PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION FOR

NORTHWEST LABORERS-EMPLOYERS HEALTH & SECURITY TRUST FUND

REVISED EDITION

April 1, 2020

NORTHWEST LABORERS-EMPLOYERS HEALTH & SECURITY TRUST FUND

This revised Plan booklet includes changes to the Plan that have been made since the last booklet was printed. We encourage you to read this booklet carefully and keep it with your important documents. If you have questions, contact the Trust Office.

This document is a description of the Northwest Laborers-Employers Health & Security Trust Fund (the Plan) as of April 1, 2020. This Plan provides benefits for medical, vision, Prescription Drug, dental, short term disability, life, and accidental death & personal loss.

The medical, vision, prescription, Dental Plan B, short term disability, life and accidental death & personal loss benefits are self-funded and are paid in accordance with this booklet, which constitutes the Plan Document.

Dental benefits provided under Dental Plan A are fully insured under a policy that the Plan maintains with Willamette Dental Group.

Coverage under the Plan becomes effective upon satisfaction of all the eligibility requirements. The Plan provides benefits only for expenses incurred while this coverage is in force. No benefits are payable for expenses incurred before coverage begins or after coverage terminates, even if the expenses were incurred as a result of an Injury or Sickness that occurred, began, or existed while coverage was in force. An expense for a service or supply is incurred on the date the service or supply is furnished.

The Board of Trustees fully intends to maintain this Plan indefinitely. However, it reserves the right to terminate, suspend, discontinue, or amend the Plan at any time and for any reason. Changes may occur in any or all parts of the Plan including benefit coverage, Deductibles, maximums, Co-payments, exclusions, limitations, definitions, eligibility, and the like.

The Board of Trustees has authority to administer the Plan. The Trustees also have the exclusive right and discretion to construe the provisions of the Plan and to determine all questions pertaining to administration, Eligibility, and benefit entitlement, including the right to remedy possible ambiguities and inconsistencies or omissions. The only party authorized by the Board of Trustees to answer questions regarding the Plan and benefits described in this document is the Contract Administrative Agent (Trust Office), Zenith American Solutions. No Employer or local union, nor any representative of any Employer or local union, is authorized to interpret this Plan nor can such person act as an agent of the Board of Trustees to guarantee benefit payments. No oral interpretations can change this Plan.

All questions concerning Plan benefit interpretations should be referred to the Trust Office. Telephone contact with the Trust Office does not guarantee eligibility for benefits or benefit payments. Eligibility for benefits and benefit payments will be determined only when a claim is submitted to the Trust Office.

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ELIGIBILITY

Please be sure to verify eligibility at the time of service.

ACTIVE ELIGIBILITY AND TERMINATION PROVISIONS

There are four eligibility classifications:

1. Active Hour Bank Eligibility
2. Active Flat Rate Eligibility
3. Associate/Non-Bargaining Unit Eligibility
4. Retiree Medical Eligibility

Those Employees who work under a collective bargaining agreement requiring contributions to the Trust, or whose Employer has entered into an associate agreement with the Trust and whose Employer makes the required contribution to the Trust are eligible to participate in the Plan. The collective bargaining agreement or the associate agreement defines the eligibility classification. Dependents of eligible Employees are also eligible to participate in the Plan.

Retirees who satisfy the Retiree Medical eligibility provisions and their Dependents are eligible to participate in this Plan. Refer to page 23 for Retiree eligibility requirements.

Active Hour Bank Eligibility

Eligibility is determined on the basis of an hour bank system. For purposes of calculating hour bank eligibility, the dollar value of one hour is based on the contribution rate set in the collective bargaining agreements requiring contributions to the Trust. Hours reported and contributions paid in amounts less than or greater than the rate set in the collective bargaining agreements are prorated. Any contributions paid that are less than the current hourly contribution rate will earn less than one hour in the hour bank, and any contributions paid that are greater than the current hourly contribution rate will earn more than one hour in the hour bank. The Trustees periodically review the dollar value of one hour. The requirements for hour bank eligibility are:

Initial Eligibility Requirements for Medical and Prescription Drug Coverage. A minimum of 350 hours in the hour bank is required for initial eligibility for medical and Prescription Drug coverage.

NOTE: An Employee has six months to accumulate the 350 hours. If an Employee does not accumulate 350 hours in the first six months of Covered Employment, the Plan will look to subsequent six-month periods until the Employee meets the 350 hour requirement. For example, if an Employee works January through June and fails to accumulate 350 hours, the Plan will look to February through July hours to determine whether the 350 hour requirement is met. The January hours are dropped from the hour bank.

Eligibility for medical and Prescription Drug coverage becomes effective the first day of the second month following the accrual of 350 hours in a six-month period.

For example:

If an Employee works 180 hours in June and 170 hours in July, and contributions are paid at the rate set in the collective bargaining agreements requiring contributions to this Trust, the Employee becomes eligible for medical and Prescription Drug coverage on September 1st. In this example, August is the "lag month."

Initial Eligibility Requirements for Dental, Vision, Short Term Disability, Life and Accidental Death and Personal Loss Coverage. A minimum of 1000 hours is required in the hour bank (prior to deduction of the hours for medical and Prescription Drug coverage) for initial Eligibility for Dental, Vision, Short Term Disability, Life and Accidental Death and Personal Loss coverage.

Eligibility for Dental, Vision, Short Term Disability, Life and Personal Loss coverage becomes effective on the first day of the second month following accumulation of the 1,000 hours, provided that if the Employee is not eligible for medical and Prescription Drug coverage on that date, it becomes effective on the same date that medical and Prescription Drug coverage is reestablished. Furthermore, if the hour bank is forfeited before Dental, Vision, Short Term Disability, Life and Personal Loss coverage requirement is met, then the initial Eligibility requirements begin again.

Continuing Coverage. Once the initial Eligibility requirements are satisfied for medical and Prescription Drug coverage, 300 hours will be deducted from the Employee's hour bank for the first month of coverage and 130 hours will be deducted for each subsequent month of coverage. This will provide coverage beginning the first day of the second month following each month in which hours are deducted. An Employee will continue to be covered as long as there are 130 hours or more in the hour bank. A maximum of six consecutive months of continuous coverage (780 hours) can be accumulated in an Employee's hour bank.

