Seattle Area Plumbing & Pipefitting Industry Health Trust

U.A. Local 32 and Mechanical Contractors Association

Mechanical Contractors Association
WESTERN WASHINGTON

Benefit Plan and Summary Plan Description

Revised January 1, 2023

To Eligible Employees:

We are pleased to present this new updated booklet describing the health and welfare benefits available to you and your family through the Seattle Area Plumbing & Pipefitting Industry Health Trust.

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

Sincerely,

Board of Trustees

Employer Trustees	**Labor Trustees**
Ed Kommers	Jeffery Owen
Rory Olson	Joel Crabtree
Pat Damitio	Michael Kunkel

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

- Address
- Dependent status (birth, adoption, legal placement for adoption, legal guardianship, death, marriage, legal separation, divorce, child custody)
- Designated beneficiary

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

IMPORTANT NOTICE

Seattle Area Plumbing & Pipefitting Industry Health Trust is committed to maintaining health care coverage for employees and their families at an affordable cost, however, because future conditions cannot be predicted, the Board of Trustees reserves the right to amend or terminate coverage at any time and for any reason.

The Board of Trustees has the exclusive authority to interpret the provisions of the Plan, to determine eligibility for an entitlement to Plan benefits or to amend the Plan. Any interpretation or determination by the Trustees made in good faith, which is not contrary to law, is conclusive on all persons affected. The Board of Trustees has delegated to the Trust Office the authority to administer the Plan and provide information relating to the amount of benefits, eligibility, and other plan provisions. The Board of Trustees may also refer certain questions or plan administration issues to medical review organizations or other third-parties. In administering the Plan, the Trust Office and any medical review organization used by the Trust may utilize its internal guidelines and medical protocols in determining whether or not specific services or supplies are covered under the terms of the Plan. Neither the Trust Office nor any other third party has the authority to change the provisions of this Plan document. An interpretation of this Plan document by the Trust Office or any other third party is subject to review by the Board of Trustees. No individual trustee, employer, employer association, labor organization, or any individual employed by an employer or labor organization, has any authority to interpret or change the Plan.

Be sure to keep this document, along with notices of any plan changes, in a safe and convenient place where you and your family can find and refer to them.

Table of Contents

Summary of Benefits

Here's a summary of benefits under the Plan. This is only a summary. Please read each benefit section for specifics about covered expenses as well as exclusions and limitations.

Note: If you are an active employee or non-Medicare retiree enrolled in the Trust's self-funded Kaiser medical plan or a Medicare eligible retiree enrolled in the Trust's insured Kaiser Medicare Advantage plan, only the eligibility, dental, vision, death benefit, accidental death & dismemberment benefit and weekly disability income benefits described in this booklet apply to you. A separate description of Kaiser medical and prescription drug benefits is available from the Trust's Administration Office.

Medical			
Vera Whole Health • Primary care • Preventive care • Wellness	***No Out-of-Pocket cost*** No deductible, copay or coinsurance when you visit a Vera Whole Health clinic. Services include primary and preventive care and wellness services, including lab work and certain generic prescriptions (see page 24).		
Annual Deductible – per calendar year			
• Per person	$300		
• Per family maximum	$900		
Copays (unless otherwise specified in the Plan)	Office Visit	ER Visit	Hospital Stay
• Preferred (PPO) providers	$20	$100	None
• Non-PPO providers	$40	$100	$100
Coinsurance (unless otherwise specified in the Plan)	After deductible and ER or Hospital Copays:		
• Preferred (PPO) providers	The Plan pays 80%; you pay 20%		
• Non-PPO providers	The Plan pays 60%; you pay 40%		
Annual Coinsurance Maximum – per calendar year	Once your coinsurance portion (20% PPO; 40% non-PPO) reaches the amounts listed below, the plan coinsurance will increase to 100% for the remainder of the calendar year. Applicable deductibles and copays will still apply.		
• Preferred (PPO providers)	$2,000 per person/$4,000 per family		
• Non-preferred providers	$5,000 per person/$10,000 per family		
Annual PPO Out-of-Pocket Maximum – per calendar year	Once your total out-of-pocket expenses (including deductible, coinsurance and copays) for PPO providers reaches the amounts below, all deductibles, coinsurance and copays are waived for PPO providers for the remainder of the calendar year.		
• Per person	$5,600		
• Per family maximum	$10,200		
Prescription Drugs			
Annual Prescription Drug Out-of-Pocket Maximum (per calendar year)			
• Per person	$1,000		
• Per family maximum	$3,000		
Retail Copays Per Script	Up to 30-day supply		
• Tier 1 - Generic	$8 ($23 for Maintenance Drugs[1])		
• Tier 2 – Formulary Brand	$40 ($60 for Maintenance Drugs[1])		
• Tier 3 – Non-Formulary Brand	$55 ($85 for Maintenance Drugs[1])		
Mail Order Copays Per Script	Up to 90-day supply		
• Tier 1 - Generic	$20		
• Tier 2 – Formulary Brand	$100		
• Tier 3 – Non-Formulary Brand	$137.50		

[1] Maintenance Drug prescriptions should be filled through Mail Order after the first three fills at a retail pharmacy. If you continue to fill a Maintenance Drug prescription at a non-CVS retail pharmacy, you will pay a higher copay as shown above.

Specialty drugs must be purchased through the Specialty Pharmacy and are limited to a 30-day supply (normal Retail copays apply).

Dental Care		
Basic Dental Services		
• Reimbursement	80%	
• Annual Maximum	$2,000/person/calendar year (The annual maximum does not apply to Class I Benefits for children under age 18.)	
Orthodontia (Active Plan only)		
• Reimbursement	70%	
• Lifetime Maximum	$2,000/person	
Vision Care		
Vision Services	**VSP Provider**	**Non-VSP Provider**
Eye exam (one per calendar year)	100% after $10 copay	Plan pays up to $101
Glasses	Plan pays:	Plan pays:
Standard Lenses (two pair per calendar year)	100% after $10 copay	$39 to $112 per pair
Frames (two pair every two calendar years)	$150 to $200 per frame +20% discount	Up to $91 per frame
Contacts Lenses (twice per calendar year)	Plan pays $205	Plan pays $190
Safety Glasses - active employees only (lenses once per calendar year; frames once every two calendar years)	Plan pays 100% (Protec collection only)	Plan pays up to $35 to $90 for lenses and $25 for frames
Weekly Disability (Active Employees Only)		
Employee Benefit	Up to $800 per week	
Death Benefits and Accidental Death & Dismemberment Benefits		
Employee Death Benefit	$10,000	
Employee Accidental Death and Dismemberment Benefit	Up to $10,000	
Dependent Death Benefit	Up to $2,000	
Retiree Death Benefit	$10,000	
Retiree Accidental Death and Dismemberment Benefit	Up to $10,000	

Important Contacts

For information about…	Contact…	At…
Medical Claims and Benefits	**Trust Office** *Mailing Address* Seattle Area Plumbing & Pipefitting Industry Health Trust PO Box 91076 Seattle, WA 98111-9176	(206) 352-9728 (888) 406-3246 Email: sapphcustomerservice@zenith-american.com www.zenith-american.com
Eligibility Vacation Benefits Reciprocity COBRA	**Trust Office** *Street Address* 11724 NE 195th Street, Suite 300 Bothell, WA 98011	(206) 352-9728 (888) 406-3246 Email: sapphcustomerservice@zenith-american.com www.zenith-american.com
PPO Network –preferred providers (Aetna Choice POSII network)	**Aetna** PO Box 981106 El Paso, TX 79998	(888) 632-3862 www.aetna.com
Pre-Admission Authorization Case Management **for Providers**	**Aetna**	(888) 632-3862
Substance Abuse/Mental Health for Members	**Aetna**	(800) 424-4047
Beginning Right Maternity for Members	**Aetna**	(800) CRADLE-1 (800-272-3531) option 3
HMO Network	**Kaiser**	(888) 901-4636 www.kp.org/wa
Dental Claims	**Delta Dental of Washington**	(800) 554-1907 or (206) 522-2300
Vision Claims	**VSP Vision Care**	(800) 877-7195 www.vsp.com
Employee Assistance Plan	**First Choice Health Employee Assistance Plan**	(800) 777-4114 www.firstchoiceeap.com
24 Hour Nurse line	**Aetna**	(800) 556-1555
Tobacco Cessation	**Quit For Life**	(866) 784-8454 www.quitnow.net
Prescription Drug Plan	**CVS/caremark**	(866) 818-6911 www.caremark.com
Primary Care Clinics	**Vera Whole Health**	(206) 337.6080 patients.verawholehealth.com
U.A. Local 32 Benefit Specialist	**Julie Pock**	(425) 277-6680 julie@ualocal32.com

Trust Website

The Trust website address is: www.zenith-american.com. The first time you login as a plan participant, click onto the “Log onto your account” button in the top right corner. Click on Account Type and Select “Participant” as your account type from the drop-down menu and then enter:

Username: Your Last Name
Password: Your Social Security Number (without dashes)

You will then be prompted to enter a unique username and password. Please be sure to change your username and password right away to something you can easily remember.

The website provides benefit information on your health plan, as well as work history and hours on your pension plans, including the following:

- Contact Information for the Trust Office and Plan Benefit Providers
- Downloadable Plan Forms and Documents
- Health Plan Eligibility
- Processed Claims/Explanation of Benefits
- Summary Plan Document and Summary of Material Modifications (updated inserts to the booklet)
- Work History
- Other Plan Information

Eligibility

Active Employee Eligibility

Employees eligible to participate in the Plan are those working under a labor agreement between UA Local 32 and an employer, or under a special participation agreement, that obligates the employer to make contributions to the Trust. It is your responsibility to check with your employer, the Trust Office or your local union office to make certain that health and welfare contributions are being made for you by your employer.

Initial Eligibility

In determining your eligibility, the Plan utilizes a dollar bank system. Your dollar bank is credited with contributions made to the Plan on your behalf by your employer. A deduction from your dollar bank is made on the first day of every month for that month's coverage. The deduction rate for a month of coverage is determined from time to time by the Board of Trustees.

Here's an example of how it works:

Work Month	Lag Month	Eligible Month
In January you work for a participating employer that makes contributions to this Trust	During February your employer submits the contributions to the Trust Office for work performed in January. The Trust Office credits the contributions to your dollar bank account	You are eligible on the first day of March and subsequent months as long as your dollar bank has enough dollars to pay for the coverage

The maximum amount of contributions you can accumulate in your dollar bank is the equivalent of five months of coverage, after the deduction for the current month.

Continuing Eligibility

Once you are eligible, you will remain eligible provided there are sufficient dollars in your dollar bank to pay for at least one month of coverage at the current dollar bank deduction rate.

Forfeiture of Dollar Bank

If you lose coverage and there has been no activity in your dollar bank for 12 months or longer - that is, no eligibility (including continuation coverage), no self-payments and no contributions made on your behalf - the contributions remaining in your dollar bank will be forfeited. If your dollar bank forfeits to the Trust, you must re-qualify as a new employee.

When you retire you may run out your dollar bank. Any residual amounts remaining after you have run out your dollar bank will be forfeited.

Reciprocity

The Trustees of this Plan have entered into reciprocity agreements with certain other health and welfare trusts. Contributions paid to this Trust for employees from outside this area, who are working temporarily in this area, may be transferred to their home trust and vice versa. Check with UA Local 32 to determine which reciprocity agreements exist. Contact the Trust Office or UA Local 32 to obtain an authorization form to transfer funds back to the employee's home Trust.

Contributions transferred to this Trust, for hours worked in another jurisdiction, can delay your health eligibility. If this happens, you will need to make a self-payment until the hours and contributions are received by the Trust Office. Your self-payment can be refunded or used for the next month's coverage.

Your dollar bank may also be frozen if you gain additional eligibility under another health plan that results from employer contributions made pursuant to a collective bargaining agreement within the jurisdiction of the UA, provided that a written request is made within 30 days of the date you first become eligible for the other coverage. The request will be referred to a committee of Trustees who will approve or disapprove the request. This Plan will provide no coverage during the period the dollar bank is frozen. The dollar bank may not be frozen for more than 12 months except as specifically described under USERRA (see page 12), or after written notice from the Trustees of termination of the Trust.

Termination of Active Employee Eligibility

The coverage of an active employee shall terminate on whichever of the following dates occurs first:

- The last day of the month in which your dollar bank no longer provides a month of coverage and continuation coverage is not elected.
- The day of your death.
- The last day of the month in which you enroll in the retiree plan.
- The date the employee enters the armed forces on full-time active duty, subject to the employee's right to continue coverage under the Uniformed Services Employment and Reemployment Right Act (USERRA). You must contact the Trust Office if you want your dollar bank frozen.
- The date the Trust or Plan ceases providing benefits.

In the event your coverage is terminated, you may have the right to continue coverage pursuant to one of the Trust's continuation options described beginning on page 11.

Eligible Dependents

Eligible dependents of an eligible employee or retiree shall include:

- Their lawful spouse, if not divorced or legally separated.
- Natural children, stepchildren, legally adopted children or children placed for adoption under the age of 26. A child is considered placed for adoption if the employee or retiree has a legal obligation for financial support in anticipation of an adoption. Stepchildren may continue to be covered following the death of the child's biological parent provided that the stepchild continues to reside with the employee or is enrolled in a college or post-secondary educational institution and remains financially dependent on the employee.

- Foster children and legal wards under the age of 18, or under the age of 26 if the child continues to reside with the employee or is enrolled in a college or post-secondary educational institution and remains financially dependent on the employee. Legal wards are children placed by an authorized placement agency, judgment decree, or court order who reside with the employee and for who the employee is financially responsible for their care and support. For children other than natural children, you must provide the Trust Office copies of court papers or other official documents demonstrating your legal relationship with or obligation to support a child.
- Children aged 26 and over, if as of the date they would otherwise lose coverage, the child is disabled, the disability arose before the child reached age 26 and as a result of that disability the child is primarily dependent on the employee or retiree for support. For this purpose, disability is defined as a mental or physical condition that is expected to be permanent and continuous for the remainder of the child's life and results in the inability to engage in self-sustaining employment, including one or more of the following: the inability to perform activities of daily living, the inability to engage in normal social functions, the inability to independently complete tasks. Disability does not include conditions that are temporary or where recovery would be expected through treatment. A Social Security Disability Award will be considered presumptive evidence of disability. Absent a Social Security Disability Award, the Plan will make a disability determination based on the individual's facts and circumstances. The Plan may consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment.

In accordance with federal law, the Plan also provides medical/vision/dental coverage to certain dependent children (called alternate recipients) if directed to do so by a qualified medical child support order (QMCSO) issued by a court or state agency of competent jurisdiction. Contact the Trust Office for details. You and your dependents may obtain, without charge, a copy of the procedures governing medical child support orders and determinations from the Trust Office.

Enrollment

Initial Dependent Enrollment

An employee or retiree must be eligible for benefits to have their dependents covered. For all new dependents the employee should enroll them within 90 days of the spouse or dependent becoming eligible and provide all enrollment documents within those time frames. The employee must provide a copy of their state certified marriage certificate for a spouse and state certified birth certificate (and parenting plan if divorced) for all dependent children.

Enrolling New Dependents

Contact the Trust Office immediately for information on enrolling new dependents.

Once the required information is provided, coverage for their eligible dependents shall become effective on the latest of the following dates:

- On the date the employee's or retiree's coverage becomes effective, or
- On the date the employee or retiree first acquires an eligible dependent.

Dependents will not be eligible for coverage until all requested enrollment documentation is provided. Please note: If requested enrollment documentation is not provided, the Plan will not pay claims until the documentation is received. A delay in providing the required enrollment documentation may result in the denial of claims. In order for a claim to be processed, all required information (including eligibility information) must be received within the 12 months from the date the claim is incurred.

Annual Open Enrollment

Upon enrollment and once each year (usually in the fall), participants may choose to change coverage to the Trust PPO plan or the Kaiser plan. Only participants may change coverage. Spouses of participants or dependent children of an active participant or retiree may not independently make a change. The only exception to this rule is for COBRA participants and QMCSOs. Changes become effective the following January 1st. If no plan is selected, the participant and dependents will be enrolled in the Trust PPO plan.

Certain life changing events may allow you to change coverage options outside of the normal open enrollment period. This type of enrollment is called special enrollment. The Plan provides the following opportunities for special enrollment:

- New dependent by marriage, birth, adoption, placement for adoption or court order. If you acquire a new dependent as a result of marriage, birth, adoption, placement for adoption or court order you may request to change your Plan option within 90 days after you have acquired the dependent, or 150 days for newborns, provided all enrollment documents are timely received.
- Loss of other coverage. If your dependent did not enroll in the Plan because your dependent had other health insurance or group health coverage, and your dependent subsequently loses that other coverage, you may change your plan option within 30 days of the loss of that other coverage (or 60 days if the other coverage was Medicaid or State Children's Health Insurance Program). In order to qualify for this special enrollment right, you must provide the Trust Office with proof that your dependent had other coverage as of the last open enrollment period.

Dependent Opt Out of Coverage

Your dependent spouse or adult dependent children (over age 18) may elect to opt-out of Plan coverage by submitting a signed written request to the Plan. The opt-out will be effective for all claims incurred on and after the first of the month following the month in which the opt-out request is received by the Plan. The opt-out will apply to all Plan coverage, including medical, prescription drug, dental, vision and death benefits.

An opt-out of Plan coverage is not a COBRA qualifying event and a dependent who opts out will not be eligible for COBRA Continuation Coverage. A dependent who opted out of coverage and is not enrolled in the Plan at the time of a COBRA qualifying event will not be eligible to re-enroll or to elect COBRA Continuation Coverage.

A dependent of an employee who opted out of coverage may re-enroll, provided the employee is still enrolled and the dependent still satisfies the requirements for dependent eligibility. A written request for re-enrollment must be submitted to the Plan. Re-enrollment will be effective the first day of the month following the month in which the enrollment request is received by the Plan.

An employee or retiree may not unilaterally remove an adult dependent from coverage without the adult dependent's written consent. A minor child cannot opt-out of Plan coverage and cannot be removed from the Plan by the employee or spouse.

Termination of Dependent Eligibility

The coverage of any dependent shall terminate on the earliest of the following dates:

- The last day of the month such dependent ceases to be an eligible dependent.
- The last day of the month that the employee's coverage terminates.
- The date this Plan or group policy is amended to cease providing benefits.
- The last day of the month the dependent opts out or is no longer enrolled in the Plan.

In the event your coverage is terminated, you may have the right to continue coverage pursuant to one of the Trust's continuation options described beginning on page 11.

Right to Continue Coverage

Under certain defined circumstances, eligible employees, retirees and their dependents may be able to continue coverage under this Plan beyond the time coverage would ordinarily end. The right to continued coverage may come from certain Plan policies adopted by the Trust or from federal laws, such as the Family Medical Leave Act (FMLA), the Uniformed Services Employment and Reemployment Rights Act (USERRA) or the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA).

In the event your coverage ends, review the sections below to determine if you or your dependents may be eligible to continue some or all of your Plan coverage.

Continued Eligibility When Disabled

If you stop working because you are disabled, you may continue coverage for up to six months without deductions from your dollar bank. Disabled or disability, as used for this provision, means your inability to work in your normal job because of an illness or injury.

In order to be eligible for this extension you must have had continuous active Trust coverage for the six months preceding the date of your disability. Your disability must last for four weeks or more and you must be disabled at the time the Trust Office received your application.

If you are eligible for this extension, you must contact the Trust Office for an employee Waiver of Premium Application. The Waiver of Premium application must be signed by you and your physician documenting the disability. Once the application is received, the Trust Office will freeze any dollars in your dollar bank the first of the following month and coverage will continue as long as you remain disabled, up to the six-month maximum.

REMEMBER the Trust Office needs to receive the Waiver of Premium Application and the dollar bank will be frozen the first of the following month.

Examples:

> Joe has the maximum amount in his dollar bank and is working steadily. Joe suffers a serious injury on January 5th and will be unable to work for at least six months. Joe sends in his disability waiver application, which is received on January 10th. Contributions will be deducted from Joe's bank to provide coverage through March. If Joe remains disabled, Joe's dollar bank will be frozen in February, and he will continue to have coverage during the period of his disability (up to a maximum of six month) without any additional deduction from his dollar bank.
>
> In the same situation as above, if Joe does not submit his disability application until February 5th (the month following his disability), Joe's bank will be deducted to provide coverage for both March and April. If Joe remains disabled, Joe's dollar bank will be frozen in March, and he will continue to have coverage during the period of his disability (up to a maximum of six month) without any additional deduction from his dollar bank.

Following the expiration of the six-month period, if there are insufficient funds in your dollar bank to reinstate eligibility, you will have the right to elect COBRA continuation coverage.

Continued Dependent Coverage of a Deceased Active Participant

Eligible dependents of an employee who dies while on active coverage may continue to be covered until the deceased employee's dollar bank is exhausted. This coverage is in addition to any COBRA continuation rights (see page 14 for information on COBRA Continuation Coverage).

Federal and State Family Medical Leave Acts

There are both state and federal laws that provide paid or unpaid leave to care for yourself or family members in specific situations (generally referred to as FMLA). The application of these leave laws depend on where the employer is located and the size of the employer. Generally, to be eligible for FMLA coverage, you must be covered under the Plan when the leave began, and your employer must continue to make the required contributions during the leave. FMLA coverage is limited to the permissible leave provided in the applicable statute. Coverage terminates the earlier of the expiration of FMLA leave or sooner as provided in the statute.

As a general matter, the Trust does not determine whether you are eligible for FMLA leave. If you believe you may be eligible for a FMLA leave, you should contact your employer immediately. An employer must provide documentation to the Trust to confirm eligibility for FMLA leave and make arrangements to pay the required contributions to continue coverage.

If you are eligible for FMLA leave, you may request that your dollar bank be frozen at the beginning of your leave period, which the Trust may grant at its discretion provided contributions are received from your employer and you do not lose coverage.

Following FMLA, the Plan's other Continuation of Coverage Options may be available.

Military Service Under USERRA

If you leave covered employment to perform military service that is covered under the Uniformed Services Employment and Reemployment Rights Act (USERRA), you may elect to continue your medical, dental, vision and prescription drug coverage for you and your dependents for up to 24 months. If your military service lasts less than 31 days, coverage will be continued at no cost to you. If your military service lasts more than 30 days, a monthly self-payment will be required at the rate established by the Trustees (see page 6 for dollar bank rules).

Under USERRA, you must notify your employer before taking leave unless prevented from doing so by military necessity or other reasonable cause. You should also tell your employer how long you expect to be gone. Upon release from military duty, you must return or apply to return to covered employment or hiring hall status within the following time limits:

- Less than 31 days of military service – next calendar day following completion of service time plus time required for safe transportation to your residence plus eight hours.
- 31-180 days of military service – within 14 days.
- More than 180 days of military service – within 90 days.

