Washington Teamsters Welfare Trust

Summary Plan Description
Medical Plan A

March 2013

WASHINGTON TEAMSTERS WELFARE TRUST
SUMMARY OF MATERIAL MODIFICATIONS

AUGUST 2018

Dear Plan Participant:

This is a "summary of material modifications" (SMM) to the Washington Teamsters Welfare Trust's Summary Plan Descriptions (plan books) for Medical Plans A, B, C, Z and JC-28XL. The information in this SMM updates and/or replaces the applicable sections of each book until new books become available. Please read it carefully and keep it with your benefit plan booklet(s). If you have questions about the information presented here, feel free to contact the Trust Administrative Office at 800-458-3053.

The following change is effective November 1, 2018:

DIALYSIS TREATMENT - OUTPATIENT MEDICAL PLANS A, B, C, Z & JC-28XL

This benefit applies to all eligible employees and dependents requiring outpatient dialysis treatment. If you or your eligible dependents require dialysis due to end-stage renal disease ("ESRD") you may be eligible for Medicare coverage by nature of the diagnosis. You are not obligated by the Plan to apply for or enroll in Medicare Part A and/or Part B if you have ESRD. However, benefits will be based on an assumption that you enroll in Medicare when eligible to do so. Enrolling in Medicare when eligible may offer some protection from balance billing by the provider of outpatient dialysis services. Failure to enroll in Medicare when eligible may result in balance billing from the provider. Balance billing means the difference between the billed amount and the amount allowed by the Plan and/or Medicare.

Effective November 1, 2018, benefits for outpatient kidney dialysis are now provided by the Plan as follows:

- **For the first three months of dialysis treatment** - Benefits are provided for dialysis according to the Medical Plan provisions in the Summary Plan Description Booklet.
- **For months 4 through 34 of dialysis treatment** - Benefits for dialysis are provided at 150% of the current Medicare allowed amount. The Plan's deductible, copays and coinsurance are waived for dialysis services.
- **For months 35 and beyond of dialysis treatment** - The Plan pays secondary to Medicare and coordinates benefits up to 100% of the then current Medicare allowed amount for outpatient dialysis treatment.

Notwithstanding the above, the Plan may, at its sole discretion, agree to a contractual arrangement for payment with a provider of dialysis services. The contract may allow for a different payment for dialysis services than listed above or in the SPD, but in no circumstances will a contractual arrangement allow for a payment less than the payments listed above.

In order to ensure the correct coordination of claim payments between the Plan and Medicare, you are required to provide the Administrative Office with the effective date of Medicare coverage.

The following change is effective February 6, 2018:

TREATMENT OF GENDER DYSPHORIA ALL MEDICAL PLANS (INCLUDING KAISER)

The Trust Medical plan exclusion #11 regarding "sex transformations or sexual dysfunction treatment" has been amended effective February 6, 2018 to state:

"Gender reassignment or sexual dysfunction treatment except for, conditions of organic origin and treatment for Gender Dysphoria, where the cause is documented by the attending physician."

WASHINGTON TEAMSTERS WELFARE TRUST
SUMMARY OF MATERIAL MODIFICATIONS

JUNE 2017

This is a "summary of material modifications" (SMM) to the Washington Teamsters Welfare Trust's Summary Plan Descriptions (plan books) for Medical Plans A, B, C, Z, and JC-28XL. The information in this SMM updates and/or replaces the applicable sections of each book until new books become available. Please read it carefully and keep it with your benefit plan booklet(s). If you have questions about the information presented here, feel free to contact the Trust Administrative Office at 800-458-3053.

NATUROPATHIC TREATMENT- MEDICAL PLANS A, B, C, Z & JC-28XL

EFFECTIVE APRIL 1, 2017

Services by a naturopath in the PPO network are no longer subject to the two visits per person per calendar year limitation. Naturopathic services are not covered if you see a non-PPO provider. Naturopathic supplies are not covered.

NOTICE OF PRIVACY PRACTICES - NOTICE OF AVAILABILITY

The Trust is required by law to take reasonable steps to protect the privacy and confidentiality of the health information of all participants. The Trust maintains a Notice of Privacy Practices explaining the possible uses and disclosures of protected health information. It also outlines participants' rights in regards to their health information and the steps the Trust has taken to protect health information and prevent unnecessary disclosures. A copy of the Notice is available upon request by contacting the Trust Administrative Office.

WASHINGTON TEAMSTERS WELFARE TRUST **OCTOBER 2016**
SUMMARY OF MATERIAL MODIFICATIONS

Dear Plan Participant:

This is a "summary of material modifications" (SMM) to the Washington Teamsters Welfare Trust's Summary Plan Descriptions (plan books) for Medical Plans A, B, C, Z, and JC28XL. The information in this SMM updates and/or replaces the applicable sections of each book until new books become available. Please read it carefully and keep it with your benefit plan booklet(s).

If you have questions about the information presented here, feel free to contact the Trust Administrative Office at 800-458-3053.

IMPORTANT CHANGE: NEW PPO MEDICAL NETWORK AND WELLNESS PROGRAM

Starting October 1, 2016 the Washington Teamsters Welfare Trust's medical PPO provider network will change from Cigna to Premera Blue Cross (Premera). The Trust's wellness program administrator will change from CareAllies to Vivacity, a Premera partner.

WHAT IS CHANGING?

The Premera BlueCard PPO network, one of the largest provider networks, will replace Cigna and its affiliated networks as the provider network for all medical services, including physician and hospital services, behavioral health and chemical dependency services, medical supplies and equipment, and wellness programs. Premera will also begin providing pre-certification and pre-authorization for inpatient stays and certain outpatient procedures, along with case management, 24-hour NurseLine services, and other health care management programs previously provided through Cigna.

You are not required to use the network, but use of network providers will result in significantly lower out-of-pocket expenses. To check if your provider is part of the Premera BlueCard PPO network, go to www.wateamsters.com and click on "Find a Provider".

WHAT WILL REMAIN THE SAME?

This change will not affect your Plan's medical benefits, deductible, copays, coinsurance, or out-of-pocket maximum, etc. It will also not affect your prescription drug benefits or pharmacy network. If you also receive dental or vision benefits through the Trust, these benefits and provider networks are remaining unchanged. In addition, Northwest Administrators will continue to process medical claims and provide customer service.

TRANSITION OF CARE

If you are undergoing covered medical treatment(s) with a provider who is not contracted with Premera as a Preferred Provider (or in-network provider), you may have questions about your new

medical coverage. Transition of Care involves working with Premera to receive the highest level of benefits available to you as you change over to your new health plan.

You may be eligible for this provision if you are being treated for any of the following:

- In your second or third trimester of pregnancy.
- Currently enrolled in a hospice program.
- Receiving treatment or care for chemotherapy, radiation therapy, new anticoagulation therapy, follow-up of reconstructive surgery or a medication regimen requiring a rapid increase in dose.
- Receiving treatment or care for recent major surgery.
- Receiving treatment or care for mental health or substance abuse.

If you qualify, Premera will approve your continued care for a limited time with your current, out-of-network healthcare provider.

To apply ask your current healthcare provider to submit a request for Transition of Care. Your healthcare provider must submit a request by phone or in writing to:

Phone: 800-344-2227 and press 3

Fax: 800-866-4198 or 800-843-1114

Premera's care management team will review the information submitted by your healthcare provider within 10 business days.

If approved the request, continued care with your current healthcare provider will be paid at the in-network benefit level described in your benefits booklet. You may still need to pay for charges that exceed the maximum allowable amount. Your Transition of Care benefits may also be limited to a defined period of time based on the treatment plan.

Although not all requests will meet the requirements for approval, Premera will work closely with you and your healthcare provider to help find the best course of treatment.

WASHINGTON TEAMSTERS WELFARE TRUST — NOVEMBER 2015
SUMMARY OF MATERIAL MODIFICATIONS

Dear Plan Participant:

This is a "summary of material modifications" (SMM) to the Washington Teamsters Welfare Trust's Summary Plan Descriptions (plan books) for Medical Plans A, B, C, and Z. The information in this SMM updates and/or replaces the applicable sections of each book until new books become available. Please read it carefully and keep it with your benefit plan booklet(s). If you have questions about the information presented here, feel free to contact the Trust Administrative Office at 800-458-3053.

The following changes are all effective January 1, 2016:

ANNUAL OUT-OF-POCKET MAXIMUMS – MEDICAL PLANS A, B, C AND Z

For 2016 the Affordable Care Act requires that medical plans have an in-network annual out-of-pocket maximum of $6,850 per person (up to $13,700 per family) for the combined amount of coinsurance, deductible, emergency room (ER) copays, and office visit copays you have to pay during a calendar year. The Trust has chosen to break the maximum into two separate maximums:

	2016	2015
Medical		
Individual	$5,000 per individual	$5,000 per individual
Family	$10,000 per family	$10,000 per family
Prescription		
Individual	$1,850 per individual	$1,600 per individual
Family	$3,700 per family	$3,200 per family

Each plan also has a separate annual maximum, which applies to the combined amount of in-network and out-of-network coinsurance you have to pay during a calendar year. The plans will continue to have those maximums on coinsurance in addition to the above maximums.

MENTAL HEALTH AND CHEMICAL DEPENDENCY BENEFITS - MEDICAL PLANS A, B, C, AND Z

Mental health and chemical dependency services will be subject to the same copay, coinsurance, annual deductible, and inpatient pre-certification requirements as other medical services except that the outpatient office visit copays will be as follows: $10.00 copay for all sessions.

ELIGIBLE DEPENDENT(S) – ALL PLANS

If you are enrolling a new dependent or changing the status of a currently enrolled dependent, you must submit documentation to verify the dependent(s) eligibility. Such documentation may include, but is not limited to:

Spouse	Marriage Certificate
Child	Birth Certificate/Proof of Adoption
Grandchild	Birth certificates of your child and your grandchild and a copy of the first page of your most recent IRS Form 1040 listing your grandchild as a dependent (you may black out Social Security numbers and income information)
Ward	Court document showing your appointment as legal guardian (custody agreements are not acceptable)

The following changes are all effective July 1, 2014:

PRESCRIPTION DRUG PROGRAM - MEDICAL PLANS A, B, C, AND JC28XL

The following provisions are being added to the prescription drug program under Medical Plans A, B, C and JC28XL on **new prescriptions only**. These provisions are currently in effect under Medical Plan Z.

Quantity Limits
For certain medications, the Plans have established a maximum quantity of medication allowed per fill or re-fill. This means there is a limit on the amount of medication that will be covered during a period of time such as during the 34-day supply limit on retail or 100-day supply limit on mail order. The Plans' Pharmacy Benefit Manager (PBM) MedImpact Healthcare Systems, Inc. uses information from the U.S. Food and Drug Administration (FDA) and from scientific research to establish these maximum quantities.

When you or your enrolled dependent takes a prescription to a participating pharmacy, and you present your ID card, the pharmacy will let you know if a quantity limit applies to your prescribed medication.

Any quantity over the established maximum is not covered, except if the amount is determined by MedImpact to be medically necessary. If you believe that the quantity limit should not apply in your case, you may have the physician who prescribed the medication contact MedImpact for a Prior Authorization (see section on Prior Authorization below). Your pharmacy may also be able to submit a Prior Authorization form to MedImpact. MedImpact may require medical information explaining the necessity for the larger quantity. If a waiver of the quantity limit is allowed by MedImpact after review with your physician, additional quantities will be allowed.

Step Therapy
Certain prescription medications are subject to step therapy protocols established and administered by MedImpact HealthCare Systems, Inc.

What is Step Therapy?
Step Therapy is designed to help you get the prescription drugs you need, with safety, cost and—most importantly—your health in mind.

In Step Therapy, certain covered drugs for specific conditions are organized in a series of "steps".

- Generally, if you are prescribed a drug for a condition covered by Step Therapy, a lower cost, clinically appropriate medication (often a generic drug) may be recommended to replace the prescribed drug. This first "step" of therapy will typically result in the anticipated clinical result, at lower cost to you and the Plan. These generics—rigorously tested and approved by the U.S. Food & Drug Administration (FDA)—allow you to begin or continue treatment with safe, effective drugs that are also affordable: Your copayment is usually the lowest with a first-step drug.

- If, after an adequate trial of the lower step agents, the lower step agents (generic or brand) have not been effective in treating your medical condition, you will progress to the next "step" medications. These are often more expensive brand name drugs. You then will consult your doctor to write you a prescription for the higher step agent based on the list of Step Therapy drugs covered by the formulary.

What should I do when my doctor is writing me a prescription?
Tell your doctor that your Plan has a Step Therapy program, and confirm whether the prescription your doctor is writing is covered by the Step Therapy program. If it is covered, ask the doctor to either write the prescription for the appropriate first step covered medication, or have them request Prior Authorization for higher level (later step) medication (see Prior Authorization instructions below).

How do I know what "first-step" drug my doctor should prescribe?
You can call MedImpact using the number on the back of your prescription card. A representative can give you some examples of possible prescription drugs for you to discuss with your doctor.

How are the drugs chosen for Step Therapy?
Step Therapy is developed under the guidance and direction of independent, licensed doctors, pharmacists and other medical experts. Together with MedImpact they review the most current research on thousands of drugs tested and approved by the Food and Drug Administration for safety and effectiveness. Then they recommend appropriate prescription drugs for the Step Therapy program, and MedImpact approves the drugs that will be covered.

What conditions are treated under Step Therapy?
A complete list of all the conditions treated by Step Therapy and a list of all the medications included in the program may be obtained by contacting MedImpact at 800-788-2949 or by going to the MedImpact website at medimpact.com.

How does the step-therapy program work when I go to the pharmacy to fill a prescription?
When you submit a prescription that isn't for a first-step drug, your pharmacist will tell you there's a note on the computer system indicating that your plan uses Step Therapy. This simply means that if you'd rather not pay full price for the drug prescribed, your doctor needs to write you a new prescription for a first-step drug.

To receive a first-step drug:

- *Ask your pharmacist to call your doctor and request a new prescription. or*
- *Contact your doctor to get a new prescription.*

Only your doctor can change your current prescription to a first-step drug.

I need a prescription filled immediately. What can I do?
At the pharmacy, you may be informed that your drug isn't covered if you've just started taking a prescription drug regularly or if you're a new member. If this occurs and you need your medication right away, you can:

- Talk with your pharmacist about filling a small supply of your prescription. You may have to pay full price for this drug.
- Then, ask your doctor to write you a new prescription for an approved first-step drug, so that your medication will be covered.

Remember: Only your doctor can approve and change your prescription to a first-step drug.

I've already tried the first-step drugs on the list. What happens now?
With Step Therapy, more expensive brand-name drugs are usually covered in a later step in the program if:

- You've tried the "first-step," generic drugs covered in the program, and it was not effective in treating your medical condition.
- You are unable to take the "first-step" drug due to intolerance.
- Your doctor decides that you medically need a higher step drug, and can medically substantiate why your condition requires this agent.

If any one of these applies to you, your doctor can submit a "Prior Authorization" for you to take a second-step prescription drug. Once the Prior Authorization is approved, you pay the appropriate copayment for this formulary-approved drug. If the Prior Authorization is not approved, and you want to take this higher step agent, you will need to pay the full price for the drug. You will still have access to the first-step agent at a lower copayment.

Prior Authorization
Your prescription drug program covers most medications when prescribed by your physician, but not all are automatically covered. Your prescription drug program includes a formulary or a preferred drug list which contains medications that are safe and effective therapies. The Prior Authorization process is in place to allow your physician to request coverage for the use of certain medications in situations where other medications may not be appropriate for you.

Your prescription drug program determines when Prior Authorization is required. If you go to your pharmacy and the pharmacist cannot fill your prescription because he/she received a computer message saying "Prior Authorization Required," then Prior Authorization must be requested to confirm appropriateness. Prior Authorization may also be available in other situations such as when you require a larger quantity of medication than your benefit allows each month. Prior Authorization is generally not available for medications used for cosmetic purposes and are excluded from your prescription drug program coverage. To request Prior Authorization for a particular drug have the physician prescribing the medication contact MedImpact at 800-788-2949.

To find out in advance if any of these restrictions apply to your medications, contact Customer Service (number on the back of your ID card) or check the MedImpact HealthCare Systems, Inc. website at www.MedImpact.com. If you are a first time visitor to the site, please take a moment to register (have your member ID available).

MENTAL HEALTH AND CHEMICAL DEPENDENCY BENEFITS - MEDICAL PLANS A, B, C, Z, & JC28XL

The Mental Health Parity and Addiction Equity Act (MHPAEA) requires financial requirements (such as co-pays, deductibles) and treatment limitations (such as number of visits or days of coverage) applicable to mental health and chemical dependency (MHCD) treatment to be no more restrictive than the predominant requirements or limitations applied to substantially all medical benefits. The Trust is required to be in compliance with MHPAEA by July 1, 2014.

Changes to the financial requirements and some limitations were made previously. In order to complete compliance by July 1, 2014, the benefits for MHCD services will be moved from the Mental Health and Chemical Dependency Program section of the Summary Plan Description to the Medical Plan Provisions section. As a result, benefits for MHCD services will be subject to the same financial requirements and limitations that apply to substantially all medical benefits. Note: however, that change will not affect the lower outpatient copays that have been in effect for MHCD services under plans A, B, C, and Z.

DIETARY AND NUTRITIONAL COUNSELING - MEDICAL PLANS A, B, C, AND Z

In addition to dietary and nutritional counseling provided in a hospital setting the plans will cover dietary and nutritional counseling provided by a Registered Dietician or comparably credentialed professional (e.g. Commission on Dietetic Registration) outside of a hospital setting when ordered by the participant's treating physician as part of a comprehensive treatment plan for patients with a known history of diabetes, renal failure, hepatic insufficiency, genetic metabolic disorder, hyperlipidemia, or other known risk factors for cardiovascular and diet-related chronic disease. Dietary and nutritional counseling will be covered under the preventive care benefit provisions of the plans and limited to four visits per person per calendar year. Nutritional counseling for morbid obesity is only covered when provided as part of a Trust approved weight management program.

JAW TREATMENT (INCLUDING TMJ AND MPD) - MEDICAL PLANS A, B, C, Z, AND JC28XL

The lifetime maximum benefit of $6,000 per person for jaw disorders (including temporomandibular jaw disorder (TMJ) and myofascial pain disorder (MPD) is eliminated.

CLINICAL TRIALS - MEDICAL PLANS A, B, C, Z, AND JC28XL

The plans will not exclude routine patient costs for items and services furnished in connection with an approved clinical trial that would otherwise be covered by the Plan. The plans will, however, not cover:

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

An approved clinical trial is a phase I, II, III, or IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life threatening disease or condition.

DEPENDENT COVERAGE – ALL PLANS

Participants may elect to not cover their spouse if they are legally separated and provide documentation of this fact to the Trust Administrative Office. Participants may otherwise elect to not cover their spouse only if their spouse consents to not being covered. Participants may elect to later reenroll their spouse or their spouse may revoke consent and again be enrolled.

Participants may elect to not cover a child age 18 or older, however, under federal law such child has a right to be enrolled in coverage under the Participants' plan through the age of 25, therefore, in order to not cover a child age 18 or older Participants must first provide the Trust Administrative Office with the child's address in order for the child to be notified coverage is being terminated. The child will be given the right to re-enroll. Participants may elect to later re-enroll a child provided the child is under age 26 at the time.

Termination of coverage or coverage upon re-enrollment of a spouse or child will be effective the first of the month following receipt of written notification by the Trust.

FILING OUT-OF-NETWORK (NON-PPO) CLAIMS – MEDICAL PLANS A, B, C, Z, AND JC28XL

If you receive healthcare services from an out-of-network provider who will not file a claim on your behalf, obtain a medical claim form from the Trust Administrative Office. The claim form may also be obtained on-line at www.nwadmin.com if you are registered on the website. Follow the instructions on the claim form and mail the form with required documentation to Cigna Healthcare – PO Box 188004 – Chattanooga TN 37422.

Introduction

This booklet describes Washington Teamsters Welfare Trust benefits and provisions for employees of employers who negotiate a collective bargaining agreement requiring Plan contributions, and who participate in Medical Plan A as of March 1, 2013, or later.

This Plan is designed to assist you and your family in staying well and to help you pay for the cost of treatment when needed. The Plan has several features to increase your purchasing power while helping the Trust manage healthcare quality and cost, including:

- A preferred network of hospitals and physicians, with incentives to use them
- *Recommended* and *Regular* network retail pharmacies plus a mail order prescription option
- Pre-certification of hospital admissions to determine medical necessity
- Care management programs
- Hospital utilization review
- STAND STRONG wellness tools and resources to help you and your family improve your health
- Mental Health and Chemical Dependency Benefits program.

We encourage you to become familiar with your benefits and the valuable protection they offer. If you have questions about your coverage or eligibility, please contact the Trust Administrative Office.

Unincorporated owners and partners are not eligible to participate in the Plan.

IMPORTANT NOTICE

Payment of benefits as specified in this booklet depends on your employer making contributions for you to the Washington Teamsters Welfare Trust sufficient to maintain these benefits. The amount of necessary employer contributions may increase from time to time. If your employer doesn't pay the required contributions, your coverage may be transferred to a lower-cost plan. If you are ineligible for Plan coverage, the fact that contributions were made on your behalf will not entitle you to benefits.

Only the Trust Administrative Office, Northwest Administrators, Inc., 2323 Eastlake Avenue East, Seattle, Washington represents the Trustees in administering the Plan and giving information about the amount of benefits, eligibility and other Plan provisions. No union employee, union officer, business agent, employer or employer representative or representative of any other organization except the Trust Administrative Office is authorized to give Plan information, interpret the Plan or commit the Trustees on any matter. In all cases, the terms of the Plan govern.

While no change in the Plan is anticipated, the Trustees reserve the right to terminate, amend or eliminate benefits as deemed necessary. The Trustees have no obligation to furnish benefits beyond those that can be supported by the Trust fund.

Si necesita ayuda para entender este panfleto, comuniquese con la oficina administrativa al 800-458-3053.

Important Contacts

For Questions About	Contact
Eligibility Medical benefits and claims Vision benefits and claims Time Loss benefits and claims Life and Accidental Death and Dismemberment Insurance benefits and claims COBRA ID/Information cards	Trust Administrative Office Northwest Administrators, Inc. 800-458-3053 **www.nwadmin.com**
Prescription drug benefits	Pharmacy Helpdesk MedImpact 800-788-2949 **www.medimpact.com**
Mail order prescriptions Specialty prescription drugs	Union Center Pharmacy 800-441-9174 **www.unioncenterpharmacy.com**
Weight management programs	Sound Health Connects 866-779-4730 **www.soundhealthconnects.com**
Assistance Program Mental health benefits and claims Chemical dependency benefits and claims	Cigna 855-402-0272 **www.cignasharedadministration.com**
Health symptoms, drug interactions, or if you're not sure whether to see a doctor, go to the ER or treat at home	Nurse Line 855-402-0272
Chronic Condition Support Program Personal Health Assessment (PHA) Health coaching Tobacco cessation program	StayWell HelpLine 888-388-8259 **www.wateamsters.online.staywell.com**
Hospital inpatient precertification	Cigna 855-402-0272
Finding a PPO network doctor, hospital or other healthcare provider	Cigna 855-402-0272 **www.cignasharedadministration.com**
Dental benefits and claims	Washington Dental Service (WDS) 800-554-1907 **www.deltadentalwa.com**

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General Information

Trust Administrative Office

Washington Teamsters Welfare Trust
Northwest Administrators, Inc.
2323 Eastlake Avenue E.
Seattle, WA 98102

Telephone: **800-458-3053**
Online: **www.nwadmin.com**

Enrollment

Participant Data Form

To receive benefits under this Plan and avoid delays in claim administration, you must complete and submit a Participant Data Form to the Trust Administrative Office when you first become eligible. Participant Data Forms can be obtained from the Trust Administrative Office or your local union.

Updating Your Personal Data

Accurate and efficient claim processing depends, in part, on the Trust Administrative Office having current data for you and your covered dependents. Changes in address, marital status, number of dependents and information about other insurance are critical. As a result, the Trust Administrative Office requires that enrollment information be verified annually. **It is your or your dependent's responsibility to notify the Trust Administrative Office within 60 days of a qualifying event that causes coverage to end for a covered dependent.** Divorce or a dependent child losing eligibility due to age are both examples of qualifying events that end coverage under the Plan. You may update your information by submitting a revised Participant Data Form or you may update your information online at **www.nwadmin.com**.

Your employer is responsible for notifying the Trust Administrative Office only when an employee's coverage ends.

ID/Information Card

Your ID/Information card contains important information for you and your healthcare providers, such as who can answer questions and where to send claims. It also lets providers know that you're a Trust participant.

Carry your ID card at all times and present it every time you seek medical care or prescription drugs. PPO providers are required to accept PPO discounts only if you present your card at the time of service.

Guide to Claim Filing

Medical Claims

General claim filing information for Preferred and Non-Preferred providers is summarized below. See page 97 for detailed claim filing procedure.

Preferred (PPO) Providers (In-network)

See page 32 for information on the Preferred Provider Organization (PPO).

When using a PPO provider:

- Be sure to present your ID card when receiving treatment. This card identifies you as a Washington Teamsters Welfare Trust participant and tells the provider where to send the bill for payment.
- You do not need to fill out a claim form if you use a preferred provider. The provider or hospital will submit the bill for you.
- If another benefit plan is primary, the Trust Administrative Office may request an Explanation of Benefits (EOB) from you showing what the other plan paid before processing your claim.
- The Trust Administrative Office will determine the amount of benefits and reimburse the provider directly, in accordance with your Plan provisions.
- You will receive an EOB specifying what was paid under this Plan.
- If you receive a bill from the provider, remember to verify with the physician or hospital that they have billed the Trust.

Non-Preferred (non-PPO) Providers (Out-of-network)

If you receive services from a provider that is not PPO, follow these steps:

- Obtain itemized hospital and physician bills listing all services and treatments you received, confirm that the participant's correct Social Security number or subscriber ID number is on all bills, and send them to the Trust Administrative Office.
- If another benefit plan is primary, submit an EOB from the other plan with your claim.
- Claims must be submitted for payment within 90 days after the expense is incurred. (Not submitting the claim within 90 days will not necessarily invalidate or reduce your claim if you can show it was done as soon as reasonably possible.)
- The Trust Administrative Office will determine the amount of benefits and reimburse you or your provider, in accordance with your Plan provisions.
- You will receive an EOB specifying what was paid under the Plan.

Prescription Drugs

See page 70 for information on filing prescription drug benefit claims.

Time Loss Benefits

If you are unable to work due to an accident or sickness, follow these steps:

- Obtain a claim form from the Trust Administrative Office or your local union.
- Complete Part I, have your employer complete Part II and have your physician complete Part III of the form.
- Submit the completed claim form to the address at the top of the form.

Life and AD&D Insurance

Claims must be submitted within one year of the date of death or accident. Claim forms are available from the Trust Administrative Office. Submit the completed claim form to the address at the top of the form.

STAND STRONG

STAND STRONG is a series of wellness tools and resources designed to help you and your family maintain your good health, manage chronic conditions, get access to healthcare information resources and generally live a healthier, stronger life. For more information, including a complete description of your Trust-sponsored wellness tools, see the STAND STRONG section beginning on page 39.

If You Have Questions

For information on who can answer claim inquiries and questions about the benefits described in this booklet, refer to Important Contacts for phone numbers and other contact information on page 3 of this booklet.

If you would like to request an ID/Information card or if you lose your card, contact the Trust Administrative Office.

Claim Reviews and Appeals

For information about the claim review and appeal process, see the Claim Review and Appeal Procedures on page 96.

Eligibility and Coverage Effective Dates

Who's Eligible

To become eligible for contributions to be made to the Trust on your behalf, you must first meet the requirements in your employer's collective bargaining agreement, consistent with Trust guidelines. You also must be an active employee with the minimum number of compensable hours or hours worked (usually 80) during a month for any one employer who makes Plan contributions.