Termination of Hour Bank Eligibility for Employees. An Employee's hour bank coverage ends on the earliest of the following dates:

1. On the first day of the second month following the month in which the hour bank has less than a month of coverage at the current hour bank deduction rate.
2. On the last day of the month in which the Employee enters the Armed Services of the United States, except for periods of Reservists Training, unless the Employee elects to run-out the hour bank. Refer to Uniformed Service on page 18.
3. On the date the Plan is terminated.

Forfeiture of Hour Bank. If the hour bank drops below 130 hours, the hours remain in the hour bank for 10 months from the last date of eligibility (either hour bank eligibility or COBRA eligibility) after which period the hour bank is forfeited.

Reinstatement of Active Hour Bank Eligibility. An Employee who was previously covered will again become covered upon accumulation of at least 130 hours in the hour bank within the ten calendar-month period immediately following the termination of Eligibility. Reinstatement is effective on the first day of the second calendar month in which this requirement is met. If coverage is not reinstated within a ten-calendar-month period, any reserve hours in the Employee's hour bank will be forfeited. In the event the hour bank is forfeited, an Employee will again become covered after satisfying the initial Eligibility

requirements for new Employees i.e., 350 hours in the hour bank in a six-month period for medical and Prescription Drug coverage, and 1,000 hours in the hour bank for Dental, Vision, Short Term Disability, Life and Accidental Death and Personal Loss coverage.

Active Flat Rate Eligibility

A bargaining unit Employee who is employed by a Covered Employer contributing to the Trust at a flat monthly rate (rather than an hourly rate) is eligible to participate in the Plan, provided the Employee has worked the minimum number of hours required by the flat rate agreement during a calendar month. Employees covered under a flat rate agreement will not accumulate an hour bank.

Eligibility for Medical and Prescription Drug Coverage. An Employee covered under a flat rate agreement becomes eligible for medical and Prescription Drug coverage on the first day of the second month following the month in which the Employee worked the required number of hours and for which the Employer made the required flat rate contribution to the Trust.

Eligibility for Dental, Vision, Short Term Disability, Life and Accidental Death and Personal Loss Coverage. An Employee covered under a flat rate agreement becomes eligible for dental, vision, short term disability, life and accidental death and personal loss coverage on the first day of the second month following six consecutive months in which the Employee worked the required number of hours and for which the Employer made the required flat rate contribution to the Trust.

Termination of Flat Rate Eligibility. An Employee's flat rate coverage ends on the earliest of the following dates:

1. The first day of the second month following the month in which the Employee did not work the number of hours required by the flat rate agreement.
2. On the last day of the month in which the Employee enters the Armed Services of the United States, except for periods of Reservists Training. Refer to Uniformed Service on page 18.
3. On the date the Plan is terminated.

Associate/Non-Bargaining Unit Eligibility

An Employee who is employed by a Covered Employer participating in a special non-bargaining unit, associate agreement with the Trust, may be eligible provided the Employee has worked the minimum number of hours required by the associate agreement during a calendar month and the Employer makes the required contributions. Employees covered under an associate agreement requiring payment of contributions on an hourly basis accumulate an hour bank and have eligibility determined in accordance with the Active Hour Bank Eligibility provisions. Employees covered under an associate agreement requiring contributions on a flat rate basis do not accumulate an hour bank and have eligibility determined in accordance with the Active Flat Rate Eligibility provisions. For complete rules to participate, please contact the Trust Office.

Money Follow-the-Man Reciprocity

The Trust has money-follows-the-man reciprocity agreements with certain other health trusts that allow Employees to request a transfer of hours and contributions to the Employee's home trust when temporarily working in another area. The Employee must contact the Trust Office to determine if a

reciprocity agreement is in force in the area where the Employee is working. Money-follows-the-man reciprocity allows the Employee to accumulate hours in the home trust to help maintain eligibility in that trust. The benefits provided are those provided under the plan of the home trust.

To request a transfer of hours and contributions, the Employee should contact the Local Union or Trust Office for an authorization form. The authorization form must be completed and returned to the Trust Office as soon as possible and generally no later than 90 days after beginning employment in another area. Employees who fail to file a timely authorization to transfer contributions will be treated as not electing a transfer.

DEPENDENT ELIGIBILITY

Eligibility Requirements for Dependents. Coverage for a Dependent who meets the definition of Dependent becomes effective on the date the Employee becomes eligible.

A Dependent of a Retiree may be covered at the time the Retiree enrolls in Retiree Medical. If a Retiree is enrolled in Retiree Medical and acquires a new Dependent as defined by the Plan through birth, adoption, or placement for adoption, the newly acquired Dependent child may be enrolled in the Plan. The Retiree must request enrollment no more than 30 days after the date of birth, adoption, or placement for adoption, and coverage becomes effective on the date of birth, adoption, or placement for adoption.

If the Retiree is enrolled in Retiree Medical and acquires a new Dependent(s) through marriage, that Dependent(s) may be enrolled in the Plan. The Retiree must request enrollment no more than 30 days after the date of marriage, and coverage becomes effective the first of the month following receipt of the enrollment form.

Definition of Dependent. A Dependent is defined to mean any one of the following persons:

1. The lawful spouse of an Employee or Retiree. The term spouse means the individual legally married to the Employee or Retiree as determined under state law, and who is treated as a spouse under the Internal Revenue Code. However, a legally separated spouse is not eligible. The Trust Office requires a copy of the legal state certified marriage certificate.
2. A child of an Employee or Retiree who satisfies either of the following requirements:
    a) The child is a natural child, stepchild, adopted child, foster child, or child "placed for adoption" and is under the age of 26; or
    b) Any child under the age of 26 for whom an Employee or Retiree has been awarded legal guardianship or legal custody, and the child has the same principal residence as the Employee or Retiree for more than one-half of the Calendar Year and has not provided over one-half of his own support for the year.

An unmarried Dependent child who is Totally Disabled, incapable of self-sustaining employment by reason of mental or physical handicap, primarily dependent upon the Covered Employee or Retiree for support and maintenance, and covered under the Plan when reaching age 26, may continue to be covered provided proof of incapacity is submitted to the Trust Office within 31 days of the date the Dependent's coverage would otherwise terminate, and the child continues to satisfy the definition of Dependent

(other than the age requirement). The Trust Office may require proof of the child's Total Disability and dependency, at reasonable intervals following the child's reaching age 26. The Plan reserves the right to have such Dependent examined by a Physician of its choice and at the Plan's expense to determine the existence of such incapacity.