If you are hospitalized for or convalescing from an illness or injury that occurred during your military service, the above deadlines are extended while you recover, but generally not longer than two years.

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

If you have dollar bank eligibility at the time your military service begins and you elect to continue your coverage under USERRA, you may either freeze your dollar bank and begin making self-payment immediately or you may run out your dollar bank coverage before you begin making self-payment.

If you elect to freeze your dollar bank, you must notify the Trust Office in writing within 30 days of the date you enter military service. If you do not notify the Trust Office of your desire to freeze your dollar bank, contributions shall continue to be deducted from your dollar bank on the assumption that you have dependents and they want coverage under the plan.

The dollar bank may be frozen for up to five years for military service. This Plan will provide no coverage during the period the dollar bank is frozen.

Any balance in your dollar bank will be retained for the duration of your military service. You may continue to self-pay for coverage under USERRA for a maximum of 24 months unless you fail to return to covered employment or hiring hall status within the period required by USERRA, in which case your USERRA coverage will terminate on the day after the deadline has passed.

To ensure proper crediting of service under USERRA, you must notify the Trust Office when you take USERRA leave and let them know how long you expect to be gone. Call the Trust Office when you apply for reemployment after your USERRA leave has ended or if you need more USERRA information.

COBRA Continuation Coverage

To obtain COBRA continuation coverage a participant must have a qualifying event, make a timely election to continue coverage, and make timely self-payments as described below. Employees and dependents who lose coverage as the result of a qualifying event have the right to elect continuation coverage under COBRA. Such employees and dependents are called “qualified beneficiaries.”

COBRA Qualifying Events

18-Month Qualifying Events:

Qualified beneficiaries may elect COBRA continuation coverage for a maximum of 18 months if their coverage would otherwise end due to one of the following:

- The employee’s termination of employment for any reason (this includes retirement and voluntarily quitting) other than gross misconduct; or
- The employee’s reduction in hours of employment.

29-Month Qualifying Events:

If Social Security determines an individual is totally disabled prior to the 18-month qualifying event or within the first 60 days of COBRA continuation coverage, the disabled individual and all qualified beneficiaries may extend COBRA coverage an additional 11 months, to a maximum of 29 months. In order to qualify for this extension, the individual or qualified beneficiary must provide the Trust Office with proof of the Social Security disability determination no later than the date that the initial 18-month COBRA continuation period ends.

36-Month Qualifying Events:

A dependent qualified beneficiary may elect COBRA continuation coverage for a maximum of 36 months if their coverage would otherwise end due to one of the following:

- Death of the employee or retiree;
- Divorce or legal separation between the employee or retiree and their spouse; or
- For a dependent child, ceasing to meet the Plan’s definition of an eligible dependent.

Second Qualifying Event:

An 18-month period of COBRA may be extended to 36 months for the affected dependent qualified beneficiary if one of the 36-month qualifying events occurs during the first 18 months of COBRA continuation coverage. In no event will COBRA continuation coverage extend beyond 36 months from the date coverage was first lost due to the initial qualifying event.

COBRA Notification Responsibilities

An employee or dependent must notify the Trust Office on any of the following events:

- Within 60 days of a death, divorce, legal separation, or child losing dependent status prior to age 26;
- Upon becoming covered under any other group health plan after electing COBRA continuation coverage;
- For a Social Security disability extension, within 60 days of Social Security determining an individual is disabled, but not later than the date the initial 18-month COBRA period ends; and
- Within 30 days of Social Security determining an individual is no longer disabled.

The employer has the responsibility to notify the Trust Office of the employee's termination of employment or reduction of hours.

Election of COBRA Coverage

Upon receiving notification that a qualifying event may have occurred, the Trust Office will notify you, your lawful spouse and each of your covered dependents of their right to elect continuation coverage. Qualified beneficiaries must then select COBRA continuation coverage by the later of:

- 60 days after the coverage ends; or
- 60 days after receipt of notification of the continuation rights from the Trust Office.

Failure to timely elect COBRA continuation coverage will result in the loss of the right to elect COBRA continuation coverage.

Newly Acquired Dependents during COBRA Coverage

If you acquire an eligible dependent while eligible for COBRA continuation coverage you may elect to enroll the dependent for continuation coverage in accordance with the Plan's normal enrollment rules. However, only child(ren) born to, adopted by or placed for adoption with you (the covered employee) during the 18-month period of COBRA continuation coverage are qualified beneficiaries entitled to an extension of coverage as a result of a second qualifying event. Spouses and stepchildren acquired after a qualified event are not eligible for 36 months of coverage due to a second qualifying event.

Types of COBRA Coverage Available

If you choose COBRA continuation coverage, you are entitled to the same benefits you had in the month immediately before you lost coverage. The following benefit options are available under COBRA:

- Medical and Prescription Drug only.
- Medical, Prescription Drug, Dental and Vision.

COBRA continuation coverage is not available for weekly income benefits.

Once you have elected COBRA coverage, you may not change your selection after the initial 60-day election period, except during an open or special enrollment period (see page 9).

Continuous COBRA Coverage Required

Your coverage under COBRA must be continuous from the date Trust coverage would have ended if monthly self-payments were not made.

Monthly Self-Payments for COBRA Coverage Required

You and your covered dependents are responsible for the full cost of COBRA continuation coverage. The payments must be made to the Trust Office within 30 days of the premium due date.

The only exception is that the initial self-payment for the period preceding the election of COBRA continuation coverage may be made up to 45 days after the date of election. All payments must become current by 45 days after the date of election. Failure to make timely payments will result in the permanent loss of COBRA continuation coverage. Eligibility will not be granted until payment has been received.

Note: Your payment is due by the 20th of the month in order to have eligibility on the first day of the following month. You may make your payments by check or by calling the Trust Office using your Visa or Master Card.

Any amount remaining in the employee's dollar bank may be used to pay the first month of COBRA continuation coverage, up to the full amount of the self-payment.

End of COBRA Coverage

COBRA continuation coverage will end on the earliest of the following dates:

- 18 months from the date continuation began for individuals whose coverage ended because of a reduction of hours or termination of employment.
- 29 months from the date continuation began if the individual was disabled as of the time their eligibility ended, and they provide proof of the Social Security Administration's disability determination within the initial 18-month continuation period.
- 36 months from the date continuation began for individuals whose coverage ended because of the death of the employee, divorce or legal separation from the employee, the dependent ceasing to meet the definition of an eligible dependent.
- End of any month for which the required premium for your COBRA coverage is not paid within 30 days of the first of the month for which the payment applies. Checks returned for non-sufficient funds will be treated as failing to make a self-payment and if not reissued by the end of the coverage period, coverage will terminate.
- The date the individual becomes covered under any other group health plan.
- The date this Plan ends.

Subsidized COBRA Self-Payment Rates

Employees are eligible to make self-payments for COBRA continuation coverage at a subsidized self-pay rate if they are available for work and are on the out of work list maintained by the local union. Employees who do not meet these criteria will be required to pay the unsubsidized rate. A subsidy may not be available for some dependent COBRA qualifying events. Also, the subsidy shall not be available to any employee who works for a noncontributing employer in the plumbing and pipefitting industry, within the geographical jurisdiction of the Washington State Association of the UA within the 12-month period immediately preceding the effective date of his self-paid coverage or while making subsidized self-payments.

Self-Pay Coverage Beyond COBRA Period

An individual who remains a member of UA Local 32 and is available for employment and on the out of work list may apply to the Trustees for an extension of the self-payment period. Such employees may petition the Trust (before their 18th month of coverage) to extend their coverage for an additional six months. This additional six months of coverage is in addition to COBRA continuation coverage.

Certificate of Creditable Coverage

A certificate of creditable coverage is available upon request. Contact the Trust Office if you need a certificate of creditable coverage.

Retiree Eligibility

General Eligibility

An employee seeking retiree plan coverage must meet all of the following requirements:

- Have active employee coverage in this Plan in the month immediately prior to their enrollment date (recency test) and in 36 of the 60 months immediately preceding their enrollment date. For the purpose of this rule, months of active employee coverage shall include waiver of premium and self-pay months of coverage; and
- The employee must have received, be receiving or currently eligible to receive a retirement benefit from the Western Washington UA Supplemental Pension Plan, the Washington State Plumbing and Pipefitting Industry Pension Plan or the UA National Pension Plan, or similar retirement plan; and
- Be at least 55 years of age (unless totally disabled); and
- Submit a complete application form for retiree plan coverage to the Trust Office (including all requested documentation) and make timely monthly self-payments.

Dependents for the purpose of retiree coverage are defined the same as for active eligibility (see page 6).

To qualify for the subsidized retiree eligibility, you must have 10 years or more of contribution service reported to this Plan (this means 120 months of active employee health eligibility under this Plan). If the retiree has less than 10 years of contributory service reported to this Plan, no subsidy will be provided, and the self-payment rate will be equal to the total monthly cost of coverage each year.

Example for June 1 Enrollment Date:

Lag Month **Eligible Month Prior Eligibility Examples**	**Meets Requirements?**
You have coverage for every month for the last 36 months through May.	Yes
You have coverage 12 months through May with a break in coverage for 6 months then 12 months of coverage, another break for 2 months, then 1 month of coverage, another break for 5 months, then 6 months of coverage, another break for 2 months, then 5 months of coverage.	Yes – 36 months
You have coverage for 36 months with no coverage in May.	No – does not meet recency test
You have coverage for 24 months through May with a break in coverage for 48 months. Did not make the 36 months of coverage in a 60-month period.	No - does not meet the 36 months, only 24 months

Disabled Employees Eligibility for Retiree Plan

Totally disabled employees who do not meet the general eligibility requirements shown above will qualify for retiree plan benefits if they meet all of the following requirements:

- Have active employee coverage in this Plan in the month immediately prior and in 36 of the 60 months immediately preceding their date of total disability. For the purpose of this rule, months of active employee coverage shall include waiver of premium and self-pay months of coverage; and
- Either (a) has been determined by the Social Security Administration (SSA) to be totally and permanently disabled and is receiving SSA disability benefits or (b) is receiving disability retirement benefits from the Washington State Plumbing and Pipefitting Industry Pension Plan; and
- Submit an application for retiree plan coverage to the Trust Office within 60 days of the initial month of eligibility for retiree plan coverage. Forms are available through the Trust Office or UA Local 32; and
- Make timely monthly self-payments.

Surviving Spouse

To be eligible to self-pay for retiree plan benefits, a surviving spouse must be the surviving spouse of a retiree who was eligible for coverage from this retiree plan at the time of death or be the surviving spouse of an employee who would have met all the eligibility requirements listed under “General Eligibility” above except for the age 55 requirement at the time of death.

Any contributions remaining in an employee’s dollar bank at the time of death can be used by the surviving spouse towards self-payment for coverage.

Coverage will terminate on the last day of the month during which the surviving spouse remarries or the last day of the month, which precedes the month the surviving spouse becomes eligible for other group coverage. You must notify the Trust Office when you remarry.

Retiree Enrollment and Delayed Enrollment

Retiree enrollment must be made within 60 days of when the retiree would otherwise lose Active Plan coverage, regardless of when the retiree begins receiving pension benefits. Retirees who are otherwise eligible to enroll in the retiree plan may elect to delay enrollment in the retiree plan in the following circumstances:

1. If the retiree and/or dependent has other employment-based medical coverage including COBRA/self-paid coverage or has dependent coverage under a spouse's group health plan on the date the retiree would otherwise lose Plan coverage, he or she may delay participation in the retiree plan until the other medical coverage ends.

   To request this delay in enrollment the retiree still must make timely application to the Trust Office on the Retiree Medical Coverage Election Form within 60 days of

when the retiree would otherwise lose active coverage in this Plan and indicate that he or she (and/or the dependent) is making a request for delayed participation (proof of other coverage will be required). If the retiree dies after electing to delay medical coverage due to other employment-based medical coverage, the election shall continue to apply to the retiree's surviving spouse following the retiree's death.

Once the other coverage ends, the retiree and/or dependent must notify the Trust Office in writing within 30 days after the other medical coverage has ended. Coverage under the other medical coverage and retiree plan must be continuous. Retirees who enroll 30 days after losing active coverage will need to pay retroactive to the month they lost coverage in order to maintain coverage with no gaps.

2. The retiree and/or spouse may make a one-time irrevocable election to delay or opt out of early retiree medical coverage until they become Medicare-eligible. There is no requirement that the individual have other group medical coverage. This election must be made on the Retiree Medical Coverage Election Form and mailed to the Trust Office. Once an election is made it cannot be changed for any reason.

   If an election is made to postpone coverage until the retiree or spouse is Medicare-eligible, the retiree or spouse must then notify the Trust Office within 30 days of becoming Medicare eligible that they want to activate their retiree plan coverage. This 30-day notification requirement is mandatory and cannot be waived. If the retiree dies after electing to delay medical coverage until Medicare eligibility, the election shall continue to apply to the retiree's surviving spouse following the retiree's death.

Cost of Retiree Plan Coverage

Retirees covered under this retiree plan must make monthly self-payments for coverage. Self-payment rates are established by the Board of Trustees. Initial coverage under self-payments must immediately follow a period of active employee eligibility.

Self-payments must be received by the Trust Office not later than the 15th of the month preceding the month for which coverage is being provided.

Coverage must be continuous, with no lapses. If a lapse occurs, coverage will be terminated permanently and cannot be reinstated.

The Trustees may elect to provide a subsidy for retiree coverage, which means the retiree self-payment may be set below the monthly cost of coverage, with the Trust covering the remaining amount. The retiree self-payment rates are as follows:

- **Retirees with Retiree Medical Plan effective dates prior to January 1, 2008** – The self-payment rate in effect on January 1, 2013 will apply. However, the self-payment rate may change when the retiree first becomes eligible for Medicare, or switches between PPO and Kaiser coverage.
- **Retirees with Retiree Medical Plan effective dates from January 1, 2008 through December 31, 2012** – If the retiree has at least 10 years of contributory service reported to the Trust, the self-payment rate in effect on January 1, 2013 will apply. However, the self-payment rate may change when the retiree first becomes eligible for Medicare, or switches between PPO and Kaiser coverage. If the retiree has less than 10 years of contributory service reported to the Trust, no subsidy will be provided, and the self-payment rate will be equal to the total monthly cost of coverage each year.

- **<u>Retirees with Retiree Medical Plan effective dates on or after January 1, 2013</u>** – To qualify for the subsidized retiree medical plan eligibility you must have 10 years or more of contribution service reported to the Trust. If the retiree has less than 10 years of contributory service reported to the Trust, no subsidy will be provided, and the self-payment rate will be equal to the total monthly cost of coverage each year.

  If the retiree has at least 10 years of contributory service reported to the Trust, the self-payment rate will be set as a percentage of the amount deducted from an active employee's dollar bank for a month of coverage (see page 7 for more information regarding dollar bank deductions). The percentage will depend on the retiree's year of retirement as follows:

Year of Retirement	% of Dollar Bank Deduction
2013	43%
2014	47%
2015 and after	50%

  During the first five years of the retiree's last worked date as completed on the Retiree Medical Coverage Election Form, the self-payment rate may be recalculated based on the dollar bank deduction in effect on January 1 each year. After five years of retirement, the self-payment rate will be capped.

  If a retiree medical coverage effective date is delayed due to the runout of the retiree's active dollar bank, or the retiree defers enrollment because the retiree has access to other employment-based medical coverage, or has COBRA/self-paid coverage, the first year to count toward the five year cap will be the month after the retiree's last day worked as completed on the Retiree Medical Coverage Election form, unless the last day worked is in the last three months of the year. If the retiree is eligible for Medicare, the self-payment will always be the lesser of 1) the calculated self-payment rate described above (based on year of retirement and the active dollar bank deduction), or 2) the total monthly cost of coverage for the retiree and their covered dependents.

  If a participant's last day worked as completed on the Retiree Medical Coverage Election form occurs during the last three months of a calendar year (October – December), the following year will be the first year to count toward the five-year cap. In addition, if a retiree goes back to work and qualifies for benefits as an active employee for more than six months of any calendar year, that year will not count toward the five-year cap.

  Below are some examples. These are not the only possible scenarios. Your specific situation will vary based on your year and date of retirement and whether you go back to work during retirement.

Example 1: **Retiree's first day of the month following the last day worked as completed on the Retiree Medical Coverage Election form *September 1, 2023***

Year	2023	2024	2025	2026	2027	2028	2029+
Toward Cap	Year 1	Year 2	Year 3	Year 4	Year 5	Capped	Capped

Self-Payment	50% of 2023 dollar bank amount	50% of 2024 dollar bank amount	50% of 2025 dollar bank amount	50% of 2026 dollar bank amount	50% of 2027 dollar bank amount	50% of 2027 dollar bank amount	50% of 2027 dollar bank amount

Example 2: **Retiree's first day of the month following the last day worked as completed on the Retiree Medical Coverage Election form *October 1, 2023 (note: 2024 counts as first year of five-year cap)***

Year	2023	2024	2025	2026	2027	2028	2029+
Toward Cap	No	Year 1	Year 2	Year 3	Year 4	Year 5	Capped
Self-Payment	50% of 2023 dollar bank amount	50% of 2024 dollar bank amount	50% of 2025 dollar bank amount	50% of 2026 dollar bank amount	50% of 2027 dollar bank amount	50% of 2028 dollar bank amount	50% of 2028 dollar bank amount

Example 3: **Retiree's first day of the month following the last day worked as completed on the Retiree Medical Coverage Election form *July 1, 2023, with return to work for more than six months in 2025 (note: 2025 does not count toward five-year cap)***

Year	2023	2024	2025	2026	2027	2028	2029+
Toward Cap	Year 1	Year 2	No	Year 3	Year 4	Year 5	Capped
Self-Payment	50% of 2023 dollar bank amount	50% of 2024 dollar bank amount	50% of 2025 dollar bank amount	50% of 2026 dollar bank amount	50% of 2027 dollar bank amount	50% of 2028 dollar bank amount	50% of 2028 dollar bank amount

Change in Self-Payments Due to Medicare Status

Any change in a participant's Medicare eligibility that affects the benefits available and the monthly self-payment amount under this retiree plan will be effective the first of the month such change becomes effective. When you are close to becoming eligible for Medicare, please call the Trust Office if you have any questions about coordination between this Plan and Medicare. Please provide a copy of your Medicare card to the Trust office.

Termination of Eligibility

Coverage will terminate on the earliest of the following:

- The date the Trustees amend the Trust or Plan to cease providing benefits.

- The last day of the month in which the death of the retiree occurs. Dependents of participants who become ineligible for benefits under these programs may still have COBRA or other self-pay rights as described in the Plan. Please check with the Trust Office for details.
- When the required self-payment is not made. Coverage will be terminated if the payment is not received by the last day of the month in which the coverage was for. Coverage will be terminated retroactive to the last day a payment was received.

When a retiree returns to work: A retiree who returns to work for an employer that is required to make contributions to this Trust will continue to receive benefits until the first day of the month following the month in which they qualify for benefits under this Trust as an active employee. When coverage as an active employee under this Trust ends, they will be reinstated under the retiree plan the first day of the month following the end of coverage under the active plan, upon written notification to the Trust Office. You must notify the Trust Office within 30 days of losing active coverage.

MEDICARE ENROLLMENT–IMPORTANT! PLEASE READ

All participants, including retired participants, spouses, and dependents, regardless of age, who are otherwise eligible and entitled to participate in the federal Medicare program for benefits, are required to enroll and participate in both Parts A and B of the Medicare program. **You are required to notify the Trust Office within 60 days of becoming eligible for Medicare. If you, your spouse or your dependent fail to enroll in Medicare, benefits will be paid as if you were enrolled in Medicare.** As a result, it is important for you and your dependent(s) to enroll in Medicare on a timely basis. You should contact your local Social Security Office regarding enrollment in Medicare before your or your dependent's 65th birthday, or if you are disabled.

If you are enrolled in the Kaiser option, you must complete the Medicare Senior Advantage enrollment form before turning 65 in order to enroll in the Medicare Senior Advantage program. Alternatively, you can transfer to the PPO Plan. If you do not complete an enrollment form, you will not be eligible to enroll in the Kaiser Medical Senior Advantage program and you will automatically be moved to the PPO Plan.

Benefits for retirees, widow(er)s and their eligible dependents are provided on a month-to-month basis to the extent that contributions from contributing employers and participant self-payments continue to be sufficient for such purposes. There is no long-range funding or reserve program. The Trustees reserve the right to change the eligibility rules, reduce the benefits, change the self-payment rates or eliminate the plan entirely, as may be required by future circumstances.

Medical Benefits

If you are enrolled in the Trust's self-funded PPO Plan, the benefits described in this booklet apply to you.

If you are enrolled in the Kaiser plan, separate medical and prescription drug benefits are available under the Kaiser plan (summarized in materials you will receive from Kaiser). If you are enrolled in Kaiser, only the benefits described in the Dental, Vision, Weekly Disability Income, Life and AD&D section of this booklet apply to you.

Vera Whole Health Primary Care Clinic

All Seattle Area Plumbing & Pipefitting Industry Health Plan PPO participants and their covered dependents, age 3 and older, have access to primary and preventive care through the Trust's primary care clinic, managed by Vera Whole Health. Medicare retirees and participants enrolled in Kaiser are not eligible for to visit the Vera Clinic.

Treatment at the Trust's primary care clinic and at any Vera locations is FREE TO YOU! No deductibles, copay or coinsurance.

The primary care clinic services include:

- **Preventive Care** Annual Whole Health Evaluation, immunizations, screenings, well women exams, family planning
- **Chronic Disease Management** For example, diabetes, hypertension, depression
- **Acute Care** Coughs/colds, wound care, sprains and strains, rashes, urinary tract infections, back pain
- **Health Support Services** Health coaching, onsite labs, provider-dispensed medications, specialty care coordination and advocacy
- **Virtual Care** Connect with your care team from anywhere for a wellness visit, health coaching, health check-in, and more

You can visit the Trust's primary care clinic even if you already have a primary care provider that is not with Vera. The Vera medical team can provide treatment to you no matter who you see outside the care center.

While the Trust's primary care clinic is based at the Fort Dent location, you have full access to all of Vera's network care centers across the Seattle region. Please visit https://patients.verawholehealth.com to find out which care center location is most convenient for you.

The Trust's primary care clinic with Vera complements the existing Plan coverage and provides a convenient and cost-effective care option. All services are paid for by the Trust and are free of charge to you, including biometric screenings, health coaching, and annual physicals.

