. Distributions are taxable.

How are benefits paid?

When you are ready to take a distribution, simply notify NWPS to gain access your benefits.

You have a choice as to the method of distribution including lump sums, regular installments and annuities. See the plan document or contact the plan administrator for more details.

Pension Benefits (continued)

Washington State Plumbers and Pipefitting Industry Pension Plan

Plan Type: Defined Benefit Plan
Administrator: BeneSys, Inc, Tukwila, WA

Eligibility

You become a participant in the Plan when you accumulate at least one hour of service where an employer is obligated to make a contribution as a result of a collective bargaining agreement. You will continue to be a participant in the Plan if you have accumulated at least 300 hours at the end of the plan year which have not been lost due to a break in service.

Service Credits

You will receive a full year of service credit if you work at least 870 hours in a calendar year. If you work less than 870 hours you may receive a partial credit depending on the number of hours worked. The number of service credits will determine your eligibility for retirement and the vested benefit. For hours worked on or after January 1, 2018, you are fully vested once you have accumulated 3 years of vested service, meaning you are entitled to your full pension at the normal retirement age.

Plan Funding

The plan is funded by employer contributions which are set out in your collective bargaining agreement.

Benefit at retirement and retirement eligibility

Your Monthly Benefit Base will determine your benefit at retirement and will vary by the number of hours of service and the amount of the employer contribution into the plan. If you retire between ages 62 and 65, you will receive 100% of your normal retirement benefit. If you retire between ages 55 and 62, or are disabled, your benefit will be reduced based on a set schedule. See the Plan Document for more details.

How are benefits paid?

Your benefits will begin the later of the first of the month following the month in which you retire, or the first of the month following the month you file your application. Plan benefits will be disbursed in the form of an annuity paid monthly, which includes additional benefits for your spouse should they survive you. There are several options; see the Plan Document for more detail.

Plumbers and Pipefitters National Pension Plan

Plan Type: Defined Benefit Plan
Administrator: Toni C. Inscoe, Alexandria, VA

Eligibility

You become a participant in the Plan on January 1 or July 1 after you work 870 hours of covered employment. This must occur within 12 consecutive months where there is a collective bargaining agreement that requires the employer to make contributions to the Plan.

Plan Funding

The plan is funded by employer contributions which are set out in your collective bargaining agreement.

Benefit at retirement and retirement eligibility

Your benefit at retirement is based on the number of pension credits earned after your contribution date. The amount of the credit is based on hours of covered employment. You will be eligible for a normal retirement benefit if you retire between ages 62 and 65 with at least 5 years of pension credit and a minimum of 1,500 hours of covered employment. You can retire earlier, but you will receive a lesser benefit. See the Plan Document for details.

Contribution Rate + Time worked for a contributing employer + Age a retirement = Amount of Pension

Vesting

You will earn one year of vested service for any calendar year in which you work at least 870 hours in covered employment. Once you have accumulated 5 years of vested service you are fully vested meaning you are entitled to your full pension at the normal retirement age.

How are benefits paid?

Your benefits will begin the later of the first of the month following the month in which you retire, or the first of the month following the month you file your application. Plan benefits will be disbursed in the form of an annuity paid monthly, which includes additional benefits for your spouse should they survive you. There are several options; see the Plan Document for more detail.

Benefit Contact Information

Where to go for more information and to have your questions answered

Plan Type	Provider or Administrator	Contact	Web/App/Access
Eligibility	BeneSys	Call: 800-205-7002	www.ua598benefits.org
Medical	BeneSys	Call: 800-205-7002	www.ua598benefits.org
Medical PPO	Aetna	Providers can call Provider Services at 888-632-3862	www.Aetna.com
Virtual Doctor Visits	Teladoc	Call: 855-835-2362	www.teladoc.com or Teladoc App
NurseLine	Aetna	Call: 800-556-1555	www.Aetna.com
Pharmacy	CVS Caremark	Call: 866-818-6911	https://www.caremark.com/wps/portal
Dental	Delta Dental	Call: 888-374-8906	www.deltadentalak.com
Vision	Vision Service Plan	Call: 800-877-7195	www.vsp.com or VSP Vision Care App
Life Insurance	BeneSys	Call: 800-205-7002	www.ua598benefits.org
Active HRA	BeneSys	Call: 800-205-7002	www.ua598benefits.org
Early Retiree HRA	BeneSys	Call: 800-205-7002	www.ua598benefits.org
Employee Assistance Plan	Canopy	Call: 800-433-2320 Text: 503-850-7721 Email: info@canopywell.com	www.canopywell.com "Company Name": Local 598 Canopy EAP
WholeLife Directions	Canopy	Call: 800-433-2320 Text: 503-850-7721 Email: info@canopywell.com	Through the Canopy Website, WholeLife Directions App, or www.wholelifedirections.com
LifeBalance	Canopy	Call: 800-433-2320 Text: 503-850-7721 Email: info@canopywell.com	Through the Canopy Website or LifebalanceProgram.com/login Activation Code: CAS2948
Vacation Plan	BeneSys	Call: 800-205-7002	www.ua598benefits.org
Retiree Health Plan Eligibility	BeneSys	Call: 800-205-7002	www.ua598benefits.org
Medicare Retiree Medical/ Pharmacy Benefits	RetireeFirst Advocates	Call: 833-268-6813	
Supplemental Pension	NW Plan Services	Call: 877-690-5410	https://www.yourplanaccess.net/nwps/
WA State Pension Plan	BeneSys	Call: 888-406-3246	
National Pension Plan	Toni C. Inscoe	Call: 800-638-7442	Ppnpf.org

Benefit Advocate

You have available an advocate who can help you with any questions or issues about your benefit plans. The Benefits Coordinator is located in Pasco, WA and is available to assist with your Health & Welfare or Pension issues. Contact us at the UA598 Hall by phone at: **509-545-1446**.

This guide describes the benefit plans and policies available to you as an employee of UA Local 598. The details of these plans and policies are contained in the official plan and policy documents, including some insurance contracts. This guide is meant only to cover the major points of each plan or policy. It does not contain all the details that are included in your Summary Plan Descriptions (as required by ERISA) found in your other employee benefit materials. If there is ever a question about one of these plans and policies, or if there is a conflict between the information in this guide and the formal language of the plan or policy documents, the formal wording in the plan or policy documents will govern.

Note: The benefits highlighted and described in this guide may be changed at any time and do not represent a contractual obligation – either implied or expressed – on the part of UA Local 598.