The term child "placed for adoption" means the assumption and retention by the Employee or Retiree of a legal obligation for total or partial support of the child in anticipation of adoption.

The term "foster child" means a child who is placed with the Employee or Retiree by an authorized placement agency or by judgment, decree, or other order of any court of competent jurisdiction.

The terms "legal guardianship" or "legal custody" shall mean any judgment, decree or order issued by a court of competent jurisdiction by which the court declares, establishes or finds that the Employee or Retiree is the guardian or custodian of the child and is legally responsible for the care, maintenance and support of the child. In addition, the Employee or Retiree who has been awarded legal guardianship or legal custody must provide over one-half of the child's support for the Calendar Year, in order for the child to qualify as an eligible Dependent.

The following are excluded as Dependents: other individuals living in the Covered Employee's or Retiree's home, but who are not eligible as defined; or the legally separated or divorced former spouse of the Employee or Retiree.

If a person covered under this Plan changes status from Employee to Dependent or Dependent to Employee, and the person is covered continuously under this Plan before, during and after the change in status, credit will be given for Deductibles and all amounts applied to Plan maximums.

If both spouses are Employees, their children will be covered as Dependents of both Employees, provided each Employee enrolls their Dependent children separately.

Qualified Medical Child Support Order. The Plan recognizes Qualified Medical Child Support Orders ("QMCSO") and enrolls an Employee's natural Dependent children, adopted Dependent children, and Dependent children placed with the Employee in anticipation of adoption as directed by the order.

A QMCSO is any judgment, decree, or order (including a domestic relations settlement agreement) issued by an administrative agency under applicable state law which:

1. Provides child support or health benefit coverage to a Dependent child; or
2. Enforces a state law relating to medical child support pursuant to Section 1908 of the Social Security Act, which provides in part that if the Employee does not enroll the Dependent child, then the non-Employee parent or State agency may enroll the child.

To be qualified, a Medical Child Support Order must clearly specify:

1. The name and last known mailing address of the Employee and the name and mailing address of each Dependent child covered or the name and mailing address of the state official issuing the order;
2. A description of the type of coverage to be provided by the Plan to each such Dependent child;

3. The period of coverage to which the order applies; and
4. The name of each plan to which the order applies.

A Medical Child Support Order will not qualify if it would require the Plan to provide any type or form of benefit or any option not otherwise provided under this Plan, except to the extent necessary to comply with Section 1908 of the Social Security Act.

Payment of Plan benefits under a QMCSO shall be made to the child or custodial parent or legal guardian if so required by the QMCSO.

No Dependent child covered by a QMCSO will be denied enrollment in the Plan on grounds that the child is not claimed as a Dependent on the Employee's Federal income tax return or does not reside with the parent.

The Employee, the Retiree, the child's custodial parent, or the applicable state agency may submit a child support order to the Trust Office. If an order is received, the Trust Office will notify the Employee and each child named in the order to the extent applicable. A properly completed National Medical Support Notice issued by a state agency shall be deemed to be a QMCSO. The order will then be reviewed to determine if it meets the definition of a QMCSO. Within a reasonable period of time, the Employee and each child named in the order will be notified of the decision. A notice will also be sent to each attorney or other representative named in the order or accompanying correspondence.

If the order is not qualified, the notice will give the specific reason for the decision. The party or parties filing the order will be given an opportunity to correct the order. If the order is qualified, the notice will give instructions for enrolling each child named in the order. A copy of the entire QMCSO and any required self-payments pursuant to an order will be subject to all provisions applicable to Dependent coverage under the Plan.

Termination of Dependent Coverage. A Dependent's coverage will terminate on the earliest of the following dates:

1. The date the Plan or Dependent coverage under the Plan is terminated.
2. The date that the Employee's coverage under the Plan terminates for any reason including death.
3. On the first day of the month following the month in which the Dependent no longer qualifies as an eligible Dependent.
4. If the Dependent is a spouse, on the first day of the month following the date of divorce or legal separation.

See the Continuation of Coverage and Alternative Continuation of Coverage Options sections for information on how to continue coverage in the event coverage under the Plan is terminated.

ENROLLMENT

Enrollment Procedures. An Employee must enroll for coverage by filling out and signing an enrollment form. To obtain an enrollment form, contact the Trust Office, or download one at www.zenith-american.com. **In order to keep the eligibility records accurate, an Employee must complete a new enrollment form and submit it to the Trust Office for any change of address or**

Dependent status. An Employee must also complete a new enrollment form to change a designated beneficiary, or to add a new Dependent such as a new spouse, newborn or adopted child or a stepchild.

When adding Dependents, proof of Dependent eligibility status must be submitted, for example, a state certified marriage certificate, a state certified birth certificate or legal adoption papers. Newborns are enrolled automatically for a period of 30 days, when claims are processed for birth expenses, provided the mother is covered under the Plan; however coverage will be suspended at the expiration of 30 days until a new enrollment form adding the newborn is submitted along with a copy of the state certified birth certificate. Eligibility for other Dependents cannot be determined until enrollment forms and proof of Dependent status are received. Please inform the Trust Office promptly in the event of a divorce or legal separation.

Failing to inform the Trust Office of a divorce or legal separation or enrolling a Dependent who is otherwise ineligible will result in the retroactive termination of the ineligible Dependent. Additionally, the Trust may take all necessary actions to recover any overpaid benefits, including seeking reimbursement from the Employee or Retiree and the Employee's or Retiree's ineligible and eligible Dependents.

CONTINUATION OF COVERAGE

COBRA CONTINUATION OF COVERAGE

Under the Consolidated Omnibus Budget Reconciliation Act ("COBRA"), Employees and their Dependents may extend health benefits on a self-pay basis under certain circumstances called "qualifying events." Employees and Dependents who are entitled to elect continuation coverage are called "qualified beneficiaries."