The address for the Trust's Fort Dent Care Center is 6700 Fort Dent Way, Suite 100 Tukwila, WA 98188. Also call 206.337.6080, email fortdent@verawholehealth.com or visit the Vera online at patients.verawholehealth.com

Hours of operation for the Fort Dent Care Center are:

Monday through Friday 8:30 am – 6:00 pm

Treatment Outside of the United States and its Territories

The Plan excludes all benefits for non-emergency treatment incurred outside the United States and its territories. The Plan also excludes all benefits for emergency treatment or an emergency medical condition incurred outside the United States and its territories if the participant, retiree and/or dependent reside outside the United States and its territories. For the purpose of the exclusion, "reside outside the United States and its territories" shall mean that the participant, retiree and/or dependent has lived or traveled outside the United States and its territories for more than 90 consecutive days within the past six months or intends to live or travel outside the United States and its territories for more than 90 consecutive days in the next six months.

Preferred (PPO) Providers

The Trust has a Preferred Provider Organization (PPO) arrangement with Aetna for access to their Choice POS II network. This network of hospitals, physicians and other healthcare providers have agreed to provide eligible employees and dependents with services and supplies at discounted rates.

Providers not in the network are called non-PPO providers and they are not required to provide discounted rates. Subject to some exceptions stated in this Plan, your coinsurance for non-PPO providers is more than for PPO providers and benefits are allowed only on charges up to usual and customary (U & C) fees. Also, if you obtain services or treatments from a non-PPO provider, the provider can bill you for the balance of the charges not covered by your health plan. This is called "balance billing." Balance billing charges are often significant and do not count towards meeting your deductible or annual out-of-pocket maximum. Balance billing is not allowed for air ambulance, emergency treatment and non-PPO providers performing services at PPO-facility. See "Protection from Balance Billing."

The choice is yours. You may choose to see any provider covered by the Plan each time you use benefits. You may have lower out-of-pocket costs if you use PPO providers. In addition, for non-PPO providers, you may be responsible for any amount above U & C fees charged by the provider.

All outpatient dialysis providers are considered non-PPO and subject to a specific pricing methodology set forth in this Plan document.

PPO Savings Example

Here's an example of how using PPO providers can save you money:

PPO Network. You have physician fees of $130 from a PPO provider. As a result of the PPO provider's agreement with Aetna, the PPO provider agrees to accept $100 as payment in full from the Plan (discounted rate). The Plan benefit is 80%, after the annual deductible. Assuming you have already satisfied the annual deductible, the Plan would pay $80 and **you would pay $20**.

Non-PPO Network: You go to a non-PPO provider for the same physician services and the non-PPO provider also charges $130. Because the provider is non-PPO, they have not agreed to accept a discounted amount. In this case, the Plan pays 60% of the cost after the annual deductible, up to the usual and customary (U & C) fee. Assuming you have already satisfied the deductible, the Plan would pay 60% of the U & C fee, which the Plan determines is $100. So, in this case, the Plan would pay $60 (60% of $100) and **you may be required to pay up to $70** for the same service as the PPO provider. (The $70 represents your 40% of the U & C fee **plus** the balance billed amount over the U & C fee that the provider has not agreed to write off.)

Visit the website at www.aetna.com for a list of current Choice POS II PPO providers. You can also ask your provider if they are in the Choice POS II network. Please note that not all Aetna contracted providers are considered providers under this Plan.

Protection From Balance Billing

The No Surprises Act, protects the Plan participants from balance billing for the following services:

- Emergency treatment of an emergency medical condition at an out-of-network facility,
- Air ambulance services, and
- Services provided at an in-network facility by an out-of-network provider (a common example is an anesthesiologist working at a PPO hospital).

If you go to non-PPO providers in other situations, they can still balance bill you.

The law provides that your costs for these services must be limited to no more than what you would have paid, had you gone to a PPO provider. PPO deductible, copays, coinsurance and annual maximums will apply.

The law's protections do not apply if you sign a consent to be balance billed by the non-PPO provider. Certain non-emergency providers, however, cannot request you to waive your balance billing protection in any situation. Providers and facilities which cannot ask you to waive your balance billing protections include assistant surgeons and hospitalists, anesthesiologists, pathologists, radiologist, laboratories, and other specialists that you typically do not select. **Always remember: You are never required to give up your protections from balance billing and you should review any document you are asked to sign regarding billing**.

If a health care provider requests your consent to balance billing:

- The written consent must be clear and understandable;
- Generally, the written consent form must be provided at least 72 hours prior to the date of the item or service;
- The written consent form must state that payment of the out-of-network bill may not accrue towards the individual's deductible or annual out-of-pocket maximum;
- The written consent form must state that by signing the consent, the individual agrees to be treated by the non-PPO provider and understand the individual may be balance billed and subject to cost-sharing requirements that apply to services furnished by the non-PPO provider; and

- The written consent form must document the time and date on which the individual received the written notice and the time and date on which the individual signed the written consent form.

You must also be provided with an estimate of the cost for the service or treatment and additional information.

Continuity of Care

Continuity of care is available when a health care provider or facility terminates its relationship with a Plan's PPO Network. When this occurs, the Plan will contact you to inform you of the change. If you are undergoing a course of treatment for services or complex care, receiving institutional or inpatient care, are scheduled for non-elective surgery, are pregnant or terminally ill, you can request that you can continue to use the provider and receive the same benefits as if they were an in-network provider for up to 90 days.

If you receive notice of a provider leaving the network, and you believe you qualify for a continuity of care accommodation, you should contact the Trust Office.

Annual Deductible

Each person/calendar year	$300
Each family/calendar year	$900

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

If two or more members of your family are injured because of the same accident, only one $300 deductible will be charged toward the covered expenses of that accident.

If you do not meet the required deductible amount in the current year, eligible expenses incurred and applied toward the annual deductible during the last three months of the calendar year are carried over to apply against the deductible for the next year.

The following services are not subject to the annual deductible:

- Behavioral health
- Pre-admission/surgery related testing done on an outpatient basis
- Immunizations
- Preventive care services performed by a PPO provider (see preventive care on page 40)

Copays

The Plan requires you to pay a copay for each provider office visit, emergency room visit and non-emergency hospital stay as follows:

Copay	Per Office Visit	Per ER Visit[1]	Per Hospital Stay
PPO providers	$20	$100	None
Non-PPO providers	$40	$100	$100[2]

[1] Copay waived if you are directly admitted to the hospital as an inpatient.
[2] Per confinement for non-emergency admissions.

Coinsurance

Once you have met the deductible and any applicable copays, the Plan generally covers 80% of PPO provider charges for covered services or 60% of non-PPO providers' usual and customary (U & C) charges for covered services.

Coinsurance	Plan pays:	You pay:
PPO providers	80%	20%
Non-PPO providers	60%	40%

Annual Coinsurance Maximum – Per Calendar Year

Once your share of coinsurance (20% PPO; 40% non-PPO) reaches the amounts listed below, the Plan coinsurance will increase to 100% for the remainder of the calendar year. Applicable deductibles and copays will still apply.

Annual Coinsurance Maximum	Per person	Per family
PPO providers	$2,000	$4,000
Non-PPO providers	$5,000	$10,000

Annual PPO Out-of-Pocket Maximum – Per Calendar Year

Once you reach your Annual Coinsurance Maximum, you will continue to pay copays up to the Annual Out-of-Pocket Maximum of $5,600 per person and $10,500 per family for the remainder of the calendar year.

Preauthorization When You Are Hospitalized or Receive Inpatient Services

To help ensure the efficient use of medical services, the Trust has contracted with Aetna for case management and preauthorization services. Aetna will work with you and your provider to determine the treatment options that will provide the most beneficial or cost-effective care in your specific case. Benefits can only be preauthorized for dates of service while you are covered under this Plan.

Approval for Inpatient Stay

All inpatient hospital, skilled nursing, or residential treatment facility stays must be preauthorization. Your provider should contact Aetna to obtain the required precertification prior to beginning any hospital, skilled nursing or residential treatment facility inpatient stay. Your provider can call Aetna at (888) 632-3862 Monday through Friday from 8:00 a.m. to 5:00 p.m. (Pacific Time).

Approval for Inpatient Pre-Surgery Testing

In most cases, inpatient care before the scheduled day of non-emergency surgery is not medically necessary. If you need surgery-related tests and have them done on an outpatient basis, rather than as an inpatient, the Plan will pay 100% of reasonable and customary allowances rather than the Plan's usual 80% or 60% and the charges will not be subject to the annual deductible. Of course, in a situation where inpatient care is medically necessary before the scheduled day of surgery, it will be covered as provided under the covered medical expenses section. *If inpatient care before surgery is not medically necessary, the Plan will not provide any benefit for those days.*

Continued Inpatient Stay Review

Aetna will contact your provider or facility on the day of your scheduled discharge to confirm discharge. If your provider or facility recommends extending your stay beyond the number of days originally approved, Aetna will obtain clinical data from the provider or facility and determine whether an extended stay is covered under the terms of the plan. If it is covered, Aetna will approve an extension of stay. If it is not covered, there will be no coverage for room and board charges beyond the length of stay originally approved by Aetna.

Remember, it is always up to you and your provider to determine which services and supplies are appropriate for your condition. Aetna is only responsible for determining which of these services and supplies are covered under the terms of the Plan.

Outpatient Preauthorization

Aetna requires providers who participate in their PPO network to preauthorize certain outpatient services and treatments. Your provider will notify you when a preauthorization is required. The treatment or services cannot be scheduled until Aetna provides a preauthorization determination. Examples of services requiring precertification include dialysis, home healthcare services, certain injectable drugs provided by a doctor and physical therapy.

Individual Benefits Management

The Plan will work with Aetna to provide case management services in certain healthcare treatment situations. The Plan, through Individual Benefits Management, may offer alternative benefits that would not normally be covered by the Plan. This benefit is subject to approval by the Trust Office. The final decision for your treatment is between you and your provider.

For alternative benefits to be provided, the employee, or person legally qualified and authorized to act for the employee, will be required to sign a written consent that sets forth terms under which the alternative benefits will be provided. The Plan's decision to offer alternative benefits is made individually for each patient, subject to the terms set forth in the written consent. Any such decision shall not be construed to alter or change all other provisions of the Plan, nor shall it be construed as a waiver of the Board of Trustee's right to administer the Plan in strict accordance of its terms in other situations. Alternative benefits will not be used to cover anyone who has exhausted Plan benefits or would otherwise not be eligible for coverage. The Plan may cease to allow alternative benefits at any time, and at the Board of Trustee's sole discretion, by sending written notice to the employee.

Covered Medical Expenses

The Plan provides benefits for the following services and supplies, provided they are medically necessary for the treatment of an illness or injury and ordered and performed by a provider.

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

Also, please refer to the benefit exclusions and limitations as listed on pages 58 – 60.

Acupuncture

Service by an acupuncturist is covered for medically necessary services for treatment of an illness, injury, or to alleviate pain. Services must be referred by MD, DO, ARNP, PA, DC, DPM and ND.

Ambulance (ground and air)

Ground Ambulance: The Plan pays 80% of the contracted rate or 80% of usual and customary charges for medically necessary ground ambulance transportation to and from a local hospital or the nearest hospital equipped to provide necessary medical treatment not available in a local hospital.

Air Ambulance: The Plan pays 80% of amount determined under applicable federal law for medically necessary air ambulance transportation to treat an emergency medical condition and to the nearest hospital equipped to provided necessary treatment for the emergency medical condition. The Plan does not pay for non-emergency air ambulance transportation.

Anesthesia

The Plan covers charges incurred for anesthetics and their administration.

Artificial Limbs and Body Parts

The Plan provides benefits for artificial limbs, eyes, organs and other parts of the body required as a result of an injury or illness that caused the loss of the natural body part.

Bariatric Surgery

The Plan covers open or laparoscopic Roux-en-Y gastric bypass (RYGB), laparoscopic gastric banding (LASGB or Lap-Band), or sleeve gastrectomy when medically necessary and appropriate.

All procedures approved by the Plan must be pre-authorized by Aetna and performed by a PPO provider. The covered individual entering the program must meet all medical appropriateness and eligibility criteria. There is no coverage for out of network providers.

Behavioral Health

The Plan covers behavioral health treatment, including substance abuse treatment and mental health treatment. Treatment is not subject to the annual deductible and generally benefits for behavioral health are no more restrictive than the predominant financial or

non-financial requirements and limitations that apply to substantially all medical/surgical benefits.

Benefits for behavioral health treatment includes emergency treatment, detoxification, treatment received in a licensed outpatient treatment facility, medically necessary treatment at a licensed or certified inpatient or residential treatment facility and medically necessary habilitative treatment. Approval for inpatient stays is required through Aetna at (800) 424-4047 (see page 29 for details).

If you contact First Choice Health EAP before treatment begins they will arrange for up to three visits for assessment and referral at no cost to you. See page 48 for a complete description of the First Choice Health EAP program.

Biofeedback Therapy

The Plan covers biofeedback therapy if prescribed by MD or DO for the treatment of certain limited conditions.

Chiropractic Treatment – See Massage Therapy and Adjustment/Manipulations

Clinical Trials

The Plan covers routine patient costs for items and services furnished in connection with an approved phase I, II, III, or IV clinical trial or a clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition that would otherwise be covered by the Plan. The Plan generally will not cover:

- The investigational item, device, or service itself (except as provided below);
- Items and services solely for data collection that are not directly used in the clinical management of the patient; or
- Services that are clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

That Plan will cover the investigational item, device, or service itself if it is part of an approved clinical trial and meets the criteria in either Category 1 or 2 below:

Category 1

- The trial is a Phase III or Phase IV trial approved by the National Institutes of Health, the FDA, the Department of Veteran Affairs or an approved research center;
- The trial has been reviewed and approved by a qualified institutional review board; and
- The facility and personnel have sufficient experience or training to provide the treatment or use the supplies

Category 2

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

Cosmetic Surgery

The Plan provides benefits for cosmetic surgical repair due to an injury or congenital abnormality, or the initial reconstruction following or coinciding with surgery that would otherwise be covered under the Plan and required for treatment of illness or disease, provided the cosmetic surgery occurs within one year of the applicable accident, birth, or surgery (unless delayed due to medical necessity).

Dental Treatment

The Plan provides benefits for the medically necessary treatment of injuries to the gum, jaw and natural teeth, if the treatment is the direct and natural result of an injury or a diagnosed illness. To be covered, the treatment must not be purely cosmetic and the need for the treatment cannot be the result of normal tooth decay or aging of natural teeth. This benefit shall only cover dental implants if the individual's mouth cannot support regular dentures or other prosthetic device.

Diagnostic X-ray and Laboratory

The Plan covers medically necessary x-rays and imaging procedures and laboratory exams for diagnostic purposes.

Dialysis Treatment

Dialysis Treatment – Inpatient

The Plan pays for medically necessary inpatient dialysis on the same basis as any other inpatient treatment. Non-emergency inpatient dialysis requires preauthorization.

Dialysis Treatment - Outpatient

For medically necessary outpatient dialysis treatment, the Plan determines the benefit amount based upon the average payment actually made for reasonably comparable services and/or supplies to all providers of the same services and/or supplies by all types of plans in the applicable market during the preceding calendar year, based upon reasonably available data, adjusted for the national Consumer Price Index medical care rate of inflation. The Plan may increase or decrease the payment based upon factors concerning the nature and severity of the condition being treated.

This Plan provision shall apply to all outpatient dialysis claims filed by, or on behalf of, Plan members for reimbursement of products and services provided for purposes of outpatient dialysis, regardless of the condition causing the need for dialysis.

The Plan may review all outpatient dialysis charges to determine whether there is a reasonable probability that market concentration and/or discrimination in charges have resulted in an increase of the charges for outpatient dialysis products and/or services for the dialysis-related charges under review. If the Plan determines that there is a reasonable probability that the charges exceed the reasonable value of the goods and/or services, the Plan may subject the claims, and all future claims for outpatient dialysis goods and services from the same provider with respect to the member, to a cost-containment review to determine the appropriate Plan benefit amount.

Where appropriate, the Plan may enter into an agreement with a provider establishing the rates payable for outpatient dialysis goods and/or services, provided that such

agreement must identify this section of the Plan and clearly state that such agreement is intended to supersede this Plan section.

End-Stage Renal Disease

If you are diagnosed with End-stage Renal Disease (ESRD), you may be eligible for Medicare coverage by nature of your diagnosis. If you apply for Medicare, you are required to provide the Trust Administration Office with the effective date of your Medicare coverage so that the Plan can ensure the correct coordination of claims payments between the Plan and Medicare.

Durable Medical Equipment

The Plan provides benefits for crutches, casts, splints, trusses, braces, and other similar appliances, as well as the rental of equipment for medically necessary treatment. Benefits are also provided for oxygen and rental equipment for its administration, diabetic equipment and supplies not covered under the prescription drug benefit, ostomy supplies and other similar appliances for medically necessary treatment prescribed by a provider.

The Plan also covers contact lenses or lens and frames immediately following cataract surgery and scleral contact lenses when medically necessary for the treatment of specific conditions of the eye such as granular cornea dystrophy or complications following a cornea transplant. Scleral contact lenses are limited to one pair of lenses every two calendar years.

The Plan covers the purchase or rental of durable medical equipment for kidney dialysis for the personal and exclusive use of the patient. The total covered purchase price will be a monthly pro-rata basis during the first 24 months of ownership but only so long as a dialysis treatment continues to be medically required. The Plan will cover all charges for supplies, materials and repairs necessary for the orderly operation of such equipment and also reasonable and necessary expenses for the training of a person to operate and maintain the equipment for the sole benefit of the patient.

The Plan covers the rental of durable medical equipment for other than kidney dialysis, including wheelchair, hospital bed, equipment for the treatment of respiratory paralysis, and equipment for the use of oxygen. Covered charges for rental equipment is limited to the purchase price of the rented equipment.

Emergency Treatment

The Plan covers all emergency services related to the treatment of an emergency medical condition (as defined in the definitions section of this book) will be reimbursed at the PPO rate for both PPO and non-PPO provider facilities. A $100 copay applies to each emergency room visit. This copay is waived if you are directly admitted to the hospital as an inpatient.

Gene and Cellular Therapy

The Plan covers medically necessary Gene and Cellular Therapy services from a designated facility/provider. Coverage is provided subject to the Plan’s annual deductible, copays, coinsurance and annual coinsurance and out-of-pocket maximums. Gene and Cellular Therapy services and treatment must be pre-certified in order to be covered. Your provider should call Aetna at the number printed on your ID card to pre-certify these services. Aetna designates facilities/providers for Gene and Cellular Therapy services. Services must be provided by a designated facility and provider in

order to be covered by the Plan. Coverage is subject to all other plan limitations and exclusions.

Gene and Cellular Therapy includes gene and cellular based therapy techniques that modify and/or use a person's genes or cells to treat or cure disease. Gene Therapy includes medically necessary gene and cellular based therapies provided by an approved physician, hospital or other provider, including, but not limited to:

- Cellular immunotherapies;
- Genetically modified oncolytic viral therapy;
- Other types of cells and tissues from and for use by the same person
- (autologous) and cells and tissues from one person for use by another person
- (allogenic) for certain therapeutic conditions.;
- All human gene therapy that seeks to change the function of a gene or alter the
- biologic properties of living cells for therapeutic use. Examples include therapies
- using:
  - Luxturna® (Voretigene neparvovec)
  - Zolgensma® (Onasemnogene abeparvovec-xioi)
  - Spinraza® (Nusinersen)
- Products derived from gene editing technologies, including CRISPR-Cas9;
- Oligonucleotide-based therapies. Examples include:
  - Antisense. An example is Spinraza (Nusinersen)
  - siRNA
  - mRNA
  - microRNA therapies

Habilitative Care Service

The Plan provides benefits for habilitative care services when medically necessary to treat mental health disorders identified in the current International Classification of Diseases (ICD) and the Diagnostic and Statistical Manual of Mental Disorders (DSM) and to treat physical or structural birth defects (congenital anomaly). To be covered, services must be prescribed and documented to either improve function or maintain function where significant deterioration in function would result without therapy. Function means the ability to execute skills required for activities of daily living which would be normal and expected based on the age of the patient. The patient must be under the care of a physician during the time the habilitative services are being provided, and all services must be provided by a provider acting within the legal scope of their license. A formal treatment plan may be required upon request and will be required after the 25th visit. Periodic re-evaluations will also be required.

Covered Services under this benefit include:

- Neurological and psychological testing, evaluations and assessments.
- Speech, occupational and physical therapy when provided as part of a formal written treatment plan.
- Neurodevelopmental therapy when provided as part of a formal written treatment plan.
- Psychotherapy, which may include ABA services
- Applied Behavior Analysis (ABA) or similar therapy for individuals diagnosed with Autism Spectrum Disorder (ASD) when the following conditions are met:

- A documented comprehensive individual treatment plan is developed based on a functional analysis completed within 6 months of the beginning of treatment;
- Routine evaluation of data on a regular basis and documentation of demonstrable progress against targeted goals at least once every six months; and
- The services are provided by, or are under the supervision of, a program manager who is a Board Certified Behavior Analyst (BCBA) or a physician or provider whose legal scope of license includes behavior analysis.

Hearing Care and Hearing Aids

The Plan provides benefits for a hearing exam by an MD, DO or other licensed provider acting within the scope of their license. The Plan also provide up to $1,500 for hearing aids per ear, every 36 months. To be covered, hearing aids must be prescribed by a licensed provider to treat a certified hearing loss that will improve by use of the hearing aid. Hearing aid coverage includes the initial fitting of the hearing aid and the batteries, warranties or other ancillary equipment obtained at the time the hearing aid is purchased.

The Plan will cover replacement of a hearing aid if you meet the above requirements and 36 months have elapsed since you received your last hearing aid. Charges for a hearing aid prescribed and ordered prior to termination of your eligibility and delivered within 30 days following your date of termination will be covered. The following items would not be covered under the hearing aid benefit:

- Batteries, warranties or other ancillary equipment not obtained at the time the hearing aid is purchased.
- Repairs, servicing or alteration of a hearing aid.

Home Healthcare

The Plan covers home healthcare services at 80% of the contracted rate or the usual and customary charges, up to 100 visits per calendar year. Services must be provided by an approved home healthcare agency for medically necessary treatment of an injury, illness or pregnancy-related condition covered by the plan.

To ensure coverage, your provider should call Aetna at (888) 632-3862 to preauthorize any home healthcare services.

Covered charges include:

- Home health aide services when acting under the direct supervision of one of the covered therapists and performing services specifically ordered by the physician.
- Registered and licensed practical nurse services.
- Services of a registered physical therapist, certified occupational therapist, certified speech therapist and certified inhalation therapist.

Hospice Care

If you or your eligible dependent is terminally ill, charges of an approved hospice agency are covered for the medically necessary treatment for the terminally ill patient.

Covered charges include:

- Room and board and related services and supplies charged by an appropriately licensed facility.
- Part-time nursing care by (or under the supervision of) an R.N.
- Home healthcare services.
- Counseling services provided by a licensed social worker or a licensed pastoral care counselor for the patient.

Bereavement counseling for the patient's covered family is covered at 50%, provided it occurs within six months after death (up to 15 visits). Bereavement counseling is also available under the Employee Assistance Program (see page 48).