Coverage Effective Dates

Lag Month Rule

To help ensure timely eligibility information is provided to your healthcare providers, the Trust uses a lag month system — the Trust advances eligibility for one month while you continue working enough hours each month for a contribution to be made on your behalf. For example, if you work enough hours in January and your employer makes a contribution in February (the lag month), your coverage is effective in March (rather than February). This continues until you have a break in contributions (see Breaks in Contributions below).

Any month the Trust waives contributions for you due to a disability will be considered a month in which contributions were made for the purpose of determining if you had a break in contributions.

When Coverage Begins

Coverage and benefits for new hires begin after one month's contribution is made on your behalf under the lag month system. For example, if you are a new hire who has satisfied the requirements of your collective bargaining agreement, you work enough hours in June and your employer makes a contribution in July (the lag month), your coverage begins August 1. *Please note, you* ***may*** *need at least two consecutive months of contributions to avoid a loss of the first month of coverage. See Breaks in Contributions below for more information.*

Breaks in Contributions

The lag month eligibility system continues while you continue working enough hours each consecutive month for a contribution to be made on your behalf. For example, if you work enough hours in July, and your employer makes a contribution in August (the lag month), coverage and benefits will be provided in September.

When you have a break in contributions due to layoffs, a reduction in your work hours, termination of employment, disability, or for any reason *other than* retirement or resignation, or your employer's cessation of participation in the plan, your coverage will continue until the end of the *second* month following the month in which you last had the minimum number of hours requiring contributions as stated in your collective bargaining agreement. For example, if you are laid off in April after working enough hours to receive a contribution, and the final contribution to the Plan is made in May, your coverage will end on June 30. If you are laid off in April without enough hours to receive a contribution, and the final contribution from your employer is made in April (for your March hours), your coverage will end on May 31.

When you retire or resign, or if your employer ceases to participate in the Plan, your coverage will stop at the end of the *first* month following the month in which you last had the minimum

number of hours requiring contributions as stated in your collective bargaining agreement. For example, if you retire in April after working enough hours to receive a contribution, and the final contribution to the Plan is made in May, your coverage will end on May 31. If you retire in April without enough hours, and the final contribution from your employer is made in April (for your March hours), your coverage will end on April 30.

If you return to work after 1) you had a break in contributions, or 2) you resigned or retired, or 3) your employer ceased making contributions, and contributions are again made on your behalf, coverage will resume under the lag month eligibility system the same as for a new hire. Trust eligibility for new hires begins after one month's contribution is made on your behalf under the lag month system. For example, if contributions are first made on your behalf in October based on your employment in September, your coverage begins November 1.

Note: Some collective bargaining agreements may have a waiting period before contributions become payable to the Trust. An agreement may also require a minimum number of hours be worked in order for contributions to be made. Refer to your collective bargaining agreement or contact your local union or employer about any waiting periods or hour requirements.

If you are a new hire or an employee reestablishing eligibility, you must have at least two consecutive months of employer contributions in order to preserve lag month coverage for the first contribution if you subsequently lose coverage due to *resignation, retirement, or if your employer ceases to participate in the Plan.* For example, if you have only one contribution on your behalf and you resign or retire, you will not qualify for coverage. However, if you have only one contribution on your behalf and your employment is terminated, you are laid off, disabled, or do not work enough hours, you will receive one month of coverage.

When Coverage Ends

Coverage for you and your dependents will end if this Plan terminates or if your employer ceases to make required contributions or stops participating in the Plan. A dependent's coverage also will end when he or she no longer meets the Plan's eligibility requirements (for instance, when your child turns age 26).

When you have a break in contributions, as explained in the preceding section, coverage stops at the end of the first or second month following the month in which you last have the minimum number of hours requiring contributions as stated in the collective bargaining agreement. Whether coverage stops at the end of the first month or second month depends on the reason for the break in contributions (see previous section).

Any employee in full-time military service will not be covered except as described in Military Service under USERRA on page 17 and COBRA Self-Pay Option on page 20.

Eligible Dependents

Eligible dependents are:

- Your spouse
- Your domestic partner ***if*** your local union and your employer negotiated domestic partner benefits for your group (see Domestic Partner Benefits)
- Your children under age 26 who are your:
    - Natural children
    - Adopted children
    - Step children
    - Children placed with you for adoption

  These children do not have to depend on you for support, do not have to attend school full time, can be married, and can have access to other health coverage through their own employment.
- Your eligible dependent children also include your unmarried children up to age 19 who live with you, are dependent on you for support, and are:
    - Children for whom you are the court-appointed guardian
    - Grandchildren
    - Children of your domestic partner ***if*** your local union and employer negotiated domestic partner benefits (see Domestic Partner Benefits below).

  These dependent children who would otherwise qualify as eligible dependents but are 19 years or older will be eligible until age 26 (through 25th year) if they are unmarried, depend on you for support/maintenance, and are full-time students in an accredited educational institution. School vacation and total disability periods that interrupt but do not terminate what would have been a continuous course of study are considered part of full-time attendance. A dependent who takes a Physician certified medically necessary leave of absence from a postsecondary school (college, university, or trade school) due to a serious illness or injury, which causes the Dependent to lose student status and the student was an eligible dependent immediately before the first day of the medical leave, will continue to have coverage through the Applicable Period. Applicable Period is defined as the earlier of one year from the first day of the medical leave of absence or the date on which Dependent coverage under the Plan would otherwise terminate. Proof of a medically necessary leave of absence must be certified in writing to the Fund by the student's treating physician. If the student recovers from the serious illness or injury, he or she must notify the Fund immediately and begin classes again at (or enroll again in) a postsecondary school if within the Applicable Period in order to resume Dependent student status under the Plan. If the medical leave of absence exceeds the Applicable Period, a Dependent cannot resume student status but will be eligible for COBRA coverage. COBRA coverage will run consecutive with any student disability coverage.

Except as noted below, all children who qualify as eligible dependents are eligible for medical and prescription benefits from the later of the effective date of your coverage or date the child meets the requirements above except for children of domestic partners, who are covered prospectively from the date they are enrolled. Children who lost coverage prior to July 1, 2011 and are eligible to be enrolled under the Patient Protection and Affordable Care Act on July 1,

2011 will be covered as of July 1, 2011 if they are enrolled no later than 31 days after that date, otherwise they will be covered prospectively from the date they are re-enrolled.

For dependent life benefits, unmarried children are covered only until age 19.

An unmarried eligible dependent child who is physically or mentally incapable of self-support is eligible under the Plan while incapacitated, if your own coverage is in effect. To cover a child under this provision, file a Proof of Incapacity Form with the Trust Administrative Office within 31 days after coverage would otherwise end or within 31 days of the date you become covered by the Plan if a child is 19 or older at that time. Additional proof will be required from time to time; unless you provide additional proof as requested, the child's coverage will end.

In accordance with federal law, the Plan also provides medical coverage (including dental and vision coverage if these coverages are being provided through a Trust plan) 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 and your own healthcare coverage is in effect. Contact the Trust Administrative Office for details.

No dependent coverage is available for Time Loss benefits, Long-Term disability benefits, or AD&D insurance, which cover only you, the eligible active employee.

Domestic Partner Benefits

If your local union and employer have negotiated to add domestic partner benefits, you may enroll your same or opposite sex domestic partner for benefits if:

- You (the covered participant) and your domestic partner have registered as domestic partners or entered into a civil union in the state or municipality where registered, or
- You and your domestic partner meet all of the following requirements:
  - You are both at least age 18
  - Neither of you is legally married to another person of the opposite sex or in a domestic partnership with another person
  - You are not related by blood to a degree of closeness that would prohibit marriage
  - You are in an exclusive, committed relationship that is intended to be permanent
  - You share a mutual obligation of support and responsibility for each other's welfare
  - You currently share a principal residence and have done so for at least 6 months, and intend to do so permanently, or
  - You are married adults of the same sex and your marriage is recognized by the state where you live.

Coverage of a domestic partner is effective upon the Trust's receipt of the required enrollment form and documentation.

Documentation Required

If your local union and employer negotiate domestic partner benefits and you want to enroll your domestic partner, you and your partner will be required to complete a notarized Affidavit of Domestic Partnership and submit a birth certificate or driver's license as proof of your domestic partner's age, plus additional documentation to verify your domestic partner's eligibility including that you have shared a principal residence for at least six months. This additional documentation must include any three of the following:

- Declaration, Affidavit, or Certification of Civil Union from a state or municipality that issues such
- Marriage certificate from a state or municipality that recognizes same sex marriages
- Legal documents indicating that, as domestic partners, they are responsible for each other's welfare
- Home title or other documents showing joint ownership of significant property
- Rental agreement documenting joint tenancy
- Canceled checks showing rent or utility payments from both partners at the same address, or bills proving same
- Evidence of joint banking accounts (savings, checking, etc.)
- Power of Attorney (durable property or healthcare)
- Wills, life insurance policies, or retirement annuities naming each other as primary beneficiary
- Co-parenting or adoption agreement.

Children of Domestic Partners

If your local union and employer negotiate domestic partner benefits and you want to enroll children of your domestic partner, the child(ren) may be enrolled subject to the plan's preceding dependent children eligibility requirements including that the child(ren) are:

- Dependent upon you for support and maintenance, and
- Unmarried, and
- Under 19 years old and residing with you and your domestic partner ***or*** at least 19 but under 26 and enrolled full-time in an accredited educational institution ***or*** disabled and physically or mentally incapable of self-support.

Other Important Information about Domestic Partner Benefits

It's important to note that domestic partner benefits are subject to different federal and state tax rules. Income taxes may be payable as a result of the Trust providing benefits to your domestic partner and his or her children. If your bargaining unit has bargained domestic partner benefits and you are covering a domestic partner, you may wish to consult a tax professional for advice on your personal situation. Domestic partners are not eligible for COBRA self-pay benefits when coverage ends and in most cases; their children will not be eligible for COBRA continuation benefits either.

Continuation of Coverage

This section describes various options for continuing coverage under specific circumstances.

Quick Guide to Continuing Your Coverage

The Trust offers a number of options for continuing your coverage after it would normally end, depending on your situation. The chart below provides an overview of these options, which are described in more detail in the following pages. Dental, Vision, Life, and AD&D coverages are listed here but only apply if you have these coverages through a Trust plan.

Continuing Your Coverage Overview

Continuation option	What coverages may be continued*	How long coverage can be continued	Who can be covered	For details
Continuing coverage lost due to delinquency of employer contributions	Medical/prescription, dental, vision, mental health and chemical dependency, life, AD&D	Up to three months	You and your eligible dependents	See page 16
Continuing coverage lost due to a strike, lockout or labor dispute	Medical/prescription, dental, vision, mental health and chemical dependency, life, AD&D	Up to six months	You and your eligible dependents	See page 16
Continuing coverage during a military leave	Medical/prescription, dental, vision, mental health and chemical dependency	During your military leave (maximum of 24 months)	You and your eligible dependents	See page 17
Continuing coverage during a Family or Medical Leave (FMLA)	Medical/prescription, dental, vision, mental health and chemical dependency	During your FMLA leave (maximum of 12 weeks)	You and your eligible dependents	See page 18
Total Disability Waiver of Contributions	First three months: medical/prescription, dental, vision, mental health and chemical dependency, life and AD&D Months four through 12 (if applicable): medical/prescription, mental health and chemical dependency, life and AD&D	Up to three months Some groups have bargained an additional 9 months (12 months total)	You and your eligible dependents	See page 18
Extension of Medical Benefits for Total Disability (may be available after you have exhausted other options such as the Disability Waiver of Contributions, COBRA, or the Six-Month Self-Pay Option)	Provides continued medical/prescription coverage for the disabling condition only if you do not have access to other group insurance.	Up to one year	The disabled participant (you or your covered dependent) only	See page 19

Continuing Your Coverage Overview				
Continuation option	**What coverages may be continued***	**How long coverage can be continued**	**Who can be covered**	**For details**
COBRA (self-pay option)	Medical/prescription dental, vision, mental health and chemical dependency	Normally up to 18 months Up to 29 months if disabled Up to 36 months for dependents in certain circumstances	You and/or your eligible dependents	See page 20
Six-Month Self-Pay Option (in lieu of COBRA if eligible for COBRA)	Plan C medical/prescription and mental health and chemical dependency coverage	Up to six months	You and/or your eligible dependents	See page 22

**You may generally only continue coverage you already had through the Trust. For instance, you may continue dental coverage only if you had dental coverage through the Trust and it is allowed under the continuation option.*

Please note, this chart is only a brief summary and does not describe many details of the continuation options. Please refer to the pages shown in the chart for more detailed descriptions, or call the Trust Administrative Office.

Continuing Coverage Lost Due to Delinquency of Employer Contributions

Coverage for you and your eligible dependents, except Time Loss benefits, may be continued for up to three months if your employer is delinquent in Plan contributions and the employer account has been referred for collection. To be eligible for continued coverage, you must provide proof of employment that would have created eligibility if the required employer contribution had been made. This continued coverage is for a maximum of three months after employer contributions stop and is available only once for an employer or successor. (This provision does not relieve an employer of any obligation to contribute to the Plan.)

Continuation of Life and Medical Coverage in the Event of a Strike, Lockout or Other Labor Dispute

If your coverage terminates because active work ends as a result of strike, lockout or other labor dispute, your coverage (other than Time Loss benefits) may continue during the dispute while the Plan is in effect if you self-pay the required contributions. You may choose between COBRA coverage and the Six-Month Self-Pay Option described on pages 20 to 23.

In no event may you continue your benefits beyond *the earliest* of these dates:

- Six months after you stop active work
- Your request that coverage be terminated
- Your failure to make the required self-payment on time

- Your eligibility for similar coverage under another group plan
- Termination of the Plan.

You will not have the group life conversion privilege described on pages 26 and 27 if your continued coverage under this provision terminates because:

- You did not make the required self-payment on time
- You were eligible for similar coverage under another group plan
- This Plan terminates.

If your continued life insurance terminates due to policy termination, you will be entitled to convert your life insurance if you have been insured for at least five years. See pages 26 and 27 for the amount of life insurance you can convert.

Military Service Under USERRA

If you leave covered employment to perform certain United States military service, you and your covered dependents may have the right to continue your group health benefits — including medical, dental, vision and prescription drug coverage. If you're military service lasts less than 31 days (for example, active duty for training), the Plan will continue to cover you and your dependents. If your military service lasts at least 31 days, you and your dependents will be eligible to continue coverage through self-payment for up to 24 months. When you return to covered employment, your regular coverage will begin immediately, if you meet the requirements summarized below.

Under the Uniformed Services Employment and Reemployment Rights Act (USERRA), you must notify your employer before taking leave (unless precluded 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 apply for reemployment as follows:

- Less than 31 days military service — apply immediately, taking into account safe transportation plus an eight-hour rest period
- 31-180 days military service — apply within 14 days
- More than 180 days military service — apply within 90 days.

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

The rules above also apply to uniformed service in the commissioned corps of the Public Health Service.

To ensure proper crediting of service under USERRA, have your employer notify the Trust Administrative Office when you go on leave and again when you are reemployed following your return from leave.

Trade Act of 2002

The Trade Act of 2002 created a tax credit for certain individuals who become eligible for trade adjustment assistance and for certain retired employees who are receiving pension payments from the Pension Benefit Guaranty Corporation (PBGC) (eligible individuals). Eligible individuals

can take a tax credit for qualified health insurance, including continuation coverage. If you have questions about these tax provisions, you may call the Health Coverage Tax Credit Customer Contact Center toll-free at 866-628-4282. TTD/TTY callers may call toll-free at 866-626-4282. More information about the Trade Act is also available at http://www.doleta.gov/tradeact/.

If You Take a Family or Medical Leave

To be eligible under the federal Family and Medical Leave Act (FMLA), you must have worked for your current employer for at least 12 months and for at least 1,250 hours in the 12 months before your leave. If you meet these requirements and work for an employer with 50 or more employees within a 75-mile radius, the law requires your employer to continue contributions for your (and your dependents') medical (and if covered under the Trust, dental and vision) coverage for up to 12 weeks during a 12-month period if you're on leave due to:

- Birth of a child, or placement for adoption or foster care
- Serious health condition of a child, spouse or parent
- Your own serious health condition.

Contact your employer as soon as you think you're eligible for a family or medical leave since the law requires you to give 30 days notice, or tell your employer immediately if your leave is caused by a sudden, unexpected event. Your employer can tell you of your other rights under FMLA.

If you haven't returned to work when your coverage under FMLA ends, you and your dependents may elect COBRA self-pay coverage, as described on pages 20 to 22.

If you qualify for a Disability Waiver of Contributions as described in the following section, and under FMLA because of your own serious health condition, employer contributions are not required by the Trust while you remain qualified for the Disability Waiver of Contributions.

Waiver of Contributions for Total Disability

If you fail to work the specified minimum monthly hours for eligibility because you're totally disabled, and you've submitted proof of the disability from your physician and employer, you may receive a waiver of contributions for up to *three* months if you remain totally disabled. The waiver period will begin on the first of the month following the month your employer's paid coverage ends. This waiver allows continuation of:

- Medical/prescription
- Vision — if covered by this Trust
- Dental — if covered by this Trust
- Life/AD&D — if covered by this Trust.

Certain employer groups have negotiated an additional nine months of waivers (12 months total). For these groups, the waiver of contributions for months four through twelve apply to medical and prescription coverage only (and if covered by the Trust, life and AD&D coverage) and do not include vision, dental or Time Loss coverage. Consult the Trust Administrative Office for details.

At the conclusion of the waiver period, you may elect COBRA and begin making COBRA self-payments, but your combined continuation coverage under the waiver period and COBRA may not exceed 18 months (29 months if you are disabled and qualify for the COBRA Disability extension. The combined continuation coverage maximums will be 21 and 32 months respectively, if you are on medical leave under FMLA while also eligible for waivers of contributions for total disability and your employer's contributions under FMLA are waived. As an alternative to COBRA, you may obtain coverage for six months as described under Six-Month Self-Pay Option on page 22.

To determine eligibility for waiver of contributions, you must become disabled in a month for which you have eligibility based on an employer contribution, or, if you have returned to covered work, for which you have eligibility based on a disability waiver of contributions due to a prior disability. You must also be:

- Totally disabled due to a covered accident or illness (including pregnancy and its complications)
- Unable to perform the normal duties of your occupation, and
- Not engaged in any occupation for wage or profit (except light-duty work that may be allowed under your collective bargaining agreement), and
- Under a physician's regular care for that injury or sickness.

A subsequent disability separated by less than two weeks of full-time work is considered the same disability unless it is due to a different cause and begins after you return to full-time work.

Extension of Medical Benefits for Total Disability

Medical benefits after coverage ends (or after an extension of medical benefits under the Disability Waiver of Contributions or self-payments under the Six-Month Self-Pay Option or COBRA end) may continue for a totally disabled employee or dependent. These benefits include covered charges incurred, for the disabling condition only, within one year from the date eligibility ended.

To qualify for extension of benefits you must not have access to other group insurance and:

- The total disability must not be work-related and must be continuous from the date coverage or self-payments end to the treatment or service date, and
- Covered charges must be a result of the injury or sickness causing the disability that existed on the date coverage or self-payments end.

To determine eligibility for this extension of benefits, you must be totally disabled, meaning you are:

- Unable to work because of an accidental injury or sickness that prevents you from performing the normal duties of your occupation (or, for a dependent, prevents the normal activities of a person of the same age and gender), and
- Not engaged in any occupation for wage or profit, and
- Under a physician's regular care for the disabling injury or sickness and have submitted certification of continuous care in a form acceptable to the Trust.

Please contact the Trust Administrative Office for a Time Loss/Waiver Application or to inquire about the medical benefit extension.

Self-Pay Options for Continuing Healthcare Coverage

The Plan provides two self-pay options when your healthcare coverage would otherwise end:

- If you're eligible for COBRA, you may choose between the COBRA self-pay option and the Six-Month Self-Pay Option
- If you're not eligible for COBRA, you may continue your coverage under the Six-Month Self-Pay Option.

These continuation options are described below. Please contact the Trust Administrative Office for more details.

COBRA Self-Pay Option

You may be eligible to continue medical coverage after it would otherwise terminate based on a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). If you are an employee covered by the Plan, you and your covered dependents may choose COBRA self-pay coverage for up to 18 months if your coverage terminates due to one of these qualifying events:

- A reduction in your hours of employment
- Termination of your employment other than for gross misconduct.

A dependent spouse covered by the Plan may choose COBRA self-pay coverage for up to 36 months if coverage terminates due to one of these qualifying events:

- Death of the employee
- Divorce from the employee
- Spouse elects Medicare as primary coverage.

A dependent child covered by the Plan may choose COBRA self-pay coverage for up to 36 months if coverage terminates due to one of these qualifying events:

- Death of the employee
- Parents' divorce
- Parent elects Medicare as primary coverage
- Dependent no longer eligible under the Plan.

A spouse or dependent child who elects COBRA self-pay coverage for 18 months due to the employee's termination or reduction in hours may be eligible to continue coverage for up to 36 months due to a second qualifying event:

- Death of the employee
- Employee's divorce
- Employee elects Medicare as primary coverage

- Dependent no longer eligible under the Plan.

You or your dependent is responsible for informing the Trust Administrative Office of a divorce or loss of dependent status no later than 60 days after the qualifying event that causes coverage to end. *The employer is responsible for notifying the Trust Administrative Office when the employee's coverage ceases.*

While self-paying under this option, you or your dependent could receive a Social Security determination confirming disability at the time of the COBRA qualifying event (or within the first 60 days of continuation coverage due to the event). If this happens, the disabled person and all COBRA-eligible family participants may be eligible for up to 29 months of continuation coverage. The Trust Administrative Office must receive a copy of the disability determination within *60 days* of the determination date and *within the original 18-month coverage period.* If the disabled individual is later determined no longer to be disabled by the Social Security Administration, *you must notify the Trust Administrative Office within 30 days of the determination.*

When the Trust Administrative Office is notified that a qualifying event has occurred, it will supply details including:

- Application for COBRA self-pay coverage
- Cost information and payment procedures
- Requirements for continuation of coverage.

Timing Is Important

Your application and self-payments must be timely. You will be eligible for COBRA self-pay coverage only within the following time frames:

- You must return the COBRA application within *60 days*, starting as of the date you are notified or the date your coverage ends, whichever is later. You won't be eligible for COBRA self-pay coverage after this 60-day election period ends.
- The first self-payment is due within *45 days* after your first bill is mailed (the exact date will be determined when you are billed). Subsequent self-payments will be due the last day of the month for which payment is being made. Your COBRA coverage will terminate automatically unless you make timely payments.

Employees who qualify for a total disability extension and waiver of contributions, described on page 18, may not have to make COBRA-payments during the waiver period. However, the combined period under COBRA self-pay coverage and the waiver may not exceed 18 months (29 months if you are disabled and qualify for the COBRA Disability extension). The combined continuation coverage maximums will be 21 and 32 months respectively, if you are on medical leave under FMLA while also eligible for waivers of contributions for total disability and your employer's contributions under FMLA are waived. To qualify for the additional 11-month COBRA disability period, you must qualify for and be receiving Social Security disability benefits. Consult the Trust Administrative Office for details.

COBRA self-pay coverage will be similar to that provided under the Plan to similarly situated employees or dependents. However, continuation coverage does not include Time Loss, AD&D or Life Insurance benefits.

If you or a dependent is eligible for Medicare coverage and you are no longer actively at work, Medicare becomes the primary payer of claims over any coverage you have under COBRA, the Six-Month Self-Pay Option or the disability extension.

COBRA self-pay coverage will terminate before the COBRA eligibility period ends for any of the following reasons:

- Payment for continuation of coverage is not received by the last day of the month for which payment is being made.
- You, your spouse and/or eligible dependents obtain coverage under any other group health plan after the last date to elect COBRA self-pay coverage (unless the other plan excludes or limits your benefits because of a preexisting condition).
- You became entitled to Medicare benefits (Part A or Part B) after the last date to elect COBRA self-pay coverage; however, your dependents may be entitled to further continuation of coverage. (If your spouse or dependent becomes eligible for Medicare for any reason, coverage for that individual will end.)
- The Plan terminates.
- Social Security determines you are no longer disabled during an 11-month disability extension period.

Six-Month Self-Pay Option

If your employee coverage terminates, you have the choice to continue reduced medical coverage for up to six months. You must make the necessary self-payments by the tenth of each month to maintain coverage.

This medical coverage will be provided under Medical Plan C rather than Medical Plan A. During the six months of self-pay coverage, no Time Loss, AD&D or Life Insurance is provided.

If you have the option to continue coverage under the COBRA self-pay option and you choose this Six-Month Self-Pay Option instead, you waive your COBRA rights. After the end of your COBRA election period, COBRA coverage will not be available to you later. However, if a qualifying event occurs, your covered family members may be entitled to continue under COBRA as described above.

Payments and medical benefits for the Six-Month Self-Pay Option under Plan C are less than for COBRA self-pay coverage under Plan A.

If you qualify for a waiver of contributions due to total disability, described on page 25, you may begin the six months of self-payments at the end of the waiver period. You may not receive more than one waiver period or make more than six months of self-payments regardless of the number of disabilities that may occur during a waiver or self-payment period.

If a qualified beneficiary rejects COBRA coverage in favor of the Six-Month Self-Pay Option, this option then becomes like a different group health plan — it's not treated like COBRA coverage. The individual's status as a qualified beneficiary will cease after the initial COBRA election period. When Six-Month Self-Pay Option coverage expires, the individual will not be offered a COBRA election.

If you choose the Six-Month Self-Pay Option and your spouse or dependent child would lose this coverage as the result of a subsequent qualifying event (see below), they may continue COBRA coverage. The maximum coverage period would be 36 months, measured from the qualifying event.

For a dependent spouse, qualifying events for this COBRA coverage are:

- Death of the employee

- Divorce from the employee
- Spouse elects Medicare as the primary coverage.

For a dependent child, qualifying events for this COBRA coverage are:

- Death of the employee
- Parents' divorce
- Parent elects Medicare as primary coverage, or
- Dependent is no longer eligible under the Plan.

If coverage is lost as the result of termination or reduction in hours, the employee's death or Medicare entitlement, the Trust Administrative Office will notify you and/or your family members of COBRA continuation options. If a family member loses coverage (because of divorce or a child no longer being eligible, for example), the Trust Administrative Office must be notified within 60 days.

Life and Accidental Death & Dismemberment (AD&D) Insurance

This booklet is your Certificate of Insurance for Life and AD&D coverage. In all instances, group policy terms and conditions will determine your insured benefits.

There are three Life and AD&D plans through the Trust that can be part of your collective bargaining agreement: Life and AD&D Plan A, Plan B, or Plan C. These plans are separate from Medical Plans A, B, C, and Z. Therefore, it is possible for you to have Medical Plan A but Life and AD&D Plan B or C. Alternatively, your collective bargaining agreement may not provide Life and AD&D insurance through a Trust Plan. Refer to your collective bargaining agreement to determine which Life and AD&D Plan may apply to you.

Each Life and AD&D Plan includes employee life insurance, dependent life insurance, and employee AD&D insurance.

Life and AD&D Coverage			
	Plan A	Plan B	Plan C
Employee Life	$30,000	$15,000	$5,000
Dependent Life	$3,000	$1,500	$500
Employee AD&D	$30,000	$15,000	$5,000

The different types of insurance under these plans are described on the following pages.

Employee Life Insurance

Death Benefit

If you die, your beneficiary will receive the scheduled benefit for you under the plan specified in your employer's collective bargaining agreement:

- Plan A — $30,000 death benefit
- Plan B — $15,000 death benefit
- Plan C — $5,000 death benefit
- No coverage.

The collective bargaining agreement will specify which level applies to you.