Qualified Beneficiaries. A qualified beneficiary means:

1. Any individual who, on the day before a qualifying event, is covered under the Plan, either as an Employee, or as a Dependent of an Employee or Retiree.
2. A child who is born to, adopted by, or placed for adoption with an Employee (as opposed to another Family member) during COBRA, provided the child is enrolled by submitting an enrollment form to the Trust Office within 30 days of birth, adoption, or placement for adoption. The child will have the same COBRA rights as a Dependent who was covered by the Plan before the qualifying event that resulted in the loss of coverage.

Dependents, other than those listed in paragraphs 1 and 2 above, who are newly acquired during a period of COBRA may be enrolled in COBRA by submitting an enrollment form to the Trust Office within 30 days of becoming a Dependent. However, such Dependents will not be considered qualified beneficiaries, and therefore will not have an independent right to COBRA.

Only qualified beneficiaries may extend COBRA when there is a second qualifying event.

18-Month Qualifying Events. An Employee and the Employee's Dependents may elect COBRA for a maximum of 18 months following the date coverage would otherwise end due to one of the following qualifying events:

1. The Employee's termination of employment; or
2. The Employee's layoff or reduction in hours of employment.

If Social Security determines that a qualified beneficiary is totally disabled either before the 18-month qualifying event or within the first 60 days of COBRA, the disabled individual and all qualified beneficiaries may extend COBRA an additional 11 months beyond the original 18 months, to a maximum of 29 months. In order to qualify for this extension, the qualified beneficiary must notify the Trust Office in writing no later than the date that the initial 18 months of COBRA expires. A copy of the Social Security determination must be included with the written notice. Thereafter, if there is a final determination by Social Security that the individual is no longer disabled, the qualified beneficiary must notify the Trust Office in writing within 30 days of the determination. For an individual who has extended COBRA beyond the initial 18 months, COBRA will end on the earlier of 29 months from the qualifying event, or the month that begins more than 30 days after the final determination has been made that the disabled individual is no longer disabled.

36-Month Qualifying Event. A Dependent may elect COBRA for a maximum of 36 months following the date coverage would otherwise end due to one of the following qualifying events:

1. Death of the Employee or Retiree;
2. Divorce or legal separation between the Employee or Retiree and spouse; or
3. The Dependent child ceases to meet the Plan's definition of Dependent.

Second Qualifying Event. An 18-month period of COBRA may be extended to 36 months for the affected qualified beneficiary (spouse or child), if one of the 36-month period qualifying events occurs during the first 18 months of COBRA or the Employee becomes entitled to (covered by) Medicare during the first 18 months of COBRA. In no event will COBRA extend beyond 36 months from the date coverage was first lost due to the initial qualifying event. This extension applies only if the qualified beneficiary notifies the Trust Office in writing within 60 days of the second qualifying event. In the absence of such notice, COBRA will terminate.

Medicare Entitlement. If an Employee has an 18-month qualifying event after becoming entitled to Medicare, the Employee's Dependents may continue COBRA until the later of:

1. 18 months from the date coverage would normally end due to the termination of employment or reduction in hours; or
2. 36 months from the date the Employee becomes entitled to Medicare.

Notice Requirements. The Plan offers COBRA only after it has been notified of a qualifying event. A qualified beneficiary is responsible for notifying the Trust Office of a qualifying event that is a divorce, legal separation, or child losing Dependent status. **The qualified beneficiary must provide this notice to the Trust Office in writing within 60 days of the later of the date of the qualifying event, or the date coverage would be terminated as a result of the qualifying event.** The notice must identify the individual who has experienced a qualifying event, the Employee's name, and the qualifying event that occurred. If the Trust Office is not notified during the 60-day period, the qualified beneficiary will lose the right to elect COBRA.

If a child is born to, adopted by, or placed for adoption with an Employee during a period of COBRA, the child must be enrolled by the Employee within 30 days of birth, adoption or placement for adoption, by submitting an enrollment form to the Trust Office, and providing a copy of the child's birth certificate or adoption papers.

In order to qualify for a Social Security disability extension, the qualified beneficiary must notify the Trust Office in writing no later than the date that the initial 18 months of COBRA expires. A copy of the Social Security determination must be included with the written notice. Thereafter, if there is a final determination by Social Security that the individual is no longer disabled, the qualified beneficiary must notify the Trust Office in writing within 30 days of the determination.

A qualified beneficiary who first becomes, after the date of the election of COBRA, covered under any other group health plan, including Medicare, must notify the Trust Office in writing of the other coverage.

Required notices should be sent to the Trust Office at the following address:

Northwest Laborers-Employers Health & Security Trust
c/o COBRA Department
11724 NE 195th St. Suite 300
Bothell, WA 98011

The Trust Office will notify qualified beneficiaries of loss of coverage due to termination of employment, reduction in work hours and the Employee's death. However, qualified beneficiaries are encouraged to inform the Trust Office of any qualifying event to best ensure prompt handling of COBRA rights.

Election of COBRA. When the Trust Office is notified of a qualifying event, an election form is mailed to the qualified beneficiaries. The election form must be completed and returned to the Trust Office within 60 days of the later of the termination of coverage, or the date the application was sent. If the election form is not postmarked or received within 60 days, the qualified beneficiaries will lose the right to elect COBRA.

Each qualified beneficiary has an independent right to elect COBRA. An Employee or spouse may elect COBRA on behalf of other qualified beneficiaries in the Family. A parent or legal guardian may elect COBRA on behalf of a minor child.

Type of Benefits. The following benefit options are available under COBRA:

1. Medical and Prescription Drug– available to any qualified beneficiary.
2. Medical, Prescription Drug, Dental and Vision– available only to qualified beneficiaries who have Medical, Prescription Drug, Dental and Vision coverage on the day immediately preceding the loss of coverage due to a qualifying event.

Life, Accidental Death and Personal Loss Benefits and Short-Term Disability Benefits are not available under COBRA.

Cost and Payment. There is a cost for COBRA. Information regarding the cost will be sent with the election forms. The first payment must be received or postmarked within 45 days from the date the election form is sent to the Trust Office. The first payment must cover all months since the date coverage would have otherwise terminated. Thereafter, payments must be made monthly to continue COBRA. All payments must be sent to the Trust Office and received or postmarked by the date due.