Hospital (non-Emergency Services)

The Plan covers non-emergency hospital care subject to a separate $100 copay for any one period of confinement. This copay is waived if you use a facility that participates in the Plan's PPO network.

Benefits include room and board as well as medically necessary inpatient services and supplies to treat an injury or illness or other covered condition:

- Diagnostic tests
- Medical services and supplies
- General nursing care
- Intensive care unit or coronary care unit
- Medications
- Nursery charges for an eligible newborn child
- Operating rooms and equipment
- Physical therapy
- Speech therapy
- X-rays, imaging procedures, and laboratory services

The Plan does not cover hospitalization primarily for diagnostic tests, x-rays, imaging procedures, or laboratory tests, or for hospital admissions the Plan considers not medically necessary. Benefits are only provided for dates of service while covered under this Plan.

To ensure coverage, your provider should call Aetna at (888) 632-3862 to preauthorize any in-patient hospitalization. In addition to authorizing the appropriate length of stay before an admission, the care you receive is reviewed to ensure the need for continued hospitalization. Hospital benefits may be reduced or denied if hospitalization is determined to no longer be medically necessary. More information about preauthorization and continued stay review is on page 28.

Immunizations

The Plan provides benefits for routine immunizations as recommended by the Advisory Committee on Immunization Practices (ACIP) and published in the Centers for Disease Control (CDC) annual immunization schedules for children and adults. Current ACIP recommendations and immunization schedules can be found at www.cdc.gov/vaccines.

This benefit is not subject to the annual deductible and is payable at 100% of covered charges.

Massage Therapy and Adjustment/Manipulations

The Plan covers massage therapy and skeletal adjustments or manipulations to treat a diagnosed musculo or skeletal condition or alleviate pain arising from a diagnosed musculoskeletal condition. For skeletal adjustments and manipulations, a $20 copay applies to each office visit to a PPO provider and a $40 copay applies for each non-PPO provider.

The therapy must meet the following criteria in order to be considered for benefits under the Plan:

- You have a prescription for the therapy from an MD, DO, ARNP, PA, DC, DPM and ND;
- You have a treatment plan, which includes the therapy and the treatment plan is specific in scope and duration;
- You have evidence of attempting and considering alternative treatments; and
- Your current treatment plan is beneficial in that alleviates and prevents debilitating pain.

The services must be performed by a licensed therapist. The Plan may, at its discretion, perform a review of the medical necessity of any on-going treatment.

Mastectomy

The Plan provides benefits for medically necessary mastectomy related services due to disease or cancer, including reconstruction and surgery to achieve symmetry between the breasts, prostheses and complications resulting from the mastectomy, including lymphedema. The Plan provides benefits for medically necessary prophylactic mastectomies that meet the guidelines established by the Plan's network provider.

Maternity Benefit

The Plan provides maternity benefits for employees and their dependents on the same basis as any other illness or injury; including the services of a licensed midwife during childbirth. No benefits are provided for the children of a dependent child (an employee's grandchild) unless the grandchild meets the definition of a covered dependent.

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

Donor breast milk will be covered during the inpatient hospital stay when Medically Necessary, provided through a milk bank and ordered by a Physician or board-certified lactation consultant.

Aetna provides a program called Beginning Right which provides a maternity management program through your pregnancy. Call Aetna at (800) CRADLE- (800-272-3531) for more information.

Naturopath

The Plan provides benefits for the medically necessary services of a naturopath for treatment of an illness or injury. Copays for office visits are $20 in network and $40 out of network.

Nutritional Counseling

The Plan provides benefits for medically necessary nutritional counseling for adults and children who are obese, and for adults who are overweight and have other cardiovascular disease risk factors (hypertension, dyslipidemia, impaired fasting glucose, or the metabolic syndrome), when it is prescribed by a physician and furnished by a licensed provider (e.g., licensed nutritionist, registered dietician, or other qualified licensed health professionals such as nurses who are trained in nutrition). The Plan also provides benefits for nutritional counseling for the treatment of other chronic disease states, including mental health conditions and diabetes, in which dietary adjustment has a therapeutic role, when it is prescribed and furnished by a licensed provider (e.g., licensed nutritionist, registered dietician, or other qualified licensed health professional who is trained in nutrition). Benefits are not provided for nutritional counseling for conditions that have not been shown to be nutritionally related, including but not limited to asthma, attention-deficit hyperactivity disorder and chronic fatigue syndrome.

Physician and Provider Visits

The Plan provides benefits for visits for the diagnosis and treatment of an illness or injury. Visits include in the physician or provider's office, in a home or inpatient hospital that is not otherwise included in a hospital bill. A $20 copay in network, or $40 copay out of network applies in addition to any applicable deductible and/or coinsurance. **Note**: the $20 copay is waived for preventive care office visits to a PPO provider.

Orthotics

The Plan provides benefits for custom orthotics prescribed by a physician or provider. Limited to one pair per year.

Podiatry

The Plan covers medically necessary services by a podiatrist for treatment of an illness or injury. The Plan does not cover routine and cosmetic foot care including, but not limited to, callus or corn paring and trimming of toenails.

Preadmission Testing

The Plan provides benefits for all necessary medical tests performed on an outpatient basis as a precondition for a scheduled surgery at 100% with no deductible.

If the scheduled hospitalization has to be canceled or postponed for more than two weeks because of medical reasons, the Plan will pay for those preadmission tests again at 100%, if done as an outpatient procedure, and as long as they meet the requirements listed above.

Inpatient preadmission testing is subject to normal coinsurance and deductible. See page 29 for requirements.

Prescription Drugs

Expenses incurred for prescriptions received at a retail pharmacy or through the mail order or specialty drug programs are covered under the separate prescription drug benefit described on pages 43 to 47.

Participants' copays for generic drugs through the separate prescription drug benefit can be submitted to the medical plan for reimbursement at 100%, not subject to the annual deductible, up to a maximum of $300 per person per calendar year.

Preventive Care

Preventive care services are covered at 100% with no copays or deductible when **performed by a PPO provider or at a Vera Whole Health clinic**. Preventive care services provided by a non-PPO provider are covered at 60% and subject to the annual deductible. Preventive care services include services such as:

- Routine wellness exams. No benefits will be paid for:
  - Charges incurred in connection with diagnosis or treatment of an illness;
  - Examinations for which benefits are provided under any other provisions of this plan;
  - Examination of the teeth, gums or eyes.
- Preventive care services and screenings per the US Preventive Services Task Force (USPSTF) A and B recommendations. A complete list of these services and screenings can be reviewed at www.uspreventiveservicestaskforce.org.
- Immunizations (see Immunizations on page 37).
- Preventive care for children recommended by the Health Resources and Services Administration (HRSA).
  - Preventative care for women recommended by the Health Resources and Services Administration (HRSA), such as: Well-woman visits;
  - Gestational diabetes screening for women;
  - High-risk human papillomavirus (HPV) DNA testing;
  - Sexually transmitted infections (STI) counseling;
  - HIV screening and counseling;
  - Contraception and contraceptive counseling;
  - Breastfeeding support, supplies and counseling for pregnant and postpartum women; and
  - Screening and counseling services for interpersonal and domestic violence.

Rehabilitative

The Plan provides benefits for rehabilitative therapy services on an outpatient basis, including occupational therapy, speech therapy and physical therapy, to the extent that the therapy will significantly restore or improve a lost function(s) following a severe illness, injury or surgery. The services must be prescribed by the treating provider (attending physician (MD, or DO, ARPN, PA, DC, DPM or ND) and administered by a physician or covered licensed therapist. The Plan may periodically request a review of the services by a physician and the patient must continue under the care of the attending physician during the time the therapy is being provided; and the services must not be custodial in nature.

Benefits for rehabilitative therapy services will end when the Plan determines that no additional clinical improvement is expected as a result of the therapy.

Inpatient rehabilitative therapy is covered under the hospital (non-emergency services) benefit.

Skilled Nursing Facility Care

The Plan covers medically necessary confinement in a skilled nursing facility provided confinement is:

- one during which a doctor visits the participant at least once every 30 days; and
- not routine custodial care.

To ensure this coverage, your provider should call Aetna at (888) 632-3862 for precertification (see page 29).

Benefits include:

- Necessary covered services and covered supplies furnished by the facility.
- Physician visit every other day up to 15 visits per period of confinement.
- Room and board up to the average semiprivate room rate.

The Plan does not cover any confinement for care that can be provided on an outpatient basis. Routine custodial care, residential treatment or benefits for any personal comfort or convenience items are not covered.

Sterilization

The Plan covers sterilization procedures, such as a vasectomy or tubal ligation.

Surgical Services

The Plan covers medically necessary surgeries resulting from illness or injury.

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

Orthognathic surgery is covered only when surgical intervention is required for the correction of a malocclusion.

Assistant Surgeon. Medically necessary services are covered up to 20% of usual and customary (U & C) charges for a surgical procedure when performed by an assistant surgeon or assistant physician (other than a hospital intern or resident).

Second Surgical Opinion. To help you understand surgery risks and alternatives, this plan covers a second surgical opinion for non-emergency procedures at 100%. Second opinions are not subject to the annual deductible.

If the second opinion differs from the first, charges for a third opinion are also paid at 100% with no deductible.

Telemedicine/Virtual Health

The Plan provides benefits for medically necessary provider visits provided via telephone or video conferencing. For a telephone or video consultation to be covered, the consultation must be in real-time with ongoing participation by the patient and the provider throughout the visit and must be interactive with a focus on diagnosing and treating an injury or illness. All visits and treatment must be appropriately documented and billed. If an invoice is paid out-of-pocket by a participant, the Trust will reimburse the participant according to Plan terms and will pay rates based on whether the provider is PPO or non-PPO. Telephonic and video visits are subject to the Plan's normal copay applicable to in-network and out-of-network office visits; and are subject to all other applicable Plan terms.

Transplants

Benefits for all transplants must be authorized in writing by Aetna in advance. Approval will be based on medical necessity, the patient's medical condition, the qualifications of the providers, appropriate medical indication for the transplant, and appropriate, proven medical procedures for the condition. If a transplant is not successful, only one re-transplant will be covered, subject to the same conditions and limitations applicable to the original transplant. Aetna has a special transplant program called National Medical Institutes of Excellence (IOE) Transplant Program. Any provider who is not in the IOE network is considered a non-PPO provider. If a member has to travel more than 100 miles from the patient's residence, lodging of $50 per person ($100 per night total) and travel costs up to $10,000 for any one procedure treatment or type will be allowed. If you or your eligible dependent is the recipient of a donated human organ, the donor's medical expenses (including compatibility testing of donors and potential donors) are covered under the Plan.

Joint or valve replacement or repair of an organ is not considered a transplant. Transplant benefits are subject to all plan conditions and limitations, and no benefits will be provided for the following:

- Nonhuman, artificial or mechanical transplants.
- Services or supplies in conjunction with experimental or investigational treatment.
- Services and supplies for the donor when the donor benefits are available through other group coverage.
- Expenses for that portion of treatment funded by government or private entities as part of an approved clinical trial.
- Lodging, food or transportation costs, unless otherwise specifically provided under this plan.
- Donor and procurement services and costs incurred outside the United States, unless specifically approved in advance.
- Expenses for organ harvesting or storage, unless specifically approved in advance by Aetna on a case-by-case basis.
- Living (non-cadaver) donor transplants of the lung, liver, or other organ (except kidney), including selective islet cell transplants of the pancreas, unless the organ donor is a family member of the person seeking the transplant; family member for this purpose means grandparent, parent, child, brother, sister, aunt, uncle, nephew, niece or cousin.
- Any expense incurred by you or your eligible dependent on account of donating your human organ or tissue.
- Expenses for donor searches.

Temporomandibular Joint Dysfunction (TMJ)

The Plan covers medically necessary diagnosis, treatment and/or surgery of TMJ.

Well Baby/Child Care

See Preventive Care on page 40.

X-ray, Chemo and Radiation Therapy

The Plan covers medically necessary x-ray, chemo and radiation therapy.

Prescription Drug Benefits

CVS/caremark administers the prescription drug benefit for the Trust. Depending on the type of drug you are taking, there are three ways to receive your medication. For new medications you should use your prescription drug card at a participating retail pharmacy. For maintenance (long-term or ongoing) medications, you will have the lowest out-of-pocket cost if you receive your prescriptions through the CVS/caremark Mail Service Order program. For certain types of drugs known as Specialty Drugs you will need to use the CVS/caremark Specialty Pharmacy.

Prescription Drug Copays

The Trust uses a prescription drug formulary plan design. A formulary is a list of drugs that have been determined by the Trust's prescription drug benefit manager to be the most clinically and/or cost effective for each disease or condition. The formulary contains both generic and brand name drugs. The Trust's current formulary is the "Advanced Control Formulary." The Advanced Control Formulary is a "closed formulary." This means that a prescription drug not included on the formulary list will be denied and are not covered by the Plan. If a drug is not on the formulary, you will need to change to the prescription drug to one that is on the formulary or pay for the full cost of the drug out of pocket.

The Advanced Control Formulary list is maintained by CVS/caremark and is updated periodically. You may call CVS/caremark at (855) 582-2026 to determine whether your prescription is on the Advanced Control Formulary before purchasing your drug. However, please note, inclusion on the Advanced Control Formulary is not a guarantee that the drug will be covered by the Trust. Coverage will ultimately be determined when you request your prescription be filled. If your physician believes that a non-formulary drug is medically necessary for your specific situation, a formulary exceptions appeal process is available through CVS/caremark. To initiate the process, you or your physician will need to call CVS/caremark at (866) 443-1183.

You will pay the lowest copay if you use generic drugs. Brand name drugs that are included in the formulary will have a higher copay than generics.

The Plan's copays are as follows:

*Retail location other than CVS/Target

Copay	**New Prescriptions Retail (30-day supply)**	**Maintenance Drug Prescription (after three fills)**	
		Retail (30-day supply) *	**Mail Order (90-day supply)**
Tier 1 – Generic	$8.00	$23.00 ($8 plus $15 penalty)	$20.00
Tier 2 – Brand	$40.00	$60.00 ($40 plus $20 penalty)	$100.00
Tier 3 – Non-Preferred Brand	$55.00	$85.00 ($55 plus $30 penalty)	$137.00

Prescription Drug Maximum Annual Out of Pocket Cost

The Maximum Out of Pocket (MOOP) applies to all prescriptions; mail, retail and specialty. Once you reach the individual annual MOOP of $1,000 or the family annual MOOP of $3,000, prescriptions will have a $0 copay for the individual and/or family for the rest of the calendar year. Dispense as Written (DAW) penalties payable for insisting on a brand name drug over a generic will not apply toward the MOOP, and you will still be responsible to pay the penalty even once the MOOP has been met (see page 46 for information on DAW penalties). Also, your out of pocket costs for a non-formulary drug will not count toward your MOOP.

Retail Pharmacy (New Prescriptions)

CVS/caremark provides a network of pharmacies where you may fill your prescriptions. You can find the list of Preferred Pharmacies on the CVS/caremark website at www.caremark.com, their smart phone app or by phone at (866) 818-6911.

Take your prescription to a network pharmacy. Give your prescription and health plan ID card to the pharmacist.

The pharmacy will check your eligibility and prescription benefits. Once eligibility is confirmed they will process your prescription and apply the applicable copay as listed above.

If your doctor prescribes a new maintenance medication, you will be allowed to fill your prescription up to three times (30-day supply each) through any retail pharmacy at the Retail (new prescription) copay. This three-month period allows you and your doctor to make any necessary drug and/or dosage changes prior to filling a 90-day supply. **After your third fill you are encouraged to order additional refills through the mail order pharmacy or a CVS pharmacy**. If you choose to continue to purchase your maintenance drugs at a non-CVS retail pharmacy, you will be required to pay an additional copay amount (“penalty”).

Mail Service Order Pharmacy (Maintenance Drugs)

If you have prescriptions that are long term or ongoing, the Plan recommends you use the mail order pharmacy after your third fill. **You will need to contact the mail service order pharmacy at least 20 days before you need your next fill to allow for processing and mailing of the prescription.** The mail order pharmacy will lower your out of pocket costs, and medications will be delivered directly to your home, or other address that you choose. If you do not set your fourth fill up at mail order you will have to pay the entire cost of the prescription at retail until your mail order prescription is set up.

To use the mail order pharmacy, simply fill out a mail order form and submit it to CVS/caremark in the pre-addressed envelope. All orders should be mailed to:

CVS/caremark
PO Box 94467
Palatine, IL 60094-4467

If you do not have a Mail Service Order Form, you can access one online at www.caremark.com or contact the Trust Office and one will be sent to you. A new order form and envelope will be sent to you with each delivery. You can also call CVS/caremark member services at (866) 818-6911.

Make your check payable to “CVS/caremark” or furnish your credit card number and expiration date. Please do not send cash.

Order refills online, by mail or by phone – any time day or night. To order online, register at www.caremark.com.

Note: Mail Order pharmacy purchases for certain “controlled substances” are limited by law to a maximum 30-day supply.

Specialty Pharmacy (Specialty Drugs)

Specialty drugs as covered the same as formulary generic and brand name drugs. Non-formulary specialty drugs are excluded. Specialty drugs must be filled through CVS/caremark Specialty Pharmacy. This means that if you are prescribed a self-injectable medication (excluding insulin) or oral medication for oncology or transplant you will need to purchase these through the specialty pharmacy. There is a specialty pharmacy mail order facility in Washington. The medications will be mailed to your home address or other address you choose to use. If you have questions regarding specialty drugs, you or your doctor may call CVS/caremark Specialty Pharmacy at (800) 237-2767 or visit www.cvsspecialty.com.

Additionally, the Plan has adopted a new specialty medication program offered by PrudentRx. The PrudentRx program provides access to drug manufacturer financial support, lowering the cost of specialty medications for both you and the Plan. To receive full Plan benefits for any specialty medication included on the PrudentRx drug list, a participant must enroll in the PrudentRx program. If you are currently on a specialty medication or start taking a new medication that is on the PrudentRx specialty drug list, you will be contacted by PrudentRx and asked to enroll in the program*. If you enroll in the program, your copayment will be $0 for all PrudentRx specialty medications; accordingly, it is very important that you enroll in the program*. If you do not enroll in the program, your copay will be equal to the greater of the normal plan benefits or 30% of the cost of the specialty medication and may not count toward your prescription drug out-of-pocket maximum. The PrudentRx drug list may be updated periodically. Please call PrudentRx at 1-800-578-4403 to enroll or ask questions regarding the PrudentRx program. Please note, this program applies only to specialty medications that are on the PrudentRx specialty drug list.

Non-Network Pharmacy

If you choose to use a pharmacy that is not in the CVS/caremark network, you will need to pay for the prescription in full and then send the receipt with a reimbursement claim form to:

CVS/caremark
PO Box 52136
Phoenix, AZ 85072-2136

These claims will be reimbursed at the negotiated pharmacy rate, less the appropriate co-payment. This usually means you will pay more for your prescription than if you used a CVS/caremark network pharmacy.

Compound Drugs

All compound drug prescriptions costing $500 or more will require a prior authorization. Your doctor should follow the standard prescription preauthorization process.

30-Day Only Fills

ADD/ADHD drugs and Class II Narcotics are limited to a 30-day fill.

Dispense as Written (DAW)

When a prescription is written by the physician, the option is given to “Dispense As Written” (with no changes allowed). In this scenario, the standard prescription copay would apply.

Alternatively, the physician may indicate on the prescription that the pharmacy may substitute a generic for a prescribed brand name drug, if such a generic is available. If the prescription permits the substitution of a generic drug, the pharmacy will always fill the generic. If you refuse the generic and direct the pharmacy to fill the brand name drug, you will pay the brand copay plus a penalty equal to the difference in cost (after discounts) between the brand and generic drugs.

Example: Your physician prescribes you a brand name drug that has a discounted cost of $200, but permits the pharmacy to substitute a generic that has a discounted cost of $50. If you insist on the brand name drug, you would pay the $30 brand copay plus a $150 penalty (difference between the cost of the brand and generic) for a total of $180. You will never pay more than the actual cost of the drug.

The penalty payable for insisting on a brand name drug over a generic will not apply toward the MOOP, and you will still be responsible for paying the penalty even if you have met the MOOP.

New Specialty Drugs Program

If your doctor prescribes a new specialty drug, it will require approval through the prior authorization process. This process ensures that the drug is being used in accordance with the FDA approved and current approved Plan guidelines. This program is only for new to market specialty drugs and your current prescribed specialty drugs will not be disrupted.

Preventive Care Prescription Drugs

The Plan covers certain preventive prescription drugs at no cost to you. These drugs are covered at 100%. Preventive drugs are deemed preventive by the United States Preventive Services Task Force. Some services may be covered under your pharmacy benefit while others may be covered under your medical benefit. A complete list of these services and screenings can be reviewed at www.uspreventiveservicestaskforce.org. This list is subject to change and limitations may apply. These items require a written prescription.

Generic Drug Co-pay Reimbursement

Participant copays for generic drugs through the prescription drug retail and mail order programs can be submitted to the Trust Office for reimbursement at 100%, not subject to the annual deductible, up to a maximum of $300 per person per calendar year.

Exclusions

The following are some of the common categories of drugs that are excluded from this prescription drug benefit plan and not covered by the Plan:

1. Any drugs for illness, disease or injury provided whole or in part by state or federal Worker's Compensation laws or other legislation.
2. Cosmetic drugs or health and beauty aids.
3. Contraceptives for the purpose of birth control (except as covered for preventive care).
4. Multiple or nontherapeutic vitamins or dietary supplements, unless prescribed for prenatal care or specifically stated as covered for preventive care.
5. Weight loss drugs or supplements.
6. Over-the-counter drugs, unless prescribed and covered for preventive care.
7. Fertility and infertility drugs.
8. Medications to treat erectile dysfunction (such as Viagra), unless prior authorization is received.
9. Claims received after the 12-month filing limit.
10. Drugs administered or taken while confined in the hospital.
11. Drugs prescribed for the treatment of conditions that are not within the medical uses approved by the FDA or the manufacturer (i.e. off label uses).
12. Drugs that are considered experimental or investigational as defined on pages 86 to 87.
13. Drugs reimbursable by any government program – national, state, county, or municipal.
14. Medicines not requiring a prescription.
15. Drugs lost, stolen, or damaged. However, one replacement prescription per person per lifetime can be requested for non-narcotic mail order prescriptions if you have a reasonable belief the original prescription has been stolen. Call the Trust Office or CVS/caremark for specific requirements.
16. Drugs in excess of quantity limits.
17. Periodontal anti-infectives administered by an oral health care professional. For example, Arestin (minocycline microspheres).
18. Drugs that are not included on the Trust's prescription drug formulary list.