If you die while covered by this employee life insurance, Principal Mutual Life Insurance Company will pay your beneficiary the scheduled benefit in force on the date of your death. If your beneficiary does not survive you, or if you haven't designated a beneficiary, Principal will pay:

- First, to your spouse if living, then
- To your surviving natural or adopted children in equal shares, then
- To your surviving parents in equal shares, then

- To your brother(s) and sister(s) in equal shares, then
- To your estate.

Contact the Trust Administrative Office for information about any of the settlement options available to your beneficiary at your death.

Beneficiary

You may change your beneficiary by filing a Beneficiary Form with the Trust. Contact the Trust Administrative Office or your local union for forms. A change in your beneficiary will not be effective until the Trust Administrative Office records the change.

Life Insurance Premium Waiver During Total Disability

If you stop active work for any reason, your employee life insurance will normally terminate. However, if you stop active work because you're totally disabled, you may qualify to continue this coverage, without having to pay a premium.

You are considered totally disabled when, because of sickness or injury, you are not able to perform the duties of any occupation that reasonably fits your background or training, as determined by the Trust and Principal Financial Group.

To be qualified for insurance during total disability, you must also:

- Become totally disabled while insured for employee life insurance
- Remain totally disabled continuously
- Be under the regular care of a physician
- Agree to exams by a physician when required by Principal (Principal will pay for these exams and choose the physician)
- Send proof of disability to Principal within one year of the date the disability starts and each year thereafter
- Return, without claim, any individual life insurance policy that may have been issued to you under your individual purchase rights (see page 26).

If you qualify, life insurance coverage continuation due to your total disability generally begins nine months after the date your total disability begins. However, if you die during this nine-month waiting period but you would have otherwise qualified for continuation life insurance coverage, your beneficiary will receive your life insurance benefit.

If you die while insurance is extended by this total disability provision, the Plan will pay your beneficiary the scheduled benefit that would have been paid had you remained insured under this Plan. The amount will be determined by the scheduled benefit in force on the date your disability began.

When Premium Waiver Coverage Ends

Insurance under this premium waiver provision ends when:

- The group policy terminates,
- You are no longer totally disabled,

- You fail to send required proof of Total Disability to Principal or refuse to undergo a required physician's examination, or
- You cease to be under the care of a physician.

Individual Purchase Rights

You will have the right to buy an individual life insurance policy without submitting proof of your good health if:

- Your total employee life insurance terminates because you end active work or become ineligible. In either instance, the maximum you may buy will be your employee life insurance amount on the termination date minus any individual amount purchased earlier under these rights.
- The group policy terminates or is amended to exclude your insurance class after you've been insured for at least five years. In either instance, the maximum you may buy will be the smaller of $2,000 or your employee life insurance amount on the termination date, minus any amount you become eligible for under any group policy within 31 days.

To purchase an individual life insurance policy, you must apply and pay the first premium within 31 days after your group life insurance ends. Contact the Trust Administrative Office for the proper forms. Any individual policy issued will be effective on the thirty-second day.

The individual policy will be for life insurance only; no disability or other benefits will be included. The premium you pay will be at Principal's normal rate for your age and risk class on the individual policy's date of issue.

If you die within the 31-day purchase period, your beneficiary will receive any life insurance amount you had the right to buy. This payment will be made whether or not you applied for an individual policy.

Dependent Life Insurance

Death Benefit

Dependent life insurance pays you a benefit if your eligible dependent dies. The benefit amount you will receive depends on the plan specified in your employer's collective bargaining agreement:

- Plan A — $3,000 death benefit
- Plan B — $1,500 death benefit
- Plan C — $500 death benefit
- No coverage.

You cannot be covered as both a dependent and an employee under the life insurance plans.

Payment is made to you if you survive the dependent. Otherwise, Principal will pay the beneficiary you named for employee life insurance.

Individual Purchase Rights

Your spouse may buy an individual life insurance policy without submitting proof of good health if:

- Dependent life insurance for your spouse ends because you're divorced or separated or because you die, end active work or become ineligible. In these instances, the maximum your spouse may buy will be the amount of dependent life insurance in force on the termination date minus any individual amount purchased earlier under these rights.

- The group policy terminates or is amended to eliminate dependent life insurance or your insurance class after your spouse has been insured for at least five years. In these instances, the maximum your spouse may buy will be the smaller of $2,000 or the spouse's dependent life insurance amount on the termination date, minus any amount your spouse becomes eligible for under any group policy within 31 days.

To purchase an individual life insurance policy, your spouse must apply and pay the first premium within 31 days after the group insurance ends. Contact the Trust Administrative Office for the proper forms. Any individual policy issued will be effective on the thirty-second day.

The individual policy will be for life insurance only; no disability or other benefits will be included. The premium to be paid will be at Principal's normal rate for your spouse's age and risk class on the individual policy's date of issue.

If your spouse dies within the 31-day purchase period, Principal will pay to you any life insurance amount your spouse had the right to buy. This payment will be made whether or not your spouse applied for an individual policy.

Employee AD&D Insurance

AD&D insurance covers you if you die or suffer certain injuries as the result of an accident. The Plan specified under your employer's collective bargaining agreement determines your AD&D benefit:

- Plan A — $30,000 death benefit
- Plan B — $15,000 death benefit
- Plan C — $5,000 death benefit
- No coverage.

A percentage of the death benefit is paid if you suffer certain non-fatal injuries as a result of an accident.

Benefit Qualification

To qualify for AD&D benefit payment, all of the following must occur:

- You must be injured while covered by AD&D insurance
- Your injury must be through external, violent and accidental means
- Your injury must be the direct and sole cause of a loss listed as follows, and
- Your loss must occur within 365 days of your injury.

Benefit Payable

If all of the previous qualifications are met, Principal will pay the following percentages of your scheduled benefit:

- 50% if one hand is severed at or above the wrist
- 50% if one foot is severed at or above the ankle
- 50% if the sight of one eye is permanently lost
- 100% if more than one of the listed losses occurs, or
- 100% if you lose your life.

Total payment for all losses that result from the same accident will not exceed 100% of your scheduled benefit.

Payment for loss of life will be to the beneficiary you named for employee life insurance. Payment for all other losses will be to you.

Limitations

Payment will not be made for any loss with one of these contributing causes:

- Willful self-injury or self-destruction, while sane or insane
- Disease or the treatment of disease
- Voluntary participation in a riot, assault, felony or insurrection
- War or act of war, including terrorism.

Time Loss Benefits — Employee Only

Time Loss benefits provide weekly income when you are disabled and cannot work due to a non-work related injury or illness. This benefit is sometimes referred to in collective bargaining agreements as weekly income benefits, short-term disability benefits or accident and sickness benefits. The Time Loss plans are separate from your Medical Plan. For example, you may have Medical Plan A, but Time Loss Plan C. Your weekly benefit is determined under the Plan specified in your employer's collective bargaining agreement:

- Time Loss Plan E — $500 per week
- Time Loss Plan A — $400 per week
- Time Loss Plan B — $300 per week
- Time Loss Plan C — $200 per week
- Time Loss Plan D — $100 per week
- No coverage.

If the benefit specified in the collective bargaining agreement increases or decreases while you're on Time Loss benefits, your benefit will change to the new rate if a contribution at the new rate is required and made on your behalf. The change will be effective with the month of coverage for which the contribution is made.

To qualify for Time Loss payments you must:

- Become disabled in a month for which you have eligibility based on an employer contribution for this coverage or, if you have returned to covered work, for which you have eligibility based on a disability waiver of contributions due to a prior disability, and
- Be unable to perform the normal duties of your occupation because of a disability due to a covered accidental injury or sickness (including pregnancy and its complications), and
- Be under a physician's regular care for the covered accidental injury or sickness, and
- Not engage in any occupation for wage or profit (except any light-duty work allowed under your collective bargaining agreement).

Your benefit is payable starting the first day for disabilities resulting from an accidental injury (see page 31) or medically necessary surgery or the eighth day for disabilities due to an illness, but will not begin before your first physician's visit. Written certification of your disability and beginning date is required.

Unless you're under a physician's care, you will not be considered disabled; your first day of disability for purposes of the accidental injury or sickness disability qualification period will not be before the date you first visit the physician.

The payment will continue for as long as you're disabled and under a physician's regular care — up to a maximum dollar amount for each disability equal to 26 times the weekly benefit specified in your employer's collective bargaining agreement. For example, if the collective bargaining agreement provided a benefit of $200 per week, the maximum benefits payable are $5,200 (26 x $200). During partial weeks of total disability, you will be paid at the daily rate of one-seventh of the Time Loss payment.

If you are receiving Time Loss benefits and are able to return to light-duty work, or to your normal job less than full-time with the same employer, your Time Loss benefits **will be limited to** not more than the difference between your normal weekly straight-time pay before your disability and the combined amount for light-duty work and any holiday or sick leave pay.

No Time Loss benefits will be paid if your combined wages and sick leave and holiday pay equal or exceed your straight-time pay prior to the disability.

A subsequent disability separated by less than two weeks of full-time work is considered the same disability unless it's due to a different cause and the disability period begins after you return to full-time work. After your return to work from a disability, you can qualify for Time Loss benefits or a disability waiver of contributions for a new disability, only if the new disability occurs during a month in which you have either eligibility due to a disability waiver of contributions for the prior disability or as the result of an employer contribution.

Contact the Trust Administrative Office to find out when your benefits begin, determine the amount of your Time Loss payment and obtain a Weekly Income/Disability Waiver application. All sections of the form must be completed before your claim can be processed.

Exclusions

1. Time Loss benefits will not begin before the time specified in the collective bargaining agreement

2. You will not be considered disabled and eligible for these benefits unless you are under a physician's regular care and provide certification of continuous treatment in a form acceptable to the Trust

3. These benefits do not cover disability due to an accident or sickness when coverage is available under any Workers Compensation Act or similar law (including LEOFF Act), whether or not you elect that coverage or meet the claim filing deadline

4. Disabilities resulting from war or act of war (declared or not) including terrorism are not covered

5. Disabilities that begin in a month for which you do not have eligibility based on an employer contribution or, if you have returned to covered work, for which you do not have eligibility based on a employer contribution or disability waiver of contributions due to a prior disability, are not covered by these benefits.

Social Security (FICA) Tax

The liability for FICA taxes is divided between you and your employer. The Plan is required by federal law to withhold your share of the tax from each Time Loss benefit payment made during the six months after you stop working.

Income Tax

Time Loss payments are subject to federal income tax. Upon written request, you may have income tax withheld by the Trust Administrative Office. Please contact the Trust Administrative Office for a withholding application and other details. Income tax will be withheld from Time Loss payments payable eight or more days after the Trust Administrative Office receives your

written request. This withholding will end with the Time Loss payments payable eight or more days after the Trust Administrative Office receives your written notice to terminate withholding.

Time Loss Definitions

The following definitions apply to Time Loss benefits only:

Accidental Injury — Physical harm from a sudden, traumatic, unforeseen event caused by the intervention of an external force, at a specific time and place. This is independent of sickness except for infection of a cut or wound.

Disabled — Unable to perform the normal duties of your job, as determined by a physician, because of an accidental injury or sickness. In determining whether you are disabled for the purpose of receiving Time Loss benefits, the Trust has the right, at our sole discretion, to require you to undergo an independent medical evaluation by a physician of the Trust's choice, at the Trust's expense.

Light Duty — Returning to work for the same employer and performing normal job duties less than full-time or other light-duty work while under a physician's regular care.

Sickness — An illness recognized by authoritative medical or scientific literature and diagnosed by a physician.

Care Management Programs

Care management programs help you get the most appropriate healthcare in the most appropriate setting. They also help the Trust fulfill its obligation to control costs and ensure appropriate use of Trust resources. The Trust uses the services of several care management program partners who help you by:

- Advising on care and setting options
- Informing you of available health service alternatives to avoid unnecessary surgery and the corresponding risks
- Saving you out-of-pocket costs when you use providers who have agreed to discounts.

To receive maximum benefits, use the following for medical care coordination and healthcare cost containment programs:

- Hospital and physician Preferred Provider Organization (PPO)
- Mandatory hospital utilization review
- Case management programs.

These services are provided in conjunction with other cost management services such as the Prescription Drug program, the Mental Health and Chemical Dependency Program and the Stand Strong Program. Together, these services are part of the Trust's overall program designed to ensure that you receive effective healthcare at the appropriate time and in the most appropriate setting for all medically necessary treatment. Of course the final decision about your medical treatment is between you and your physician.

The Preferred Provider Organization (PPO)

The Trust has a PPO arrangement with Cigna for medical services. This network of Physicians, Hospitals and other health care professionals provide access to services and supplies at discounted rates. Using PPO providers will result in lower cost to the Trust and less out of pocket cost for you.

Using the PPO Network Can Save You Money

The PPO helps us offer healthcare at a lower cost. Of course, as a covered Washington Teamster participant, you can use any covered provider you wish. But when you use a PPO (in-network) provider, there are financial advantages.

The PPO credentials and contracts with preferred providers to offer a network of primary care physicians, specialists, hospitals, clinics, and other health care providers. The PPO also negotiates fees with these providers and facilities and passes the savings on to you, so that you can obtain medical services from these providers at a favorable rate.

When you choose from the PPO's diverse network of qualified providers, they will handle your claim paperwork. You also have the option to use any preferred physician or specialist without first obtaining a referral for most services.

When you use a PPO provider, your out-of-pocket expenses will be less than if you were treated at a non-PPO provider since your benefits are based on discounted rates. When you use a PPO provider for services that are subject to coinsurance, you will also pay at a 20%

lower coinsurance level after your annual deductible until you meet your annual maximum for coinsurance.

If you elect to use a non-PPO provider, the Plan's coverage will not include charges which exceed the usual, customary and reasonable (UCR) amount for the services provided. So, in addition to the higher coinsurance, you'll be responsible for any amount charged by a non-PPO provider which exceeds the UCR amount.

The following non-PPO providers will be covered at the PPO coinsurance rate until you reach your annual maximum for coinsurance **if** a PPO facility (hospital, ambulatory surgery center) is used for treatment:

Anesthesiologist

Radiologist

Laboratory

Pathologist

Emergency Room Physician

Ambulance

Attending Physician (staff and on-call) treating the patient in an emergent situation

The following non-PPO providers will be covered at the PPO coinsurance rate until you reach your annual maximum for coinsurance when services are coordinated through a PPO physician:

Co-Surgeon

Assistant Surgeon

Anesthesiologist

Radiologist

Laboratory

Pathologist

The PPO coinsurance level will also be applied to any claim where case management has negotiated a discount at a non-PPO provider for services on a single claim basis, for example where the case manager has negotiated a discount for durable medical equipment.

Despite the fact that the in-network PPO coinsurance level will be paid by the Plan for services performed by non-PPO providers in the above situations, the covered charges will still be limited to the UCR amount. You will be responsible for any amount charged by a non-PPO provider that is in excess of the UCR amount.

Finding a PPO Provider

The Washington Teamsters Welfare Trust contracts with **Cigna** to provide a **PPO** (preferred provider organization) — a network of preferred hospitals, physicians, and other providers who agree to offer services at discounted rates — to help control plan costs and save you money. .

You may use non-preferred (out-of-network) providers any time; however, you'll generally **save money** and keep the cost of your plan down when you see PPO (in-network) providers.

To locate a PPO provider in your area, you may refer to a hard copy of the directory. However, as providers may be added or deleted from time to time, it is also strongly recommended that you should:

- Call Cigna toll-free at **855-402-0272** to confirm the provider's status before services are performed. This is the most current source of provider information.

You may also find provider information by visiting **www.cignasharedadministration.com**. Click the link, "Find a Doctor," to begin your search. Although online information is updated monthly, you should call Cigna for the most current information.

- IMPORTANT — Because PPO providers change, be certain to verify your provider's participation before obtaining services; being listed in the PPO directory does not guarantee the provider continues to participate in the PPO. Contact Cigna to confirm the status of your provider or hospital before services are received.

Not all the providers in the Cigna PPO are covered by the Washington Teamsters Welfare Trust. Certain types of providers may be in the PPO but are not covered by your plan. To avoid having your claims denied, it's important to review the section, "What Types of PPO Providers Are Not Covered." If you have questions about services or types of providers covered by your plan, it's also a good idea to call the Trust Administrative Office at 800-458-3053 *before* you receive care.

What If My Provider Isn't In the Network?

It's your choice. You can switch to a preferred provider or go to the non-preferred provider — but you're likely to have higher out-of-pocket costs with the non-preferred provider. You may also nominate your provider for the PPO network, as described below.

Can My Doctor Join the PPO Network?

If your provider isn't currently in the Cigna PPO Network, you can ask your provider if he or she is interested in joining. Contact Cigna or the Trust Administrative Office to request a provider nomination form or ask your provider to contact Cigna at 800-882-4462. Nomination forms may also be found on the website at **www.cignasharedadministration.com**. Nomination doesn't guarantee your provider will be added to the PPO network. Your provider must meet the selection criteria of Cigna in order to join the network.

What Types of PPO Providers Are Not Covered

Not all providers in the Cigna PPO Network are covered by the Washington Teamsters Welfare Trust — even if they are in the PPO network and even if a PPO doctor refers you. Contact the Trust Administrative Office to verify that treatment you receive will be covered by the Trust.

- **Non-preferred providers are not covered as PPO providers, even if you are referred by a PPO provider.** When a referral is necessary, always ask your PPO provider if he or she can refer you to a PPO provider.

- **Only acupuncturists and naturopaths in the PPO network are covered by the plan.** Contact Cigna for a list of preferred acupuncturists or naturopaths.

- **Ophthalmologists and optometrists in the PPO can be used for injuries and diseases of the eye, not routine eye care.** Call NBN Vision at 800-732-1123 for the vision plan provider network and routine eye care; i.e., refractions (routine eye exam), lenses, and frames.

- **For prescription benefits, the Trust uses the MedImpact network, not Cigna.** Call MedImpact at 800-788-2949 to find a participating pharmacy.

Retaining Your Freedom of Choice

Using the PPO is voluntary — you're free to go to any covered provider, even if that physician or facility is not a PPO member. However, no PPO benefits will be allowed for services from a non-PPO provider (even in a case of non-availability or travel).

Getting the Most from Your PPO

Here are a few helpful hints on using the PPO network:

- Always present your ID/Information card when you receive medical care
- Be familiar with your Plan, including what services and types of providers are — and are not — covered under the Plan or PPO
- Remind your physicians to send lab work to a preferred lab and to refer you to PPO hospitals, clinics or specialists
- Remind your doctor that you have a pre-certification requirement for all inpatient hospital stays before you're admitted
- Claims will be submitted for you by your PPO provider.

Mandatory Hospital Utilization Review

The Trust provides utilization review (UR) to ensure you are hospitalized only when medically necessary, and for the appropriate length of stay. Pre-certification is required for all admissions, whether PPO or non-PPO. UR nurses will discuss the proposed hospitalization with your physician, then evaluate the necessity of admission and anticipated length of stay compared with locally accepted standards of care. In certain circumstances, actively practicing physician advisors may also review your hospitalization and consult with your physician. You, your physician, the Trust and the hospital will be notified in writing of the outcome from this review. *Pre-certification does not guarantee coverage — all services must be covered expenses under the Plan to be eligible for benefits.*

The UR manager also reviews outpatient procedures, such as hysterectomies and spinal surgeries, that are usually performed on an inpatient basis to determine whether the outpatient procedure could be considered medically necessary.

Your benefits will be reduced $200 for each hospitalization if you don't follow the pre-certification procedures described below. This applies to all scheduled inpatient, maternity and emergency admissions. Any days or hospitalizations that are not pre-certified as medically necessary will not be covered.

Pre-Certification Procedures

If Medicare is a patient's primary coverage, pre-certification of a hospital stay is not required.

Non-Emergency Hospital Admissions

All non-emergency admissions must be pre-certified before you or a covered dependent enters the hospital. You, a family member or your physician must call the UR manager to discuss the proposed hospitalization, medical necessity of the proposed procedure and anticipated length

of stay. UR nurses and doctors will review your physician's treatment plan to determine medical necessity and the appropriate length of stay; they may be able to suggest safe, more cost-effective treatment alternatives.

Emergency or Maternity Admissions

If the admission is an emergency or maternity related, you, a family member, your physician or hospital must call the UR manager to pre-certify the hospital stay within 48 hours after admission or on the first business day following a weekend or holiday admission.

Inpatient hospital stays for childbirth are allowed for up to 48 hours following a vaginal delivery or 96 hours following a cesarean section. The discharge may be earlier as long as the patient and provider agree.

Concurrent Review

After admission, UR nurses and doctors will continue to evaluate your length of stay through concurrent review. If the recommended length of continued confinement is found to be longer than the generally accepted standards of care — as determined by the UR manager — you, the Trust and your physician will be notified. (An explanation of your right to appeal will be included with the notice when a non-certification is issued by the UR manager.)

Maximizing Your Benefits

You and your physician always have the final decision regarding hospital confinement and medical treatment, but the coverage of related charges will be subject to Plan terms and conditions. Hospital charges for days not certified as medically necessary by the UR manager will not be covered.

With Pre-Certification

Covered admissions and hospital days that are medically necessary and approved by the UR manager will receive regular plan benefits. After reviewing your medical information and consulting with your physician, when it is determined the hospital stay is no longer medically necessary, the hospital will receive verbal notification immediately. In addition, you, your physician and the hospital will be notified by letter.

Without Pre-Certification

Failure to pre-certify non-emergency admissions, or to report emergency and maternity admissions within the stated time limits, will result in a benefit reduction of $200 even if the stay is later found medically necessary. *Claims for any days not certified as medically necessary will be denied.*

Second Surgical Opinion

A second opinion is occasionally required by the UR manager when the reasons for a requested surgical procedure are not clear from the information provided by your physician.

In addition to the surgeries listed below, the plan reserves the right to request a second opinion for any surgery. Surgical procedures may be added or deleted as medical standards dictate.

- Breast surgery (excluding needle biopsy), including breast cyst removal, mammoplasty and mastectomy.
- Hysterectomy (removal of the uterus).

- Knee surgery by either surgical incision or arthroscope.
- Nasal surgery, including submucous resection and septoplasty.
- Spinal surgery, including laminectomy and spinal fusion.
- Orthognathic surgery.

Please contact the UR manager to determine if the proposed procedure is medically necessary and if a second surgical opinion is recommended. In that case, a UR nurse will refer you to an appropriate provider for a second opinion.

Case Management Programs

Medical Case Management Services

Under special circumstances, UR nurses act as patient advocates to help meet the needs of patients with catastrophic or chronic medical problems. They work with you, your family and your physician to help you assess, plan and coordinate all of your healthcare options and find the most appropriate care for your condition. This is a voluntary program available at no cost to you.

Hospital Discharge Planning

Discharge planning helps in situations when you require continued medical care, but not necessarily care that's as intensive as in an acute (hospital) setting. Case management nurses will work with you, your physician and the hospital staff to develop a plan that provides for safe discharge from the hospital. Working with your physician and the hospital staff, the case management nurses can also arrange home healthcare, skilled nursing facilities and hospice care.

Catastrophic/Chronic Illness

The case management program can help patients with long-term, high-cost illnesses and injuries to obtain needed care. Case management nurses work with other medical professionals to identify patients who might benefit from case management — often during the UR process. A patient who chooses to participate is assigned a case manager to help coordinate care. Many times case managers identify hospital alternatives, such as home healthcare or skilled nursing facilities.

Alternative Care and Treatment

Hospital confinement is not always the best environment for treating an illness. For a patient who needs significant long-term medical supervision, case management may recommend alternative care and treatment or facilities that are:

- Not normally covered by this Plan
- Covered by this Plan, but payable on a different basis from the care and treatment they replace
- Payable on the same basis as the care and treatment they replace, once approved.

In these situations, the Trust may approve coverage for alternative care and treatment that would otherwise not be covered, when medically necessary treatment can be delivered more cost-effectively.

Contact the Trust Administrative Office when you need details about how any case management service applies to you.

STAND STRONG

STAND STRONG is a series of wellness tools and resources designed to help you and your family maintain your good health, manage chronic conditions, get access to healthcare information resources and generally live a healthier, stronger life. By leading a healthier lifestyle, you can improve your health and help keep healthcare affordable for all Trust participants.

Personal Health Assessment (PHA)

The STAND STRONG Personal Health Assessment or PHA is a series of questions about your health and lifestyle habits. Your personalized results will identify your health risks and help you find ways to improve or maintain your health. The PHA is designed for you to take every year so you'll be able to compare your results each year.

The health information you share is completely confidential. StayWell Health Management, an independent provider of health promotion programs and services, analyzes your results and provides personalized feedback. No one at your employer, your union or the Trust will ever see your information. Your privacy is assured.

Health Coaching

If your STAND STRONG Personal Health Assessment shows that you have a certain health risk, such as high blood pressure, you may be invited to participate in the STAND STRONG StayWell NextSteps Program, a personal Health Coaching program provided at no cost to you. Health Coaches work one-on-one with participants to help them make healthy changes in a variety of areas including:

- Back care
- Blood pressure
- Cholesterol
- Nutrition
- Physical activity
- Stress management
- Tobacco use
- Weight

Chronic Condition Support Program

If your medical or pharmacy claims data shows that you have one of the chronic conditions covered by the program—asthma, diabetes or coronary artery disease, then you may be invited to participate in the STAND STRONG Chronic Condition Support Program. If you choose to participate (you don't have to), the program is provided at no additional cost to you. The Chronic Condition Support Program supports your doctor's treatment plan to help you stay as healthy as possible, but does not replace the advice and treatment of your doctor. With the program, you'll receive education and support through regularly scheduled one-on-one calls with health care professionals including advice on how to follow your doctor's instructions, information about your medications and access to online tools and resources.

Quit Tobacco

If you're thinking about quitting tobacco, the Trust provides two ways to help you kick your habit for good.

Through the STAND STRONG StayWell NextSteps Health Coaching Program**, Nicotine replacement therapy** is covered 100% for you and your eligible spouse (or domestic partner if domestic partners benefits have been negotiated under your collective bargaining agreement). Nicotine replacement therapy combines nicotine replacement products (nicotine gum and patches) with the support of a personal Health Coach. Nicotine gum or patches are covered only when you enroll in the StayWell NextSteps Tobacco Cessation program and complete at least one call with a Health Coach. Call the StayWell HelpLine at **888-388-8259** anytime throughout the year to enroll.

Tobacco cessation prescription medications to help you quit tobacco, such as Zyban or Chantix, are also covered — subject to copays — up to $500 each year with a lifetime maximum benefit of $1,000 per person. In order to have a prescription refill covered by the Plan, you will need to enroll in StayWell NextSteps Tobacco Cessation program and complete one call with a Health Coach. Therefore, it is recommended you enroll in the Health Coaching program prior to, or at the time you first get a prescription for tobacco cessation drugs. Call the StayWell HelpLine at **888-388-8259** anytime throughout the year to enroll.

Nurse Line

Nurse Line is a resource that you can call for advice 24 hour a day, 7 days a week; and it's toll-free to participants and covered dependents.

Nurse Line: call toll-free at 855-402-0272.

The Nurse Line is staffed with trained, registered nurses who can answer many of your health questions and advise you about self-care steps. This service can be especially helpful when you're not sure whether or not you need to see a doctor right away. Your calls are always held in the strictest confidence. Contact the Nurse Line anytime you have a **medical question** or **you're not sure what to do** about a healthcare symptom or diagnosis.

The 24-hour health line is not a substitute for regular, scheduled care from your physician or other healthcare provider. **In an emergency, call 9-1-1, not the Nurse Line.**

Mental Wellness

Assistance Program connects you and your family to professionals who can help with personal and work-related issues such as managing stress, coping with grief and loss, family relationships, work-life balance and more. Up to three telephone or face-to-face clinical consultations per person per incident are covered each calendar year. Call Cigna at **855-402-0272** 24 hours a day, seven days a week.

Behavioral Healthcare Services provide help for more serious emotional or mental health challenges and chemical dependency treatment.

See Mental Health and Chemical Dependency Benefits Program starting on page 77 for program details.