COBRA eligibility will not commence, nor will claims be processed for expenses incurred following the date of the qualifying event, until the appropriate COBRA payments have been made. COBRA terminates automatically if a monthly payment is made later than 30 days from the beginning of the month to be covered. If the initial payment or any subsequent payment is not made in a timely fashion, COBRA automatically terminates.

Termination of COBRA. COBRA ends on the first of the dates indicated below:

1. The last day of the month the maximum coverage period for the qualifying event has ended (18, 29, or 36 months).
2. The last date for which payments were paid, or when the qualified beneficiary does not make the next payment in full when due.
3. The date the qualified beneficiary first becomes, after the date of election of COBRA, covered under any other group health plan that does not contain any exclusion or limitation that actually applies to any pre-existing condition of the qualified beneficiary.
4. The date the qualified beneficiary becomes entitled to Medicare after the date of election of COBRA.
5. The last day of the month that begins more than 30 days from the final determination that the qualified beneficiary is no longer disabled as determined by Social Security. This applies only to the 19th through 29th month of disability extended COBRA.
6. The date the Trust no longer provides group health coverage or the date the Employee's Employer no longer participates in the Plan, unless the Employer or its successor does not offer another health plan for any classification of its Employees which formerly participated in the Trust.

COBRA is provided subject to the provisions described in this booklet. Failure to inform the Trust Office within 60 days of a divorce, legal separation, child losing Dependent status, or Social Security disability award may result in the Trust denying COBRA coverage. The Plan reserves the right to terminate COBRA retroactively if the qualified beneficiary is determined to be ineligible for coverage.

Relationship Between COBRA and Medicare or Other Health Coverage. A Participant's COBRA coverage will terminate if he or she becomes entitled to Medicare or other group health coverage after his or her COBRA election. If Medicare or other group health coverage already existed when the Participant elects COBRA, however, the Participant can be eligible for both.

If the Participant has coverage under a Trust-sponsored Plan based on COBRA and is entitled to Medicare based on age or disability and no longer has current employment status under applicable law, Medicare will pay first and the Trust will only pay as the secondary payer and coordinate with Medicare.

If the Participant has Medicare coverage based on end-stage renal disease and has Trust coverage (based on COBRA or otherwise), the Trust will pay primary during the 30-month coordination period provided for by statute. If the Participant has other group health coverage, it will pay as primary payer and the Trust's continuation coverage will be secondary.

ALTERNATIVE CONTINUATION OF COVERAGE OPTIONS

There is no individual or group conversion option available for the Medical, Prescription Drug, Dental, Vision, or Life and Accidental Death and Personal Loss coverage provided by the Trust. However, instead of enrolling in COBRA there may be other coverage options, and some of them may be more affordable than continuing coverage through COBRA.

FAMILY MEDICAL LEAVE

A federal law known as the Family Medical Leave Act ("FMLA") may apply to Family and medical leaves for those Employees who work for a Covered Employer that employs 50 or more Employees within a 75-mile radius. To be eligible for FMLA coverage, an Employee must be covered under the Plan when the leave began and the Covered Employer must make the required contributions during the leave. FMLA coverage is limited to 12 work weeks during a 12-month period while the Employee is on leave. Coverage terminates the earlier of the expiration of FMLA leave or the date the Employee gives notice to the Employer that the Employee does not intend to return to work at the end of FMLA leave. After FMLA coverage ends, an Employee and the Employee's Dependents may be entitled to elect COBRA Continuation Coverage.

Employees who think they may be eligible for a FMLA leave should contact their Employer immediately. An Employer must provide documentation to the Trust to confirm eligibility for FMLA leave, and make arrangements to pay the required contributions to continue coverage.

UNIFORMED SERVICE

USERRA Continuation Coverage. Under the Uniformed Services Employment and Reemployment Rights Act ("USERRA"), an Employee with hour bank eligibility who leaves employment with a Covered Employer for USERRA qualified military service may elect to:

1. Run-out the hour bank;
2. Freeze the hour bank until a return from military service; or
3. Extend coverage after it would otherwise terminate by making self-payments for USERRA continuation coverage. This option is available regardless of whether the Employee elects to run-out or freeze the hour bank.

An Employee with flat rate eligibility also has the option of extending coverage after it would otherwise terminate by making self-payments for USERRA continuation coverage.

Notice of Military Service. Employees are responsible for notifying the Trust Office in writing that they are entering military service. Employees wanting to freeze their hour bank, must notify the Trust Office within 60 days of beginning military service. If timely notice is not provided, the hour bank will continue to run.

Employees wanting to elect USERRA continuation coverage under the Plan must notify the Trust Office of military service within 60 days of termination of coverage. Employees who fail to notify the Trust Office within the 60-day time period, will not be entitled to elect USERRA continuation coverage.

Election of USERRA Continuation Coverage. After timely notification to the Trust Office of military service, an Employee will be sent an election form to affirmatively elect USERRA continuation coverage. The completed election form must be sent to the Trust Office, and postmarked or received within 60 days from the later of the date coverage would otherwise end, or 60 days from the date the notification is furnished. An Employee who fails to return the election forms by the due date, will not be allowed to elect USERRA continuation coverage.

Length of USERRA Continuation Coverage. If an Employee provides timely notice and properly elects to freeze the hour bank, it will be frozen the first of the month following the month in which the Employee begins military service.

If an Employee properly elects to freeze the hour bank and thereafter elects USERRA continuation coverage, the USERRA continuation coverage will begin on the first day of the month following the month in which military service begins, provided the required self-payments are made.

If an Employee decides to run-out the hour bank before commencing USERRA continuation coverage, or works under a flat rate agreement, USERRA continuation coverage will begin immediately following the date coverage would otherwise end, provided the required self-payments are made.

USERRA continuation coverage will end on the first of the dates indicated below:

1. 24 months following the month in which an Employee's hour bank was frozen, or coverage would have otherwise ended because of entry into military service.
2. The last day of the month in which an Employee fails to return to employment or apply for a position of reemployment within the time required by USERRA.
3. The last day of the month for which a timely self-payment is not received or postmarked.

Available Coverage. An Employee may elect to self-pay for USERRA continuation coverage for Employee only, Employee and Dependents or Dependents only. An Employee may elect the following coverage options:

1. Medical and Prescription Drug option – available to any Employee who has a period of USERRA qualified military service.
2. Medical, Prescription Drug, Dental, Vision option – available only to Employees who have medical, Prescription Drug, Dental and Vision coverage on the day immediately preceding the period of USERRA qualified military service.