Employee Assistance Program

The Trust has contracted with First Choice Health to provide an Employee Assistance Program (EAP) to you and your family. The EAP is a completely confidential service that helps you and your covered family members work through personal problems.

Providers for the EAP include licensed mental health counselors, psychologists, clinical social workers, marriage and family therapists and chemical dependency professionals.

Discussions of your personal affairs are completely confidential. The EAP is required by law to release information if it is in the interest of public safety (harm to self or others, child abuse or elder abuse).

How It Works

The EAP provides assessment and referral for many personal issues, including:

- Stress, depression and anxiety
- Relationships and family concerns
- Legal or financial consultation
- Alcohol/Drug, gambling and addiction
- Crisis management
- Grief and loss
- Work conflict

Up to three assessment and referral sessions are available per issue every 12 months, for you, your spouse and each eligible child to age 26. Where more extensive help is needed after clarifying the problem and developing an agreed upon resolution plan, the EAP can make the arrangements. You'll be responsible for any other extended counseling charges not covered under the EAP or your medical benefits.

You may use this service through telephone consultation or face to face appointments. Either way, your personal affairs will be discussed in complete privacy with a professional EAP provider. You're encouraged to call directly, toll-free at (800) 777-4114, or TTY (800) 777-4969 if hearing impaired, to arrange for services. The EAP is available 24/7 to support your needs.

What Happens After You Call

The EAP customer service staff is ready to respond to your questions, needs and preferences. After assessing your needs, they will arrange for an EAP professional to call you and arrange for a face-to-face appointment.

EAP Online Services

At www.firstchoiceeap.com you can view the "Employee Orientation" or schedule an appointment. The screening tools assess your vulnerability to stress, anxiety or depression. For your convenience you can use "Online Conference" to consult with a licensed mental health professional. To access the online resources, login by entering your username: local32.

Tobacco Cessation Program

A confidential Tobacco Cessation Program is available to you, your spouse and your dependents age 18 and over. The Trust has contracted to provide these services through their Quit For Life® program. The following services are available through the program:

- Quit Guide: An easy-to-use printed workbook you can reference in any situation to help you stick with your Quitting Plan.
- Quit Coach: You will have expert phone support and assistance whenever you need it.
- Quitting Aids: A Quit Coach will help you decide which type, dose, and duration of nicotine substitute or medication is right for you, and teach you how to use it so it really works. As an eligible member, you have access to free nicotine gum or the patch through this program. Prescription drugs to help you stop smoking are not provided as Quitting Aids under this program, but are covered under the prescription drug benefit (see page 43).
- Web Coach®: You will get access to a private, online community where you can complete activities, watch videos, track your progress, and join in discussions with others in the program.

To enroll call (866) 784-8454 and tell them you are a participant of the Seattle Area Plumbing & Pipefitting Industry Health Trust.

Dental Benefits

Delta Dental of Washington

The Trust contracts with Delta Dental of Washington (DDWA) to provide you and your dependents with access to dental benefits and to process dental claims. You will pay less if you see a DDWA contracted service provider.

To locate a DDWA provider, The Group Plan number for Seattle Area Plumbing & Pipefitting Industry Health Trust is #03990. You can call (206) 522-2300 or (800) 554-1907 for questions. The website is www.deltadentalWA.com. Please call Delta Dental, check their website or ask your dentist if they are a Delta Dental dentist.

Reimbursement for services provided by a dentist in the Dental Delta of Washington PPO network are reimbursed at 80% for Class I, II, III services and orthodontia is reimbursed at 70%.

The annual maximum benefit is $2,000 per person. The annual maximum does not apply to Class I Benefits for children under age 18. The lifetime orthodontic benefit is $2,000 per person. Retiree dental benefits exclude orthodontic benefits.

Class I Benefits

Diagnostic ■ Diagnostic evaluation for routine or emergency purposes ■ X-rays	**Limitations** ■ Comprehensive or detailed and extensive oral evaluation is covered twice in a calendar year. ■ Routine evaluation is covered twice in a benefit period. Routine evaluation includes all evaluations except limited, problem-focused evaluations. ■ Limited problem-focused evaluations are covered twice in a calendar year.
Preventive ■ Prophylaxis (cleaning) ■ Periodontal maintenance ■ Sealants ■ Topical application of fluoride including fluoridated varnishes ■ Space maintainers ■ Preventive resin restoration	**Limitations** ■ Prophylaxis is covered twice in a calendar year. **Exclusions** ■ Oral hygiene instruction
Periodontics (maintenance) ■ Prescription-strength fluoride toothpaste ■ Antimicrobial rinse dispensed by the dental office	

Class II Benefits

Sedation

- General anesthesia when administered by a licensed Dentist or other Licensed Professional who meets the educational, credentialing and privileging guidelines established by the Dental Quality Assurance Commission of the state of Washington or as determined by the state in which the services are provided.
- Intravenous sedation when administered by a licensed Dentist or other Licensed Professional who meets the educational, credentialing and privileging guidelines established by the Dental Quality Assurance Commission of the state of Washington or as determined by the state in which the services are provided.

Limitations

- General anesthesia is covered in conjunction with certain covered oral surgery procedures, as determined by DDWA.
- Intravenous sedation is covered in conjunction with covered oral surgery procedures, as determined by DDWA.

Palliative Treatment

- Palliative treatment for pain

Restorative

- Restorations (fillings)
- Posterior composites
- Stainless steel crowns

Refer to "*Class III Restorative"* if teeth are restored with non-stainless steel crowns, inlays, veneers, or onlays.

Oral Surgery

- Major and minor oral surgery which includes the following general categories:
  - Removal of teeth
  - Preprosthetic surgery
  - Treatment of pathological conditions
  - Temporomandibular joint abnormalities
  - Traumatic facial injuries
  - Ridge extension for insertion of dentures (vestibuloplasty)
- Refer to "Class II Sedation" for Sedation information.

Periodontics

- Surgical and nonsurgical procedures for treatment of the tissues supporting the teeth

- Services covered include:
  - Periodontal scaling/root planning
  - Periodontal surgery
  - Limited adjustments to occlusion (eight teeth or fewer)
  - Localized delivery of antimicrobial agents

  Gingivectomy

Endodontics

- Procedures for pulpal and root canal treatment, services covered include:
  - Pulp exposure treatment
  - Pulpotomy
  - Apicoectomy
- Refer to "Class II Sedation" for Sedation information.

Exclusions

- Bleaching of teeth

Class III Benefits

Periodontics – Occlusal

- Under certain conditions of oral health, services covered are:
  - Occlusal guard (nightguard)
  - Repair and relines of occlusal guard

Complete occlusal equilibration

Restorative – Crowns

- Crowns, veneers, inlays or onlays for treatment of carious lesions (visible destruction of hard tooth structure resulting from the process of removing dental decay) or fracture resulting in significant loss of tooth structure (e.g., missing cusps or broken incisal edge).
- Crown buildups
- Post and core on endodontically treated teeth

Limitations

- A crown, veneer, inlay or onlay on the same tooth is covered once in a five-year period from the seat date.
- An implant-supported crown on the same tooth is covered once in a five-year period from the seat date of a previous crown on that same tooth.
- A crown buildup or a post and core are covered once in a five-year period on the same tooth from the date of service.

Prosthodontics

- Full and immediate dentures
- Removable and fixed partial dentures (fixed bridges)
- Inlays when used as a retainer for a fixed partial denture (fixed bridge)
- Adjustment or repair of an existing prosthetic appliance
- Surgical placement or removal of implants or attachments to implants

Limitations

- Replacement of an existing prosthetic appliance is covered once every five years from the delivery date and only then if it is unserviceable and cannot be made serviceable.
- Implants and superstructures are covered once every five years.

Exclusions

- Replacement and/or repair of any lost, stolen or broken dental appliance

Predetermination of Benefits

A predetermination is a request made by your dentist to DDWA to determine your benefits for a particular service. This predetermination will provide you and your dentist with general coverage information regarding your benefits and your potential out-of-pocket cost for services.

A predetermination is not an authorization for services but a notification of covered dental benefits available at the time the predetermination is made. It is not a guarantee of payment (please refer to the "Initial Benefits Determination" section regarding claims requirements).

A standard predetermination is processed within 15 days from the date of receipt of all appropriate information. If the information received is incomplete DDWA will notify you and your Dentist in writing that additional information is required in order to process the predetermination. Once the additional information is available, your Dentist should submit a new request for a predetermination to DDWA.

In the event your benefits are changed, terminated, or you are no longer covered under this Plan, the predetermination is no longer valid. DDWA will make payments based on your coverage at the time treatment is provided.

Orthodontic Benefits

This benefit is not available to retirees and their eligible dependents.

Orthodontic expense benefits provide payment of 70% of the usual and customary changes up to a lifetime maximum of $2,000.00.

General Exclusions

1. Services for injuries or conditions that are compensable under worker's compensation.
2. Services that are provided to the covered person by any federal or state or provincial government agency or provided without cost to the covered person.
3. Experimental services or supplies, which include procedures, services or supplies whose use and acceptance as a course of dental treatment for a specific condition is still under investigation/observation. In determining whether services are experimental, DDWA, in conjunction with the American Dental Association, will consider them if:
    - The services are in general use in the dental community in the state of Washington;
    - The services are under continued scientific testing and research;
    - The services show a demonstrable benefit for a particular dental condition; and
    - They are proven to be safe and effective.
4. Dental hygiene instruction
5. Dentistry for cosmetic reasons
6. Missed appointments

7. Orthognathic surgery
8. Replacement or repair of any lost, stolen or broken dental appliance
9. Charges for dental services or supplies received in a hospital setting
10. Charges for sterilization of implements or infection control

Vision Benefits

VSP Vision Care

The Trust contracts with VSP Vision Care (VSP) to provide you and your dependents with access to vision benefits and to process vision claims. You will pay less if you see a VSP contracted service provider.

Log in to vsp.com to check your benefits for eligibility and to find or confirm in-network providers. VSP guarantees coverage from VSP providers only.

Benefits

The Plan pays for the following services rendered by a legally qualified ophthalmologist, optometrist or optician.

BENEFIT	IN-NETWORK BENEFIT	OUT-OF-NETWORK BENEFIT	FREQUENCY LIMITS
EYE EXAM – $10 copay (for both In-Network and Out-of-Network)			
Complete initial vision analysis which includes an appropriate examination of visual functions, including the prescription of corrective eyewear where indicated.	100% after $10 copay.	Up to $101	Once every calendar year
PRESCRIPTION GLASSES – $10 copay (for both In-Network and Out-of-Network)			
Frames	$150 frame allowance. Additional $50 on featured frames 20% savings on the amount over the allowance	Up to $91	Twice every two calendar years (two pairs of glass in any 24 month period beginning January 1st)
Lenses	Standard single vision, lined bifocal, lined trifocal and lenticular lenses covered in full.	Single vision up to $39 Bifocal up to $62 Trifocal up to $80 Lenticular lenses up to $112	Two pair every calendar year
Lens Enhancements	Premium and custom progressive lenses covered in full after $55 copay. Scratch coating, polycarbonate lenses, UV protections and standard progressive lenses covered in full.	All progressive lenses covered up to $62. Other lens enhancements not covered.	Two pair every calendar year

CONTACTS (INSTEAD OF GLASSES)			
Necessary Contacts (instead of glasses). Necessary means – prescribed by provider and specific benefit criteria is satisfied	Covered in full after $10 copay.	Up to $352 after copay	Once every calendar year
Elective Contacts (instead of glasses)	Contact lens exam (fitting and evaluation) covered in full after maximum $60 copay. Contact lenses covered up to $205.	Up to $190	Two allowances every calendar year (instead of glasses)
PROTEC SAFETY® (ACTIVE EMPLOYEE-ONLY COVERAGE)			
Frame	Fully covered when you choose a safety frame from your VSP doctor's ProTec Eyewear® collection. Certified according to the American National Standards Institute (ANSI) guidelines for impact protection	Up to $25	Benefit limited to Employees only. Frames covered once every other calendar year
Lenses	Prescription single vision, lined bifocal, and lined trifocal. Certified according to the American National Standards Institute (ANSI) guidelines for impact protection	Up to $35 to $90 depending on type of lens	Benefit limited to Employees only. Lenses covered once every calendar year
OTHER BENEFITS			
Essential Medical Eye Care – •Additional exams and services for members with diabetes, glaucoma, or age-related macular degeneration. •Treatment and diagnoses of eye conditions, including pinkeye, vision loss, and cataracts available for all members.	Fully covered after $20 copay	No Coverage	As needed. Benefit are provided secondary to the medical plan.
Low Vision Benefit (for covered person with severe visual problems that are not correctable with regular lenses)	Supplementary Testing – covered in full Supplemental Care Aids – 75% of cost Benefit Maximum $1,000	Supplementary Testing – up to $125 Supplemental Care Aids – 75% of allowed amount Benefit Maximum $1,000	Benefit maximum every two years

Glasses and Sunglasses – Additional $50 to spend on featured frame brands. Go to vsp.com/frame brands for details. 20% savings on additional glasses and sunglasses, including lens enhancements, from any VSP provider within 12 months of your last WellVision Exam.
Routine Retinal Screening – No more than a $39 copay on routine retinal screening as an enhancement to a WellVision Exam.
Laser Vision Correction – Average 15% off the regular price or 5% off the promotional price; discounts only available from contracted facilities.

Exclusions and Limitations

No benefits are payable for:

1. Services or procedures for which benefits are provided under the Plan's medical benefits.
2. Extras in excess of the benefit maximums set forth in the Plan, such as:
    - Optional cosmetic processes.
    - Anti-reflective coating.
    - Color coating.
    - Mirror coating.
    - Blended lenses.
    - Cosmetic lenses.
    - Laminated lenses.
    - Oversize lenses.
    - Photochromic lenses, tinted lenses except Pink #1 and Pink #2.
    - Certain limitations on low vision care.
    - The cost of a frame in excess of the Plan allowance.
3. Orthoptics or vision training and any associated supplemental testing; plano lenses (less than a ± .50 diopter power), or two pair of glasses in lieu of bifocals;
4. Replacement of lenses and frames furnished under this Plan which are lost or broken, except at the normal intervals when services are otherwise available;
5. Medical or surgical treatment of the eyes;
6. Corrective vision treatment of an experimental nature.
7. Costs for services and/or materials above Plan allowances.
8. Services or materials not listed under benefits above.
9. Radial keratotomy, refractive keratoplasty, and other surgery to treat refractive error correctable with eyeglasses or contact lenses.
10. Charges greater than the usual and customary charges, or the above schedule of benefits.
11. Charges for warranties, vision clubs, other memberships or similar charges.

Benefit Exclusions and Limitations

The following exclusions and limitations apply to all benefits other than death and AD&D benefits.

No benefits are provided for:

1. Conditions caused by or arising from an act of war or armed invasion.
2. Any charges related to an injury or illness that results from or arises out of any past or present employment or occupation for compensation or profit, including illnesses and injuries arising out of or occurring during the course of employment, even if the covered person fails to make timely application for or waives his right to those benefits. This includes benefits from occupational insurance purchased by an employer, benefits provided under state or federal worker's compensation acts, employer liability laws, or other laws providing compensation for work-incurred illnesses or injuries.
3. Any service or supply that is not medically necessary for the care and treatment of illness or injury (except as provided in preventive care benefits).
4. Charges for treatment, services, or supplies that exceed usual, customary fees (U&C) or the applicable Plan benefit amount.
5. Charges for services or treatment by a provider that is not within the scope of their license.
6. Charges for dental services or supplies, for treatment of the teeth, gums or alveolar processes, under the medical plan except as specifically identified in the medical plan.
7. Cosmetic procedures except for the prompt repair of an injury, treatment of a congenital abnormality, or the initial reconstruction following or coinciding with surgery that would otherwise be covered under the Plan and is required for treatment of illness or disease as described on page 33.
8. Charges for service or supplies furnished by an agency of the United States Government or a foreign government agency, unless excluding them is prohibited by law.
9. Charges for the fitting of eye glasses or contact lenses, visual training, orthoptics, radial keratotomy, refractive keratoplasty, and other surgery to treat refractive error correctable with eye glasses or contact lenses, except as covered by the vision plan.
10. Any expense or charge for injuries or illness caused by the act or omission of another person (known as a third-party) for which there is a potential opportunity to recover from the third-party, the third-party's insurer or any other liability policy including but not limited to an automobile policy, commercial premises policy, homeowner's policy, medical malpractice policy, renter's policy, or any other liability policy, including first-party uninsured or underinsured motorist policy. The Plan may agree to advance benefits if the participant agrees to reimburse the Plan as set forth in the Plan's provisions.

11. Services, supplies, and other artificial means to induce pregnancy including, but not limited to, reversal of tubal ligation or vasectomy, fertility drugs, artificial insemination, in vitro fertilization, embryo transplant, gamete intrafallopian transfer, and cryogenic storage costs, or any other confinement, treatment or service relating to restoring fertility or promoting conception.
12. Custodial care or care when no significant clinical improvement is expected (except hospice care).
13. Drugs or devices not approved for marketing and for the prescribed use by the U.S. Food and Drug Administration.
14. Charges for treatment, surgery, complications from surgery, and/or services rendered in connection with weight loss are excluded, except for the services allowed under the Plan's bariatric surgery policy.
15. General convenience items (e.g. shower benches, ramps, hot tubs, spas, tanning beds, exercise equipment, equipment for lifting in and out of bed or baths).
16. Counseling by ministers or church affiliations is not covered.
17. Experimental or investigational services, procedures, medicines, equipment, devices, supplies, facilities or treatment (see definition on pages 86 to 87). As with other plan interpretations, the Trustees have full and exclusive authority to decide what constitutes experimental or investigational treatment.
18. Claims received or completed after the 12-month filing limit. A claim is completed when all requested documentation needed to process the claim has been received.
19. Education, or training services, or related supplies for:
    - Dyslexia
    - Disorders or delays in the development of language, cognitive, motor, or social skills, except as covered under the plan's neurodevelopmental therapy and/or rehabilitation/habilitation benefit.
20. Charges for autologous blood.
21. Travel or transportation, whether by ambulance or otherwise, unless the charges are for professional ambulance service used to transport a participant when medically necessary.
22. Expenses incurred prior to the effective date of coverage.
23. Charges for missed appointments or completion of claim forms.
24. Any service or supply for which no charge is made or no payment is required.
25. Food supplements, including formula for enteral feeding unless it is the primary source of nutrition or part of the primary source of nutrition.
26. Genetic testing except when there are medically documented symptoms or signs presented indicating a possible disease presence and genetic testing is needed to identify the disease in order for the attending physician to prescribe appropriate treatment.
27. Late fees, finance charges, or collection charges imposed by providers.
28. Medical exams or tests not connected with an illness or injury, except as provided under preventive care on page 40.
29. Refractive eye surgery to correct vision deficiencies.

30. Treatment for injuries sustained while engaged in an act for which the covered individual is charged with a felony, except in the case where the covered individual's act is related to being a victim of domestic violence.

31. Any treatment of any individual while the individual is on active duty in the U.S. Armed Forces, subject to the individual's right to continue coverage under USERRA.

32. Any services or supplies received in connection with a participant or dependent acting as a surrogate mother, regardless of whether a participant or covered dependent is a biological parent. This exclusion applies to services or supplies related to the surrogate mother becoming pregnant, pregnancy and delivery charges. Additionally, a child of a surrogate mother shall not be considered a covered dependent if the child is not the biological child of a participant or adult covered dependent or if the surrogate mother has entered into a contract or has an understanding prior to becoming pregnant that she will relinquish the child following its birth. The Plan also does not cover services or supplies provided to an individual not covered by the Plan who acts as a surrogate mother for a participant or covered dependent. "Surrogate mother" is defined as a woman who becomes pregnant through artificial or assisted methods for the purpose of carrying the fetus to term for a third party.

33. Any services or supplies for non-emergency treatment incurred outside the United States and its territories. The Plan also excludes all benefits for emergency treatment incurred outside the United States and its territories if the participant, retiree and/or dependent reside outside the United States and its territories. For the purpose of the exclusion, "reside outside the United States and its territories" shall mean that the participant, retiree and/or dependent has lived or traveled outside the United States and its territories for more than 90 consecutive days within the past six months or intends to live or travel outside the United States and its territories for more than 90 consecutive days in the next six months.

34. Any services or supplies that are contrary to guidelines adopted by the Trust, the Trust's Preferred Provider Organization or the Trust's Prescription Benefit Manager, including guidelines concerning industry standards for diagnosis, treatment, prescription or billing practices.

35. Charges for services or supplies which are not provided or billed in accordance with generally accepted professional standards and/or medical practice, including up-coding, unbundling, duplication, excessive or improperly coded billing charges.

Weekly Disability Income Benefits

If you are an actively working employee and become disabled because of a non-occupational injury or sickness, you may be eligible for weekly disability income benefits. To qualify for benefits, your disability must commence while you are eligible for this benefit and you must be under continuous care and treatment of a physician or other provider. This benefit is not available to dependents.

Benefit

The weekly disability income benefit is 70% of the employee's weekly earnings, minus the total amount of benefits, if any, the employee receives or is entitled to receive, for the same period of time from Federal Social Security Disability Benefits. Earnings means money paid to the employee by his employer as base pay. This does not include overtime, bonus, incentive, commission, and other non-base pay or professional fees, retainers, and directors' fees.

The maximum benefit is $600 per week, after FICA taxes have been withheld.

Effective September 1, 2023, the weekly disability income benefit is $800 per week, after FICA taxes have been withheld, and minus the total amount of benefits, if any, the employee receives or is entitled to receive, for the same period of time from Federal Social Security Disability Benefits.

Benefits begin on the first day of disability due to surgery, injury or hospitalization, and on the eighth day of disability due to illness. Benefits are paid for a maximum of 26 weeks of a continuous disability. A participant is not eligible for concurrent Weekly Disability and Maternity Leave Benefits. If a participant qualifies for both, the participant will only be provided the Maternity Leave Benefit.

Disabled or disability, as used for this benefit, means your inability to work in your normal job because of an illness or injury.

Disability includes all continuous periods of disability due to the same or related causes separated by less than two weeks of full-time active work.

Taxation of Benefits

Weekly disability income benefit payments are subject to both federal income tax and FICA (Social Security) taxes. The Trust Office will automatically withhold the appropriate FICA tax from your weekly check and the Trust will pay the corresponding employer portion. You have the option of having the Trust Office withhold federal income tax from your weekly check. To do this, you must file a W-4S form with the Trust Office. The Trust Office will provide you a W-2 form at year-end for use in filing your federal income tax return.

Exclusions

1. Conditions caused by or arising from an act of war or armed invasion.
2. Disability beginning prior to the effective date of coverage.
3. Disease or injury arising out of, caused by, contributed to by, or arising out of, any employment or occupation for compensation or profit. No benefits are available under this Plan for any accident or sickness covered under any workers'

compensation law or act, whether or not enrolled. Labor & Industries claims are excluded.