Weight Management Programs

The Trust sponsors the following weight management programs for participants struggling with obesity or weight-related illnesses.

If your personal health assessment shows you have a weight-related health risk, you might receive a call to participate in the **StayWell NextSteps Program**, a personal health coaching program provided at no cost to you. The NextSteps weight program offers telephone based coaching to help you set and meet goals to improve your health.

Sound Health Connects (SHC) offers clinically supervised weight-management programs that include both a non-surgical and surgical option. For participants who meet certain eligibility and pre-surgical criteria, the Trust will also consider weight-loss surgery as an option. The selection criteria for weight-loss surgery are in place to help ensure participants are prepared for surgery and have a more successful outcome.

Non-Surgical Weight-Loss Program

The 24-week **non-surgical** weight-loss program is intended for eligible participants who are struggling with obesity or who are overweight with certain health risks. It is clinically supervised by Sound Health Connects (SHC).

Criteria for Participation

To qualify to participate in the program, you must meet these three criteria:

- Be at least 18 years old, and
- Be eligible for a Trust-sponsored medical plan (other than a Group Health Options plan), and
- Meet the medical definition of obesity as measured by Body Mass Index (BMI). You must have a BMI of 30 or over, or a BMI of at least 27 with two or more of the following risk factors: arthritis, asthma, congestive heart failure, coronary artery disease, depression/anxiety, diabetes Type II, GERD (heartburn), high blood pressure, high cholesterol, low back pain, polycystic ovary syndrome, sleep apnea.

Pre-Certification Procedures

Pre-certification is required before you or a covered family member can participate in the non-surgical weight-loss programs and receive benefits. You or your family member must call Sound Health Connects (SHC) at 1-866-779-4730 to obtain the pre-certification form and then schedule an appointment with your primary care provider to complete the form and return it to SHC. SHC will then determine if you qualify for the non-surgical weight-loss program.

If you qualify, the program will consist of the following:

Non-Surgical Weight-Loss Program (24 Weeks)	
Weeks 1 - 12	**Weeks 13-24**
Nutrition Counseling (by webcam or phone with a Certified Nutritionist at SHC) • 1 one-hour assessment • 2 half-hour sessions • Half-hour webinar every two weeks • Unlimited email support	Nutrition Counseling (by webcam or phone with a Certified Nutritionist at SHC) • 2 half-hour sessions • Half-hour webinar every two weeks • Unlimited email support
Change Counseling (by webcam or phone with a Licensed Counselor at SHC) • 1 one-hour session • 3 half-hour sessions • Half-hour tele-seminar every two weeks • Unlimited email support	Change Counseling (by webcam or phone with a Licensed Counselor at SHC) • 6 half-hour sessions • Half-hour tele-seminar every two weeks • Unlimited email support
Health Counseling (by phone with a Health Coach at SHC) • Weekly 10-minute consultation calls with a SHC Health Coach	Health Counseling (by phone with a Health Coach at SHC) • Weekly 10-minute consultation calls with a SHC Health Coach
Personal Training (at location of your choice) • 3 sessions per week with your own personal fitness trainer	Personal Training (at location of your choice) • 1 session per week with your own personal fitness trainer
Benefits and Cost • The Trust will pay 80% of the SHC fee, you will pay 20%. • The Trust will pay 80% of your personal fitness trainer's fee up to maximums of $41.67 per session and $1,500 total for all sessions. You will pay the balance of your trainer's fee.	Benefits and Cost • The Trust will pay 80% of the SHC fee, you will pay 20%. • The Trust will pay 80% of your personal fitness trainer's fee up to maximums of $41.67 per session and $500 total for all sessions. You will pay the balance of your trainer's fee.

Non-Surgical Weight-Loss Program (12 Weeks)	
This 12-week program is designed to serve participants who have completed the 24-week program and are seeking additional support. To qualify for participation a participant must have had 90% attendance in the 24-week program. If significant time has elapsed since completing the 24-week program, a new physician consent form must be signed by the participant's primary care physician.	
Weeks 1 - 4	**Weeks 5-12**
Nutrition Counseling (by webcam or phone with a Certified Nutritionist at SHC) • 2 half-hour consultations • Half-hour webinar every two weeks	Nutrition Counseling (by webcam or phone with a Certified Nutritionist at SHC) • 1 half-hour consultation • Half-hour webinar every two weeks
Change Counseling (by webcam or phone with a Licensed Counselor at SHC) • 1 fifty-minute session	Change Counseling (by webcam or phone with a Licensed Counselor at SHC) • 1 fifty-minute session
Health Counseling (by webcam with a Health Coach at SHC) • 3 sessions per week	Health Counseling (by webcam with a Health Coach at SHC) • 2 sessions per week
Benefits and Cost • The Trust will pay 80% of the SHC fee, you will pay 20%.	Benefits and Cost • The Trust will pay 80% of the SHC fee, you will pay 20%.

Surgical Weight-Loss Programs

The **surgical** weight-loss programs are intended for eligible participants who are struggling with obesity or who are overweight with certain health risks and whose physician(s) are prescribing surgical intervention. It is clinically supervised by Sound Health Connects (SHC).

Criteria for Participation

To be considered as a candidate for weight-loss surgery, participants must meet all the following criteria:

- Presence of severe obesity that has persisted for at least 5 years, defined as any of the following:
  - Body mass index (BMI) exceeding 40; or
  - BMI greater than 35 in conjunction with one of the following severe co-morbidities:
    - Coronary heart disease; or
    - Clinically significant obstructive sleep apnea; or
    - Medically refractory hypertension (blood pressure greater than 140 mmHg systolic and/or 90 mmHg diastolic despite optimal medical management).
- Participant must be 18 to 60 years of age (participants over age 60 are reviewed on a case-by-case basis).
- Participant has had a medical evaluation and documented work-up to rule out underlying "treatable causes" of morbid obesity within the past year.
- Successful completion of the Plan's Weight-Loss Pre-Surgical Program through Sound Health Connects (SHC). Successful completion is defined as:
  - Participant attends more than 90% of the program
  - 5% or greater weight loss
  - Participant is a non-drinker and non-smoker
  - Participant has passed a psychological screening for surgical readiness.

In addition to the 24-week Pre-Surgical Program, participants will be required to complete a 52-week Post-Surgical Program after surgery has been performed.

You will not qualify for weight-loss surgery if you have any of these conditions: pregnancy, lactation, active substance abuse, end-stage cardiovascular disease, severe or uncontrolled psychiatric disorders or anorexia.

You may not qualify for surgery if you have any of these conditions: bulimia nervosa or active binge eating disorder, an unstable medical condition or kidney disease.

Pre-Certification Procedures

Pre-certification is required before you or a covered family member can participate in the surgical weight-loss programs and receive benefits. You or your family member must call Sound Health Connects (SHC) at 1-866-779-4730 to obtain the pre-certification form and then schedule an appointment with your primary care provider to complete the form and return it to SHC. SHC will then determine if you qualify for the surgical weight-loss programs.

At the conclusion of the Pre-Surgical Program, you will be required to follow up with your primary care provider. A SHC clinician will review your progress with your provider and

determine final eligibility for surgery. If you are determined eligible by SHC, surgery will be covered according to the specific plan benefits for bariatric surgery.

After your bariatric surgery, you must be cleared by your surgeon to resume activity in order to re-engage with the staff at Sound Health Connects in the 52-week post-surgery program.

Weight-Loss Pre-Surgical Program (24 Weeks)	
Weeks 1 - 12	**Weeks 13 - 24**
Nutrition Counseling (by webcam or telephone with a Certified Nutritionist at SHC) • 1 one-hour assessment • 2 half-hour sessions • Half-hour webinar every two weeks	Nutrition Counseling (by webcam or telephone with a Certified Nutritionist at SHC) • 2 half-hour sessions • Half-hour webinar every two weeks
Change Counseling (by webcam or telephone with a Licensed Counselor at SHC) • 1 one-hour session • 3 half-hour sessions • Half-hour tele-seminar every two weeks	Change Counseling (by webcam or telephone with a Licensed Counselor at SHC) • 6 half-hour sessions • Half-hour tele-seminar every two weeks
Personal Training • 2 sessions per week with your own personal fitness trainer	Personal Training • 1 session per week with your own personal fitness trainer
Benefits and Cost • The Trust will pay 80% of the SHC fee, you will pay 20%. • The Trust will pay 80% of your personal fitness trainer's fee up to maximums of $55.55 per session and $1,333 total for all sessions. You will pay the balance of your trainer's fee.	Benefits and Cost • The Trust will pay 80% of the SHC fee, you will pay 20%. • The Trust will pay 80% of your personal fitness trainer's fee up to maximums $55.55 per session and $667 total for all sessions. You will pay the balance of your trainer's fee.

Weight-Loss Post-Surgical Program (52 Weeks)	
Weeks 1 - 12	**Weeks 13 - 52**
Nutrition Counseling (by webcam or telephone with a Certified Nutritionist at SHC) • 2 one-hour consultations • 2 half-hour sessions	Nutrition Counseling (by webcam or telephone with a Certified Nutritionist at SHC) • 3 half-hour session .
Change Counseling (by webcam or telephone with a Licensed Counselor at SHC) • 1 fifty-minute session • 4 half-hour sessions	
Personal Training • 1 training session per week with your own personal fitness trainer	Personal Training • 1 training session every two weeks with your own personal fitness trainer
Benefits and Cost • The Trust will pay 80% of the SHC fee, you will pay 20%. • The Trust will pay 80% of your personal fitness trainer's fee up to maximums of $31.25 per session and $375 total for all sessions. You will pay the balance of your trainer's fee.	Benefits and Cost • The Trust will pay 80% of the SHC fee, you will pay 20%. • The Trust will pay 80% of your personal fitness trainer's fee up to maximums of $31.25 per session and $625 total for all sessions. You will pay the balance of your trainer's fee.

Weight-Loss Surgery Aftercare and Follow-up

After successful completion of the Post-Surgical Program, participants are required to return to their doctor to obtain ending metric data such as blood pressure, weight, waist measurement and lipid blood panel. Participants will continue to be monitored via webcam with SHC's certified exercise specialist at 6 months, one year, and every year thereafter for an additional four years. The exercise specialist will review your exercise program and suggest changes, if necessary. Additionally, SHC may request certain blood tests at regular intervals during the follow-ups.

Benefits

As well as meeting the weight-loss program requirements, you must be eligible for benefits during the month in which services are provided in order for those services to be covered by the Plan. If you are eligible during the month in which services are provided, benefits will be provided by the Trust for that month at a straight 80% up to any specified limits. Trust participants pay 20% plus all amounts in excess of any limits. These rates apply to the non-surgical, pre-surgical and post-surgical services provided by SHC and your fitness trainer. Benefits for fitness training provided by your own personal trainer are limited to $2,000 for the non-surgical program, $2,000 for the pre-surgery program, and $1,000 for the post-surgery program.

If you are approved for surgery by SHC, benefits for covered surgical services are paid at a straight 80% if using a PPO provider and 60% if using a non-PPO provider. Charges by non-PPO providers are limited to usual, customary, and reasonable (UCR) charges. You pay 20% if using a PPO provider and 40% plus any amounts in excess of UCR charges if using a non-PPO provider.

The benefits for these program services and surgery are not subject to the deductible or copays and your share of the costs do not count toward the Plan's coinsurance annual out-of-pocket maximum. The Plan's coinsurance annual out-of-pocket maximum also does not apply to these

benefits, the maximum coinsurance rate paid by the plan is 80% (PPO) or 60% (non-PPO) even if you have met your coinsurance annual out-of-pocket maximum for the year.

If You Have Questions

Contact Sound Health Connects at 1-866-779-4730 or **www.soundhealthconnects.com** for more information about the clinically supervised weight-loss program or the pre- and post-surgical programs including SHC costs and participation criteria.

Contact the Trust Administrative Office for more information about your eligibility for benefits and the benefits that will be paid by the Plan if you qualify.

Medical Plan Provisions

Medical Plan A Summary

Please note, this is a summary and many details are not included in this chart, but are covered in the rest of this section. The **calendar year deductible, out-of-pocket maximum** and **coinsurance** shown below **DO NOT** apply to the:

- Prescription Drug Program,
- Weight Management Programs, or
- Mental Health and Chemical Dependency Benefits Program.

Expenses for Mental Health and Chemical Dependency treatment, Weight Management, Bariatric Surgery, prescription drugs and professional office visits will not be paid at 100% once the out-of-pocket maximum is met, except to the extent that mental health and chemical dependency services might already be covered at 100%.

Plan Features	
Calendar Year Deductible (excluding copays)	**$100** per person; **$300** per family if you were eligible and took the Trust's Personal Health Assessment in the prior calendar year[1] **$300** per person; **$900** per family if you were eligible and did not take the Trust's Personal Health Assessment in the prior calendar year[1] **$200** per person; **$600** per family if you become eligible during the calendar year[1]
Coinsurance (applies to most benefits) Coinsurance percentages listed in this summary refer to: • Percentage paid of discounted charges for an in-network (PPO) provider • Percentage paid of UCR (usual, customary, and reasonable) charges for an out-of-network (non-PPO) provider	**90%** In-network (PPO)[2] **70%** Out-of-network (non-PPO)[2]
Calendar Year Out-of-Pocket Maximum for Coinsurance (excluding all plan deductibles and copays)	**$1,500** per person; **$3,000** per family[2]
Plan Year Annual Maximum (July 1-June 30) through June 30, 2014	**$2,000,000** per person. No maximum effective July 1, 2014
PPO Network	Cigna

1. The deductible does not include copays and does not apply to office visits that are subject to copays, prescription drug program, mental health and chemical dependency program, or weight loss program. To qualify for the $100 per person/$300 per family deductible both the participant and spouse, if married, or domestic partner, if covered, must complete Personal Health Assessment(s) during the prior calendar year when it is available for completion.

2. Once an individual reaches the out-of-pocket maximum for coinsurance during a calendar year, the Plan pays most eligible expenses at 100% for the rest of that calendar year. Costs for mental health treatment, chemical dependency treatment, weight management, bariatric surgery, outpatient professional copays, deductible, prescription drug expenses, non-covered expenses, charges over UCR amounts, and penalties for not pre-certifying hospitalizations do not apply to the out-of-pocket maximum for coinsurance. Hospital emergency room services at an out-of-network (non-PPO) hospital will be paid at 90%

Plan Features	
Hospital and Emergency Room Benefits	
Hospital Emergency Room Care	$75 copay per visit (waived if admitted), then 90% after the deductible
Hospital Pre-Certification/Utilization Review	Hospital pre-certification required; $200 penalty when admission not pre-certified; no coverage for days not certified by Cigna as medically necessary
Inpatient Hospital (room and board)	Applicable coinsurance after the deductible
Second Surgical Opinion	100% (not subject to deductible) if required by Cigna
Surgery (inpatient and outpatient)	Applicable coinsurance after the deductible
Physician Services	
Office Visits	100% after $20 copay per visit (not subject to deductible)
Preventive Care	In-network (PPO) - 100% Out-of Network (Non-PPO) - 70% after $20 copay per visit and deductible.
Inpatient Care and Surgery	Applicable coinsurance after the deductible
Diagnostic X-Ray/Lab	Applicable coinsurance after the deductible
Other Plan Benefits	
Acupuncture Treatment	100% after $20 copay per visit (not subject to deductible), up to 15 visits per calendar year; acupuncturist (LAC) covered only if a PPO provider is used
Alternative Treatment Settings, instead of Hospitalization:	Applicable coinsurance after the deductible
• Alternate Housing Facility	Up to $60 per day and 70 days for each period of confinement
• Home Healthcare	Up to 130 visits per calendar year[3]
• Hospice Care	Up to 60 visits per lifetime[3]
• Skilled Nursing Facility	Up to 180 days per same or related condition[3]
Durable Medical Equipment	Applicable coinsurance after the deductible; pre-certification for items over $2,000 purchase price or $500 per month rental fee
Hearing Aids	Applicable coinsurance after the deductible up to $1,000 per person per ear every 36 months (maximum waived for children with a congenital defect)
Inpatient Rehabilitation	Applicable coinsurance after the deductible
Jaw Treatment (including TMJ and MPD)	Applicable coinsurance after the deductible up to $6,000 per lifetime (maximum waived if for a congenital defect in children)
Massage Therapy	100% after $20 copay per visit (not subject to deductible), up to 12 visits per calendar year per person. Prescription required
Naturopathic Services	100% after $20 copay per visit (not subject to deductible), up to two visits per person per calendar year. Covered only if a PPO provider is used. Does not include naturopathic supplies
Organ Transplants	Special rules and limits apply
Outpatient Physical or Occupational Therapy	100% after $20 copay per visit (not subject to deductible), up to 24 visits for physical therapy and 24 visits for occupational therapy per calendar year; up to 48 visits for physical therapy and 48 visits for occupational therapy per calendar year following an accident, surgery, or stroke

Plan Features	
Speech Therapy	100% after $20 copay per visit (not subject to deductible), up to 60 visits per lifetime
Spinal Treatment	100% after $20 copay per visit (not subject to deductible), up to 15 visits per calendar year; diagnostic X-rays at the applicable coinsurance after the deductible, up to one set of x-rays per calendar year
Vision Therapy	Applicable coinsurance after the deductible, up to 60 visits per lifetime; special rules apply[3]

3. *Benefit limits on number of visits or days apply whether or not the visits or days are subject to the deductible*.

Prescription Drug Program – See page 70 for program details

Program Description	Generic Drugs	Formulary (Preferred) Brand-Name Drugs	Non-Formulary (Non-Preferred Brand-Name Drugs
Recommended Network Retail Pharmacy (up to 34-day supply)	100% after 10% copay	100% after 30% copay	100% after 40% copay
Regular Network Retail Pharmacy (up to 34-day supply)	100% after 15% copay	100% after 35% copay	100% after 45% copay
Non-Network Retail Pharmacy (covered for medical emergencies only)	100% after $9 handling fee *plus* your normal copay or cost share		
Mail Order Pharmacy (up to a 100-day supply)	100% after lesser of 10% or $15 copay per prescription	100% after lesser of 30% or $90 copay per prescription	100% after lesser of 40% or $130 copay per prescription
Contraceptives	Covered, retail or mail order		

Weight Management Programs – See page 41 for program details

Non-Surgical Program, Surgery, and Pre- and Post-Surgery Programs	80% for the Plan's non-surgical and pre- and post-surgery programs; 80% for in-network and 60% for out-of-network surgery if surgery is approved upon completion of the Plan's pre-surgery program; Preauthorization is required. Deductible does not apply. Calendar year out-of-pocket maximum for coinsurance does not apply.

Mental Health and Chemical Dependency Program – See page 77 for program details

Benefit	Network Provider/Facility	Non-Network Provider/Facility
Assistance Program		
Assessment Visits	**Call 855-402-0272 24 hours a day, 7 days a week** Program pays 100% for up to 3 face-to-face counseling sessions per incident per person per calendar year and unlimited telephone-based counseling. Must be authorized by Cigna	None

Mental Health and Chemical Dependency Program – See page 77 for program details			
Benefit	**Network Provider/Facility**		**Non-Network Provider/Facility**
Mental Health Treatment Program			
Ambulance or Emergency Room	100% (not subject to Medical Plan deductible) if admitted for mental health treatment		Program pays 50% of UCR (not subject to Medical Plan deductible) if admitted for mental health treatment; 100% for hospital emergency room services
Outpatient	Program pays 100% after applicable copay if you preauthorize with Cigna Program pays 50% after applicable copay if you **do not** preauthorize treatment with Cigna		Program pays 50% of UCR Cigna preauthorization is not required
	Individual Sessions 1-20 sessions: $10 copay 21-50 sessions: $15 copay	**Group Sessions** 1-20 sessions: $5 copay 21-50 sessions: $7.50 copay	
	Up to 50 individual/group sessions per person per calendar year, combined network and non-network.		
Inpatient/ Alternate Care and Residential/ Partial Treatment	Program pays 100% if you preauthorize with Cigna Program pays 50% if you **do not** preauthorize treatment with Cigna The following alternate care levels equal 1 day of inpatient treatment: • 2 days of partial hospitalization • 2 days of residential treatment at a licensed residential treatment center • 4 sessions of in-home or outpatient (office) treatment by a licensed therapist • 4 home nursing visits for psychiatric or detox 23 hours of 1 to 1 observation		Program pays 50% of UCR if you preauthorize with Cigna No benefits are payable if you **do not preauthorize** treatment with Cigna
	Up to 45 days of authorized residential/inpatient/alternate/partial care treatment per person per calendar year combined network and non-network. Ninety days lifetime maximum per eligible participant. Two days of residential and/or partial treatment equal one day of inpatient treatment. Emergency admissions require Cigna authorization within 48 hours of the admission.		

Mental Health and Chemical Dependency Program – See page 77 for program details		
Benefit	**Network Provider/Facility**	**Non-Network Provider/Facility**
Chemical Dependency Treatment Program		
Ambulance or Emergency Room	100% (not subject to Medical Plan deductible) if admitted for chemical dependency treatment	Program pays 50% of UCR (not subject to Medical Plan deductible) if admitted for chemical dependency treatment; 100% for hospital emergency room services
Outpatient/ Inpatient	Program pays 100% if you preauthorize with Cigna	Program pays 50% of UCR if you preauthorize with Cigna
Alternate Care and Residential/ Partial Treatment	Program pays 50% if you **do not** preauthorize treatment with Cigna	No benefits are payable if you **do not preauthorize** treatment with Cigna
	Program pays 100% of authorized Substance Abuse Professional (SAP) services for eligible active employees who fail a DOT alcohol or drug test	Non-network SAP services are not covered
	Emergency admissions require Cigna authorization within 48 hours of the admission.	

Deductibles

You must generally pay a deductible each calendar year before the Plan pays any benefits.

The combined deductible for PPO and non-PPO physician services, outpatient care and other covered services is $200 per person per calendar year, with a maximum of $600 per family per calendar year if you first become eligible and covered during the calendar year. See page 47 for the deductible amounts if you were eligible and covered prior to the calendar year. The deductible does not apply to:

- In-network (PPO) preventive or routine care, office visits and office visit copays
- Second surgical opinions, when required by the UR manager
- The out-of-pocket maximum for coinsurance.

Since weight management, mental health, chemical dependency and prescription benefits are covered under separate programs charges for those services do not apply to the medical deductible.

Deductible Carry-Over Provision

The calendar year deductible must be satisfied by eligible expenses incurred in that calendar year. Any eligible expenses incurred during the last three months of the previous calendar year and applied to that year's deductible will be carried over and also applied to the next year's deductible. This carry-over provision does not apply to out-of-pocket expenses.

Copays

Office visit: $20 per visit (waived for preventive care obtained at a PPO provider)

Emergency Room: $75 per visit (waived if admitted)

Coinsurance

Plan A pays 90% of covered in-network (PPO) and 70% of covered out-of-network (non-PPO) hospital, physician, outpatient care, X-ray, lab, home healthcare, skilled nursing facility and hospice charges after the deductible and before your out-of-pocket maximum for coinsurance is reached. Once you reach the out-of-pocket maximum for coinsurance during a calendar year, eligible charges will be paid at 100% until the calendar year ends. Emergency room services at an out-of-network (non-PPO) hospital will be paid at 90%.

The Plan pays 100% after a $20 copay per visit for professional office visits, including related X-ray and lab for preventive or routine care (copay waived for preventive care obtained at a PPO provider).

Covered charges for non-PPO providers are subject to UCR limits.

Since weight management, mental health, chemical dependency and prescription benefits are covered under separate programs, charges for those services are subject to different coinsurance or copay levels.

Out-of-Pocket Maximum for Coinsurance

The out-of-pocket maximum for coinsurance limits your portion of covered coinsurance charges to a certain dollar amount each calendar year.

After the deductible has been met, the Plan pays 90% in-network (PPO) and 70% out-of-network (non-PPO) for most services until your out-of-pocket expenses for covered coinsurance adds up to $1,500 per person or $3,000 per family during a calendar year. Then the Plan pays 100% of most eligible charges for the rest of that calendar year.

The out-of-pocket maximum for coinsurance **does not** apply to:

- Copays for outpatient professional visits (and copays are not applied toward the out-of-pocket maximum)
- Charges applied to the deductible or in excess of UCR
- Charges not covered by the Plan
- Hospital pre-certification penalty or hospital days not certified as medically necessary.

Since weight-loss, mental health and chemical dependency benefits and prescription benefits are covered under separate programs, charges for those services do not apply to the out-of-pocket maximum for coinsurance.

Maximum Annual Benefit

In order to comply with the Patient Protection and Affordable Care Act, the Trust's maximum annual payment per Plan Year (July 1 – June 30) is $2,000,000 per person through June 30, 2014. No maximum will apply effective July 1, 2014.

Since weight-loss, mental health and chemical dependency benefits and prescription benefits are covered under separate programs, charges for those services do not apply to the annual maximum.

Covered Charges

The following charges are covered by the Plan and paid according to the Summary starting on page 47. For more information on what isn't covered and benefit limits, see Medical Plan Exclusions starting on page 66.

Benefit limits on number of visits or days apply whether or not the visits or days are subject to the deductible.

Inpatient Hospital Charges

Charges for Room and Board

Hospital room and board charges for admissions that have been certified as medically necessary.

Other Hospital Charges

Medically Necessary services and supplies furnished by the hospital for drugs, medicines, X-rays, lab tests, anesthesia, operating room facilities and other non-physician services and supplies used during a hospital stay. Take-home drugs or prescription drugs obtained at discharge that are used on an outpatient basis, and not during an inpatient stay, are covered only if obtained through the Prescription Drug program. See page 70.

Other Covered Charges In or Out of the Hospital

Acupuncture

Services by an MD, DO, or PPO acupuncturist for chronic pain or anesthesia up to the limits in the Summary on page 48. Acupuncture is not covered if you see a non-PPO acupuncturist.

Ambulance

Local professional licensed ambulance service, when medically necessary, to or from the nearest accredited hospital qualified to treat the condition. Air ambulance services are covered when medically necessary and only when other ambulance or transportation would endanger life or safety.

Anesthesia

Anesthetics and their administration.

Blood Transfusions

Including cost of blood and blood derivatives used by a covered patient and not replaced by a donor.

Contraceptive Devices

Charges for contraceptive devices and/or injections for the purpose of birth control when administered or prescribed by a physician. See Prescription Drug Program starting on page 70 for other contraceptive medical coverage.

Dental Coverage

Charges for treatment by a physician, dentist or dental surgeon for removal of a tumor or treatment of accidental injuries to natural teeth within 12 months after the accident. Emergency room care is not covered unless emergency care to treat dental pain is not available from a dentist under the dental plan. Except as noted, this medical plan does not cover treatment involving the teeth, surrounding tissue or structure.

Durable Medical Equipment and Supplies

Covered for items that are:

- Able to stand repeated use (except certain consumable medical supplies)
- Primarily and customarily used to serve a medical purpose, but generally not useful to a person in the absence of illness or injury
- Ordered and/or prescribed by a physician for the patient's exclusive use such as oxygen and rental equipment for its administration, surgical dressings, casts, splints, braces, trusses and crutches, pacemakers, blood glucose monitors and (up to the purchase price) hospital beds, wheelchairs or respirators.

Durable medical equipment does not include modifications to vehicles or residences, exercise equipment, ergonomic chairs or hot tubs.

Pre-certification is required for items over a $2,000 purchase price or $500/month rental fee or as otherwise deemed necessary by the Plan.

Education and Training Expenses

Medically necessary education and training provided in a hospital setting, inpatient or outpatient, as treatment for an illness. Examples include diet and nutrition counseling for diabetic patients, instructions for self-injections, wound care, ostomy care, and instruction for self-catheterization of kidney patients. Other types of education and training expenses are not covered.

Inpatient Well-Baby Care

Physician and approved nursery room charges for well newborns while hospitalized for routine care received within 72 hours of birth. No other physician or hospital charges are covered unless the infant is ill or injured.