Life insurance, Accidental Death and Personal Loss Benefits, and Short-Term Disability benefits are not available under USERRA continuation coverage.

Once an Employee elects a coverage option, that election cannot be changed for the duration of USERRA continuation coverage. Benefits are the same as those provided to similarly situated Employees. If the Trust changes its benefits, USERRA continuation coverage will also change.

Monthly Self-Payments. If military leave is less than 31 days, coverage is continued at no cost. If military leave is for 31 days or more, a monthly self-payment is required for USERRA continuation coverage. The Trust Office will notify an Employee of the self-payment amount when it sends the election forms. The rate for USERRA coverage is the same as the COBRA continuation coverage rate.

The initial payment for USERRA coverage is due within 45 days from the date the Trust Office receives a completed election form. The first payment must cover all months for which coverage is sought through the month in which the first payment is made. Eligibility will not commence, nor will claims be processed until the initial payment has been made.

After the initial payment, monthly payments are due on the first of each month for that month's coverage. USERRA continuation coverage terminates if a monthly payment is not postmarked or received by the Trust Office within 30 days from the beginning of the month to be covered.

USERRA continuation coverage must be continuous and must immediately follow the date coverage would have otherwise ended (or was frozen).

Reinstatement of Eligibility Following Military Service. Employees are responsible for notifying the Trust Office of discharge from military service, and reemployment with a Covered Employer. Notification must be in writing and it should include a copy of the discharge papers.

If an Employee properly elected to freeze the hour bank upon entry into military service, the balance in the hour bank will be carried over until the Employee is discharged from military service. Frozen hour bank eligibility will be reinstated the first of the month in which the Employee is discharged. Following reinstatement, hour bank eligibility will terminate the first day of any month the hour bank has less than a month of eligibility at the current hour bank deduction rate, unless the Employee returns to employment with a Covered Employer within the time period specified by USERRA, as explained below.

If an Employee returns to employment with a Covered Employer immediately following military service or within the time period specified by USERRA, eligibility will be reinstated without waiting periods or any other initial eligibility requirements. If an Employee is on the out-of-work list at the local union, it is considered a return to employment with a Covered Employer for purposes of reinstatement of eligibility.

If an Employee elects to run out the hour bank, and subsequently returns to employment within the time period specified by USERRA, eligibility will be reinstated the first of the month in which the Employee returns to employment. The Plan will then provide eligibility at no cost to the Employee, for up to six consecutive months, or if earlier, until the Employee reestablishes hour bank or flat rate eligibility based upon hours worked.

For example, if an Employee runs out the hour bank while in military service and, upon discharge, timely returns to employment January 1, the Plan will provide eligibility through the earlier of June 30 or the second month following the month the Employee works sufficient hours to reestablish hour bank or flat rate eligibility.

If an Employee elected to freeze the hour bank and returns to employment within the time period specified by USERRA, the Employee may first run-out the previously frozen hour bank. Once the previously frozen hour bank has less than a month of eligibility at the current hour bank deduction rate, the Plan will provide eligibility at no cost to the Employee for up to six consecutive months, or if earlier, until the Employee reestablishes hour bank or flat rate eligibility based upon hours worked.

For example, if an Employee froze three months of hour bank eligibility upon entering military service and, upon discharge, timely returns to employment January 1, the Plan will use the hour bank to provide eligibility through March 31. If, between January 1 and March 31, the Employee is unable to accumulate sufficient hours to provide eligibility beyond March 31, the Plan will provide eligibility through the earlier of September 30 or the second month following the month the Employee works sufficient hours to reestablish hour bank or flat rate eligibility.

Relationship of USERRA Continuation Coverage to COBRA. An Employee may have the right to elect COBRA continuation coverage in lieu of USERRA continuation coverage. The length of USERRA continuation coverage may be different from that of COBRA continuation coverage. If an Employee elects USERRA continuation coverage, COBRA may not be elected when USERRA continuation coverage ends.

SPOUSE AND DEPENDENTS OF DECEASED EMPLOYEES

Dependents of a deceased Covered Employee will continue to be covered under the Plan until the active eligibility earned by the deceased Employee terminates.

Coverage may also be extended for a Dependent spouse or Dependent children of a deceased Employee who was vested in the Western Washington Laborers-Employers Pension Trust, the Washington-Idaho Laborers-Employers Pension Trust or a related pension plan approved by the Trustees; who worked at least 15,000 hours in Covered Employment; and was a Covered Employee at the time of death. To be eligible, a Dependent spouse must have been married to the deceased Employee for a period of at least one year. Coverage may continue until the spouse remarries or the children no longer qualify as Dependents. Self-payments are required to extend coverage through Retiree Medical. Refer to page 23 for more information.

HEALTH INSURANCE MARKETPLACE

Instead of enrolling in COBRA, there may be other more affordable coverage options available through the Health Insurance Marketplace. Employees or Dependents who enroll in coverage through the Marketplace may qualify for lower monthly premiums and lower out-of-pocket costs than under COBRA.

Employees or Dependents who elect COBRA can switch to a Marketplace plan during the Marketplace open enrollment. Employees and Dependents may also be able to end COBRA early and switch to a Marketplace plan if there is an event that gives rise to a special enrollment period, such as marriage or birth of a child. However, if COBRA is terminated early without an event that gives rise to a special enrollment, then Marketplace coverage is not available until the next Marketplace open enrollment period.

Once COBRA is exhausted and expires, special enrollment is also available through the Marketplace, even if the open enrollment ended.

If a Marketplace plan is selected instead of COBRA then COBRA may not thereafter be elected unless there is a new COBRA qualifying event.

For information about health insurance options available through the Health Insurance Marketplace, and to locate an assister in a particular geographic area who can provide information about the different options, visit www.HealthCare.gov.

RETIREE MEDICAL

Employees and their Dependents, who qualify for both COBRA and Retiree Medical, may elect COBRA in lieu of Retiree Medical. Following termination of COBRA, the Employee and eligible Dependents may apply for Retiree Medical. However, if COBRA is declined in favor of Retiree Medical, COBRA may not thereafter be elected, unless there is a new qualifying event.