4. Injury sustained while engaged in an act for which the covered individual is charged with a felony, except in the case where the covered individual's act is related to being a victim of domestic violence.

Maternity Leave Benefits – September 1, 2023

The Plan's Maternity Leave Benefit is intended to reflect the physical demands of working in the construction trade and the health risks of engaging in this physically demanding and potentially dangerous work while pregnant. The Trustees want to ensure that pregnant workers can take care of their medical needs without jeopardizing their health, employment, or health care coverage.

If you are an active employee and you become pregnant or are pregnant as of the effective date of this benefit, you may be eligible for the Plan's Maternity Leave Benefit. To qualify for this benefit, you must be eligible under the Plan as an active employee. This benefit is not available to the spouse of a pregnant person or employee (paternity) and dependents.

Benefit

The Plan's Maternity Leave benefit provides income of $1,000 per week for up to a maximum of 26 weeks. The benefit will be available starting 13 weeks prior to your due date and up to 13 weeks post-birth.

To qualify for this benefit, you must be under continuous care and treatment of a physician or other provider, and your provider must certify that you are unable to perform your job during your pregnancy and/or post-partum. You must be eligible for benefits under the Trust in the month your leave begins. Beginning with the following month, your dollar bank will be used to continue coverage. However, if during Maternity Leave your dollar bank falls to three months of coverage or less, your dollar bank will be frozen, and coverage will be continued as part of the Maternity Leave Benefit. If employer contributions received on your behalf increase your dollar bank beyond three months of coverage, your dollar bank will be used until the balance again reaches three months. Starting with the month after your Maternity Leave ends, your dollar bank will be unfrozen and eligibility for coverage will be determined under normal Plan rules.

If you are eligible for coverage under the federal Family Medical Leave Act ("FMLA") leave or the Washington Paid Family Medical Leave Act ("WA-PFMLA") and your employer makes healthcare contributions on your behalf, those contributions will be used to continue your coverage, regardless of your dollar bank balance. Employer contributions for FMLA or WA-PFMLA will be used before your dollar bank. FMLA or WA-PFMLA contributions are submitted and applied under the Trust's "lag month". For example, FMLA or WA-PFMLA contributions for leave in January are submitted to the Trust by your employer in February and provide March coverage.

Benefits will begin the latter of 1) up to 13 weeks prior to your due date or 2) the date you ceased to work and will end on the earlier of 1) the first date you return to work or 2) 13 weeks post-birth, for a maximum benefit period of 26 weeks. Benefits for partial weeks will be paid on a pro-rata basis for a seven-day work week. Benefits will not be paid until your doctor's certification that you are unable to work in your normal job because of your pregnancy or childbirth is received by the Trust Office.

Participants cannot receive Maternity Leave Benefits and Weekly Disability Income Benefits from the Plan at the same time. If you are eligible for both the Weekly Disability

Income Benefit and the Maternity Leave Benefit, the Plan will limit the benefit available to the Maternity Leave Benefit.

Taxation of Benefits

The Plan's Maternity Leave income benefit payments are subject to federal income tax, Social Security (FICA) and Federal Unemployment (FUTA) taxes which are reported to the government. The Trust Office will automatically withhold the appropriate FICA tax from your weekly check and the Trust will pay the corresponding employer portion. You have the option of having the Trust Office withhold federal income tax from your weekly check. To do this, you must file a W-4S form with the Trust Office. The Trust Office will provide you with a W-2 form at year-end for use in filing your federal income tax return.

Availability of Benefits Outside of the Plan

The Plan's Maternity Leave Benefit is in addition to other benefit sources that may be available during your maternity leave. Other benefit programs that may provide benefits during your maternity leave include:

- ***Washington Paid Family & Medical Leave (WA-PFML)*** – Provides a weekly income benefit of up to 12 to 18 weeks for childbirth and bonding with your new child. You must have worked 820 hours in Washington State in the prior four calendar quarters to qualify for this benefit.
- ***Federal Family and Medical Leave Act (FMLA)*** – May require your employer to continue your healthcare coverage for up to 12 weeks while you are on maternity leave as well as provide other job protection benefits. FMLA generally applies only to large employers (50+ employees) and you must have worked 1,250 hours in the 12 months prior to your leave.
- ***Dollar Bank coverage under the Trust*** – Your dollar bank will be used to continue healthcare coverage under the Trust before coverage is extended under the Maternity Leave Benefit.
- ***State Family and Medical Leave Programs*** – Benefits from other state family and medical leave programs if you work or live in a state other than Washington – This will be determined on a case-by-case basis.

Application for Maternity Leave Benefits

1. Obtain a Maternity Leave Benefit form from UA Local 32, the Trust Office or through your on-line account at www.zenith-american.com.
2. Complete, sign and date your portion of the form.
3. Have your physician complete, sign and date their portion of the form. Mail the fully completed form to the address at the top of the form.
4. For more information, please contact the Trust Office.

Exclusions

The Plan excludes the following from Maternity Leave Benefits:

5. The spouse of the pregnant employee.
6. Dependents covered by the Plan.

7. Non-bargaining unit employees covered by the Plan.
8. Pregnancies beginning prior to the effective date of coverage.

Death Benefits

Death benefits are available for active and retired employees; spouses of active or retired employees and dependent children. You and your dependents remain eligible for death benefit as long as you are covered by the Plan; however, death benefits may not be eligible under certain continuation coverage, such as USERRA or COBRA continuation coverage.

Benefit

The death benefit amount shown below will be paid to your beneficiary upon your death, from any cause at any time or place, provided you were eligible at the time of your death.

Covered Life	Benefits
Employee/Retiree	$10,000
Employee/Retiree Spouse	$2,000
Child 3 months to 6 months	$400
Child 6 months to 2 years	$800
Child 2 years to 3 years	$1,600
Child 3 years through 25	$2,000

Beneficiary Designation

You may name anyone you wish as your beneficiary. When you choose more than one beneficiary you should indicate their shares; if not, then the Plan will divide the death benefit among them equally. You may change your beneficiary at any time by completing the proper form. The change will be effective when it is received by the Trust Office.

If your death benefits are payable to a beneficiary who is a minor, the Plan will pay the proceeds to the legally appointed guardian of the minor's estate. If there is no guardian, the Plan will pay benefits to the adult or adults who the Plan determines have assumed custody and main support of the minor.

If you do not select a beneficiary, then the proceeds will be paid in this order: to your spouse, equally to your child(ren) including legally adopted child(ren), equally to your parents, equally to your brothers and sisters, executor or administrator.

Employee Accidental Death and Dismemberment (AD&D) Benefit

Accidental Death and Dismemberment benefits are available for active and retired employees. Spouses and dependent children are not eligible for this benefit. You and your dependents remain eligible for death benefit as long as you are covered by the Plan; however, death benefits may not be eligible under certain continuation coverage, such as USERRA or COBRA continuation coverage.

Benefit

The AD&D amount will be paid if you suffer accidental bodily injury that results in the loss of:

Loss	Benefits
Life	$10,000
Both hands	$10,000
Both feet	$10,000
One hand and one foot	$10,000
One hand or one foot and the sight of one eye	$10,000
Sight of both eyes	$10,000
One hand	$5,000
One foot	$5,000
Sight of one eye	$5,000

Loss of sight means total and permanent loss of sight. Loss of a hand means severance of the hand at or above the wrist. Loss of a foot means severance of the foot at or above the ankle.

An additional amount equal to the amount for loss of life will be paid if you die as a result of an automobile accident while:

1. A passenger in, or the licensed operator of a registered automobile;
2. Wearing a seat belt, as verified in the police accident report;
3. Driving on a public road, private driveway or parking lot; and
4. The AD&D death benefit is payable.

This benefit will not be paid if you were operating the automobile while legally intoxicated as defined by the laws of the state in which the accident occurred, or under the influence of any excitant, hallucinogen, narcotic, other drug or similar substance, unless administered under the advice of a physician.

For this benefit, “Automobile” means a motor vehicle licensed for use on public highways, and “Seat Belt” means a lap restraint or lap and shoulder restraint installed by the manufacturer of the automobile.

Benefits for bodily injury will be paid to you. Benefits for your death will be paid to your beneficiary.

Limitations

Benefits will not be paid if loss of life, limb or sight occurs more than 365 days after the accident.

Benefits will not be paid in the event of injury or death resulting from:

1. Sickness, bodily or mental infirmity, or diagnosis or treatment thereof;
2. Ptomaines or any infection, other than a pyogenic infection occurring through, and at the time of, an accidental cut or wound;
3. Suicide or attempted suicide or intentionally self-inflicted injury, while sane or insane;
4. Declared or undeclared war or act of war;
5. Inciting or taking part in any form of public violence; or
6. Injuries sustained while engaged in an act for which the covered individual is charged with a felony, except in the case where the covered individual’s act is related to being a victim of domestic violence.

Vacation Benefits

Eligibility to Participate in the Vacation Plan and Receive Benefits

A Participating Employee shall be eligible to receive Vacation benefits paid on the Participating Employee's behalf by a Participating Employer, as required by Collective Bargaining Agreements or Special Agreements. In no case will the amount transferred be greater than the amount contributed to the Trust by the Participating Employer for the Participant Employee. Participating Employees are not entitled to any interest or earnings on Contributions accrued prior to the transfer to their account.

Establishment of Employee Accounts for Vacation Benefits

A Participating Employee is required to establish a participant account with the Trust's designated bank or similar entity in order to receive payment of Vacation benefits. Once a participant's account is established, contributions will be transferred to the participant's account within 30 days of when they are received by the Trust. Once the contributions are transferred to a Participating Employee's account, those funds are no longer Trust assets and are property of the Participant.

Failure to Establish an Account within 36 Months

If a Participating Employee does not establish a participant account within 36 months or terminates their participant account and does not re-establish their participant account within 36 months of the submission of contributions by a Participating Employer, the contributions shall be escheated to the State of Washington as discussed below.

Death of Participant

If a Participating Employee dies prior to establishing a participant account, any Vacation benefits paid on the Participating Employee's behalf will be paid out to the Participating Employee's dependents in the following order:

- Your designated Beneficiary on file with the Trust Office;
- If no designated Beneficiary, to your Legal Spouse;
- If no Legal Spouse, to your children, natural and adopted, in equal portions;
- If no children, to your living parents;
- If none of the above, to your siblings, equally;
- If none of the above, to your estate or escheat to the State of Washington, at the Trust's discretion.

Forfeiture of Vacation Benefits – Escheat to the State of Washington

If the Participating Employee does not establish a participant account with the designated bank within 36 months of contributions being submitted to the Trust, any funds held by the Trust shall be escheated to the Washington Department of Revenue as abandoned property. The funds shall be reported as abandoned in accordance with RCW 63.29.010, *et seq*., and any regulations interpreting the statute. Prior to distributing an unclaimed funds to the Washington Department of Revenue, the Trust will send at least one letter notifying the Participating Employee of the Trust's intention to distribute the unclaimed funds to the State.

Once the funds are distributed to the State of Washington, they will no longer be Trust assets. In the event a participating employee, or a participating employee's beneficiary, seeks payment of funds escheated to the Washington Department of Revenue, their only recourse shall be through the procedures provided by the Washington Department of Revenue.

Contact

Contact the Trust Office below for more information if you have questions about how to establish an account and obtain benefits.

All vacation contributions made on an employee's behalf will be deposited in an account in your name at Waterfront Credit Union (WFCU). It is your responsibility to contact Waterfront Credit Union to establish the account. You must:

- Complete the WFCU signature card. If your mailing address is a PO Box you must include your street address.
- Send a check or money order for a $5.00 minimum deposit with your signature card.
- Provide a government issued picture identification (driver's license, military ID, passport, student ID, etc.) for every signer on the account.
- Leave a minimum deposit of $5.00 in this account.

Their address is:

Waterfront Credit Union (WFCU)
2414 SW Andover Street, Suite E100
Seattle, WA 98106-1156

If you have any questions contact WFCU at (206) 622-8415 or (800) 423-1071 (outside of area code 206).

Coordination of Benefits (COB)

You may have medical, prescription drug, dental or vision coverage, such as through your spouse's employer, in addition to this Plan's benefits. The other plan is taken into account when your benefits under this Plan are determined. This provision, known as coordination of benefits, may reduce benefits under the Plan.

Coordination of Benefits with an HMO Plan

If an HMO plan is primary, the Plan will not consider as an allowable expense any charge which would have been covered had the participant used the services of a participating HMO provider (including the Trust's HMO plan with Kaiser). Nor will this Plan consider any charge in excess of what an HMO provider has agreed to accept as payment in full.

Coordination of Benefits with All Other Group Health Plans

The plan that pays benefits first is considered the primary plan and pays benefits without regard to those payable under other plans. When another plan is primary, this Plan pays an amount that, when added to other plan benefits, does not exceed 100% of eligible expenses. In no case will this Plan pay more in benefits than it would have paid had the Plan paid first. This has the effect of maintaining this Plan's deductibles, coinsurance and exclusions. As a result, when this Plan pays second, you may not receive the equivalent of 100% of the total cost of the health care services. Eligible expenses means any necessary, reasonable and customary item of expense which is covered, in whole or in part, under one or more plans covering the participant for whom the claim is made.

A plan is any arrangement that provides health care coverage for a participant's claims except as follows:

- COB will not apply to plans that provide coverage for accidents for students, including athletic injuries. This Plan always pays primary to student accident plans.
- This Plan is always a secondary plan to benefits provided under any mandatory no-fault auto insurance act (personal injury protection or PIP) in the state in which the participant resides.

Coordination With Medicare

For Medicare eligible active employees and their dependents, benefits payable under this Plan normally are primary and Medicare secondary. However, active employees have the option of electing Medicare as primary coverage. If an employee or dependent spouse age 65 or older makes this election, the Plan pays no further medical benefits.

For retired employees age 65 and over and their dependents age 65 and over, benefits will be coordinated with Medicare as the primary coverage and this Plan as the secondary coverage, **whether the retired person has enrolled in Medicare Part B or not. If you, your spouse or your dependent fail to enroll in Medicare, benefits will be paid as if you were enrolled in Medicare.** As a result, it is important for you and your dependent(s) to enroll in Medicare on a timely basis.

An exception to these rules is Medicare coverage for a person with end stage renal disease. During the first 30 months, coverage through this Plan is primary and Medicare is secondary. After 30 months, Medicare becomes primary.

When Medicare is primary, claims for Medicare eligible participants are not subject to PPO discounts.

Order of Benefit Determination

Group plans determine the sequence in which they pay benefits, or which plan pays first, by applying a uniform set of order of benefit determination rules that are applied in the specific sequence outlined below. This Plan uses the order of benefit determination rules established by the National Association of Insurance Commissioners (NAIC) and which are commonly used by insured and self-funded plans. Any group plan that does not use these same rules always pays first.

When two group plans cover the same person, the following order of benefit determination rules establish which plan is the primary plan that pays first and which is the secondary plan that pays second. If the first of the following rules does not establish a sequence or order of benefits, the next rule is applied, and so on, until an order of benefits is established. These rules are:

Rule 1: Non-Dependent or Dependent

A. The plan that covers a person other than a dependent, for example, as an employee, retiree, member or subscriber is the primary plan that pays first; and the plan that covers the same person as a dependent is the secondary plan that pays second.

B. There is one exception to this rule. If the person is also a Medicare beneficiary, and Medicare is secondary to the plan covering the person as a dependent; and primary to the plan covering the person as a retired employee; then the order of benefits is reversed, so that the plan covering the person as a dependent pays first; and the plan covering the person as a retired employee pays second.

Rule 2: Dependent Child Covered Under More Than One Plan

A. The plan that covers the parent whose birthday falls earlier in the calendar year pays first; and the plan that covers the parent whose birthday falls later in the calendar year pays second, if:

   1. the parents are married;
   2. the parents are not separated (whether or not they ever have been married); or
   3. a court decree awards joint custody without specifying that one parent has the responsibility for the child's health care expenses or to provide health care coverage for the child.

B. If both parents have the same birthday, the plan that has covered one of the parents for a longer period of time pays first; and the plan that has covered the other parent for the shorter period of time pays second.

C. The word "birthday" refers only to the month and day in a calendar year; not the year in which the person was born.

D. If the specific terms of a court decree state that one parent is responsible for the child's health care expenses or health care coverage, and the plan of that parent has actual knowledge of the terms of that court decree, that plan pays first. If the parent with financial responsibility has no coverage for the child's health care services or expenses, but that parent's current spouse does, the plan of the spouse of the parent with financial responsibility pays first. However, this provision does not apply during any Plan Year during which any benefits were actually paid or provided before the plan had actual knowledge of the specific terms of that court decree.

   If the specific terms of a court decree state that both parents are responsible for the dependent child's health care expenses or health care coverage, the plan that covers the parent whose birthday falls earlier in the calendar year pays first, and the plan that covers the parent whose birthday falls later in the calendar year pays second.

E. If the parents are not married, or are separated (whether or not they ever were married), or are divorced, and there is no court decree allocating responsibility for the child's health care services or expenses, the order of benefit determination among the plans of the parents and their spouses (if any) is:

   1. The plan of the custodial parent pays first; and
   2. The plan of the spouse of the custodial parent pays second; and
   3. The plan of the non-custodial parent pays third; and
   4. The plan of the spouse of the non-custodial parent pays last; and
   5. If there is no custodial parent (i.e. the child is over age 18), the plan that covers the parent whose birthday falls earlier in the calendar year pays first, and the plan that covers the parent whose birthday falls later in the calendar year pays second.

Rule 3: Active/Laid-Off or Retired Employee

A. The plan that covers a person either as an active employee (that is, an employee who is neither laid-off nor retired), or as that active employee's dependent, pays first; and the plan that covers the same person as a laid-off or retired employee, or as that laid-off or retired employee's dependent, pays second.

B. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.

C. If a person is covered as a laid-off or retired employee under one plan and as a dependent of an active employee under another plan, the order of benefits is determined by Rule 1 rather than by this rule.

Rule 4: Continuation Coverage

A. If a person whose coverage is provided under a right of continuation under federal or state law is also covered under another plan, the plan that covers the person as an employee, retiree, member or subscriber (or as that person's dependent) pays first, and the plan providing continuation coverage to that same person pays second.

B. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.

C. If a person is covered other than as a dependent (that is, as an employee, former employee, retiree, member or subscriber) under a right of continuation coverage under federal or state law under one plan and as a dependent of an active employee under another plan, the order of benefits is determined by Rule 1 rather than by this rule.

Rule 5: Longer/Shorter Length of Coverage

A. If none of the four previous rules determines the order of benefits, the plan that covered the person for the longer period of time pays first; and the plan that covered the person for the shorter period of time pays second.

B. To determine how long a person was covered by a plan, two plans are treated as one if the person was eligible for coverage under the second plan within 24 hours after the first plan ended.

C. The start of a new plan does not include a change:

   1. in the amount or scope of a plan's benefits;

   2. in the entity that pays, provides or administers the plan; or

   3. from one type of plan to another (such as from a single employer plan to a multiple employer plan).

D. The length of time a person is covered under a plan is measured from the date the person was first covered under that plan. If that date is not readily available, the date the person first became a member of the group will be used to determine the length of time that person was covered under the plan presently in force.

Rule 6: Other Plan has no COB rules

If the other coverage has no COB rules, this Plan will always pay secondary.

Right to Reimbursement

The Plan excludes medical, prescription drug, dental and time loss benefits for any injury or illness caused by the act or omission of another person, (known as the “third party”), where a potential opportunity for recovery exists from the third party, including, but not limited to, an injury or illness potentially covered by any liability policy of a third party or first party coverage available under an automobile insurance policy (including coverage for underinsured or uninsured motorist), homeowners policy or commercial premises policy. If an eligible individual has a potential right of recovery for which a third party or insurer may have legal responsibility, the Plan, as a convenience to the eligible individual, may advance benefits pending the resolution of the claim. However, the Plan’s payment of benefits is conditioned upon reimbursement from any judgment, settlement, disputed claim settlement, or other recovery, up to the full amount of all benefits provided by the Plan, but not to exceed the amount of the recovery.

If the Plan provides benefits, the Plan is entitled to reimbursement of all benefits paid, regardless of whether the eligible individual is made whole by the recovery, and regardless of the characterization of the recovery, except that if the eligible individual complies with the terms of the Plan and any agreement to reimburse, the Plan will deduct reasonable attorney fees and a pro rata share of the costs from the reimbursement amount. Costs incurred solely for the benefit of the eligible individual shall be the responsibility of the eligible individual. The Plan’s deduction for attorney fees and costs is contingent on compliance with the Plan’s reimbursement provisions and/or the agreement to reimburse.

Prior to advancing funds on the eligible individual’s behalf, the Plan can require that an eligible individual and the eligible individual’s attorney execute an agreement acknowledging this Plan’s reimbursement right, and provide the name and address of the party at fault, the name of any insurance company through which coverage may be available, the name of any other lien holders involved, a factual description of the accident and/or injury or illness, and any other information requested by the Plan to protect its reimbursement interest.

When any recovery is obtained from a third party or insurer, an amount sufficient to satisfy the Plan’s reimbursement amount must be paid into a trust account or escrow and held there until the Plan’s claims are resolved by mutual agreement or court order. The eligible individual shall request written permission from the Plan prior to distribution of any settlement funds prior to satisfaction of the Plan’s reimbursement interest. The obligation to place the reimbursement amount in trust is independent of the obligation to reimburse the Plan. If the funds necessary to satisfy the Plan’s reimbursement amount are not placed in trust, the eligible individual, or the individual who receives or distributes the recovery funds shall be liable for any loss the Plan suffers as a result.

The Plan may cease advancing benefits, if there is a reasonable basis to determine that the eligible individual or the eligible individual’s attorney will not honor the terms of the plan or the agreement to reimburse, or there is a reasonable basis to determine that the agreement is not enforceable.

After recovery by the eligible individual, and pending reimbursement to the Plan, the Plan may elect to recoup the reimbursement amount from benefit payments, including benefit payments for the eligible individual’s family members, by denying such payments until the amount of benefits provided has been recovered. The Plan may also seek to recoup the reimbursement amount from the source to which benefits were paid.

If the Plan is not reimbursed, it may bring an action against the eligible individual to enforce its right to reimbursement and/or the agreement to reimburse, or to seek a constructive trust, or in the alternative may elect to recoup the reimbursement amount by offsetting future benefits. If the Plan is forced to bring a legal action, it shall be entitled to its reasonable attorney fees, costs of collection and court costs.

Motor Vehicle Accidents

Most motor vehicle liability policies are required by law to provide liability insurance, primary medical payment insurance and uninsured motorist insurance, and many motor vehicle policies also provide underinsurance coverage.