Massage Therapy

When prescribed by a physician as part of a rehabilitation program for a diagnosed medical condition, up to the limit in the Summary on page 48.

Naturopathic Services

Services by a naturopath in the PPO network, up to the limits in the Summary on page 48. Naturopathic services are not covered if you see a non-PPO provider. Naturopathic supplies are not covered.

Occupational and Physical Therapy

By a licensed or registered physical or occupational therapist, up to the limits in the Summary on page 48.

Orthotics

Impression casting, corrective shoes or appliances. Must be prescribed by a physician for therapeutic purposes for an injury or covered medical condition under the Plan, and not primarily for use during participation in sports, recreational or similar activities. See Medical Plan Exclusions starting on page 66.

Outpatient Services

Emergency room care and other hospital-based outpatient care. Emergency room care will be paid at the applicable coinsurance percentage of the allowed charge after the deductible. The $75 copay per visit will be waived if you or a family member is admitted to the hospital and the charge is billed as an inpatient stay by the hospital.

Outpatient Surgery Center

Surgical treatment.

Physician Services

Covered surgery or assistant surgery, home, office or hospital visits and other medical care.

Preventive Care

Routine physical exams and screenings, outpatient well-baby care and immunizations recommended by the United States Preventive Services Task Force, Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention and the Health Resources and Services Administration (HRSA) and consistent with the Patient Protection and Affordable Care Act (PPACA) are covered at 100% if provided by an in-network (PPO) provider. If provided by an out-of-network (non-PPO) provider, standard out-of-network deductible, copays, or coinsurance and out-of-pocket limits apply.

The following table provides examples of the preventive care and immunizations covered. For a complete list of the covered preventive services pursuant to the PPACA, please contact the Trust office, or refer to the following website:
http://www.healthcare.gov/law/resources/regulations/prevention/recommendations.html

Preventive Care Guidelines	
Routine Physicals/Wellness Exam (Age 19+)	One physical exam every 3 to 5 years – age 19 to 65 One physical exam every 1 to 2 years – age 65+
Total Cholesterol/HDL Screenings	Men beginning at age 35, test every 5 years, shorter or longer intervals depending on lipid levels Women beginning at age 45, test every 5 years, shorter or longer intervals depending on lipid levels
Blood Pressure Screenings	Every 1 to 2 years
Other Screenings	Based on risk factors
Adult Immunizations (Age 19+)	Influenza – every year for adults at risk or age 50 and older Pneumonia – once for adults at risk and booster after 5 years for adults at highest risk and those most likely to lose their immunity Tetanus/Diphtheria – booster every 10 years Chicken Pox – test for immunity if under age 50; for adults at risk for exposure and blood test does not confirm immunity, administer two doses 4 to 8 weeks apart Measles, Mumps, Rubella – one dose if born 1957 or later unless vaccinated prior or immune; second dose if at risk Hepatitis A – two doses at least six months apart if at risk Hepatitis B – three doses if at risk Meningitis – one dose if at risk and additional dose for those that remain at high risk Tuberculin Skin Test – annual test if at high risk Human Papillomavirus (HPV) – at physician's discretion, three-dose series approved for all women 19 to 26 years.
Well Child Exams	Exams within first two weeks after birth and at 2, 4, 6-9, 12 and 15 months of age 2 to 3 years – exam at age 2 4 to 18 years – 4 to 7 exams
Child Immunizations	Immunizations per HHS/CDC schedule (includes Papillomavirus (HPV) three-dose series approved for all females 11 to 12 years; at physician's discretion, approved for females 9 to 10 years, and 13 to 18 years if not previously vaccinated)
Breast Cancer Screening	Beginning at age 40, every one to two years; earlier if at increased risk
Colon and Rectal Cancer Screening	Beginning at age 50, or earlier if at high risk, both men and women should follow one of these four testing schedules: Yearly fecal occult blood test (FOBT) Flexible sigmoidoscopy every 5 years Yearly fecal occult blood test plus flexible sigmoidoscopy every 5 years Colonoscopy every 10 years
Cervical Cancer Screening	Beginning three years after onset of sexual activity, but no later than age 21, women should be screened annually until 2 to 3 consecutive normal pap smears, then every three years At risk women should continue with annual screenings
Prostate Cancer Screening	Beginning at age 50, or age 40 if at increased risk, men should be offered the prostate-specific antigen (PSA) blood test and digital rectal exam (DRE) annually

Prostheses

Artificial limbs, eyes and larynx to replace natural body parts. Cosmetic or elective prostheses are not covered. Prostheses replacements are covered only if the original cannot be made functional.

Radiation Therapy and Chemotherapy

Radiation Therapy and Chemotherapy are covered when medically necessary.

Speech Therapy

If part of a prescribed treatment program, medically necessary speech therapy by a covered provider to restore or improve function that was normal but lost due to injury or sickness or to treat a congenital anomaly is covered up to the limits in the Summary on page 49 if part of a treatment program prescribed by a physician. Pre-certification by the Trust Administrative Office is recommended.

Spinal Treatment

Non-surgical treatment of the spine and its supporting structures, up to the limits described in the Summary on page 49. Diagnostic tests and X-rays in conjunction with the spinal treatments are covered up to one set of x-rays per calendar year.

Vision Therapy

Treatment by a covered provider such as an OD when medically necessary. Care must be part of a treatment program prescribed by a physician up to a 60-treatment lifetime maximum. Pre-certification by the Trust Administrative Office is recommended.

X-ray and Laboratory

Tests and analysis.

Special Treatment Benefits

Hearing Aids

Charges for hearing evaluation examinations and hearing aid devices. Benefits will be paid at the applicable coinsurance percentage of the allowed charge after the deductible up to a maximum of $1,000 per ear per person every 36 months.

The $1,000 maximum will be waived for hearing aids purchased for dependent children whose hearing loss was the result of a congenital anomaly. The child must still be in his or her physical growth years. The maximum will apply once the child has reached growth maturity.

You must be examined by a physician before obtaining a hearing aid. The physician must certify that your hearing loss may be lessened by the use of the hearing aid.

In conjunction with the purchase of a hearing aid, benefits will be provided for:

- An otologic examination by a physician and surgeon
- An audiologic examination and hearing examination by a certified or licensed audiologist (including a follow-up consultation)

- A hearing aid (monaural or binaural) prescribed as a result of such examination (including ear molds, the hearing aid instrument, the initial batteries, cords and other necessary ancillary equipment, a warranty, and follow-up consultation within 30 days following delivery of the hearing aid).

Hearing aid benefits will not be provided for:

- More than one examination during a period of three consecutive years without a hearing aid being obtained
- Replacement of a hearing aid for any reason more than once in any three consecutive years
- Batteries or other ancillary equipment other than that obtained on purchase of the hearing aid
- Repairs, servicing or alteration of hearing aid equipment
- A hearing aid exceeding specifications prescribed for correction of hearing loss
- Expenses incurred after termination of coverage under the Plan except expenses for a hearing aid ordered prior to termination and delivered within 30 days after the date of termination.

Cochlear Implants

Cochlear implants are covered only when medically necessary and pre-approved by the UR manager. When approved, the plan will pay the applicable coinsurance percentage of the allowed expenses after the deductible. The $1,000 hearing aid maximum benefit does not apply to pre-approved cochlear implants.

Jaw Treatment Benefits

Diagnosis and treatment, surgical and non-surgical, by a physician or dentist for Temporomandibular Joint (TMJ)/Myofascial Pain Dysfunction (MPD) and conditions which the Trust, upon medical review, determines are related to such jaw conditions, will be covered up to a $6,000 lifetime maximum. Orthodontia is not covered. Regular plan benefits apply to other jaw conditions, including treatment related to congenital skeletal deformities, tumors, or malignancies.

Jaw treatment maximums do not apply to jaw surgery or repair if the required treatment is for accidental injury. Regular plan benefits apply and require treatment to be started within the 12 months immediately following the accident unless you can show it was not reasonably possible to begin treatment within the 12 months and the treatment began as soon as reasonably possible. Orthodontia is not covered.

Organ, Tissue, and Bone Marrow Transplant Benefits

Human organ transplants considered medically necessary, appropriate and effective using prevailing standards of community medical practice. Experimental transplants are not covered.

These and other criteria are used to evaluate transplants:

- The patient is faced with a high risk of death
- All conventional therapies must have been attempted and proven unsuccessful
- The patient must not have a concurrent terminal disease

- The procedure must be to sustain life in a normal functioning state.

The transplant recipient becomes eligible for organ and bone marrow transplant benefits on the first day of the seventh month of continuous coverage under this Plan — whether or not the condition is pre-existing or an emergency. An infant (less than six months old) must have been continuously covered by the Plan since birth to be eligible for transplant benefits.

For breaks in coverage of more than 12 consecutive months, a new six-month waiting period for transplants is required.

The Plan pays covered charges for all related medically necessary services or supplies for these transplants subject to the conditions and limits described above:

- Heart
- Heart/Lung (combined)
- Kidney
- Kidney/Pancreas (combined)
- Liver
- Cornea
- Bone marrow
- Lungs (single/bilateral)

Benefits for all transplants are subject to pre-certification by the Utilization Review manager.

If a transplant is not successful, one re-transplant will be covered, except for medically necessary corneal transplants; additional corneal transplants will be covered if medically necessary.

The donor's medical expenses are covered in the absence of other group insurance, including tests for potential donors as well as selecting and procuring the organ. If donor expenses are eligible under another plan, this Plan's Coordination of Benefits (COB) provision applies (see pages 91 to 94). No transplant benefits are paid for:

- Non-human, artificial or mechanical transplants
- Recipients not covered under this Plan
- Experimental or investigational procedures as determined by the Plan
- Donor and procurement costs incurred outside the United States unless approved by the Plan.

Hospital Alternative Treatment

The Plan covers skilled nursing facility care, home healthcare, hospice care and alternative housing facility care in place of hospitalization. The Plan pays for covered charges incurred in the most appropriate treatment setting. The care must be recommended by the attending physician in a written treatment plan.

After your deductible is met and before your out-of-pocket maximum is reached, covered charges are paid at the applicable coinsurance percentage. Once you meet the out-of-pocket maximum, covered charges are paid at 100% until the beginning of the next calendar year or until the benefit maximum is reached (whichever occurs first). Plan payments for these alternatives are subject to the conditions and limits described below.

Skilled Nursing Facility Expenses

- The Plan pays for confinement in a skilled nursing facility ordered by a physician for up to 180 days for the same or related condition. The confinement must be for medically necessary treatment of a covered illness or injury. To ensure coverage, call Cigna at 855-402-0272 for preauthorization of your stay.
- Excluded from coverage are charges for any confinement deemed not medically necessary for the treatment of a covered illness or injury, primarily for rehabilitation or care that can be provided on an outpatient basis, custodial care, residential treatment , personal comfort items or private duty nursing.

Home Healthcare Expenses

- The Plan pays for medically necessary care by registered nurses, licensed practical nurses, home health aides, physical, occupational, speech or respiratory therapists and professional ambulance services
- Rental of durable medical equipment (such as wheelchairs, hospital beds and crutches), lab services, drugs, medicines and other supplies prescribed by the attending physician are covered if they're medically necessary and would have been covered in a hospital
- Services and supplies for infusion therapy by an infusion therapy provider are covered (the infusion therapy provider must submit a written treatment plan to the Trust Administrative Office that specifically describes the infusion therapy services to be provided)
- The Plan excludes services by any person who normally lives in your home or by volunteer agencies, custodial care (such as meals and personal grooming), transportation services, nutritional guidance, supportive environmental materials (such as handrails, ramps and air conditioners) or any services/supplies not included in the treatment plan
- The Plan pays for up to 130 home healthcare visits in any calendar year; each visit counts toward the maximum whether or not any of the visits apply to the deductible
- A visit of any duration to provide home healthcare constitutes one visit.

Hospice Care Expenses

- The Plan pays for hospice care when, in the opinion of the attending physician, the patient is terminally ill
- Services may be provided by a hospice care team, a hospital, home healthcare agency or skilled nursing facility, but must be under the terms of a hospice care program and billed through the hospice that manages the program
- Hospice services may include inpatient and outpatient care, home healthcare, nursing care, counseling and other supportive services and supplies
- Professional ambulance services certified as medically necessary by a physician as well as drugs, medicines and other supplies prescribed by a physician are covered
- Respite care is covered in the most appropriate setting up to five continuous days per three months of hospice care
- The Plan excludes hospice care services not approved by the attending physician, transportation except as provided by professional ambulance service and custodial care (such as meals or personal grooming)

- Home care services of an approved hospice agency are covered up to 60 visits per person per lifetime. All visits by any person representing the hospice agency will count toward the 60 visit maximum. If the life expectancy of the patient is extended, or benefits are otherwise exhausted, the patient's family should contact the Trust Office to request an extension. Limited extensions will be granted if it is determined the care is medically necessary.

Alternative Housing Facility Expenses

- The Plan pays covered charges for alternative housing while receiving special treatment unavailable at a local facility if the patient's medical condition prohibits traveling between the home and the site of treatment

- A physician must certify that the medical condition requires hospitalization and that the alternative housing is instead of hospitalization

- The alternative housing facility must be an approved facility

- The Plan pays the lesser of the single occupancy rate or $60 per day up to 70 days for each period of confinement. The level of payment is constant and will not change when your out-of-pocket maximum for coinsurance is reached (charges above $60 per day do not apply to the annual out-of-pocket maximum for coinsurance).

Medical Plan Definitions

Accidental Injury — Physical harm from a sudden, traumatic, unforeseen event caused by the intervention of an external force, at a specific time and place.

Acupuncture — A therapy used for relieving chronic pain or anesthesia, covered only if performed by a covered PPO acupuncturist, MD or DO.

Calendar Year — Period of one year beginning January 1 and ending December 31.

Coinsurance — The percentage of the allowed charge you're responsible for paying (for example, after you meet your deductible you pay 10% coinsurance and the Plan pays 90% for covered services obtained from an in-network (PPO) provider, or you pay 30% coinsurance and the Plan pays 70% for covered services obtained from an out-of-network (non-PPO) provider.

Copays — A flat dollar amount you generally pay at the time you receive a specified healthcare service or supply. Copays are not applied toward deductibles or out-of-pocket maximums.

Cosmetic Surgery — Surgery performed to alter the texture or configuration of the skin or any bodily feature's configuration or relationship with adjoining structures. It is performed primarily for psychological purposes and does not correct or materially improve a bodily function.

Covered Charges — Medically necessary expenses for care provided according to the Plan's conditions and limits that do not exceed UCR charges (defined on page 66). Covered charges means the same as covered expenses or covered services.

Custodial Care — Any portion of a service, procedure or supply that, in the Trust's judgment, is provided primarily:

- For ongoing maintenance of health and not for its therapeutic value in treating an accidental injury or sickness

- To assist the patient in meeting the activities of daily living such as help in walking, bathing, dressing, eating, preparing special diets and supervising self-administration of medicines
- To sustain a patient without attempting to treat an illness or injury.

Deductible — The amount of eligible medical expenses you must pay each calendar year before the Plan pays benefits. Eligible expenses applied to the deductible in the last three months of the calendar year apply to the next calendar year deductible. Does not apply to office visits, preventive care, or to second surgical opinions required by the UR manager.

Durable Medical Equipment — Items that are able to stand repeated use (except certain consumable medical supplies)

- Primarily and customarily used to serve a medical purpose, but generally not useful to a person in the absence of illness or injury
- Ordered and/or prescribed by a physician for the patient's exclusive use such as oxygen and rental equipment for its administration, surgical dressings, casts, splints, braces, trusses and crutches, pacemakers, blood glucose monitors and (up to the purchase price) hospital beds, wheelchairs or respirators.

Durable medical equipment does not include modifications to vehicles or residences, exercise equipment, ergonomic chairs or hot tubs.

Experimental/Investigational — Any service (treatment, procedure, facility, equipment, drug, drug usage, medical device or supply) that meets one or more of the following criteria as determined by the Trust:

- A drug or device that cannot be lawfully marketed without United States Food and Drug Administration (FDA) approval and has not been granted that approval on the date it is furnished
- A facility or provider that has not demonstrated proficiency in the service, based on experience, outcome or volume of cases
- Reliable evidence shows the service is the subject of ongoing clinical trials to determine maximum toxicity, safety, efficacy or tolerated dose
- Reliable evidence shows the service is not safe or effective for a particular medical condition compared to other generally available services, or
- Poses a significant risk to the patient's health or safety

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

Home Health Aide — A person, other than a registered nurse, who provides medical or therapeutic care under the supervision of a home healthcare agency.

Home Healthcare Agency — A hospital, agency or other service certified to provide home healthcare by the proper authority of the state where it's located.

Home Healthcare Treatment Plan — A program of home care that is:

- Required as the result of sickness or injury
- Established and reviewed at least every 60 days by the attending physician

- Certified by the attending physician as a replacement for hospital confinement or confinement in a skilled nursing facility that would otherwise be necessary.

The treatment plan must also describe the services and supplies to be provided by the home healthcare agency. Treatment plans are subject to periodic review by any designated agent of the Trust or Trust Administrative Office.

Hospice — A facility, agency or service that:

- Is licensed, accredited or approved by the proper regulatory authority to establish and manage hospice care programs
- Arranges, coordinates and/or provides hospice care services for dying individuals and their families
- Maintains records of hospice care services provided and bills for those services on a consolidated basis.

Hospice Care Program — A program to meet the special physical, psychological and spiritual needs of dying individuals and their families that are:

- Managed by a hospice
- Established jointly by a hospice, a hospice care team and an attending physician.

Hospital — A legally-operated institution providing inpatient care and treatment through medical, diagnostic and major surgical facilities on its premises, under supervision of a staff of physicians, and with 24-hour nursing service or one accredited as a hospital by the Joint Commission on Accreditation of Healthcare Organizations. The term also includes:

- An approved Christian Science Sanatorium or other institution approved by the Committee on Christian Science Nursing Homes by the Mother Church of the First Church of Christ Scientist in Boston, Massachusetts (confinement for spiritual guidance or rest in any such institution is not covered)
- Transitional care facility for rehabilitation (subject to pre-certification)
- A state-licensed birthing clinic.

The term hospital does not include a nursing home or institution (or part of one) used mainly as a facility for convalescence, nursing, rest, the aged, treatment of chemical dependency or domiciliary or custodial care.

Massage Therapist — A licensed massage therapist.

Medically Necessary/Medical Necessity — Treatments, services or supplies that must be ordered through a physician or other covered, qualified provider and commonly and customarily recognized by the physician's profession as appropriate to treat the patient's diagnosed injury or sickness (as specified by authoritative medical or scientific literature). This also must be the least costly of alternative treatments, settings, services or supplies that can safely be provided. It does not include maintenance or supportive treatments or services or those that are educational, experimental or primarily for medical or other research. The fact that any treatments, services or supplies are furnished, prescribed or approved by a physician or other qualified provider does not in itself mean it is medically necessary. A medical treatment, service, supply or setting may be medically necessary in part only.

Network or Preferred Provider — A provider who has contracted with the Trust's PPO; also referred to as an in-network provider or PPO provider.

Non-Network or Non-Preferred Provider — A provider who has not contracted with the Trust's PPO; also referred to as an out-of-network or non-PPO provider.

Nurse — Includes Licensed Registered Nurses (RNs), Licensed Practical Nurses (LPNs) and Certified Registered Nurse Practitioners (CRNPs).

Occupational Therapy — Rehabilitative treatment for an illness, injury or condition when performed by a certified occupational therapist and prescribed by a physician.

Out-of-Pocket Maximum for Coinsurance — Refers to the calendar year limit on your coinsurance portion of covered charges. Does not include:

- Emergency room or office visit copays
- Charges applied to the deductible
- Mental health or chemical dependency treatment charges
- Excluded charges
- Amounts in excess of UCR
- Any portion of the benefit reduction due to failure to obtain pre-certification or for hospital stays not considered medically necessary
- Prescription drug charges
- Weight-loss treatment charges

Outpatient Care — Treatment in a non-hospital facility or by a hospital for outpatient treatment.

Outpatient Surgical Center — A physician's office, medical clinic or legally-operated institution engaged primarily in providing outpatient surgical care that meets all established standards for this kind of facility.

Physical Therapy — Treatment of an illness, injury or condition by physical means (such as hydrotherapy, heat or similar treatments) when performed by a licensed or registered physical therapist and prescribed by your physician.

Physician — A physician licensed to practice medicine and perform surgery. For Plan purposes, the term includes these health professionals only:

- A licensed medical doctor (MD), osteopathic doctor (DO), dentist, podiatrist, chiropractor or optometrist who:
  - Is legally licensed or certified by the state
  - Is legally licensed to perform services for which benefits are provided under the Plan
  - Acts within the scope of that license in performing services (benefits for certified registered nurse charges are payable only if in place of physician charges).
- A Christian Science Practitioner authorized by the Mother Church of the First Church of Christ Scientist in Boston, Massachusetts
- A certified registered nurse who:

  - Is legally licensed or certified by the state
  - Is legally licensed to perform services covered under the Plan
  - Acts within the scope of that license in performing services (benefits for certified registered nurse charges are payable only if in place of physician charges).
- A midwife who:
  - Is legally licensed to perform services covered under the Plan
  - Acts within the scope of that license in performing services (benefits for midwife charges are payable only if in place of physician charges).
- Licensed acupuncturist (only if a PPO provider).
- Licensed naturopath (only if a PPO provider).

Physician or Office Visit — A personal interview where the physician sees the patient. Telephone consultations are not considered visits.

Plan Year — Period of one year beginning July 1 and ending June 30.

PPO Allowed Amount — A discounted or set negotiated rate for PPO services. The PPO provider cannot charge the patient more than the PPO allowed amount for any service.

Preferred Provider Organization (PPO) — A network of doctors, hospitals, specialists, clinics and other healthcare providers who are members of the contracted PPO. These providers furnish medical services to Trust participants at negotiated rates.

Prescription Drug — Any medical substance with a label required (by the federal Food, Drug and Cosmetic Act) to say: “Caution: federal law prohibits dispensing without a prescription.”

Respite Care — Care for a homebound participant requiring continuous attendance to relieve from their duties all persons caring for and residing with the patient.

Skilled Nursing Facility/Home — A licensed facility having seven or more beds, accredited by the Joint Commission on Accreditation of Healthcare Organizations and primarily for convalescent care. It must be under the supervision of a physician and surgeon and not a home for the care of mental health/chemical dependency patients or the aged, or a rest home or place for custodial care. This includes a facility that would be classified as a skilled nursing care facility under Medicare if the facility actively sought Medicare approval.

Subrogation (third-party reimbursement) — If you receive benefits for any condition or injury caused by another party, this Plan has the right of recovery. Also, if you sue the person who may have been responsible for your condition, benefits paid or payable by the Plan must be included in your suit. When the suit is settled, the Plan must be reimbursed for the amount of benefits provided.

Temporomandibular Joint (TMJ) Disorder and Myofascial Pain Disorder (MPD) — A disorder of the temporomandibular joint (the joint that connects the mandible or jawbone to the temporal bone), generally characterized by:

- Pain, tenderness or muscle spasms in one or more of the following areas: face, jaw, neck, head, ears, throat, shoulders or the preauricular, temporal, occiput or masticatory muscles
- Popping or clicking of the jaw or TMJ
- Abnormal range of motion, or locking of the jaw or TMJ

- Malocclusion, overbite or underbite and/or mastication (chewing) difficulties.

Terminally Ill Person — A person whose life expectancy is six months or less, as certified by the primary attending doctor.

Totally Disabled — A person is considered totally disabled when, because of a covered accident or illness (including pregnancy and its complications) they are:

- Not able to perform the normal duties of their occupation
- Not engaged in any occupation for wage or profit (except for light-duty work with the same employer)
- Under a physician's regular care for that injury or sickness. A dependent is considered totally disabled when, because of a disability, they're unable to engage in the normal activities of a person of the same age.

Trust Administrative Office — The Administrative Office retained by the Trust to provide administrative services. (See page 106 for the address and telephone number.)

Usual, Customary and Reasonable (UCR) charges — Charges that do not exceed the fee usually charged by the individual or institution and are similar to charges by other providers with similar training and experience in the same geographic area for comparable services and supplies as determined by the Trust.

Medical Plan Exclusions

Medical benefits are not payable for any of the following listed items. This applies to all medical benefits as described on pages 53 to 61.

1. Services or supplies received while not eligible under the Plan.
2. Expenses in excess of the usual, customary and reasonable (UCR) charges.
3. Services or supplies that are:
   a. Not recommended by a licensed physician or surgeon
   b. Not medically necessary
   c. Considered experimental or investigational
   d. Provided by or paid for by the United States Government or any of its agencies, except as otherwise required by law
   e. Not considered by the Trust to be durable medical equipment such as air purifiers, hot tubs, waterbeds, exercise equipment, modifications to vehicles or residences, ergonomic chairs, etc. (whether or not prescribed by a physician)
   f. Prescribed or provided by non-covered providers
   g. For your convenience or that of your family, or personal services such as meals for guests, phone charges, TV charges or barber/beautician charges
   h. Furnished to you by yourself or by a provider who lives in your home or is related to you by blood, marriage or adoption.
4. Services, supplies or Time Loss for a claim not submitted within one year of the date the services or supplies were provided or the disability took place.

5. Injury or sickness for which you have received, or are entitled to receive, compensation under any workers compensation, occupational disease law or other similar legislation, whether or not you elect that coverage or meet the claim filing deadline (not applicable to LEOFF 1 participants).

6. Loss incurred while serving the armed forces or as the result of an act of war, including terrorism.

7. Custodial care.

8. Expenses an eligible person does not have to pay.

9. Physical exams or immunizations required as a condition of employment.

10. Diagnosis and treatment to restore fertility or promote conception, such as:

    a. Artificial insemination
    b. In vitro fertilization
    c. Embryo transplant
    d. Microinjections
    e. Zona drilling or other artificial means of conception
    f. Consecutive follicular ultrasounds
    g. Cycle therapy
    h. Reversal of sterilization procedures
    i. Tuboplasty
    j. Fertility drugs
    k. Corresponding lab tests associated with artificial means of conception (for a covered person or surrogate as a donor or recipient)

    Any expenses in connection with conception, pregnancy, or delivery with a surrogacy arrangement are also not covered.

11. Sex transformations or sexual dysfunction treatment except for conditions of organic origin where the cause is documented by the attending physician.

12. Sexual problems (including counseling).

13. Maternity expenses for covered dependent children, including delivery, abortion or miscarriage.

14. Education or training other than the covered expenses described on page 54 or covered under Preventive Care on page 55. Examples of education and training exclusions include:

    a. Lifestyle, fitness or tobacco cessation programs, except as provided under the Stand Strong wellness programs beginning on page 39. See Prescription Drug Program for covered smoking cessation medications and limits.
    b. Rehabilitation or job training or outreach
    c. Vocational assistance or counseling.

15. Learning disabilities (unless medically necessary).

16. Marital or family problems (including counseling).

17. Sleeping or eating disorders.

18. Over-the-counter drugs or medications, vitamins or nutritional or dietary supplements (whether or not prescribed by a physician).

19. Vision exams, glasses or the fitting of glasses or contact lenses, or any type of surgery to correct visual acuity (such as radial keratotomy or LASIK surgery).

20. Periodontal or dental disease or any condition involving the teeth, surrounding tissue or structure (except as described under Covered Charges beginning on page 53).

21. Jaw surgery, orthodontic treatment for malocclusion or TMJ (except as described on page 58).

22. Cosmetic or reconstructive surgery, except for:

    a. Accidental injuries occurring while you or a covered dependent is eligible under the Plan, so long as treatment occurs within 12 months of the injury

    b. Repair of defects resulting from a covered surgery for which benefits are paid under the Plan

    c. Reconstruction of a breast after mastectomy, including all stages of any reconstructive breast reduction performed on the non-diseased breast to make it equal in size with the reconstructed diseased breast

    d. Prostheses and treatment of physical complications of mastectomies including lymphedemas.