RETIREE MEDICAL COVERAGE

The Board of Trustees is providing this program of Retiree Medical and Prescription benefits to the extent that money is currently available to pay the cost of such programs. The Board of Trustees retains full and exclusive authority at its discretion to determine the expenditures of such money for the program. The program may be terminated or modified at any time by the Board of Trustees.

BENEFITS PROVIDED UNDER RETIREE MEDICAL

Retiree Medical provides coverage for the medical and Prescription Drug benefits described in this booklet. No benefits are provided for dental, vision, short term disability, life or accidental death and personal loss coverage.

ELIGIBILITY FOR RETIREE MEDICAL

Retirees who meet the eligibility requirements and apply for Retiree Medical are eligible for medical and Prescription Drug benefits.

Eligibility Requirements. Effective January 1, 2003, Retirees are eligible for Retiree Medical if they satisfy the following requirements:

1. The Retiree must have worked at least 15,000 hours in work covered by a collective bargaining agreement that required contributions to the Western Washington Laborers-Employers Pension Trust, the Washington-Idaho Laborers-Employers Pension Trust, a pension plan approved by the Board of Trustees, or the Northwest Laborers-Employers Health & Security Trust.
2. The Retiree must be a Covered Employee in the Northwest Laborers-Employers Health & Security Trust at retirement or have elected continuation of coverage through COBRA. A Marketplace plan does not satisfy this requirement. The requirement that a Retiree be a Covered Employee will be waived in the following circumstances:
    a) If coverage under the active eligibility provisions of the Plan or COBRA terminated during the 24-month period preceding the Retiree's retirement effective date, and the Retiree submits medical evidence that the termination of active or COBRA coverage was the result of a disability.
    b) If, for the six-month period immediately preceding retirement, the Retiree continuously worked under a collective bargaining agreement with the Washington and Northern Idaho District Council of Laborers or its affiliates which does not require contributions to the Northwest Laborers-Employers Health & Security Trust, provided the Retiree worked at least 15,000 hours in work covered by a collective bargaining agreement that required contributions to the Northwest Laborers-Employers Health & Security Trust.
    c) If the Retiree was a member of a bargaining unit that was required to cease participating in the Trust Pursuant to RCW 41.05.740 and who continued to work for an affected School

District under a Laborers' bargaining agreement until the Retiree's retirement effective date.

3. The Retiree must be receiving a pension from the Western Washington Laborers-Employers Pension Trust, the Washington-Idaho Laborers-Employers Pension Trust, or a pension plan approved by the Trustees.
4. If the Retiree has not worked and been covered under the Northwest Laborers-Employers Health & Security Trust during any period of five consecutive years or more commencing with the date that the Retiree first began participating in the Plan, the Retiree must return to Covered Employment for at least 6,000 hours during the five-year period immediately prior to the retirement date. Time worked under a collective bargaining agreement with the Washington and Northern Idaho District Council of Laborers or its affiliates which does not require contributions to the Northwest Laborers-Employers Health & Security Trust will not be counted in determining whether the Retiree had a five year break in coverage. This requirement is waived for a Retiree described under Section 2.c above.

Effective Date of Coverage. Retiree Medical coverage becomes effective the first of the month following the last month of coverage from hours worked or the first of the month pension payments commence, whichever is later. In no event will coverage commence prior to a Retiree's 55th birthday unless eligible for and receiving a disability pension.

Postponement or Suspension of Retiree Medical. A Retiree who is between the ages of 55 and 65, and who is otherwise eligible for Retiree Medical benefits from the Trust, may elect to postpone Medical benefits while covered under other employment-based group health coverage. The Coverage may be the Retiree's own or through a spouse. The postponement may be made at the time the Retiree initially qualifies for Retiree Medical coverage or after it has begun. To qualify:

1. The Retiree must have satisfied all eligibility for Retiree Medical coverage at the time of retirement;
2. Provide written notice to the Trust Office prior to the time Retiree Medical coverage would begin or ends that the Retiree is postponing or suspending Retiree Medical benefits because he or she has other employment-based group health coverage;
3. Have no gap in employment-based group health coverage from the date active coverage under the Trust ceased; and
4. The Retiree notified the Trust Office within 30 days of the date that the other employment-based group health, ended.

A Retiree between ages 55 and 65 who elects to enroll in a plan through the Health Insurance Marketplace instead of enrolling in Retiree Medical, may later enroll in Retiree Medical on a one-time basis at any time prior to the Retiree's age 65 if the following requirements are satisfied:

1. The Retiree satisfied the eligibility requirements for Retiree Medical at the time of retirement.
2. There is no gap in coverage between the loss of active eligibility under this Plan and the effective date of coverage under the Marketplace plan.
3. There is no gap in coverage between the loss of coverage under the Marketplace plan and the effective date of Retiree Medical coverage unless the Retiree is re-electing coverage at either age 62 or age 65.

A Retiree between ages 55 and 65 who was enrolled in Retiree Medical and terminates that coverage to enroll in a Health Insurance Marketplace plan, may later re-enroll in Retiree Medical on a one-time basis prior to the Retiree's age 65 if the following requirements are satisfied:

1. The Retiree satisfied the eligibility requirements for Retiree Medical at the time of retirement.
2. There is no gap in coverage between the loss of Retiree Medical and the effective date of coverage under the Marketplace plan.
3. There is no gap in coverage between the loss of coverage provided by the Marketplace plan and the effective date of Retiree Medical unless the Retiree is re-electing coverage at either age 62 or age 65.

DISABILITY RETIREES

To be eligible for Retiree Medical under the age of 55, a Retiree must be receiving a disability pension and meet the requirements for a disability pension from the Western Washington Laborers-Employers Pension Trust, Washington-Idaho Laborers-Employers Pension Trust, or a related pension plan approved by the Trustees and must meet the requirements for Retiree Medical eligibility.

NOTE: Eligible disability Retirees must remain qualified for a disability pension in order to continue to be eligible for the Retiree Medical Plan.

RETIREE MEDICAL/DEPENDENT COVERAGE

Dependent spouse and children as defined by the Plan, of the Retiree, may be covered at the time the Retiree enrolls in Retiree Medical.