The Plan will not pay benefits for health care costs to the extent that the eligible individual is able to, or is entitled to, recover from motor vehicle insurance, including payments under a PIP policy. Benefits will not be provided to the extent an eligible individual has failed to acquire PIP coverage where required to do so by law or PIP coverage has been terminated before being exhausted for failure to cooperate or otherwise for cause. The Plan will pay benefits toward expenses over the amount covered by motor vehicle insurance subject to the Plan's Third-Party Reimbursement Provision.

If the Plan pays benefits before motor vehicle insurance payments are made, the Plan is entitled to reimbursement out of any subsequent motor vehicle insurance payments made to the eligible individual and, when applicable, the Plan may recover benefits the Plan has paid directly from the motor vehicle insurer or out of any settlement or judgment which the eligible individual obtains in accordance with the Plan's Third-Party Reimbursement Provisions.

Recovery of Improperly Paid Benefits

In the event that through mistake, misrepresentation, fraud, inadvertent payment or any other circumstance, the Plan has paid an individual or has paid a provider on an individual's behalf, more than the individual or provider is entitled to under the Plan or under the law, the payment will not constitute a waiver of applicable Plan provisions, including any limitation or exclusion. The Plan may set off, recoup or recover the amount of overpayment or excess credit accrued or thereafter accruing from the individual, or it may offset future benefit payments due to the individual or the individual's family members by the amount paid in error.

The Plan may also request refunds from a provider or reduce future payments to the provider by the amount of the overpayment. The reduction or offset of future payments may involve this Plan or other health plans that are administered by the Plan's joint claim administrator/network provider. Under this process, the Plan's joint claim administrator/network provider reduces future payments to providers by the amount of the overpayment they received, and then credit the recovered amount to the plan that overpaid the provider. Payments to providers under this Plan are subject to this same process when the Plan's joint claim administrator/network provider recovers overpayments for other plans administered by the joint claim administrator/network provider. The Plan may also take such further action as the Board of Trustees shall determine.

Submitting A Claim

Active and Non-Medicare Retiree Medical Benefits

1. In most cases your provider will submit your claim to Aetna either electronically or via mail to Aetna at PO Box 981106, El Paso, TX 79998. If your provider does not submit a claim on your behalf, call the Trust Office at (888) 406-3246.
2. Claims received more than 12 months after the date of service are not covered by the Plan and will not be reimbursed. In order for a claim to be considered received, all required information must be received within the 12 months from the date the claim is incurred.
3. All payments for services by PPO providers will be made directly to such providers. In the case of non-PPO providers, payments will be made, at the Trust's option, to the participant, to his or her estate, to the provider or as required under federal law, including qualified medical child support orders. No assignment whether made before or after services are provided, of any amount payable according to this Plan shall be recognized or accepted as binding upon the Trust, unless otherwise required by federal law.

If your dependent is employed and has other group coverage, give your provider your dependent's other insurance information.

Retiree Benefits Coordination with Medicare.

This Plan participates in "Medicare Crossover" for Medicare eligible retirees and spouses. This means that the provider will bill Medicare and after Medicare processes the claim, Medicare will forward the claim and the Medicare payment information directly to the Trust Office for processing. Please keep a copy of the Explanation of Medicare Benefits (EOMB) so it is available in the event the Trust Office requests it. If the retiree is enrolled in a Medicare Part C Medicare Advantage Plan, the retiree or the provider may need to submit a copy of the provider's bill along with a copy of the Explanation of Medicare Benefits payment to the Trust Office.

Vision Benefits

1. In most cases, your provider (in-network and out-of-network) will submit your claim to VSP either electronically or via mail. If your provider does not submit a claim, you may submit a claim to VSP.
2. For individual claims, obtain your itemized bills that describe the services and treatments. You can complete a claim form available at www.vsp.com. Be sure to include the member's name, last four of the member's social security number and date of birth. You may submit the form online or by mail to:

   VSP
   PO Box 385018
   Birmingham, AL 35238-5018

3. To obtain benefits under this Plan, charges should be submitted within 90 days of the incurred expense. Claims received by VSP more than 12 months after the date services are received are not covered by the Plan and will not be reimbursed. In order for a claim to be considered received, all required information must be received within the 12 months from the date the claim is incurred.

Dental Benefits

4. In most cases, your provider (in-network and out-of-network) will submit your claim to Delta Dental of Washington either electronically or via mail to Delta Dental of Washington, PO Box 75983, Seattle, WA 98175-0983. If your provider does not submit a claim, you may submit a paper claim to Delta Dental.
5. For paper claims, obtain your itemized bills that describe the services and treatments. Be sure to include the member's name and social security number or alternate ID number. Submit the bills to Delta Dental:

   Delta Dental of Washington
   PO Box 75983
   Seattle, WA 98175-0983
   (206) 522-2300 or (800) 554-1907

6. To obtain benefits under this Plan, charges should be submitted within 90 days of the incurred expense. Claims received by the Trust Office more than 12 months after the date services are received are not covered by the Plan and will not be reimbursed. In order for a claim to be considered received, all required information must be received within the 12 months from the date the claim is incurred.

Prescription Drug Benefits

See page 43 for a detailed description of the prescription drug program administered by CVS/caremark.

Death and Accidental Death or Dismemberment Benefits

Notify the Trust Office, and in the case of death, submit a certified copy of the death certificate or other information to:

Seattle Area Plumbing & Pipefitting Industry Health Trust
11724 NE 195th St., Suite 300
Bothell, WA 98011
Attn: Death and AD&D Benefits
(206) 352-9728 or (888) 406-3246

Weekly Disability Income Benefits

5. Obtain a weekly disability income claim form from UA Local 32, the Trust Office or through your on-line account at www.zenith-american.com .
6. Complete, sign and date part 1 of the form.
7. Have your physician complete, sign and date part 2 of the form. Mail the fully completed form to the address at the top of the form.

8. For information on applying for a waiver of premium and how to freeze your dollar bank while disabled, see page 11.

Procedures for Processing Claims

Properly filed claims are processed according to these guidelines:

Post-Service Claims

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

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

Pre-Service Claims

These procedures apply only to processing treatment plans submitted for preauthorization. As explained in more detail on page 28, a preauthorization must be requested for all non-emergency inpatient admissions.

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

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

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

Urgent Care Claims

Urgent care claims are for services where following the normal claims processing timing rules: 1) could seriously jeopardize the claimant's health or ability to regain maximum function, or 2) in the opinion of a provider familiar with the claimant's medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim. Urgent care claims may be filed, orally, or in writing, by the claimant, or provider or provider with knowledge of the condition. The claimant will be informed as soon as possible, but not more than 24 hours after the claim is received if more information is required to process the claim, with specifics on the information needed.

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

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

Concurrent Care Claims

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

Any request to extend treatment that involves urgent care will be decided as soon as reasonably practical. The claimant will be notified of the determination within 24 hours of when the Plan receives the claim, if it's received at least 24 hours before the previously approved treatment ends.

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

Notice of Denial

A benefit denial contains this information:

1. The reason for the denial.
2. Reference to the Plan provision(s) relied on.
3. Description of any additional material needed for the claim, with an explanation of why it is necessary.
4. Reference to any internal rule, guideline or protocol used in denying the claim, with a statement that a copy is available without charge upon request.
5. If the denial is based on the service or supply being medically necessary or experimental or investigational, or an equivalent exclusion, an explanation of the medical judgment involved in making the decision.
6. An explanation of the Plan's appeal procedures, including applicable time limits.

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

Filing an Appeal

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

Appeal of Benefit Denial

Claimants will have 180 days from the date of denial to appeal an adverse benefit determination, except denials of death benefits and accidental death and dismemberment ("AD&D" benefit claims must be filed within 60 days). An appeal shall be submitted by the participant or an authorized representative in writing. Appeal must be submitted to the proper address for either the Trust Office or the claims administrative agent that made the denial. An appeal shall identify the benefit determination involved, set forth the reasons for the appeal and provide any information the participant believes is pertinent. Except for Urgent Care Claims, appeals will be accepted from an authorized representative only if accompanied by a written statement signed by the claimant (or parent or legal guardian where appropriate), which identifies the representative and authorizes him or her to seek benefits for the claimant. An assignment of benefits is not sufficient to make a provider an authorized representative.

A failure to file a claim appeal within 180 days of the denial (or 60 days for life and AD&D claims) will serve as a bar to any claim for benefits or for other relief from the Trust.

Appeal Procedures

The procedures specified below shall be the exclusive procedures available to a participant who is dissatisfied with an eligibility determination, benefit award or is otherwise adversely affected by an action of the Trust or its authorized claims payers. These procedures must be exhausted before a claimant may file suit under Section 502(a) of ERISA. If the Plan is changed to offer a fully insured benefit, a participant who is seeking benefits from the insurance company with which the Trust contracts shall utilize the procedures established by that entity.

Information To Be Provided Upon Request

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

If a denial is based upon a medical determination, an explanation of that determination and its application to the claimant's medical circumstances is also available upon request.

Conduct of Hearings By the Appeal Committee

Except for urgent care and pre-service health claims, an appeal will be presented to the Trust's Appeals Committee at its next quarterly meeting. If an appeal is received less than 30 days before the next quarterly meeting, consideration of the appeal may be postponed (if necessary) until the second quarterly meeting following receipt of the appeal.

The Appeals Committee shall consist of at least one employer and one labor organization Trustee. The Appeals Committee will review the administrative file, which will consist of all documents relevant to the claim. A copy of the administrative file will be provided to the participant. The participant may provide additional information for the administrative file prior to the close of the appeal hearing. The Appeals Committee will review any additional information provided. The review will be de novo and without deference to the initial denial.

If the denial is based on medical judgment, the Appeals Committee may consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. The Trust may have an individual with a different licensure review a matter if they are trained to deal with the condition involved. The health care professional consulted will not be the individual who made the initial benefit determination nor the subordinate of that individual. The Appeals Committee will identify by name any individuals consulted for medical or vocational advice.

The claimant or his or her representative will be allowed to appear before the Appeal Committee and present any evidence or witnesses. If the claimant does appear at the hearing (or if the Appeals Committee otherwise determines that such a record is appropriate) a stenographic record shall be made of any testimony provided. If the claimant does not elect to appear, the hearing will be determined based on the administrative file and the comments of any witnesses consulted. The Appeals Committee may in its discretion set conditions upon the conduct of the hearing, the testimony or attendance of any individual or address other procedural matters which may occur during a specific hearing.

Issuance of a Decision

The Appeals Committee will provide the claimant written notification of its decision within five days. Where appropriate, the Board of Trustees may issue a more detailed explanation of the reasons for its decision within 30 days of the hearing. The decision will set out the specific reasons for an adverse decision, reference the Plan procedure involved, inform the claimant that all information relevant to the individual's claim is available upon request and free of charge, notify the claimant of his or her rights under section 502(a) of ERISA, identify any internal rule or guideline relied on (or reference that it is available free of charge), and if a denial is based on a medical judgment, an explanation of the medical judgment applying it to the claimant's case or a statement that such information is available.

If a decision cannot be reached at the initial meeting at which an appeal is heard, the Appeals Committee may defer a decision on an appeal until the next quarterly scheduled appeals meeting provided that written notice is provided to the claimant.

Modifications to the Appeal Procedures for Urgent Care Claims

Appeals involving denial of urgent care will be subject to the rules set forth above with the following modifications:

- An initial decision will be made within 72 hours if the initial claim was complete when submitted or an additional 48 hours after receiving additional information if it was necessary to process the claim.
- An appeal may be made orally or in writing.
- A health care professional with knowledge of the claimant's medical condition may act as an authorized representative of the claimant without a prior written authorization.
- Information will be provided to the claimant or authorized representative via telephone, facsimile or other expedited method.
- A decision will be issued within 72 hours of an appeal of an initial denial.

External Review

If you remain dissatisfied after the Board of Trustees issues its decision on appeal, you may request an external review with an Independent Review Organization or bring a civil action under ERISA § 502(a). If you request an external review, such request is subject to the following:

- The Plan's claim appeal process must be exhausted before external or judicial review can be sought.
- External reviews are only available for appeals involving medical judgment or the retroactive rescission of coverage. There is no external review for weekly disability, accidental death and dismemberment or death benefits.
- You have four months from the date of the final adverse benefit determination to file a request for external review. Failure to request an external review within the four-month period will end your ability to seek external review.

Requests for external review should be sent to the Trust Office at the following address:

Seattle Area Plumbing & Pipefitting Industry Health Trust Appeals Committee
c/o Zenith American Solutions
11724 NE 195th Street, Suite 300
Bothell, Washington 98011
(206) 352-9728
(888) 406-3246

Preliminary Review of External Review Request

Within five business days of receipt of a request for external review, the Plan will complete a preliminary review of the external review request. The preliminary review will be expedited if the request satisfies the requirements for an expedited external review. Within one business day after completion of this review, the Plan will notify you of its decision. If the request is not eligible for external review, the Plan will notify you. If the

request for external review is incomplete, the Plan will identify what is needed and you will have the longer of 48 hours or the remaining portion of the four-month external review request period to provide the information. If the external review request is complete and eligible for external review, the Plan will refer the matter to an Independent Review Organization.

Expedited External Review

You may request an expedited external review if you received:

- an adverse denial of benefits which involves a medical condition for which the timeframe for completing an expedited appeal to the Board of Trustees would seriously jeopardize your life or health or your ability to regain maximum function and you have filed a request for an expedited appeal to the Board of Trustees; or
- an adverse decision on appeal to the Trustees which involves a medical condition for which the timeframe for completion of a standard external review would seriously jeopardize your life or health or your ability to regain maximum function, or the decision concerns an admission, availability of care, continued stay, or health care item or service for which you received emergency services, but have not been discharged from a facility.

Review by Independent Review Organization

If a properly filed request for external review is received, the Plan will provide the Independent Review Organization with the required documentation in the time required by applicable federal regulations. The Independent Review Organization will provide a response to you within 45 days after it has received the request to review.

If a claim satisfies the requirements for an expedited external review, the Independent Review Organization will provide a response to you within 72 hours after it has received the request to review, provided that written confirmation may be provided within 48 hours after the date the response is provided.

Judicial Review of Denied Claims

The Trust provides for no voluntary alternative dispute resolution procedures. If a claimant remains dissatisfied after the issuance of the Trustees' decision or the Independent Review Organization's decision, you may bring a civil action under ERISA § 502(a). Any civil action must be brought no later than 180 days after the date of issuance of the Trustees' decision or the Independent Review Organization's decision. The question on review will be whether, in the particular instance, the Trustees:

- were in error upon an issue of law;
- acted arbitrarily or capriciously in the exercise of their discretion; or
- whether their findings of fact were supported by substantial evidence.

Right to Sue

A lawsuit to obtain benefits will be deemed untimely if it is filed before:

- You have appealed the denial of your claim to the Board of Trustees, or
- The Board of Trustees has issued a decision on appeal; or
- You have exhausted the Plan's appeals processes for every issue you deem relevant.

The ERISA Statement of Rights provides additional information on legal action you can take if you feel your right to a benefit has been improperly denied.

Definitions

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

Cosmetic Procedures are services to improve change or restore physical appearance and/or self-esteem due to deformity or abnormality without materially correcting a functional disorder, or to prevent or treat a psychological disorder through a change in bodily appearance.

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

Dollar Bank means a notional account established for each employee into which health and welfare contributions are credited. Necessary amounts are deducted from the dollar bank account to provide coverage for the employee, and their eligible dependents, as set forth in the rules of the Plan. Dollar bank accounts do not create vested eligibility and the Trustees have the discretion to alter, reduce or eliminate dollar bank accounts at any time.

Emergency Medical Condition means a medical condition or injury with acute symptoms of sufficient severity (including severe pain) that, lacking immediate medical attention, could reasonably be expected to result in the health of the person (including an unborn child) being placed in serious jeopardy or result in serious impairment or dysfunction of any bodily organ or part.

Experimental Treatment or Procedures:

Experimental or Investigational Treatment (Dental Care) means a service or supply is considered experimental or investigational if any of these conditions is present:

1. The service or supply is described as an alternative to more conventional therapies in written documents by the provider that performs the services;
2. The service or supply may be given only with approval of an Institutional Review Board as defined by federal law;
3. There is an absence of authoritative dental, medical, or scientific literature on the subject, or that literature indicates the service or supply is experimental or investigational or that more research is needed;
4. The Food and Drug Administration (FDA) has not approved marketing of the service or supply or has it under consideration; or
5. The service or supply is available only through clinical trials sponsored by the FDA, the National Cancer Institute or the National Institutes of Health.

The Board of Trustees has the discretion and authority to determine if a service or supply is or should be considered experimental or investigational. That determination is based on the information and resources available when the service is performed or the supply is provided.

Experimental or Investigational Treatment (Medical Care) means a service or supply if any of the following apply:

1. The drug or device cannot be lawfully marketed without approval of the FDA and approval for marketing has not been given for regular non-experimental or non-investigational purposes at the time the drug or device is furnished;
2. The drug, device, medical treatment, or procedure has been determined experimental or investigational by the treating facility's institutional review board or other body serving a similar function, and the patient has signed an informed consent document acknowledging such experimental status;
3. Federal law classifies the drug, device or medical treatment under an investigational program;
4. Reliable evidence shows the drug, device, medical treatment or procedure is the subject of ongoing Phase I or Phase II clinical trials or is otherwise under study to determine its maximum tolerated dose, toxicity, safety, efficacy, or efficacy compared with standard means of treatment or diagnosis; or
5. Reliable evidence shows the prevailing opinion among experts regarding the drug, device, medical treatment or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, toxicity, safety, efficacy, or efficacy compared with standard means of treatment or diagnosis (except as provided below).

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

A service or supply will not be considered experimental or investigational if it is part of an approved clinical trial. The Plan's administrator shall investigate each claim for benefits that might include experimental or investigational treatment. The administrator may consult with medical professionals, including its own staff, to determine whether the treatment is excluded as experimental or investigational, or whether it is covered as one of the exceptions stated above.

Home Health Aide means an individual who is employed by an approved home healthcare agency or an approved hospice agency and who provides: part-time or intermittent personal care; ambulation and exercise; household services essential to health care at home; assistance with medications ordinarily self-administered; reports of changes in a patient's condition and needs; and completion of appropriate records. The home health aide must be under the supervision of a registered nurse, physical therapist, occupational therapist, speech therapist or inhalation therapist.

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

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

Hospital is a facility which:

- Is licensed (if required) as a hospital; and
- Is open at all times; and
- Is operated mainly to diagnose and treat illnesses on an inpatient basis, and
- Has a staff of one or more doctors on call at all times; and
- Has 24-hour nursing services by registered nurses; and
- Is not mainly a skilled nursing facility, clinic, nursing home, rest home, convalescence home or like place; and
- Has organized facilities for major surgery.

Illness/Sickness means any condition marked by a pronounced change from the normal health state. All illnesses due to the same cause, or to a related cause, will be deemed to be one illness.

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

- It is appropriate to the diagnosis and/or treatment of the patient's illness or injury.
- It is known to be effective in improving health outcomes for the patient's medical condition in accordance with sufficient scientific evidence and professional recognized standards.
- It represents the most economically efficient use of medical services and supplies that may be provided safely and effectively to the patient.
- It is not primarily for the convenience of the patient or provider.
- When applied to an inpatient, it cannot safely be provided to the patient as an outpatient.
- A service or supply may be medically necessary in part only.
- The fact a procedure, service, or supply may be furnished, prescribed, recommended or approved by a provider or other provider does not, of itself, make it medically necessary under the terms of the Plan.

Occlusal Adjustment means adjusting the way the biting surface of the teeth meet.

Out of Pocket Costs means services that you are responsible for each calendar year including coinsurance, deductible and copays.

Provider means a healthcare provider who is acting within the scope of the provider's license or certificate under applicable state law. Certain licensed or certified professionals providing services covered by the plan may be required to be under the supervision of an MD, DO, DDS, or DMD as determined by the plan. Covered providers may include:

- Acupuncturist
- Anesthetist
- Certified Nurse Midwife
- Podiatrist
- Chiropractor
- Clinical Psychologist
- Denturist
- Licensed Practical Nurse
- Marriage and Family Therapist
- Mental Health Counselor
- Nurse Practitioner
- Physical Therapist
- Physician's Assistant
- Optometrist
- Registered Nurse

Before receiving treatment from any practitioner other than an MD or DO, check with the Trust Office to find out if the expenses will be recognized as covered.

Physician means MD or DO.

Reciprocity Agreement means an agreement with another health and welfare trust fund that allows for contributions paid to this Trust, for employees from outside this Trust's area, who are working temporarily in this Trust's area, to be transferred to their home trust, and vice versa.

Residential Treatment Facility means an institution providing treatment for behavioral health disorder and operating under the direction and control of the Washington State Department of Social and Health Services or the equivalent department of another state. If the facility does not operate under the direction and control of a state department of health, then it must provide effective treatment through a contract with the state department of health, be included in the state department of health's current list of approved public and private treatment facilities, and meet all applicable government standards. The facility must also meet the following requirements:

- Have on-site licensed providers 24 hours per day/7 days a week;
- Provide a comprehensive patient assessment (preferably before admission, but at least upon admission);

- Approve all admissions by a physician;

- Have access to necessary medical services 24 hours per day/7 days a week and 24-hours per day/7 days a week supervision by a physician with evidence of close and frequent observation;

- Provide living arrangements that are consistent with developmental needs, including appropriate room and board;

- Offer group therapy sessions with at least an RN or Masters-Level Health Professional;

- Provide access to at least weekly sessions with a psychiatrist or psychologist for individual psychotherapy;

- Manage all services by a licensed provider who needs to (1) meet the appropriate credentialing criteria as an individual practitioner, and (2) function under the direction/supervision of a licensed physician;

- Have individualized active treatment plan directed toward the alleviation of the impairment that caused the admission; and

- Provide a level of skilled intervention consistent with patient risk.

Skilled Nursing Facility are facilities which primarily provide convalescent care for patients transferred from accredited general hospitals and approved by the Joint Commission for Accreditation of Hospitals or by Medicare.

Special Agreements are those agreements that allow for participation of working owners and their non-bargaining employees.