23. Hygienic or routine foot care, such as treatment of:

    a. Weak, strained, flat, pronated, unstable or unbalanced feet

    b. Metatarsalgia

    c. Bunions (except open cutting operations)

    d. Corns, calluses or trimming of nails.

24. Orthopedic appliances, shoes or orthotics for non-covered injuries or medical conditions or prescribed primarily for use during participation in sports, recreational or similar activities.

25. Obesity, including surgery and its complications, as well as services or supplies connected with weight loss/weight control, except as provided in Weight Management Programs beginning on page 41. (This exclusion applies even if you also have an accidental injury or sickness that might be helped by weight loss.)

26. Long-term storage of blood other than charges in connection with bone marrow transplants associated with a diagnosed medical condition.

27. Surgery or other services required to repair or treat a condition resulting from an excluded medical treatment or procedure.

28. Milieu therapy (treatment designed primarily to provide a change in environment or a controlled environment).

29. Dyslexia, attention deficit disorder or delays/disorders in the development of a child's language, cognitive, motor or social skills except for physician services for the management of prescribed medications.

30. Claims incurred while legally confined for participation in criminal activities.

31. Prescription drugs obtained from a retail pharmacy, except for oral vaccines. See pages 70 to 76 for a description of your prescription drug benefit.

32. Acupuncture except as described on page 53.

33. Charges for any covered services in excess of the maximum benefits specified under this Plan.

34. Hearing aids or cochlear implants except as described on page 57.

35. Naturopathy services and supplies except as described on page 55.

Prescription Drug Program

MedImpact administers your prescription drug program and provides a **nationwide network** of *Recommended* and *Regular* network pharmacies and a Mail Order pharmacy. The *Recommended* network, *Regular* network and Mail Order pharmacy have an agreement to provide discounted prices. However, the Mail Order and the *Recommended* pharmacies offer better discounts; they are also unionized employers or pharmacies that do business with unionized employers.

A list of the network pharmacies (*Recommended* and *Regular*) including the Mail Order pharmacy is available through MedImpact. All network pharmacies are linked to a computer system that identifies Trust participants by plan and provides your pharmacy immediate pricing and other information based on plan provisions (see Quality Control on page 76 for details).

Prescription drug benefits are not subject to the medical plan deductible, and the reimbursement level doesn't change when your medical plan coinsurance out-of-pocket maximum is satisfied.

The Trust is the primary payer for prescription drug benefits, and therefore doesn't coordinate these benefits with other plans outside the Trust. Contact the Trust Administrative Office for details.

Retail Prescription Benefits

Except in medical emergencies, only prescriptions purchased at a MedImpact *Recommended* or *Regular* network pharmacy are covered by the Plan.

When you use a retail network pharmacy you pay only your share of the cost to the pharmacy, as listed below. The pharmacy then submits the claim to the Plan, and the Plan pays the balance of the cost directly to the pharmacy. A maximum 34-day supply is allowed for retail.

Prescription Drugs — Retail Pharmacy			
Type of Drug	***Recommended* Network Pharmacy – you pay:**	***Regular* Network Pharmacy – you pay:**	**Non-Network Pharmacy (medical emergency only) – you pay:**
Generic	10% of the drug cost	15% of the drug cost	$9 handling fee in addition to your normal cost share
Formulary Brand (preferred)	30% of the drug cost	35% of the drug cost	$9 handling fee in addition to your normal cost share
Non-formulary Brand (non-preferred)	40% of the drug cost	45% of the drug cost	$9 handling fee in addition to your normal cost share

Your retail pharmacy benefit depends on whether the prescription drug is generic or Formulary or non Formulary brand and whether you buy your prescription drugs at a *Recommended* or *Regular* MedImpact network pharmacy. You pay only your share of the cost to the pharmacy when you purchase your prescription. The Plan then pays the balance of the cost directly to the pharmacy.

Non-Network Pharmacy

Prescriptions purchased from a non-network pharmacy are **not covered** except in a medical emergency where using a network pharmacy is not reasonable. See Medical Emergency Non-Network Benefits, below.

Mail Order Prescription Benefits

You can save time and money in many cases and get a larger supply of your medication (up to 100 days) using the Mail Order prescription program.

Prescription Drugs – Mail Order Pharmacy	
When you use the network mail order pharmacy you pay only the copay amount. The pharmacy then submits the claim to the Plan, and the Plan pays the balance of the cost directly to the mail order pharmacy as listed below. A maximum 100-day supply is allowed for mail order.	
Type of Drug	**You pay the lesser of:**
Generic	10% of the drug cost or $15 copay per prescription
Formulary Brand (preferred)	30% of the drug cost or $90 copay per prescription
Non-formulary Brand (non-preferred)	40% of the drug cost or $130 copay per prescription

Specialty Prescription Drug Program

The Plan offers a specialty prescription drug program that covers medications used to treat the following health conditions:

- Crohn's disease
- Growth hormone deficiency
- Hepatitis C
- HIV/AIDS
- Multiple sclerosis
- Psoriasis
- Rheumatoid arthritis

Prescription medications covered under the specialty prescription drug program may change from time-to-time.

You can order many specialty prescription drugs through the Plan's Mail Order pharmacy which can save you money. You can get a 100-day supply for the lesser of a $15 or 10% copay on generic drugs, or the lesser of a $90 or 30% copay for brand-name drugs. Ancillary supplies, such as syringes and alcohol swabs are included with your order at no charge. Your medication will be delivered to your home or doctor's office at no cost to you.

If you have questions about the specialty prescription drug program or to refill a prescription, call the Union Center Pharmacy at 800-441-9174.

Medical Emergency Non-Network Benefits

Prescriptions purchased at non-network pharmacies are covered under certain circumstances by Trust medical plans for medical emergencies where using a network pharmacy is not feasible.

Here's how the prescription drug program works *in a medical emergency.* If you are:

- Traveling outside the United States or traveling within the United States in an area with no network pharmacy — At the *Recommended* pharmacy benefit level using the full price of

the prescription less a $9 handling fee. The $9 is in addition to your normal Recommended network pharmacy cost share.

- In a city with a network pharmacy, but due to unusual circumstances or circumstances beyond your control, you cannot use a network pharmacy — At the *Regular* pharmacy benefit level using the *discounted price* of the prescription less a $9 handling fee. The $9 is in addition to your normal Regular network pharmacy coinsurance or cost share. The *discounted price* is the price the Trust would have received if you had used a *Regular* network pharmacy.

To receive benefits, you must file an *Emergency non-network prescription drug claim form*, including proof of purchase and an explanation of the medical emergency that made it unreasonable to use a network pharmacy. *Emergency non-network prescription drug claim forms* are available from MedImpact or the Trust Administrative Office. If approved, you will be reimbursed according to the description above.

Generic Drugs

The generic name of a drug is simply its chemical name. Generic drugs meet strict requirements under the FDA and are considered to be as safe, efficient and effective as brand-name drugs, but are usually much less expensive. Unless otherwise specified by your doctor, your prescriptions will be filled with generic drugs. You may override this policy and request the brand-name prescription if you don't want to accept a generic drug, but the Plan will require you to pay the difference in cost between the brand-name and generic drug in addition to the brand-name copay or cost share.

Trial Doses

Certain new and/or high-cost prescriptions may be limited to a trial dose (instead of the usual 34- or 100-day supply) on the first and possibly second order of a new prescription to determine patient tolerance and drug effectiveness.

Using the Retail Pharmacy

- You must use a MedImpact *Recommended* or *Regular* network pharmacy
- You will receive a higher level of benefits if you use a *Recommended* MedImpact network pharmacy
- Give the pharmacist your Trust ID card or identify yourself as a participant in the Washington Teamsters Welfare Trust
- The pharmacist will ask for identifying information (such as employee Social Security number or Trust ID # and patient date of birth) to enter into the computer system
- The pharmacist may recommend alternative medications after consulting with your physician The pharmacist will fill your prescription up to a 34-day supply
- You pay the pharmacy only your share of the cost of the prescription
- Network pharmacies will substitute generic drugs when permitted by the prescribing physician; you may override this policy and request the brand-name prescription if you don't want to accept a generic drug, but the Plan will require you to pay the difference in cost between the brand-name and generic drug in addition to the brand-name copay or cost share
- The pharmacy will electronically submit your prescription data to MedImpact to verify eligibility and payment of the remaining balance.

When Refills Are Available

The Plan will only cover prescriptions that are refilled after a certain amount of time has passed. Have your prescription refilled when at least 75% of the medication has been used. If you refill your prescription when more than 25% of the total days supply remains, the Plan will not cover the cost of the refill.

Using the Mail Order Pharmacy

The Mail Order program is designed for individuals using maintenance medications (for 30 days or longer) to treat chronic or long-term conditions such as diabetes, arthritis, heart conditions, high cholesterol, digestive, asthma and high blood pressure. Mail order is not intended for medications needed immediately.

Prescription drugs supplied by the Mail Order pharmacy meet the highest pharmaceutical standards of quality, safety and effectiveness. Each prescription is filled and checked by a registered pharmacist to assure the quantity and strength is accurate. A patient profile is maintained to help avoid undesirable drug interaction.

To use the Mail Order program, request a mail order form from Union Center Pharmacy or your local union and follow the instructions. Refills can generally be ordered over the phone or online. Again, follow the instructions enclosed with your original prescription. Allow about 10 days to receive your medication by mail.

The Plan cannot reimburse prescriptions that are refilled too soon. Have your prescription refilled when at least 75% of the medication has been used. If you refill your prescription when more than 25% of the total days supply remains, your reimbursement cannot be processed.

For questions about using the network Mail Order program or your benefits, contact the Trust Administrative Office.

Talk to Your Doctor About Your Medication

- Bring a copy of the Plan's formulary (preferred drug list) to your next doctor's visit; using formulary drugs can result in lower overall costs for you — and the Trust. The formulary is available on the MedImpact website at **www.medimpact.com** or from the Trust Administrative Office.

- Ask about lower cost alternatives such as generic medications and preferred medications listed on the formulary

- Check the prescription to make sure the dosage, your doctor's signature, your name and your address are included and are clear

- If the medication is for a long-term condition or is considered a maintenance drug, think about using the Mail Order program. After you and your doctor have confirmed the drug is effective for your condition, ask your doctor to write your prescription for up to a 100-day supply with up to three refills. If you need medication immediately, ask your doctor to write two prescriptions — one for an immediate supply to be taken to your retail pharmacy, and the second for an extended supply to be sent to the mail order pharmacy.

Covered Prescriptions

The following drugs, medicines and supplies are covered when prescribed in writing by a physician:

- Antacids containing aluminum hydroxide, aluminum hydroxide with magnesium trisilicate, aluminum and magnesium hydroxide gel, calcium carbonate, magnesium carbonate suspension and dihydroxy-aluminum amino acetate
- Compounded dermatological preparations including ointments and lotions prepared by a pharmacist under doctor's prescription. You will be charged the brand-name drug copay and/or coinsurance.
- Contraceptives or contraceptive devices requiring a prescription
- Diabetic supplies (excluding appliances) including insulin, syringes, needles, test tape or strips, acetone test tablets, Benedict's solution or equivalent, lancets and similar test supplies
- Eye or ear medications requiring a prescription
- Legend drugs requiring a prescription from a physician or dentist (that is, any medicine labeled "Caution: federal law prohibits dispensing without a prescription")
- Miscellaneous items such as bee sting kits, ephedrine sulfate and ferrous sulfate (only the sulfate)
- Smoking cessation prescriptions (limited to $500 in benefits per calendar year to a $1,000 lifetime maximum per person). You must enroll in the StayWell Nextsteps Tobacco Cessation program and complete one call with a Health Coach in order to have a prescription refill covered by the Plan.

Prescription Drug Program Exclusions

1. Any prescription or refill that individually, or cumulatively over time, creates dosages exceeding the FDA or manufacturer recommendations.
2. Claims not electronically filed by a network pharmacy (unless it was not reasonably possible to file the claim and the claim is submitted within one year with proper documentation).
3. Contraceptives or contraceptive devices that do not require a prescription.
4. Cosmetic purpose drugs such as Minoxidil or Retin A.
5. Devices used to administer drugs.
6. Dietary supplements and vitamins including fluorides or any medication containing fluorides.
7. Drugs dispensed in a hospital, nursing home, clinic, ambulatory surgical center, doctor's office or other institution.
8. Drugs dispensed to a dependent child because of pregnancy.
9. Drugs labeled "Caution — limited by federal law to investigational use," or experimental drugs.
10. Drugs prescribed or purchased while in service in the armed forces or as a result of war or act of war, including terrorism.
11. Drugs to treat conditions that are not within uses approved by the FDA or manufacturer (including experimental uses).

12. Drugs used to restore fertility or promote conception.
13. Drugs purchased at non-MedImpact network pharmacies, including take-home drugs or drugs purchased at discharge from an inpatient facility for outpatient use, if those drugs are not obtained from a MedImpact network pharmacy.
14. Immunization agents, biological sera or non-drug items.
15. Medications, drugs or supplies that are compensated or furnished by the United States government or any of its agencies.
16. Medicines or drugs procured or procurable without a prescription from a physician or dentist, including all over-the-counter drugs (except as may be allowed by the Trust or described in Covered Prescriptions on page 74).
17. More than a 34-day supply at a retail pharmacy or a 100-day supply from the mail order pharmacy.
18. Smoking cessation products that do not require a prescription.
19. Reimbursement of drugs when the Trust is paying as the secondary insurer (or when another insurance plan has made a primary payment).
20. Prescriptions for illness or injuries as a result of service in the armed forces or as a result of an act of war, including terrorism.

Drug Utilization Review (DUR)

The Trust has authorized a structured system to analyze and improve drug prescribing and use patterns. This Drug Utilization Review committee consists of professors, pharmacists and physicians with experience in drug benefit management, clinical pharmacy and drug interactions. The committee confidentially reviews prescription profiles using predetermined medical and pharmaceutical standards; these reviews may include:

- Possibility of clinically significant drug interactions
- Profiles with an unusual number of prescriptions in a given period
- Numerous prescribing physicians and dispensing pharmacies
- Profiles with a high number of controlled substances
- Physician prescribing patterns or pharmacy dispensing patterns that result in excessive drug costs.

If the reviews disclose possible inappropriate use of prescription drugs or drug interactions, the DUR committee is authorized to contact the prescribing physicians or dispensing pharmacies to resolve the matter. Unresolved cases may be referred to the Trust Administrative Office with a recommendation for benefit denial.

Formulary

Your prescription benefit uses a list of preferred drugs called a formulary. These drugs have been selected by a panel of physicians and pharmacists based on therapeutic effectiveness and favorable pricing arrangements, including volume rebates. The formulary is available on the MedImpact website at **www.medimpact.com** or from the Trust Administrative Office. Compliance with the formulary is voluntary but will affect the amount of your copay or

reimbursement. Please share this list with your physician during your visit; use of formulary drugs can result in lower overall costs to the Trust — and to you.

Medicare and Prescription Drug Coverage

The prescription drug benefits you have under the Washington Teamsters Welfare Trust medical plan are expected to pay out, on average, at least as much as the standard Medicare Part D prescription drug coverage. (This is known as “creditable coverage.”) The reason this is important is that if you or a covered dependent are or become eligible for Medicare and you decide to enroll in a Medicare prescription drug plan during a subsequent annual enrollment period, you will not be subject to a late enrollment penalty as long as you had creditable coverage within 63 days of your Medicare prescription drug plan enrollment. The Trust will review the benefits annually to determine if they continue to qualify as creditable coverage and issue an annual notice to participants.

Quality Control

All MedImpact retail and mail order pharmacies are electronically linked to a central computer system containing certain information on Plan participants. This system is updated frequently based on current eligibility status. Occasionally you may attempt to purchase a prescription from a MedImpact network pharmacy that cannot confirm your eligibility because pertinent data isn’t in the system. This may happen because:

- You are a new participant and have not been entered into the Trust data files
- You have not been eligible under the Plan for an extended period (usually two or more months)
- You have an inconsistent pattern of eligibility
- Your dependent child reaches an age that makes him/her ineligible
- Your newly acquired dependents (due to marriage or remarriage, newborn children, stepchildren, etc.) have not been entered into the Trust data files
- Your employer’s contributions have not been received.

On other occasions, a new network pharmacy not yet familiar with the MedImpact program may have difficulty confirming your eligibility.

If you experience any of these issues with a MedImpact network pharmacy, ask the pharmacist to call MedImpact at 800-788-2949.

Mental Health and Chemical Dependency Benefits Program

The Mental Health and Chemical Dependency Benefits program is designed to provide you and your family with counseling for personal problems and mental health or chemical dependency treatment options. Your benefits include 24-hour assistance, assessment, referral, outpatient counseling, inpatient and alternate care programs, utilization management, and case management.

You can call Cigna 24 hours a day, 7 days a week, 365 days a year at **855-402-0272**. Cigna staff is available to assist you in obtaining referrals, answering questions about your benefits or can connect you immediately to a staff clinician for a clinical emergency.

Assistance Program & Behavioral Healthcare Services: Two Components Working Together

Component One: Assistance Program

The Assistance Program provides referral, legal and identity theft recovery services along with financial planning and short-term counseling with Cigna network practitioners who identify, discuss, and develop a plan of action to help resolve your problem. For longer-term care, your network practitioner works with Cigna to facilitate continued treatment based on your coverage and your clinical needs.

You can access the Assistance Program by calling Cigna 24 hours a day, 7 days a week, 365 days a year at 855-402-0272. Referral and authorization are always required for Assistance Program services. Cigna only provides Assistance Program referrals to its network practitioners.

The Assistance Program provides up to three 50-minute face-to-face sessions per incident per person each year and unlimited telephone-based counseling for you and your eligible dependents with an Cigna network practitioner. The Assistance Program service is covered at 100% if preauthorized by Cigna. There are no copays, coinsurance, or deductible payments.

The Program also provides Substance Abuse Professional (SAP) services for eligible employees who are subject to Department of Transportation (DOT) alcohol and drug testing rules. Employees referred to Cigna due to a positive alcohol or drug test will be provided with a SAP evaluation that satisfies DOT requirements along with SAP recommended clinically appropriate treatment/education under their managed mental health and chemical dependency benefits program.

The Assistance Program benefit does not provide coverage for:

- Inpatient treatment or outpatient treatment for any medically treated illness
- Prescription drugs
- Treatment/services for mental retardation or autism
- Counseling services beyond the number of sessions covered by the Program
- Services by non-network practitioners
- Counseling required by law, a court, or paid for by Workers' Compensation, or

- Formal psychological evaluations and fitness-for-duty opinions.

If you use Cigna's services, your treatment's confidentiality is protected by state and federal law. Exceptions to confidentiality include, but are not limited to, mandatory reporting of child and elder abuse, threat of homicide or suicide, subpoena or court order and certain disclosures made by persons dangerous to themselves or others. See Notice of Privacy Practices on page 91 for more information.

You acknowledge that healthcare providers may disclose health information about you or your dependents, including information about substance abuse or mental/emotional conditions, to Cigna. Cigna uses and discloses this information for purposes of treatment, payment and health plan operations, including but not limited to utilization management, quality improvement or disease or case management programs.

Component Two: Behavioral Healthcare Services

You or your eligible dependents may need services to deal with mental health disorders and chemical dependency problems. These problems can include, but are not limited to:

- Alcohol and drugs
- Anxiety
- Depression
- Family (marital and parenting issues)
- Gambling
- Stress

Mental health and chemical dependency covered services consist of outpatient counseling (both individual and group sessions), inpatient acute hospitalization (includes detoxification) and alternate care programs. Alternate care programs include day treatment, intensive outpatient services, chemical dependency rehabilitation programs and partial hospitalization. Services are provided by licensed mental health professionals including psychiatrists, psychologists, licensed clinical social workers, marriage and family therapists, and licensed/certified chemical dependency professionals. Services received must be medically necessary and clinically appropriate for your condition. Cigna counselors monitor treatment for mental disorders and chemical dependency conditions to determine medical necessity and clinically appropriate level of care.

About Providers

Covered Providers

The following types of licensed providers are covered by this program:

- Psychiatrists
- Psychologists
- Clinical social workers
- Marriage and family therapists
- Masters level counselors
- Chemical dependency, rehabilitation and mental health facilities.

Network and Non-Network Providers

Network Outpatient Providers

To maximize your benefits, mental healthcare or chemical dependency treatment must be preauthorized by Cigna and provided by an Cigna network provider. To access benefits call Cigna at 855-402-0272 24 hours a day, 7 days a week. A specially trained Cigna staff member will be there to take your call. Calls can also be made to Cigna on your behalf by your physician or family member with your permission.

For a list of Cigna network providers located within your geographic area, call **855-402-0272** or visit *www.cignasharedadministration.com*. Cigna's roster of network providers is subject to change. Although the website is updated each week to include only currently available providers, Cigna cannot guarantee the initial or continued availability of any particular network provider. If you locate a network provider using the *cignasharedadministration.com* website, you still must call Cigna for precertification.

You do not need to submit a claim for preauthorized treatment by an Cigna network provider. You are responsible only for any copay.

Non-Network Outpatient Providers

You may receive outpatient mental health services from a non-network provider, or a Cigna network provider whose treatment has not been authorized by Cigna, but you will receive a lower level of benefits except for hospital emergency room services. Outpatient chemical dependency benefits must be preauthorized by Cigna or no benefits will be paid under the Program. See the Schedule of Benefits on page 81. You will also need to submit a claim form. See Filing Claims for more details.

Inpatient or Alternate Care Treatment

The Program provides benefits for inpatient hospitalization and alternate care treatment. You will receive the maximum benefits if your treatment has been authorized by Cigna and provided by an Cigna network facility. However, you may elect to receive inpatient hospitalization or alternate care treatment from a non-network facility, but at a lower level of benefits.

Preauthorization from Cigna is required for all **non-emergency** inpatient or alternate care treatment, provided by a Cigna network facility or a non-network facility. If you do not receive preauthorization prior to entering a hospital or alternate care facility, your benefits will be paid as follows:

- Cigna network providers – Program pays 50%
- Non-network providers – No benefits are payable.

Only medically necessary and clinically appropriate services will be authorized.

To preauthorize mental health and chemical dependency inpatient or alternate care program admissions call Cigna at 855-402-0272.

For emergency admissions, see Emergency Care on page 80.

Special Provision Where an Cigna Network Provider or Facility Is Not Available

The Cigna nationwide network of providers and facilities can be expanded as the need for services in a particular location arises. Should you or a dependent need care, and Cigna is unable to refer you to an Cigna network provider or facility located in your area (within a 30-minute driving distance or 30-mile radius from your home), you may use the services of a non-

network provider or facility and benefits will be paid as if a network provider or facility has been used. This provision applies only if you call Cigna first and give Cigna an opportunity to refer you to a network provider/facility in your area, or a provider/facility who is willing to become a network member for the services that you or your dependent may require. Special situations must be reviewed and approved in advance by Cigna. Exceptions to this rule are cases of an emergency, if authorization is provided in writing by Cigna's Medical Director or his/her designee, or as otherwise permitted under this Program.

How to Obtain Behavioral Healthcare Services

Emergency Care

An emergency is any situation in which you experience a sudden onset of severe symptoms that would lead a prudent layperson acting reasonably to believe the failure to provide immediate behavioral healthcare services could result in serious impairment to your health or others. If you need immediate assistance, call 911 or go to the nearest emergency room. Emergencies do not require preauthorization for treatment. However, you, your provider, or a family member must call Cigna at **855-402-0272** within 48 hours of an admission for authorization of continued care following the emergency.

Coverage after an emergency admission is based on Cigna's determination of medically appropriate care. If Cigna determines transferring your care to a network provider is medically appropriate, your consent and cooperation with the transfer is a condition of receiving network coverage. If you refuse to transfer to a network provider, Cigna may apply non-network benefit limits (except for hospital emergency room services) or coverage for treatment may be denied from the date Cigna determines such treatment does not meet the medical necessity criteria for that level of care.

Non-Emergency Care

For network coverage, call Cigna at **855-402-0272** for a referral to a network provider and authorization of services. Cigna will review your treatment with your provider, monitor the treatment for medical necessity and appropriate level of care. Cigna must authorize all network services in advance, including transfers to different levels of care and additional services, except in emergency situations. For information about non-network coverage, see Network and Non-Network Providers on page 79 and the Schedule of Benefits on page 81.

All inpatient, residential or alternate treatment programs must be authorized by Cigna in advance, whether network or non-network, except in an emergency as described in Emergency Care above. Cigna's referral and authorization is based on your eligibility for coverage at the time covered services are received. If you become ineligible for coverage after authorization is generated, Cigna will deny coverage accordingly.

Schedule of Benefits

Benefit	Network Provider/Facility		Non-Network Provider/Facility
Assistance Program			
Assessment Visits	**Call 855-402-0272 24 hours a day, 7 days a week** Program pays 100% for up to 3 face-to-face counseling sessions per incident per person each calendar year and unlimited telephone-based counseling. Must be authorized by Cigna		None
Mental Health Treatment Program			
Ambulance or Emergency Room	100% (not subject to Medical Plan deductible) if admitted for mental health treatment		Program pays 50% of UCR (not subject to Medical Plan deductible) if admitted for mental health treatment; 100% for hospital emergency room services
Outpatient	Program pays 100% after applicable copay if you preauthorize with Cigna Program pays 50% after applicable copay if you **do not** preauthorize treatment with Cigna		Program pays 50% of UCR Cigna preauthorization is not required
	Individual Sessions 1-20 sessions: $10 copay 21-50 sessions: $15 copay	**Group Sessions** 1-20 sessions: $5 copay 21-50 sessions: $7.50 copay	
	Up to 50 individual/group sessions per person per calendar year, combined network and non-network.		
Inpatient/ Alternate Care and Residential/ Partial Treatment	Program pays 100% if you preauthorize with Cigna. Program pays 50% if you **do not** preauthorize treatment with Cigna. The following alternate care levels equal 1 day of inpatient treatment: • 2 days of partial hospitalization • 2 days of residential treatment at a licensed residential treatment center • 4 sessions of in-home or outpatient (office) treatment by a licensed therapist • 4 home nursing visits for psychiatric or detox • 23 hours of 1 to 1 observation		Program pays 50% of UCR if you preauthorize with Cigna. No benefits are payable if you **do not preauthorize** treatment with Cigna.
	Up to 45 days of authorized residential/inpatient/alternate/partial care treatment per person per calendar year combined network and non-network. Ninety days lifetime maximum per eligible participant. Two days of residential and/or partial treatment equal one day of inpatient treatment. Emergency admissions require Cigna authorization within 48 hours of the admission.		

Benefit	Network Provider/Facility	Non-Network Provider/Facility
Chemical Dependency Treatment Program		
Ambulance or Emergency Room	100% (not subject to Medical Plan deductible) if admitted for chemical dependency treatment	Program pays 50% of UCR (not subject to Medical Plan deductible) if admitted for chemical dependency treatment; 100% for hospital emergency room services
Outpatient/ Inpatient/ alternate Care and Residential/Partial Treatment	Program pays 100% if you preauthorize with Cigna Program pays 50% if you **do not** preauthorize treatment with Cigna Program pays 100% of authorized SAP services for eligible active employees who fail a DOT alcohol or drug test	Program pays 50% of UCR if you preauthorize with Cigna No benefits are payable if you **do not preauthorize** treatment with Cigna Non-network SAP services are not covered
	Emergency admissions require Cigna authorization within 48 hours of the admission.	

Changing Providers

When you call Cigna, every attempt is made to help you select a network provider who will best meet your needs. If you are dissatisfied with the network provider, you may request a referral to another network provider. There may be times when you require care that your initial network provider is unable to administer. In this case, you or your provider can call Cigna for a referral to another network provider.

Continuity of Care

New Participants

If you became newly eligible for Trust benefits while you were receiving services from a non-network provider for a current episode of an acute, chronic or serious mental health condition, Cigna may authorize continuing services from your non-network provider. This decision is determined by Cigna, after consulting with you and the non-network provider, consistent with current professional practices. If authorized, Cigna will allow you to continue your treatment with the non-network provider for 90 days prior to transferring to a network provider.

Continuity of care services, where Cigna allows you to continue seeing your non-network provider, will not apply in the following situations:

- You were offered a non-network option by the Trust, but refused it
- You could continue with your previous health plan or non-network provider and voluntarily chose to change health plans
- Your non-network provider does not agree to follow the terms and conditions of Cigna's standard network provider contract.

Participants Whose Provider's Contract Has Been Terminated

Under certain circumstances, a provider whose contract has terminated with the Cigna network may continue to provide medically necessary care for Trust members for a current episode of an acute, chronic or serious mental health condition for the time period necessary to complete a

course of treatment or arrange a safe transfer, subject to any benefit limits. This provision only applies when benefits are provided by a Cigna network provider.

If the terminated provider does not agree to comply or does not comply with Cigna's contractual terms and conditions, Cigna is not obligated to continue the provider's services beyond the contract termination date. If the terminated provider voluntarily terminates his or her contract, Cigna is not obligated to continue the provider's services beyond the contract termination date.

Your copays during continuation of care with a terminated provider will be the same amount that you would have paid when receiving care from a currently contracted network provider. Your provider must agree to accept Cigna reimbursement as payment in full for covered services.

Filing Claims

You do not need to submit claims for behavioral healthcare services received from network providers. Network providers will file the claim for you and they will be paid directly by the Trust Administrative Office.

Non-network provider claims must be submitted according to the terms of this Program. Written notice of a claim must be submitted to Cigna within 90 days after the occurrence or beginning of any loss covered by the Program, or as soon as is reasonably possible. Claim forms are available at **www.cignasharedadministration.com**. Submit claims to:

Cigna Healthcare
PO Box 188004
Chattanooga, TN 37422

Utilization Review

This Program includes prior, concurrent and retrospective reviews of proposed treatments to determine medical necessity and if the services are covered. An example of concurrent review is Cigna's review of whether current use of an inpatient facility is the appropriate treatment setting for the patient's symptoms as determined by medical necessity criteria. An example of retrospective review is Cigna's review of whether past use of a hospital was appropriate for the patient's symptoms and met medical necessity. If required clinical information is not supplied by the provider in support of the treatment, Cigna will deny coverage of such treatment.

The final judgment of the reviewer or professional review organization is not a substitute for the independent judgment of the treating provider about a treatment plan. Utilization review decisions that are not consistent with a treating provider's determination do not preclude treatment or hospitalization — but do determine Cigna's coverage for treatment or hospitalization.

A medically necessary service is defined as psychiatric and/or other related healthcare services proposed by a provider, which must meet all of the following conditions as determined by Cigna:

- The requested services facilitate the diagnosis and/or active treatment of a covered current *Diagnostic and Statistical Manual of Mental Disorders* (DSM)–IV Axis I mental disorder or substance-related disorder.

- The proposed treatment plan represents an active, necessary and appropriate intervention for the timely resolution of symptoms and the restoration to baseline level of functioning. The proposed services are not primarily custodial.
- The type, level and length of the proposed services and setting are consistent with Cigna's level of care criteria and guidelines provided in the least restrictive level of care in which the patient can be safely and effectively treated.
- The proposed treatment is not experimental in nature; its safety and efficacy have been clearly demonstrated and widely accepted in modern psychiatric literature.
- The proposed treatment plan has been demonstrated in peer reviewed journals to be at least equally effective in bringing about a rapid resolution of symptoms when compared to alternative treatment interventions.
- The proposed treatment plan utilizes clinical services efficiently when compared to alternative treatment interventions and contributes to effective management of your benefit.
- Treatment is provided by a mental health professional licensed to practice independently who meets Cigna's credentialing standards.

The Independent Contractor Relationship

The relationship between Cigna and network providers is that of an independent contractor. Network providers are not agents or employees of Cigna, nor is Cigna and/or its employees and agents an employee or agent of any network provider. Cigna and its network providers are not authorized to represent each other for any purposes, nor are they or their respective officers, agents or employees considered officers, agents or employees of the other. Network providers maintain the provider-patient relationship with participants and are solely responsible to participants for their services. In no event will Cigna be liable for the negligence, wrongful acts or omissions of network providers.

Cigna and the Trust are independent contractors in relation to one another and no joint venture, partnership, employment, agency or other relationship is created by the agreement. Neither Cigna nor the Trust are liable for any act, negligence or omission of the other, nor are they each other's agents or employees. Neither Cigna nor the Trust is authorized to represent the other for any purpose. None of the parties to the agreement nor any of their respective officers, agents or employees shall be construed to be the officer, agent or employee of any other party.

Non-Assignability of Benefits

You cannot transfer the coverage and benefits of this Program to another person without Cigna's prior written consent. Such a request may be denied for any reason. Cigna reserves the right to make payment of benefits, at its sole discretion, directly to the network provider or to the participant.

Mental Health and Chemical Dependency Benefits Program Definitions

Acute — The sudden onset or abrupt change of a mental health condition requiring prompt attention, but is of limited duration, as determined by the administrator.

Administrator — Cigna and/or the Trust Administrative Office depending on the program provision.

Alternate Treatment — A planned, medical therapeutic program for persons with mental disorders. This includes diagnosis, medical care, and treatment when the patient does not require full-time hospitalization, but does need more intensive care than traditional outpatient visits. Alternate treatment includes residential treatment, partial hospitalization or day treatment program and intensive outpatient programs authorized by Cigna and is considered an inpatient benefit.

Authorization — A decision, issued in writing by the Cigna medical director or his/her designee, that benefits are payable for certain services that a covered person will receive or has received.

Behavioral Healthcare Services — Chemical dependency, substance abuse and/or mental healthcare services determined by Cigna to be covered services under this plan.

Chemical Dependency and/or Substance Abuse — Psychological or physical dependence on alcohol or other mind-altering drugs that requires diagnosis, care and medically necessary treatment.

Copay — The payment to be collected directly by the network provider or non-network provider from you for covered services, excluding any deductibles.

Covered Services — Behavioral healthcare services that constitute benefits covered under the plan. The determination that a benefit is a covered service rests with the administrator.

Dependent — The eligibility provisions for the Program's benefits and services are the same as those described in the Summary Plan Description (SPD) for your medical plan. See Eligibility and Coverage Effective Dates for information detailing the rules on who is eligible for benefits.

This Program is not applicable for participants who are enrolled in a Group Health Options Plan through the Trust.

Diagnostic and Statistical Manual of Mental Disorders (DSM) — A listing of diagnostic categories and criteria that provides guidelines for diagnosing mental and substance abuse disorders. The DSM is a widely accepted basis for describing the presence and type of these disorders. A DSM diagnosis of mental or substance abuse disorder is a minimum requirement for the demonstration of medical necessity under the Policy. The diagnosis must be contained in the most recent edition of the DSM.

Eligible Participant — An individual who meets the eligibility requirements as set forth by the Trust and meets the eligibility requirements in the Eligibility and Coverage Effective Dates section of your Washington Teamsters Welfare Trust Medical Summary Plan Description.

Emergency — The sudden onset of a condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that, a prudent layperson possessing an average knowledge of medicine and health could reasonably expect in the absence of immediate behavioral healthcare services, could reasonably result in:

- Serious impairment to bodily functions
- Permanently placing the person's health, or others, in serious jeopardy, or
- Causing serious and permanent dysfunction to the person.

Facility — A hospital or a facility providing alternate treatment which furnishes covered services to you or your dependents.

Hospital — Any institution that is a duly licensed and/or accredited healthcare organization as:

- Providing behavioral healthcare services
- A chemical dependency or substance abuse treatment facility that is under the supervision of a staff of physicians, with 24 hours-a-day nursing service, and operated primarily to assist in the withdrawal from dependency on alcohol or drugs
- A psychiatric treatment facility that is under the supervision of a staff of physicians, with 24 hours-a-day nursing service, and operated primarily to provide treatment of mental disorders, or
- Any other institution designated as a hospital by the administrator.

Inpatient — You or your dependent who have been admitted to a hospital or other authorized institution for bed occupancy for purposes of receiving medically necessary behavioral healthcare services, with the reasonable expectation that you or your dependent will remain in the institution at least 24 hours.

Medical Director — A physician who is:

- Licensed to practice medicine and board certified as a psychiatrist, and
- Employed or contracted by the administrator to coordinate and monitor the quality management, utilization management, and provide services for the administrator.

Medically Necessary or Medical Necessity — Services that must meet ALL of the following conditions:

- The requested services provide for the diagnosis and/or active treatment of a covered current DSM–IV Axis I Mental Disorder or substance-related disorder.
- The proposed treatment plan represents an active, necessary and appropriate intervention for the timely resolution of the participant's symptoms and the restoration to baseline level of functioning. The proposed services are not primarily custodial in nature.
- The type, level and length of the proposed services and setting are consistent with Cigna's level of care guidelines and are rendered in the least restrictive level of care in which the participant can be safely and effectively treated.
- The proposed treatment is not experimental in nature; that is, its safety and efficacy have been clearly demonstrated and widely accepted in the modern psychiatric literature.
- The proposed treatment plan has been demonstrated in peer reviewed journals to be at least equally effective in bringing about a rapid resolution of symptoms when compared to possible alternative treatment interventions.
- The proposed treatment plan utilizes clinical services in an efficient manner when compared to alternative treatment interventions and contributes to effective management of the patient's benefit.
- Treatment is provided by a mental health/substance abuse professional licensed to practice independently who meets Cigna's credentialing standards.

Mental Disorder — A nervous or mental condition that meets **ALL** of the following conditions:

- It is a clinically significant behavioral or psychological syndrome or pattern; AND
- It is associated with a painful symptom, such as distress; AND
- It impairs a patient's ability to function in one or more major life activities; AND
- It is a condition listed in an Axis I Disorder (excluding V Codes) of the Diagnostic and Statistical Manual of Mental Disorders (Fourth Edition) by the American Psychiatric Association (DSM-IV), or successor publication.

Mental Healthcare Services — Those services determined by the administrator to be medically necessary for the treatment of a mental disorder.

Network Provider — A practitioner, facility or hospital that has contracted with Cigna to provide care and treatment to persons covered by the Policy.

Non-Network Provider — A practitioner, facility or hospital that has not contracted with Cigna to provide care and treatment to persons covered by the Policy.

Outpatient — An ambulatory person receiving covered services who has not been admitted to a hospital or facility.

Peer Reviewer — A mental health professional licensed to practice in the state in which he or she practices and who is employed by or contracted with the administrator to provide ongoing services involving peer review, utilization review and claims payment review.

Practitioner — A mental health professional who is appropriately licensed as a psychiatrist, clinical psychologist, marriage, family or child counselor, social worker or other person designated by Cigna and acting within the scope of their license.

Prepayment Fee/Premium — A pre-negotiated fixed monthly fee that is payable to the administrator by a Fund for each participant who is enrolled with the administrator pursuant to the policy.

Reasonable Charge(s) (UCR, Usual and Customary Rates) — An amount measured and determined by comparing the actual charge for the service or supply with the prevailing charges made for it. The prevailing charge is determined utilizing the 90th percentile MDR UCR Index. This takes into account all pertinent factors including:

- The complexity of the service
- The range of services provided
- The prevailing charge level in the geographic area where the practitioner, hospital or facility is located and other geographic areas having similar medical cost experience.

Mental Health and Chemical Dependency Benefits Program Exclusions

The following are specifically excluded from covered services:

1. Treatment of detoxification in newborns.
2. Treatment of congenital and/or organic disorders. This includes, without limitation, Alzheimer's disease, mental retardation (other than the initial diagnosis), organic brain

disease, delirium, dementia, amnesic disorders and other cognitive disorders as defined in the DSM.

3. Treatment for chronic pain and other pain disorders, smoking cessation, nicotine dependence, nicotine withdrawal and nicotine-related disorders.

4. Treatment of obesity and eating disorders unless otherwise required by law. This does not include the diagnosis of anorexia and bulimia nervosa as defined in DSM.

5. Court-ordered testing and treatment.

6. Private hospital rooms and/or private duty nursing, unless determined to be a medically necessary service and authorization from Cigna is obtained.

7. Ancillary services such as:

   a. Vocational rehabilitation.

   b. Behavioral training.

   c. Speech or occupational therapy.

   d. Sleep therapy and employment counseling.

   e. Training or educational therapy for reading or learning disabilities.

   f. Other education services.

8. Testing, screening or treatment for:

   a. Learning disorders, expressive language disorders, mathematics disorder, phonological disorder and communication disorder NOS.

   b. Motor skills disorders and developmental coordination disorder.

   c. All disorders of infancy and early childhood and developmental disorders including, but not limited to, communication disorders, pervasive developmental disorders, autistic disorder, Rett's disorder, Asperger's disorder (except as otherwise required by law).

   d. Disorders resulting from general medical conditions, including but not limited to: catatonic disorder due to general medical condition, personality change due to general medical disorder, narcolepsy, stuttering, stereotypic movement disorders, sleep disorders, TIC disorders, elimination disorders, sexual dysfunctions, and primary insomnia.

   e. Personality disorders.

   f. Pedophilia.

   g. Primary sleep disorders, primary hypersomnia, and dyssomnia NOS.

   h. Age-related cognitive decline.

9. Treatment of conditions which are medical in nature, even when such conditions may have been caused by a mental disorder.

10. Treatment by providers other than those within licensing categories then recognized by the administrator as providing medically necessary services in accordance with applicable medical community standards.

11. Treatment rendered for conditions not listed as an Axis I disorder (V Code diagnoses listed as an Axis I disorder are also excluded unless otherwise specified in the Plan).

12. Services in excess of those with respect to which authorization by Cigna is obtained.

13. Psychological testing except as authorized by Cigna and conducted by a licensed psychologist for assistance in treatment planning, including medication management or diagnostic clarification and specifically excluding all educational, academic and achievement tests, psychological testing related to medical conditions or to determine surgical readiness and automated computer-based reports.

14. Missed appointments. Cigna will consider one of the participant's counseling sessions used if the participant fails to cancel with the provider at least 24 hours in advance, unless the appointment is missed because of an emergency or circumstances beyond the participant's control.

15. All prescription or non-prescription drugs and laboratory fees, except for drugs and laboratory fees prescribed by a psychiatrist in connection with inpatient treatment.

16. Medication management or other pharmacological services rendered by a non-psychiatrist provider.

17. Inpatient services, treatment, or supplies rendered without authorization, if required, except in the event of an emergency.

18. Healthcare services, treatment, or supplies rendered in a non-emergency by a non-participating provider, unless authorization by Cigna has been received or as otherwise provided by the Plan.

19. Damage to a hospital or facility caused by the participant.

20. Healthcare services, treatment or supplies determined to be experimental by administrator in accordance with accepted mental health standards, except as otherwise required by law.

21. Healthcare services, treatment or supplies:

    a. Provided as a result of any Workers' Compensation law or similar legislation.

    b. Obtained through, or required by, any governmental agency or program.

    c. Caused by the conduct or omission of a third party for which the participant has a claim for damages or relief.

22. Healthcare services, treatment, or supplies for military service disabilities for which treatment is reasonably available under governmental healthcare programs.

23. Treatment for biofeedback, acupuncture or hypnotherapy.

24. Healthcare services, treatment, or supplies rendered to the participant which are not medically necessary services. This includes, but is not limited to, services, treatment, or supplies primarily for rest or convalescence, custodial or domiciliary care as determined by administrator.

25. Services received before the participant's effective date, during an inpatient stay that began before the participant's effective date or services received after the participant's coverage ended, except as specifically stated herein.

26. Services for which:

    a. The person is not legally obligated to pay.

    b. No charge is made to the person.

    c. No charge is made to the person in the absence of insurance coverage.

    d. It is provided without cost to the person by a local, state or federal government agency.

27. Services in connection with conditions caused by an act of war.

28. Conditions caused by release of nuclear energy, whether or not the result of war.

29. Emergency room services not provided by a psychiatrist directly related to the treatment of a mental disorder in accordance with the limitations listed above.

30. Professional services received from a person who lives in the participant's home or who is related to the participant by blood or marriage.

31. Any services or supplies under Parts A or B of Medicare if either:

    a. The participant is enrolled in Part A of Medicare, whether or not the participant is enrolled in Part B of Medicare, or

    b. The participant is entitled to enroll in Medicare and has made the required number of quarterly contributions to the Social Security System, whether or not the participant has actually enrolled in Medicare or claimed Medicare benefits.

32. Services performed in any emergency room which are not directly related to the treatment of a mental disorder.

33. Services received out of the participant's primary state of residence except in the event of an emergency and as otherwise authorized by the administrator.

34. Electro-Convulsive Therapy (ECT) except authorized by the administrator according to the administrator's policies and procedures.

35. All other services, confinements, treatments or supplies not provided primarily for the treatment of specific covered benefits outlined in the Schedule of Benefits and/or specifically included as covered services elsewhere in this Plan.

36. County-based case management services.

Plan Administration

About the Privacy of Your Health

The Plan Sponsor and the Trust group healthcare plans (the medical, mental health and chemical dependency, prescription drug and care management health plans described in this booklet) are subject to HIPAA's privacy requirements beginning on April 14, 2003, and HIPAA's privacy protections apply to them.

Participants will receive a copy of the Trust's HIPAA privacy notice separately.

Federal Mandates

Newborns' and Mothers' Health Protection Act

Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a caesarian section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the Plan or the issuers for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Women's Health and Cancer Rights Act

Under federal law, group health plans and health insurance issuers offering group health insurance coverage that includes medical and surgical benefits with respect to a mastectomy shall include medical and surgical benefits for breast reconstructive surgery as part of a mastectomy procedure. Breast reconstructive surgery in connection with a mastectomy shall at a minimum provide for:

- Reconstruction of the breast on which the mastectomy has been performed
- Surgery and reconstruction of the other breast to produce a symmetrical appearance
- Prostheses and treatment of physical complications for all stages of mastectomy, including lymphedemas in a manner determined in consultation with the attending physician and the patient.

Coordination With Other Medical Benefits

Coordination of Benefits or COB refers to how the Trust Plan coordinates benefits payments when you or your dependents have group coverage under more than one plan. The intent of coordination with other medical and mental health benefits (but not prescription drug benefits) is to ensure the total paid under this Plan and all other group plans does not exceed the actual charge or allowed charge for a treatment or service.

If your spouse or dependent children have primary medical coverage under a group plan outside of the Trust, the Trust plan will pay benefits secondary to your dependent's primary coverage, with payments made up to 100% of covered charges rather than to only the Trust's level of benefits. If the allowed charge for a covered service is less under

the primary plan, the Trust plan will coordinate only up to the allowed charge of the primary plan.

Conventional COB

Effect on Benefits

Benefits otherwise payable under this Plan for allowable expenses during a claim determination period may be reduced if:

- Benefits are payable under any other plan for the same allowable expenses
- Under the rules listed below, benefits payable under the other plan are to be determined before benefits payable under this Plan.

The reduction will be the amount needed to ensure that the sum of payments under this Plan plus benefits under the other plan is not more than the total of allowable expenses under the primary plan or the Trust plan, whichever is less. Each benefit that would be payable without this section will be reduced proportionately. The total amount paid will be charged against any applicable benefit limit of this Plan.

For this purpose, benefits payable under other plans will include those that would have been paid if claims had been made for them. Also, for any person covered by Medicare Part A, benefits payable will include benefits provided by Medicare Part B, whether or not the person is covered under Part B.

Under conventional COB, when this Plan is secondary and its payment is reduced because of the primary plan's benefits, a record is kept of the reduction. The amount will be used to increase this Plan's payments on the patient's later claims in the same calendar year — to the extent there are allowable expenses that would not otherwise be fully paid by this Plan and other plan(s). This provision applies only to the Trust's medical benefits.

Definitions

For the purposes of COB, the following definitions apply:

Plan — Means this Plan and any medical or dental benefits provided under any of the following:

- Insured or non-insured group, service, prepayment or other program arranged through an employer, trustee, union or association
- Program required or established by state or federal law (including Medicare Parts A and B, but excluding Medicaid)
- Program sponsored by or arranged for students through a school or other educational institution.

The term Plan does not include benefits provided under a student accident policy or under a state medical assistance program where eligibility is based on financial need. Plan applies separately to parts of any program that contain COB provisions and separately to parts of any program that do not contain COB provisions.

Allowable Expense — All prevailing charges for treatments or services when at least part of those charges is covered under at least one of the plans then in force for the covered person. However, the difference between the cost of a private room and a semi-private room will be an allowable expense only when confinement in a private room is medically necessary. If a plan provides benefits in other than cash payments, the cash value of those benefits will be both an allowable expense and a benefit paid.

Claim Determination Period — The part of a calendar year when you would receive benefit payments under this Plan if this section were not in force.

Order of Benefit Determination

Except as described under Medicare Exception below, the benefits payable by a plan that doesn't have a COB provision will be determined before those of a plan that does have a COB provision. In all other instances, the order of determination will be:

1. **Employee/Dependent.** The benefits of a plan that covers the person as an employee participant are determined before those of a plan that covers the person as a dependent participant.

2. **Dependent Child — Parents Not Separated or Divorced.** When this Plan and another plan cover the same child as a dependent of parents who are not separated or divorced, benefits of the plan of the parent whose birthday falls earlier in a calendar year are determined before those of the plan of the parent whose birthday falls later in that year. If both parents have the same birthday, the benefits of the plan that covered the parent longer are determined before those of the plan that covered the other parent for a shorter time.

3. **Dependent Child — Parents Separated or Divorced.** If two or more plans cover a dependent child of divorced or separated parents, and the terms of the specific court decree state the parents have joint custody or that both parents are responsible for the child's health care expenses, benefits of the plan of the parent whose birthday falls earlier in a calendar year are determined before those of the plan of the parent whose birthday falls later in that year. If both parents have the same birthday, the benefits of the plan that covered the parent longer are determined before those of the plan that covered the other parent for a shorter time.

   If there is no specific court decree that determines responsibility for the child's health care expenses, benefits for the child are determined in this order:

   - First, the plan of the custodial parent
   - Second, the plan of the custodial parent's spouse, if applicable
   - Third, the plan of the non-custodial parent.
   - Finally, the plan of the non-custodial parent's spouse.

     However, if the specific terms of a court decree state that one of the parents is responsible for the child's healthcare expenses, and the entity obligated to pay or provide benefits for the plan of that parent has knowledge of those terms, the benefits of that plan are determined first. (This doesn't apply to any claim determination period or plan year when any benefits are actually paid or provided before the entity has that knowledge.)

     If the specific terms of a court decree state that both of the parents are responsible for the child's healthcare expenses, benefits of the plan of the parent whose birthday falls earlier in a calendar year are determined before those of the plan of the parent whose birthday falls later in that year.

4. **Active/Inactive Employee.** The benefits of a plan that covers a person as an employee who is neither laid off nor retired, or as that employee's dependent, are determined before the benefits of a plan that covers that person as a laid-off or retired employee or as that employee's dependent. If the other plan doesn't have this rule, and if, as a result, the plans disagree on the order of benefits, this rule will not apply.

5. **Longer/Shorter Length of Coverage.** If none of the above rules determines the order of benefits, the benefits of the plan that has covered a person longer are determined before those of a plan that has covered the person for a shorter time. It does not apply to prescription drug, mental health or chemical dependency benefits.

Benefit Credit Provision

When this Plan is secondary and its payment is reduced because of the primary plan's benefits, a record is kept of the reduction. The amount will be used to increase this Plan's payments on the patient's later claims in the same calendar year, to the extent there are allowable expenses that would not otherwise be fully paid by this Plan and other plan(s). This provision applies only to the Trust's medical benefits.

Medicare Exception

You are considered actively at work and this Plan is primary if you are:

- Actively working as an employee, or
- Not actively working and are receiving disability benefits from an employer for up to 6 months; or
- Not actively working but meet all of the following conditions:
    - Retain employment rights in the industry;
    - Have not had your employment terminated by the employer;
    - Are not receiving disability benefits from your employer for more than 6 months;
    - Are not receiving Social Security disability benefits; and
    - Have employment-based health coverage that is not COBRA continuation coverage.

If you or a dependent is eligible for Medicare coverage and you are no longer actively at work, Medicare becomes the primary payer of claims over any coverage you have under this Plan, including COBRA, the Six-Month Self-Pay option or Extension of Benefits.

For employees and dependents, the benefits payable under this Plan will normally be primary and Medicare will normally be secondary. However, employees have the option of electing Medicare as primary coverage. If an employee or dependent spouse age 65 or over makes this election, the Trust will pay no further medical benefits.

Importance of Enrollment in Medicare Part B

Medicare Part A (hospital charges) is generally automatic when you reach age 65, and requires only completion of a Medicare form. However, Medicare Part B (physician charges) requires enrollment and monthly premium payments. Even if you retain primary coverage under this Plan, it's still beneficial to enroll in Medicare Part B to cover certain expenses not paid by the Trust and to avoid being without coverage for physician charges if you lose coverage under the Trust. Unless you enroll for Medicare Part B when first eligible, or promptly after coverage under this Plan ends, a 10% penalty will be added to the monthly Medicare Part B premium for every 12 months you were eligible to enroll but did not.

Special rules for individuals with end stage renal disease (ESRD) – If you are eligible for Medicare due to ESRD, Medicare becomes primary over this plan after an initial 30-month coordination period and benefits under this plan will be secondary at that time even if you have coverage under this plan as an active employee. If you are eligible for Medicare, but are not

enrolled in both Medicare Parts A and B, this plan will estimate what Medicare would have paid as primary and will only pay secondary based on the estimated primary coverage. Therefore, you will need to be enrolled in both Medicare Parts A and B in order to have primary coverage after the initial 30-month coordination period.

If you are no longer covered as an active employee or the dependent of an active employee, benefits under this plan will be reduced by Medicare Parts A and B benefits. This provision is applicable even if you are not covered by Medicare Part A and B.

Subrogation (Third-Party Reimbursement)

If you or your dependents incur any medical expense resulting from injury or sickness for which there is right of recovery against a third party (including workers compensation claims), Trust benefits will be paid on the condition the Trust will be reimbursed from any amount you or your dependents receive in settlement or judgment. You or your dependents also must give the Trust the name and address of the responsible third party and, if requested, execute a Trust Subrogation Agreement agreeing to reimburse the Trust. The Trust may withhold benefit payment if you are requested to execute a Trust Subrogation Agreement and do not comply.

As security for the Trust's right to this reimbursement, the Trust will be subrogated to all rights of recovery against the third party to the extent of any benefits the Trust paid. You or your dependents must do whatever is necessary to fully secure and protect, and nothing to prejudice, the Trust's rights to this subrogation.

Recovery of Unauthorized Benefit Payments

The Trust provides benefits only under the written terms of this Plan. If the Trust has mistakenly made benefit payments to or for an ineligible person, or payments exceeding those authorized by this Plan — or if you or a dependent fails to reimburse benefits advanced under an agreement to reimburse — the individual profiting from the benefit is obligated, upon notice from the Trust, to reimburse the overpayment. Otherwise, the Trust is entitled to bring legal action to recover the overpayment. The court may award the Trust reasonable attorney fees and court costs in addition to the overpayment amount.

The Trust also has the right to deduct the overpayment amount from any future benefits to the individual or others claiming eligibility through the same individual.

Use of Medical and Dental Consultants

The Board of Trustees has authorized the Trust Administrative Office to refer claims for medical, dental, prescription drug or Time Loss benefits to outside doctors, dentists or other professionals for review and advice. In determining the issues presented, these consultants may rely on their own expertise and on professional standards, procedures and protocols.

Any claim denial that incorporates or is based on medical or dental consulting advice may, as any other claim denial, be reviewed in accordance with the Trust's appeals process (see below).