Usual and Customary Charges (U&C) charge means the amount payable to a non-PPO provider (for services other than outpatient dialysis) as determined by the Board of Trustees or its designee for a particular service, and subject to the following:

1. The U&C Charges for a claim governed by the No Surprises Act, or similar federal balance billing protections, will be determined in accordance with the applicable law;

2. Charges for services or supplies which are not provided or billed in accordance with generally accepted professional standards and/or medical practice are not considered U&C Charges regardless of the amount billed;

3. In no event will the U&C charge exceed the amount billed or the amount for which the covered person is financially responsible;

4. U&C may not reflect the actual billed charges and does not take into account the professional service provider's training, experience or category of licensure;

5. The Plan's U&C methodology may vary between claims based on the facts and circumstance of the claim, the services provided and the expected savings;

6. The Trust may hire a third-party reviewer to determine the U&C amount consistent with this provision;

7. Irrespective of the Plan's U&C methodology or U&C determination, the Trustees reserve the right to negotiate an acceptable U&C amount directly with a provider; and

8. For outpatient dialysis services, see the Dialysis benefit section for the determination of the Plan benefit amount.

For properly billed non-PPO professional service provider charges, the U&C amount shall be no higher than the 90th percentile identified by a commercially available database selected by the Trust. When there is, in the Board of Trustees' determination, minimal data available from the database for a covered service, the Board of Trustees will determine the U&C amount by calculating the unit cost for the applicable service category using the database, and multiplying that by the relative value of the covered service assigned by the Medicare resource based relative value scale (supplemented with a commercially available relative value scale selected by the Plan where one is not available from Medicare). In the event of an unusually complex procedure, a new procedure, or a procedure that otherwise does not have a relative value that is in the Board of Trustees' determination applicable, the Trust may assign one.

For non-PPO professional services, the Trust may attempt to establish a negotiated rate that if accepted will result in no balance billing for the Plan participant as beneficiary beyond deductible and co-insurance.

For properly billed non-PPO facility charges, U&C means 200% of the Medicare reimbursements amount. For non-PPO facility services, the Trust reserves the right to attempt to establish a negotiated rate that if accepted will result in no balance billing for the Plan participant or beneficiary beyond deductible and co-insurance. Non-PPO providers (including both professionals and facilities) seeking claim payment under the Plan shall be obligated to submit to a prompt audit of their claims by the Trust, notwithstanding any internal rules they may have to the contrary. In the event a non-PPO provider refuses or delays a reasonable audit request by the Trust, the Trust shall have the right to withhold payment to the said non-PPO provider on the claim in question and on other pending or future claims by said non-PPO provider.

Summary Plan Description

Name of Plan

This Plan is known as the Seattle Area Plumbing & Pipefitting Industry Health Trust.

Name and Address of Plan Sponsor and Plan Administrator

This Plan is sponsored and administered by a joint labor-management Board of Trustees, the name, address and telephone number of which is:

Board of Trustees
Seattle Area Plumbing & Pipefitting Industry Health Trust
c/o Zenith American Solutions
11724 NE 195th Street, Suite 300
Bothell, Washington 98011
(206) 352-9728
(888) 406-3246

Information as to whether a particular employer or employee organization is a Plan sponsor and, if so, such employer or employee organization's address may be obtained by participants and beneficiaries upon written request to the Trust Office. The Trustees may impose a reasonable charge to cover the cost of providing this information. Participants and beneficiaries may wish to inquire as to the amount of the charges before requesting such information.

Identification Number

The employer identification number assigned to the Trust by the Internal Revenue Service is EIN 91-0838639.

Type of Plan

This Plan is as a self-funded welfare plan which provides medical, prescription drug, dental, vision, disability and death benefits.

Type of Administration

This Plan is administered by the Joint Board of Trustees, with the assistance of Zenith American Solutions, a contract administrative agent.

Name and Address of Agent for Service of Legal Process

The agent for service of legal process is Barlow Coughran Morales & Josephson, P.S., 1325 Fourth Ave, Suite 910, Seattle Washington 98101. Each member of the Board of Trustees is also an agent for purposes of accepting service of legal process on behalf of the Plan. The names and addresses or the Trustees are set forth below.

Names and Addresses of Joint Board of Trustees

The names and addresses of the participants currently serving on the Joint Board of Trustees are:

EMPLOYER TRUSTEES

Ed Kommers
Mechanical Contractors
Association of Western Washington
1100 Olive Way, Suite 1250
Seattle, WA 98101-1873

Pat Damitio
UMC, Inc.
11611 49th Place West
Mukilteo, WA 98275-4255

Rory Olson
MacDonald-Miller Facility Solutions
7717 Detroit Avenue S.W.
Seattle, WA 98106

LABOR TRUSTEES

Jeffery Owen
UA Local 32
597 Monster Rd. S.W.
Renton, WA 98057-2937

Joel Crabtree
UA Local 32
597 Monster Rd. S.W.
Renton, WA 98057-2937

Michael Kunkel
UA Local 32
597 Monster Rd. S.W.
Renton, WA 98057-2937

Description of Collective Bargaining Agreements

This Plan is maintained pursuant to more than one collective bargaining agreement. A copy of the relevant agreements may be obtained by participants and beneficiaries upon written request to the Trustees. Further, agreements are available for examination by participants and beneficiaries at the Trust Office, and at local union office, upon 10 days advanced written request. The Trustees may impose a reasonable charge to cover the cost of furnishing the agreement. Participants and beneficiaries may wish to inquire as to the amount of the charges before requesting copies.

Participation and Eligibility

Employees are entitled to participate in this Plan if they work under the collective bargaining agreement described above, and if their employer makes contributions to the Trust on their behalf. Employees may also be able to participate under a special participation agreement with the Trust.

The eligibility rules that determine which employees and beneficiaries are entitled to benefits are set forth beginning on page 6.

The Trustees retain the right and authority to determine eligibility under the Plan and to interpret the terms of the benefit plan sponsored by the Trust.

Termination of Eligibility

Circumstances that may result in termination of eligibility are set forth beginning on page 7.

Source of Contributions

The Plan is supported by employer contributions, the amount of which is specified in the underlying collective bargaining agreements and special agreements. Also, self-payments by employees and dependents are permitted for continuation coverage and retiree benefits. The amount of self-payments is fixed from time to time by the Board of Trustees.

Entities Used for Accumulation of Assets and Payment of Benefits

The employer contributions and employee self-payments are received and held in trust by the Joint Board of Trustees pending the payment of benefits and administrative expenses. The Joint Board of Trustees pays all benefits directly from the Trust.

The Trust also has a stop loss insurance policy under which the insurance company has assumed the financial responsibility for medical and prescription claims exceeding an individual specific deductible, up to the applicable lifetime maximum specified in the Plan, and for aggregate claims exceeding 200% of the expected claims for the policy year.

Disposition of Uncashed Claim Checks

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

Discretionary Authority

Seattle Area Plumbing & Pipefitting Industry Health Trust is committed to maintaining health care coverage for employees and their families at an affordable cost, however, because future conditions cannot be predicted, the Board of Trustees reserves the right to amend or terminate coverage at any time and for any reason.

The Board of Trustees has the exclusive authority to interpret the provisions of the Plan, to determine eligibility for an entitlement to Plan benefits or to amend the Plan. Any interpretation or determination by the Trustees made in good faith which is not contrary to law is conclusive on all persons affected. The Board of Trustees has delegated to the Trust Office the authority to administer the Plan and provide information relating to the amount of benefits, eligibility, and other plan provisions. In administering the Plan, the Trust Office and any medical review organization used by the Trust may utilize its internal guidelines and medical protocols in determining whether or not specific services or supplies are covered under the terms of the Plan. The Trust Office does not have the authority to change the provisions of the Plan. An interpretation of the Plan by the Trust Office is subject to review by the Board of Trustees. No individual trustee, employer, employer association, labor organization, or any individual employed by an employer or labor organization, has any authority to interpret or change the Plan. Be sure to keep this document, along with notices of any Plan changes, in a safe and convenient place where you and your family can find and refer to them.

End of Plan Year

This Plan is on a July 1 – June 30 fiscal basis. The end of the plan year is June 30th

Your ERISA Rights

As a Seattle Area Plumbing & Pipefitting Industry Health Trust participant you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants be entitled to the following:

Receive Information About Your Plan and Benefits

Examine, without charge, at the Plan's Trust Office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the US Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain, upon written request to the Plan administrator, copies of documents governing Plan operation, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.

Receive a summary of the Plan's annual financial report. The Plan administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Health Plan Coverage

If your coverage under this Plan ends and you become eligible for a new health plan, the time you were covered under this Plan may be used to eliminate certain penalties for late enrollment in Medicare. When your coverage ends, either as an employee or dependent, or under COBRA coverage, you may request to receive a certificate of creditable coverage containing information your new plan may need.

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

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

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

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

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

Assistance With Your Questions

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

Notice of Privacy Practices (HIPAA)

Pursuant to regulations issued by the federal government, the Seattle Area Plumbing & Pipefitting Industry Health Trust is providing you this Notice about the possible uses and disclosures of your health information. Your health information is information that constitutes protected health information as defined in the Privacy Rules issued by the Department of Health and Human Services pursuant to the Health Insurance Portability and Accountability Act of 1996 ("HIPAA").

As required by law, the Trust has established a policy to guard against unnecessary disclosure of your health information. The Trust is required by law to maintain the privacy of protected health information, to provide individuals with notice of its legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured health information.

This Notice describes the circumstances under which and the purposes for which your health information may be used and disclosed and your rights with regard to such information.

Use And Disclosure Of Health Information

Your health information may be used and disclosed without an authorization in the following situations:

To Make or Obtain Payment. The Trust may use or disclose your health information to make payment to or collect payment from third parties, such as other health plans or providers, for the care you receive, to determine benefit responsibility under the Trust's Plan or to coordinate Plan coverage. For example, the Trust may use health information to pay your claims or share information regarding your coverage or health care treatment with other health plans to coordinate payment of benefits. The Trust may also share your protected health information with another entity to assist in the adjudication or reimbursement of your health claims.

To Facilitate Treatment. The Trust may disclose information to facilitate treatment which involves providing, coordinating or managing health care or related services. For example, the Trust may disclose the name of your treating provider to another provider so that the provider may ask for your x-rays.

To Conduct Health Care Operations. The Trust may use or disclose health information for its own operations, to facilitate the administration of the Trust and as necessary to provide coverage and services to all of the Trust's participants. Health care operations includes: making eligibility determinations; contacting health care providers; providing participants with information about health-related issues or treatment alternatives; developing clinical guidelines and protocols; conducting case management; medical review and care coordination; handling claim appeals; reviewing health information to improve health or reduce health care costs; participating in drug or disease management activities; conducting underwriting; premium rating or related functions to create, renew or replace health insurance or health benefits; and performing the general administrative activities of the Trust (such as providing customer service, conducting compliance reviews and auditing, responding to legal matters and compliance inquiries, handling quality assessment and improvement activities, business planning and development including cost management and planning related analyses and formulary development, and accreditation, certification, licensing or credentialing activities). For example, the

Trust may use your health information to conduct case management of ongoing care or to resolve a claim appeal you file.

If the Trust discloses protected health information for underwriting purposes, the Trust is prohibited from using or disclosing protected health information that is genetic information of an individual for such purposes.

For Disclosure to the Plan Trustees. The Trust may disclose your health information to the Board of Trustees (which is the plan sponsor), or any insurer or HMO with which the Trust contracts, and to necessary advisors which assist the Board of Trustees in performing plan administration functions, such as handling claim appeals. The Trust also may provide summary health information to the Board of Trustees so that it may solicit bids for services or evaluate its benefit plans. Summary health information is information that summarizes participants' claims information but from which names and other identifying information have been removed. The Trust may also disclose information about whether you are participating in the Trust or one of its available options.

For Disclosure to You or Your Personal Representative. When you request, the Trust is required to disclose to you or your personal representative your protected health information that contains medical records, billing records, and any other records used to make decisions regarding your health care benefits. Your personal representative is an individual designated by you in writing as your personal representative, attorney-in-fact. The Trust may request proof of this designation prior to the disclosure. Also, absent special circumstances, the Trust will send all mail from the Trust to the individual's address on file with the Trust Administration Office. You are responsible for ensuring that your address with the Trust Administration Office is current. Although mail is normally addressed to the individual to whom the mail pertains, the Trust cannot guarantee that other individuals with the same address will not intercept the mail. You have the right to request restrictions on where your mail is sent as set forth in the request restrictions section below.

Disclosure Where Required by Law. In addition, the Trust will disclose your health information where applicable law requires. This includes:

In Connection With Judicial and Administrative Proceedings

The Trust will in response to an order from a court or administrative tribunal disclose protected health information in accordance with the express terms of such an order. The Trust may also disclose protected health information in response to a subpoena or other lawful process if the Trust receives satisfactory documentation that you have received notice of the subpoena or legal process, the notice provided sufficient information to allow you to raise an objection and the time for raising an objection has passed and either no objections were filed or were resolved by the court or administrative tribunal. Alternatively, the party requesting disclosure may provide satisfactory documentation you have agreed to the disclosure or that it has obtained a qualified protective order which meets the requirements of the Privacy Rules and which allows for disclosure. For example, if the Trust receives a court order requiring it to disclose certain information, it will respond to the court order.

When Legally Required And For Law Enforcement Purposes

The Trust will disclose your protected health information when it is required to do so for law enforcement purposes. This may include compliance with laws which require

reporting certain types of injuries, pursuant to court issued legal process; or a grand jury subpoena or other administrative requests if satisfactory documentation is provided that the request is relevant to a legitimate law enforcement purpose, the request is reasonably tailored to meet this legitimate law enforcement purpose and de-identified individual cannot be reasonably provided as an alternative. Additionally, limited disclosure may be made for purposes of identifying or locating a suspect, fugitive, material witness or missing person, identifying a victim of a crime or in connection with a criminal investigation that occurred on Trust premises. For example, the Trust could upon request of a law enforcement agency provide information concerning the address of a fugitive.

To Conduct Public Health and Health Oversight Activities

The Trust may disclose your health information to a health oversight agency for authorized activities (including audits, civil administrative or criminal investigations, inspections, licensure or disciplinary action), government benefit programs for which health information is relevant, or to government agencies authorized by law to receive reports of abuse, neglect or domestic violence as required by law. The Trust, however, may not disclose your health information if you are the subject of an investigation and the investigation does not arise out of or is not directly related to your receipt of health care or public benefits.

In the Event of a Serious Threat to Health or Safety

The Trust may, consistent with applicable law and ethical standards of conduct, disclose your health information if the Trust, in good faith, believes that such disclosure is necessary to prevent or lessen a serious and imminent threat to your health or safety or to the health and safety of the public. For example, the Trust may disclose evidence of a threat to harm another person to the appropriate authority.

For Specified Government Functions

In certain circumstances, federal regulations require the Trust to use or disclose your health information to facilitate specified government functions related to the military and veterans, national security and intelligence activities, protective services for the president and others, and correctional institutions and inmates.

For Workers Compensation

The Trust may release your health information to the extent necessary to comply with laws related to workers compensation or similar programs.

Authorization To Use Or Disclose Health Information

Other than as stated above, the Trust will not disclose your health information without your written authorization. Generally, you will need to submit an Authorization if you wish the Trust to disclose your health information to someone other than yourself. Authorization forms are available from the Privacy Contact Person listed below. If you

have authorized the Trust to use or disclose your health information, you may revoke that Authorization in writing at any time. The revocation should be in writing, include a copy of or reference to your Authorization and be sent to the Privacy Contact Person listed below.

Special rules apply about disclosure of psychotherapy notes. Your written Authorization generally will be required before the Trust will use or disclose psychotherapy notes. Psychotherapy notes are a mental health professional's separately filed notes which document or analyze the contents of a counseling session. They do not include summary information about your mental health treatment or information about medications, session stop and start times, the diagnosis and other basic information. The Trust may use and disclose psychotherapy notes when needed to defend against litigation filed by you or in other limited situations.

Your written authorization will be required for any disclosure of your health information that involves marketing, the sale of your health information, or any disclosure involving direct or indirect remuneration to the Trust.

Your Rights With Respect To Your Health Information

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

Right to Request Restrictions. You may request restrictions on certain uses and disclosures of your health information. You have the right to request a limit on the Trust's disclosure of your health information to someone involved in payment for your care. The Trust is not required to agree to your request unless the protected health information pertains solely to a health care item or service for which you, or a person on your behalf, has paid the provider or Plan in full, and the disclosure at issue is for the purpose of carrying out payment or health care operations.

Right to Inspect and Copy Your Health Information. You have the right to inspect and copy your health information. This right, however, does not extend to psychotherapy notes or information compiled for civil, criminal or administrative proceeding. The Trust may deny your request in certain situations subject to your right to request review of the denial. A request to inspect and copy records containing your health information must be made in writing to the Privacy Contact Person listed below. If you request a copy of your health information, the Trust may charge a reasonable fee for copying, assembling costs and postage, if applicable, associated with your request. Notwithstanding the foregoing, the fee for a copy of your health information in electronic form shall not be greater than the labor costs in responding to the request.

Right to Receive Confidential Communications. You have the right to request that the Trust communicate with you in a certain way if you feel the disclosure of your health information through regular procedures could endanger you. For example, you may ask that the Trust only communicate with you at a certain telephone number or by e-mail. If you wish to receive confidential communications, please make your request in writing to the Privacy Contact Person listed below. The Trust will attempt to honor reasonable requests for confidential communications.

Right to Amend Your Health Information. If you believe that your health information records are inaccurate or incomplete, you may request that the Trust amend the records. That request may be made as long as the information is maintained by the Trust. A request for an amendment of records must be made in writing to the Trust's Privacy Contact Person listed below. The Trust may deny the request if it does not include a reasonable reason to support the amendment. The request also may be denied if your

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

Right to an Accounting. You have the right to request a list of disclosures of your health information made by the Trust. The request must be made in writing to the Privacy Contact Person. The request should specify the time period for which you are requesting the information. No accounting will be given of disclosures made: to you; for Treatment, Payment or Health Care Operations; disclosures made before April 14, 2003; disclosures for periods of time going back more than six years; pursuant to an authorization; or in other limited situations. The Trust will provide the first accounting you request during any 12-month period without charge. Subsequent accounting requests may be subject to a reasonable cost-based fee. The Trust will inform you in advance of the fee, if applicable.

Right to Opt Out of Fundraising Communications. In the event that the Trust engages in a fundraising activity, you have the right to opt out of any fundraising communications.

Right to a Paper Copy of this Notice. You have a right to request and receive a paper copy of this Notice at any time, even if you have received this Notice previously or agreed to receive the Notice electronically. To obtain a paper copy, please contact the individual listed below. If this Notice is modified, you will be mailed a new copy.

Privacy Contact Person/Privacy Official. To exercise any of these rights related to your health information you should contact:

Privacy Contact Person / Privacy Official

Privacy Contact Person
Seattle Area Plumbing & Pipefitting Industry Health Trust
c/o Zenith American Solutions
11724 NE 195th Street, Suite 300
Bothell, Washington 98011
Phone: (206) 352-9730

Client Services Executive
Seattle Area Plumbing & Pipefitting Industry Health Trust
c/o Zenith American Solutions
11724 NE 195th Street, Suite 300
Bothell, Washington 98011
Phone: (206) 352-9730

Duties Of The Trust

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

a copy of the revised Notice within 60 days of the change. You have the right to request a written copy of the Notice at any time.

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

Request, Use and Disclosure of PHI by Trustees

The Trustees are permitted to receive PHI from the Trust, and to use and/or disclose PHI only to the extent necessary to perform the following administrative functions:

1. To make or obtain payment for care received by Covered Persons.
2. To facilitate treatment that involves the provision, coordination or management of health care or related services.
3. To conduct health care operations to facilitate the administration of the benefit plan maintained by the Trust and as necessary to provide coverage and services to Covered Persons.
4. In connection with judicial or administrative proceedings in response to an order of a court or administrative tribunal as expressly authorized by such order or in response to a subpoena, discovery request or other lawful process.
5. If legally required to do so by any federal, state or local law, or as permitted or required by law for law enforcement purposes.
6. To review enrollment and eligibility information or claim appeals, solicit bids for services, modify, amend or terminate the plan, or perform other plan administrative functions. The Board of Trustees may also receive summary health information for purposes of obtaining premium bids or setting or evaluating rates, or for evaluating, modifying or terminating benefits.
7. For authorized activities by health oversight agencies, including audits, civil, administrative or criminal investigations, licensure or disciplinary action.
8. To prevent or lessen a serious and imminent threat to a Covered Person’s health or safety, or the health and safety of the public, provided such disclosure is consistent with applicable law and ethical standards of conduct.
9. For specified government functions as described in 45 CFR Part 164.
10. To the extent necessary to comply with laws related to workers compensation or similar programs.

Trustee Certification

The Trust will only disclose PHI to a Trustee upon receipt of a certification that this Amendment has been adopted and the Board of Trustees agrees to the following:

1. Prohibition on Unauthorized Use or Disclosure of PHI. The Trustees will not use or disclose any PHI received from the Trust, except as permitted in this Amendment or required by law.

2. Subcontractors and Agents. The Trustees will ensure that any of their subcontractors or agents to whom they may provide PHI that was received from the Trust agree to written contractual provisions that impose at least the same obligations to protect PHI as are imposed on the Trustees.

3. Permitted Purposes. The Trustees will not use or disclose PHI for employment-related actions and decisions or in connection with any employee benefit plan other than the plans maintained by the Trust.

4. Reporting. The Trustees will report to the Trust any known impermissible or improper use or disclosure of PHI not authorized by this Amendment of which they become aware.

5. Disclosure to Government Agencies. The Trustees will make their internal practices, books, and records relating to the use and disclosure of PHI received from the Trust available to the Department of Health and Human Services ("DHHS") or its designee for the purpose of determining the Trust's compliance with HIPAA.

6. Return or Destruction of Health Information. When PHI is no longer needed for the purpose for which disclosure was made, the Trustees must, if feasible, return to the Trust or destroy all PHI that the Trustees received from or on behalf of the Trust. This includes all copies in any form, including any compilations derived from the PHI. If return or destruction is not feasible, the Trustees agree to restrict and limit further uses and disclosures to the purposes that make the return or destruction infeasible.

Minimum Necessary Requests

The Trustees will use best efforts to request only the minimum necessary type and amount of PHI to carry out the functions for which the information is requested.

Trustee Certification As To Covered Persons' Rights

The Board of Trustees also certifies that it will observe the following with respect to Covered Persons and their PHI:

1. The Trustees will make PHI available to the Trust to permit Covered Persons to inspect and copy their PHI contained in a designated record set in accordance with 45 CFR § 164.524.

2. The Trustees will make a Covered Person's PHI available to the Trust to permit Covered Persons to amend or correct PHI contained in a designated record set that is inaccurate or incomplete and the Trustees will incorporate such amendments in accordance with 45 CFR § 164.526.

3. The Trustees will make a Covered Person's PHI available to permit the Trust to provide an accounting of disclosures in accordance with 45 CFR § 164.528.

Adequate Separation

The Trustees represent that adequate separation exists between the Trust and the Trustees so that PHI will be used only for plan administration. Each Trustee will certify as to the employees, or other persons under his or her control, that will have access to PHI.

Effective Mechanism for Resolving Issues of Noncompliance

The Trustees certify that anyone who suspects an improper use or disclosure of PHI may report that occurrence to the plan Privacy Official.

Trust Office:

Zenith American Solutions
11724 NE 195th Street, Suite 300
Bothell, Washington 98011
Direct: (206) 352-9728
Toll Free: (888) 406-3246

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