Interpretation of the Plan

Trust Fund administration is vested wholly and exclusively in the Trustees, who have sole discretion and entire authority to determine eligibility for benefits and to interpret and apply the

provisions of this Trust Agreement, the benefit plans, their own motions, resolutions, administrative rules and regulations and any contracts, instruments or writings the Trustees may have adopted or entered. Any benefit determination the Trustees make in good faith will be conclusive and binding on the unions, employers, employees and beneficiaries under the benefit plans and the Trust Fund.

Claim Review and Appeal Procedures

The Washington Teamsters Welfare Trust plans have adopted specific procedures and timeframes, required by law, to evaluate and process claims for benefits, as well as appeals of denied claims. The timeframes and rules for making decisions on claims and appeals vary, depending on the type of claim and the benefit plan involved. This section provides information about the specific timelines and information requirements that apply to your claims and appeals filings and the claim administrator's claims and appeals determinations. The claim administrator, unless otherwise specified, is the Trust Administrative Office.

If your claim for benefits is wholly or partially denied, you or your duly authorized representative may submit a written request for a review of the claim by the Washington Teamsters Welfare Trust Appeals Committee (Appeals Committee). In certain cases, you will have the right to ask that the decision of the Appeals Committee be reviewed by an external independent review organization. The request for review must be submitted to the Trust office within the timeframe applicable for that benefit plan and type of claim, as described in the following pages.

The length of time the claim administrator has to evaluate and process your claim generally begins on the date the claim is received. The claim administrator will consider the claim and notify you of an adverse decision on the claim, in writing, within the appropriate timeframes described on page 97, unless the claim administrator determines that special circumstances require an extension of time to process the claim. If such an extension is necessary under any of the plans, the claim administrator will notify you of any such extension, the reasons for it, and the date by which the claim administrator expects to render the decision, within the original decision timeframe.

The claim administrators for each plan are as follows:

Benefit	Claim Administrator
Medical Plans A, B, C, Z, JC-28XL, WT-100, Mental Health, and Chemical Dependency	Washington Teamsters Welfare Trust Trust Administrative Office
Prescription drug plan	MedImpact
Hospital Precertification and Hospital Concurrent Care, Mental Health and Chemical Dependency Pre-Authorization and Concurrent Care	Cigna
Group Health Options Medical Plans	Group Health Options
Dental Plans	Washington Dental Service (WDS)
Vision Plan	Washington Teamsters Welfare Trust Trust Administrative Office
Time Loss Plans	Washington Teamsters Welfare Trust Trust Administrative Office
Life and Accidental Death and Dismemberment Plan (AD&D)	Principal Mutual Life Insurance
Long-Term Disability (LTD) Plans	The Hartford

If you believe that you are entitled to a benefit under one of the Washington Teamsters Welfare Trust plans, or that you are entitled to a greater benefit than the amount you received, then you, your beneficiary (if applicable) or your authorized representative may file a written appeal with the appropriate claim administrator listed above. See "Note" on page 100 if you are covered under a Group Health Options Plan through the Trust.

The claim review and appeal procedures apply to these types of claims:

Urgent Healthcare Claim (before healthcare treatment)	A claim or pre-approval request for a medical, dental, or vision benefit where treatment delay could seriously jeopardize life, health, the ability to regain maximum function or, in the opinion of a physician who knows the medical condition, would subject the patient to severe pain that cannot be adequately managed without care or treatment that is the subject of the claim.
Pre-Service Healthcare Claim (before healthcare treatment)	Any claim or pre-approval request for a medical, dental or vision benefit, where receipt of benefit is conditioned, in whole or in part, based on advance approval.
Concurrent Healthcare Claim (changes in healthcare treatment)	Any claim involving the reduction or termination of an ongoing course of treatment before the end of that course of treatment if the treatment was previously authorized by the Plan, or a request to extend treatment beyond the authorized time or number of treatments.
Post-Service Healthcare Claim (after healthcare treatment)	Any claim for a medical, dental or vision benefit that is not a pre-service claim.
Disability Claim (income benefit, not a healthcare benefit)	Any claim for a Time Loss or LTD benefit.

Healthcare Claim Procedures

The following procedures do not apply to the Trust's Group Health Options medical plans. See your Group Health Options booklet for claim filing, review and appeal procedures.

Timeframe for Initial Claim Decisions

The timeframe for initial claim decisions for medical, dental and vision plans depends on the type of claim filed:

Type of Claim	Timeframe for Notice of Claim Decision	Extensions*
Urgent care	The claim administrator will provide notice of claim approval or denial as soon as possible, taking into account the seriousness of your condition, but no longer than 72 hours; notice of denial may be by phone with written or electronic confirmation to follow within three days.	If additional information is needed to complete your claim, you'll be notified within 24 hours.
Pre-service	The claim administrator will provide notice of a claim approval or denial within 15 days.	Up to 15 days, provided you are notified within the original 15-day period.

Type of Claim	Timeframe for Notice of Claim Decision	Extensions*
Concurrent care	If an ongoing course of treatment that was previously approved by the Plan will be reduced or terminated, the claim administrator will notify you sufficiently in advance to give you an opportunity to appeal and obtain a decision on appeal before the reduction or termination takes effect. For any request to extend ongoing treatment in an urgent care situation, you'll be notified within 24 hours, provided your request is made at least 24 hours before the end of the approved treatment. For any request to extend ongoing treatment in a non-urgent care situation, your request will be considered a new claim and decided according to post-service or pre-service timeframes, whichever applies.	
Post-service	The claim administrator will provide notice of a claim approval or denial within 30 days.	Up to 15 days, provided you are notified of the extension within the original 30-day period.

**If more time is needed to process claims due to circumstances beyond the claim administrator's control.*

Insufficient Healthcare Claims

Please note that the claims review and appeals procedures include rules that specify what happens if you file certain insufficient or incomplete claims.

Improperly Filed Pre-Service Claims

If your pre-service claim was filed improperly, you will be notified within five days after a pre-service claim is received (or within 24 hours in an urgent care case). Notice of an improperly filed pre-service claim may be provided by phone, or in writing upon request. The notice will identify the proper procedures to be followed in filing the claim.

To receive notice of an improperly filed pre-service claim, you or your authorized representative must have provided a communication regarding the claim to the claim administrator. This communication must include:

- Your name
- A specific medical condition or symptom
- Request for approval for a specific treatment, service or product.

Incomplete Pre- and Post-Service Claims

If more information is required to process your pre- or post-service healthcare claim, you'll be notified within the original 15-day period for pre-service claims, and within the original 30-day period for post-service claims. If you are notified of the need to provide additional information for a pre- or post-service claim, you will have at least 45 days to supply this information. If you supply the requested information within the 45 days and your claim is denied, the claim administrator will notify you of the denial within 15 days after the requested information is received. If you do not supply the requested information within 45 days, your claim may be denied.

Incomplete Urgent Care Claims

If more information is needed to process a properly filed urgent care claim, you'll be notified as soon as possible, but no later than 24 hours after your claim is received. This notice will include the specific information necessary to complete the claim. Once you are notified of the need to provide more information, you'll have a reasonable amount of time — considering the circumstances, but not less than 48 hours — to submit the requested information. You'll receive notice of the claim decision as soon as possible, but no later than 48 hours after whichever occurs earlier:

- The claim administrator receives the information, or
- The additional period given for providing the information ends.

Notice of Initial Claim Denial

If the claim administrator denies the claim, you'll receive written or electronic notice containing:

- Specific reasons for the denial
- References to specific plan provisions on which the denial is based
- List of any additional material or information necessary for you to perfect the claim and an explanation of why it's necessary
- Description of the plan's claim appeal procedure (and applicable time limits), including a statement of your right to bring a civil action under ERISA Section 502(a) if your appeal is denied
- Certain other information in accordance with applicable U.S. Department of Labor regulations.

Claim Appeal Procedures

You can use these appeal procedures, if, in response to your claim, you received:

- No reply after the initial decision period, as listed above
- Notice of an extension to the initial decision period, as listed above, then no reply before the end of an extension
- A denial from the claim administrator.

If the claim is denied, in whole or in part, or if you believe plan benefits have not been properly provided, you, your beneficiary (if applicable), or your authorized representative may appeal the denial. The claim administrator will provide details about your right to appeal, along with the appeals process, address for filing an appeal, and timeframes. If you don't appeal within the designated timeframes, you may lose your right to later file suit in court.

To appeal a claim denial, you must file a written request for appeal pursuant to the procedure provided by the claim administrator (see the chart on page 96 for a list of claim administrators) within a certain period after receiving the claim denial, as described herein. The appeal must set forth all the grounds on which it is based, all the facts in support of the request, and other matters which you deem pertinent. Plan provisions require that you pursue the claim and appeal rights described here before seeking other legal recourse.

During the appeal, you will receive, upon request and free of charge, reasonable access to and copies of all documents, records and other information relevant to your benefit claim. For this claim procedure, a document, record or other information is considered relevant to a claim if it:

- Was relied on by the claim administrator in making the initial claim decision
- Was submitted, considered or generated in the course of deciding the claim, without regard to whether the document, record or other information was relied upon by the claim administrator in reaching the claim decision
- Demonstrates compliance with the administrative processes and safeguards required under Department of Labor regulations in making the benefit determination.

You may submit any written comments, documents, records or other information relating to your claim. In making its determination, on healthcare, time loss, or LTD claim appeals, the Appeals Committee of the Washington Teamsters Welfare Trust will take into account all the comments, documents, records and other information you submitted relating to the claim, without regard to whether they were submitted or considered by the claim administrator in making the initial claim decision.

The Appeals Committee will conduct a review and make a final decision within a certain period after receiving your written request for review, as described as follows and on page 97. For certain plans, if the Appeals Committee needs more than this initial period to make a decision due to special circumstances, it will notify you in writing within the initial decision timeframe and explain why more time is required and the date the plan expects to make a decision.

The Appeals Committee will review your denied claim. You or your authorized representative has the right to present relevant information or testimony at the quarterly Appeals Committee meeting scheduled to hear your appeal. You will be notified of the meeting time and date, however a personal appearance is not required. The appeal review will not be conducted by the individual who denied the initial claim or that person's subordinate. The Appeals Committee will not give deference to the original decision on your claim; that is, they will take a fresh look and make an independent decision about the claim within the timeframes.

If your claim was denied based on a medical judgment, the Appeals Committee will consult with a healthcare professional who has appropriate training and experience in the field of medicine involved in your claim. The healthcare professional will not be the same person as the one consulted on the initial decision (or a subordinate of that person). A medical judgment includes whether a treatment, drug or other item is experimental, investigational or not medically necessary or appropriate. You also have the right to learn the identity of any medical or other experts who advised on your original claim decision, whether or not the Plan relied on their advice.

Note: If you are appealing benefits denied by one of the Trust's Group Health Options medical plans, see your Group Health booklet or the Appeal language provided by Group Health. In some cases, your appeals under the Group Health Options Plan will be reviewed by the Appeals Committee of the Washington Teamsters Welfare Trust, and in other cases, by Group Health Options.

Timeframes for Filing and Determination of Healthcare Appeals

You have 180 days from the date you receive notice of a healthcare claim denial to file your appeal. Appeal decision timeframes vary, depending on the type of healthcare claim filed:

- **Urgent care** — The claim administrator will provide notice of appeal decision as soon as possible, considering the medical situation, but no later than 72 hours after receiving your appeal, unless you do not provide sufficient information to determine whether, or to what extent, benefits are covered or payable under the plan (see page 99).

- **Pre-service** — The claim administrator will provide notice of appeal decision within 30 days of appeal.
- **Post-service** — The claim administrator will provide notice of appeal decision within five days after the next quarterly meeting of the Appeals Committee if the appeal is received at least 30 days before the meeting, otherwise the decision will be provided within five days after the second quarterly meeting that follows receipt of the appeal. If special circumstances require an extension of time for rendering a decision, the claim administrator will provide notice of the extension within the initial decision timeframe, and a decision will be rendered at the next quarterly meeting, with notice provided within five days after that meeting.

Notice of Decisions on Appeal

The decision on appeal will be in writing. If your appeal is denied, the notice will include:

- Reasons for the denial
- References to specific plan provisions on which the denial is based
- A statement of your right to access and receive copies, upon request and free of charge, of all documents and other information relevant to the claim for benefits
- A statement of your right to bring a civil action under ERISA Section 502(a)
- Certain other information in accordance with applicable U.S. Department of Labor regulations.

If the Appeals Committee does not respond within the applicable timeframe, you should generally consider the appeal denied. Contact the Trust Administrative Office if you have questions.

Request for External Review

You must complete the internal claims appeal process discussed above before requesting an external review. Once the internal claim appeal process is completed by the Appeals Committee making its decision, you will have 120 days from the date you receive that decision to file a request for an external review.

You may request external review for any denied claim except for denials based on finding that you did not satisfy the eligibility requirements for a benefit under the terms of the applicable Plan.

Requests for external reviews should be sent to:

External Review Appeals
PO Box 12267
Seattle, WA 98102

Preliminary Review of External Review Request

Within five (5) business days of receiving a request for external review, the Trust will complete a preliminary review of the request to make sure that:

- The patient is or was covered under the Trust at the time the health care item or service was requested or, in the case of a retrospective review, was covered under the Trust at the time the health care item or service was provided;

- The decision being appealed does not relate to any failure to meet the applicable eligibility requirements;

- The Trust's internal claims appeal process has been completed; and

- All the information and forms required to process an external review have been received.

- The matter appealed involves either medical judgment or rescission.

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

Review by Independent Review Organization

After a properly filed request for external review is referred, the Trust will provide the IRO with the required documentation in the time required by applicable Federal regulations. The IRO will notify both you and the Trust of its decision within 45 days after it has received the request to review.

Expedited External Review

You may request the IRO to provide you an expedited external review if you received:

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

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

If the Trust receives a request for expedited external review, it will proceed immediately to determine whether the request meets the reviewability requirements for a standard external review and will notify you of its determination. If the Trust determines that the appeal is eligible for a standard external review, the Trust will assign an IRO and will provide all necessary documents and information considered in making the adverse benefit determination or final adverse benefit determination to the IRO electronically or by any other available expeditious method. The IRO will notify the Trust and you of its determination as expeditiously as the patient's medical condition or circumstances require, but in no event more than 72 hours after

the IRO receives the request for an expedited external review. If the notice from the IRO is not in writing, within 48 hours after the date of providing the notice, the IRO will provide both you and the Trust written confirmation of the decision.

Actions Following the Decision of the IRO

If the IRO directs that benefits be paid, the Trust will provide benefits under the applicable Plan in accordance with the decision. If the decision is adverse, you will have the right to pursue a suit pursuant to 29 U.S.C. 1132(a). Any legal action seeking to overturn a denial or an action that has otherwise adversely affected a claimant must be brought within 180 days of the latest of the following events: the initial denial with no appeal being made; the final adverse benefit determination by the Trust; or the IRO's denial.

Life, AD&D, Time Loss and LTD Claims

Time frames for Initial Claim Decisions

The claim administrator for the LTD plan is The Hartford. For the Life and AD&D plans, the claim administrator is Principal and for the Time Loss plan, the Trust Administrative Office.

Under the Life and AD&D plans, the claim administrator has 90 days to determine initial claims. If the claim administrator determines that an extension of time is necessary under certain circumstances, then the initial decision period may be extended for an additional 90 days.

Under the Time Loss and LTD plans, the claim administrator has 45 days to determine initial claims. If the claim administrator determines that an extension of time is necessary under certain circumstances, then the initial decision period may be extended for an additional 30 days. If necessary, this initial extension may then be extended for another 30 days. You'll be notified of any extensions within the previous time period, including information on the unresolved issues that prevent a decision on your claim. If you receive notification that additional information is needed from you to complete the claim, you'll have at least 45 days to provide the information.

Notice of Initial Claim Denial

If the claim administrator denies the claim, you'll receive written or electronic notice containing:

- Specific reasons for the denial
- References to specific plan provisions on which the denial is based
- List of any additional material or information necessary for you to perfect the claim and an explanation of why it's necessary
- Description of the plan's claim appeal procedure (and applicable time limits), including a statement of your right to bring a civil action under ERISA Section 502(a) if your appeal is denied
- Certain other information in accordance with applicable U.S. Department of Labor regulations.

AD&D, Time Loss, LTD and Life Claims Appeal Procedures

You can use these appeal procedures, if, in response to your claim, you received:

- No reply after the initial decision period, as listed above
- Notice of an extension to the initial decision period, as listed above, then no reply before the end of an extension
- A denial from the claim administrator.

If the claim is denied, in whole or in part, or if you believe plan benefits have not been properly provided, you, your beneficiary (if applicable), or your authorized representative may appeal the denial. The claim administrator will provide details about your right to appeal, along with the appeals process, address for filing an appeal, and timeframes. If you don't appeal within the designated timeframes, you may lose your right to later file suit in court.

To appeal a claim denial, you must file a written request for appeal pursuant to the procedure provided by the claim administrator (see the chart on page 96 for a list of claim administrators) within a certain period after receiving the claim denial, as described herein. The appeal must set forth all the grounds on which it is based, all the facts in support of the request, and other matters which you deem pertinent. Plan provisions require that you pursue the claim and appeal rights described here before seeking other legal recourse.

During the appeal, you will receive, upon request and free of charge, reasonable access to and copies of all documents, records and other information relevant to your benefit claim. For this claim procedure, a document, record or other information is considered relevant to a claim if it:

- Was relied on by the claim administrator in making the initial claim decision
- Was submitted, considered or generated in the course of deciding the claim, without regard to whether the document, record or other information was relied upon by the claim administrator in reaching the claim decision
- Demonstrates compliance with the administrative processes and safeguards required under Department of Labor regulations in making the benefit determination.

You may submit any written comments, documents, records or other information relating to your claim. In making its determination on healthcare, time loss, or LTD claim appeals, the Appeals Committee of the Washington Teamsters Welfare Trust will take into account all the comments, documents, records and other information you submitted relating to the claim, without regard to whether they were submitted or considered by the claim administrator in making the initial claim decision.

The Appeals Committee will conduct a review and make a final decision within a certain period after receiving your written request for review, as described below and on page 97. For certain plans, if the Appeals Committee needs more than this initial period to make a decision due to special circumstances, it will notify you in writing within the initial decision timeframe and explain why more time is required and the date the plan expects to make a decision.

The Appeals Committee will review your denied claim. You or your authorized representative has the right to present relevant information or testimony at the quarterly Appeals Committee meeting scheduled to hear your appeal. You will be notified of the meeting time and date, however a personal appearance is not required. The appeal review will not be conducted by the individual who denied the initial claim or that person's subordinate. The Appeals Committee will not give deference to the original decision on your claim; that is, they will take a fresh look and make an independent decision about the claim within the timeframes.

If your claim was denied based on a medical judgment, the Appeals Committee will consult with a healthcare professional who has appropriate training and experience in the field of medicine involved in your claim. The healthcare professional will not be the same person as the one consulted on the initial decision (or a subordinate of that person). A medical judgment includes whether a treatment, drug or other item is experimental, investigational or not medically necessary or appropriate. You also have the right to learn the identity of any medical or other experts who advised on your original claim decision, whether or not the Plan relied on their advice.

Timeframe for Filing and Determination of Life, AD&D, Time Loss and LTD Plan Appeals

For Life and AD&D claims you have 60 days from the date you receive notice of a claim denial to file an appeal. The Life and AD&D claims administrator must make a decision within 60 days after receiving your written appeal. If the Life and AD&D claims administrator determines that an extension of time is necessary under certain circumstances, then the 60-day decision period may be extended for another 60 days. If an extension is necessary, you'll be notified within the initial decision timeframe.

Under the Time Loss and LTD plans, you have 180 days from the date you receive notice of a claim denial to file an appeal. The Appeals Committee must make a decision at the next quarterly meeting of the Committee if the appeal is received at least 30 days prior to the meeting, otherwise the decision will be provided within five days after the second quarterly meeting that follows receipt of the appeal. If the Appeals Committee determines that an extension is necessary under certain circumstances, then the initial decision period may be extended to the following quarterly meeting of the Appeals Committee. If an extension isn't necessary, you'll be notified within the initial claim decision timeframe.

Notice of Decisions on Appeal

The decision on appeal will be in writing. If your appeal is denied, the notice will include:

- Reasons for the denial
- References to specific plan provisions on which the denial is based
- A statement of your right to access and receive copies, upon request and free of charge, of all documents and other information relevant to the claim for benefits
- A statement of your right to bring a civil action under ERISA Section 502(a)
- Certain other information in accordance with applicable U.S. Department of Labor regulations.

If the Appeals Committee does not respond within the applicable timeframe, you should generally consider the appeal denied. Contact the Trust Administrative Office if you have questions.

Administrative Details

The Employee Retirement Income Security Act of 1974 (ERISA) as amended, requires that certain information be furnished to Plan participants and beneficiaries:

Name of Plan

This Plan is known as the Washington Teamsters Welfare Trust — Medical Plan A.

Name, Address and Telephone Number of Board of Trustees as Plan Administrator

This Plan is sponsored and administered by a joint labor-management Board of Trustees:

Board of Trustees of the Washington Teamsters Welfare Trust
2323 Eastlake Avenue East
Seattle, Washington 98102
206-329-4900

You can obtain information on whether a particular employer or employee organization is a Plan sponsor (and, if so, their address) by writing to the Trustees. This information is also available to examine at the Trust Administrative Office. The Trustees may impose a reasonable charge for furnishing this information. You may want to inquire about the charge before requesting information.

Employer Identification Number and Plan Number

The employer identification number assigned to the Board of Trustees by the Internal Revenue Service is EIN 91-6034673.

- The Plan number is 501.

Type of Plan

This Plan is a welfare plan that provides hospital, surgical, medical, Time Loss, accidental death and dismemberment and life insurance benefits.

Type of Administration

This Plan is administered by the Board of Trustees with the assistance of this administrative organization:

Northwest Administrators, Inc.
2323 Eastlake Avenue East
Seattle, Washington 98102
206-329-4900

Name and Address of Agent for Service of Legal Process

Each member of the Board of Trustees is designated as an agent for accepting service of legal process on behalf of the Plan. The names and addresses of the Trustees are below.

Legal process can also be served on:

Northwest Administrators, Inc.
2323 Eastlake Avenue East
Seattle, Washington 98102

Names and Addresses of Board of Trustees

Employer Trustees	Employee Trustees
Randy Zeiler Allied Employers, Inc. 4020 Lake Washington Boulevard NE, Suite 205 Kirkland, Washington 98033-7870 Jerry D'Ambrosio 11019 SE 60th Street Bellevue, Washington 98006 Brian Isom United Parcel Service 13035 Gateway Drive, Suite 149 Seattle, Washington 98168 John H. Mack PO Box 80681 Seattle, Washington 98108 Yvonne Peters Allied Employers, Inc. 4020 Lake Washington Boulevard NE, Suite 205 Kirkland, Washington 98033-7870 H.L. "Buzz" Ravenscraft SAHARA, Inc. 6631 113th Place SE Bellevue, Washington 98006-6429 Doug Ruygrok Safeway Stores, Inc. 618 Michillinda Avenue Arcadia, California 91007-6300 Terry Ann Bodwin United Grocers 5200 Sheila St Commerce, California 90040	Tracey Thompson Teamsters Local Union No. 117 14675 Interurban Avenue S, Suite 307 Tukwila, Washington 98168-4614 Steve Chandler Teamsters Local Union No. 38 PO Box 1548 (98206) 2601 Everett Avenue Everett, Washington 98201 John Emrick Teamsters Local Union No. 313 220 South 27th Street Tacoma, Washington 98402 Bob Hawks Teamsters Local Union No. 839 1103 W Sylvester Street Pasco, Washington 99301-4873 Rick Hicks Teamsters Local Union No. 174 14675 Interurban Avenue S, Suite 305 Tukwila, Washington 98168-4614 Rich Ewing Teamsters Local Union 231 PO Box H (98227) 1700 North State Street Bellingham, Washington 98225 Darren O'Neil Teamsters Local Union 252 217 East Main Street Centralia, Washington 98531 Scott Sullivan Teamsters Local Union No. 763 14675 Interurban Avenue S, Suite 305 Tukwila, Washington 98168-4614 John Witte Teamsters Local Union No. 589 10049 Kitsap Mall Blvd NW, Suite 105 Silverdale, Washington 98383

Description of Collective Bargaining Agreements

This Plan is maintained under many collective bargaining agreements between various employers and labor organizations. You may obtain a copy of these collective bargaining agreements by writing to the Trust Administrative Office. This information is also available to examine at the Trust Administrative Office. The Trustees may impose a reasonable charge for furnishing the collective bargaining agreements. You may want to inquire about the charge before requesting a copy.

Eligibility and Benefits

Employees are entitled to participate in the Plan if they work under a collective bargaining agreement requiring contributions on their behalf and the employer makes those contributions to the Trust. The eligibility rules describing which employees and dependents are entitled to benefits begin on page 10. The benefits are described beginning on page 47.

Termination of Eligibility

An employee or dependent who is eligible for benefits may become ineligible as a result of one or more of the following circumstances:

- The employee's failure to work the required hours to maintain eligibility (or failure to make a self-payment, where authorized). See When Coverage Ends, COBRA Self-Pay Option and Six-Month Self-Pay Option on pages 11, 20 and 22.
- The failure of the employee's employer to report the hours and remit contributions on the employee's behalf to the Trust Fund.
- An eligible dependent is no longer being a dependent as described on page 12 or attains a disqualifying age as shown on page 11.
- Termination of the governing collective bargaining agreement or the Trust.

Future of the Plan and Trust Fund

The Board of Trustees has authority to terminate the Trust Fund. The Trust Fund will also terminate when collective bargaining agreements and special agreements requiring the payment of contributions expire. In the event of termination, the Board of Trustees will:

- Use the Trust Fund to pay expenses incurred up to the date of termination and expenses incident to the termination.
- Distribute the balance, if any, of Trust Fund assets to carry out the purpose of the Trust.
- Upon termination, the Board of Trustees may transfer remaining Trust Fund assets to the Trustees of any fund established to provide substantially the same or greater benefits than this Plan. In no event will any of the funds revert to or be recoverable by any employee, employer or union.

Source of Contributions

This Plan is funded through employer contributions; the amount is specified in the collective bargaining agreements. Also, self-payments by employees are permitted as outlined in this Plan booklet. The amount of the total plan cost is changed from time to time by the Board of Trustees, including employer contributions alone or a combination of employer contributions and employee self-payments.

Entities Used for Accumulation of Assets and Payment of Benefits

Employer contributions are received and held in trust by the Board of Trustees pending the payment of benefits or premiums. The Trustees pay benefits directly from the Trust Fund for Time Loss and medical benefits.

The Trustees pay premiums to The Principal Mutual Life Insurance Company to underwrite and provide benefits for Group Term Life and AD&D insurance:

Home Office:	Regional Office:
Des Moines, Iowa	1111 Third Avenue, Suite 620 Seattle, Washington 98101

Plan Year

This Plan is on a 12-month fiscal year basis beginning July 1 and ending the following June 30.

ERISA Rights and Protections

As a participant in the Trust, you are entitled to certain rights and protections under ERISA, which provides that all Plan participants be entitled to:

- Examine, without charge, at the Plan Administrator's office and at other specified locations, such as work sites 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 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 Plan 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 healthcare coverage for yourself, spouse or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the Plan to learn the rules governing these COBRA continuation coverage rights.
- Reduce or eliminate exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan. You should receive a certificate of creditable coverage, free of charge, from your Plan or insurer when you lose coverage under the Plan, when you become entitled to elect COBRA continuation coverage and when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after enrolling.

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

If your claim for a welfare benefit is denied or ignored, in whole or in part, you must receive a written explanation of the reason for the denial. You have the right to have the Plan review and reconsider your claim.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of documents or the latest annual report for the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the Plan 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 fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the 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.

If you have any questions about your Plan, contact the Trust Administrative Office (Plan Administrator). 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, contact the nearest office of the Employee Benefits Security Administration, Department of Labor, listed in your phone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, Department of Labor, 200 Constitution Avenue NW, Washington, DC 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.