SPECIAL ENROLLMENT FOR NEWLY ACQUIRED DEPENDENTS

If a Retiree is enrolled in Retiree Medical and, acquires a new Dependent child, as defined by the Plan, through birth, adoption, or placement for adoption, the newly acquired Dependent child may be enrolled in Retiree Medical. The Retiree must request enrollment no more than 30 days after the date of birth, adoption, or placement for adoption, and coverage becomes effective on the date of birth, adoption, or placement for adoption.

If the Retiree is enrolled in Retiree Medical and acquires a new Dependent(s) through marriage, that Dependent(s) may be enrolled in the Plan. The Retiree must request enrollment no more than 30 days after the date of marriage, and coverage becomes effective the first of the month following the month in which the Trust Office receives the request for enrollment.

To request enrollment or for more information, contact the Trust Office at:

Northwest Laborers-Employers Health & Security Trust
11724 NE 195th St. Suite 300
Bothell, WA 98011

SPOUSE AND DEPENDENTS OF DECEASED RETIREES

In the event of the Retiree's death, a Dependent spouse, who has been married to the Retiree for a period of at least one year, may remain covered until the spouse remarries. Covered Dependent children may

remain covered until they no longer qualify as Dependents. The spouse may delay coverage until the attainment of age 62 or 65.

SPOUSE AND DEPENDENTS OF DECEASED ACTIVE EMPLOYEES

Dependents of a deceased Covered Employee will continue to be covered under the Plan until the active eligibility earned under the Active Eligibility provisions of the Plan, by the deceased Employee terminates.

Coverage may also be extended for a Dependent spouse or Dependent children of a deceased Employee who was vested in the Western Washington Laborers-Employers Pension Trust, the Washington-Idaho Laborers-Employers Pension Trust or a related pension plan approved by the Trustees; who worked at least 15,000 hours in Covered Employment; and was a Covered Employee at the time of death. To be eligible, a Dependent spouse must have been married to the deceased Employee for a period of at least one year. Coverage may continue until the spouse remarries or the children no longer qualify as Dependents. Refer to the section on Retiree Medical Coverage.

COVERAGE COST

A self-payment is required for Retiree Medical for the Retiree, a spouse, and each Dependent child, if covered. The rates for Retirees who commenced Retiree Medical before January 1, 2003 are determined by the Board of Trustees and subject to adjustment at least annually.

For Retirees who commence Retiree Medical on or after January 1, 2003, the rates for Retiree Medical are based upon the hours worked by the Retiree for which contributions have been paid into the Western Washington Laborers-Employers Pension Trust, the Washington-Idaho Laborers-Employers Pension Trust, a pension plan approved by the Board of Trustees, or the Northwest Laborers-Employers Health & Security Trust and are subject to adjustment at least annually.

The hours worked on and after January 1, 2016 under a bargaining unit flat rate agreement are not used in determining the rate paid by the Retiree, except when the employer contribution rate included the required funding for subsidized coverage. Hours worked prior to January 1, 2016 under a bargaining unit flat rate agreement are used in determining the rate. For example, if a Retiree worked 15,000 or more hours under a bargaining unit flat rate agreement prior to January 1, 2016, those hours are used to determine the Retiree Medical rate. If a Retiree worked less than 15,000 hours prior to January 1, 2016, the hours worked under a bargaining unit flat rate agreement on and after January 1, 2016 continue to accumulate and count towards the 15,000 minimum hours required for Retiree Medical coverage but do not count in calculating the rate paid by the Retiree, unless the employer contribution rate included the required funding for subsidized coverage. Therefore, if that Retiree worked less than 15,000 hours prior to January 1, 2016, and subsequently earns the minimum hours required for Retiree Medical coverage, the coverage will be provided at the unsubsidized rate. Note: This provision applies only to hours worked under a bargaining unit flat rate agreement. Any hours worked under a bargaining unit active hourly agreement will continue to accumulate after January 1, 2016, and the total hours worked will be used to determine the rate paid for Retiree Medical, provided the member meets all of the eligibility requirements for Retiree Medical.

Please contact the Trust Office for information regarding the current Retiree rate schedule.

TERMINATION

Retiree Medical will terminate:

1. When pension benefits are suspended or terminated, provided that Retirees who return to Covered Employment may continue self-payments for Retiree Medical for up to three months while accumulating hours under the Active Eligibility provisions of the Plan. When a Retiree whose pension benefits were suspended resumes such benefits, he may elect not to reinstate Retiree Medical. If the Retiree does reinstate Retiree Medical, changes cannot be made to the original election of coverage. For example, Dependents may not be added unless they were enrolled at the time of the original retirement effective date or enrolled under the special enrollment provisions for newly acquired Dependents.
2. The month in which the required self-payments are not made and may not thereafter be reinstated.
3. Upon the death of the Retiree, or in the case of Dependents, at the end of the month in which the Retiree dies. However, Dependents may be eligible to continue Retiree Medical as provided in the section, “SPOUSE AND DEPENDENTS OF DECEASED RETIREES” on page 26.
4. At the end of the month in which a Dependent no longer qualifies as a Dependent.

MEDICARE

Medicare includes:

1. Part A (Hospital insurance) which helps cover inpatient Hospital care, Skilled Nursing Facility care, Home Health Care, and Hospice care. Generally, there is no cost for Medicare Part A. Retirees and their Dependent spouses should enroll in Medicare Part A when eligible, because the benefits of this Plan are provided as if actually enrolled in Medicare Part A.
2. Part B (medical insurance) which helps cover Physician’s services and outpatient Hospital care. It may also cover some services that Medicare Part A does not cover. A monthly premium is generally required for Medicare Part B. A Deductible is also required before Medicare starts to pay. Retirees and their Dependent spouses should enroll in Medicare Part B when eligible, because the benefits of the Retiree Plan are provided as if actually enrolled in Medicare Part B. For example, Medicare Part B benefits would have been paid at 80%, so this Plan would only consider 20% as an eligible expense. A Retiree or Dependent spouse may delay enrollment in Medicare Part B if they have been continuously covered by a group health plan based on current employment. Please contact Medicare to verify eligibility for delayed enrollment based on Medicare’s Special Enrollment Period.
3. Part C – Medicare Advantage Plan (like an HMO or PPO). Part C includes BOTH Part A (Hospital Insurance) and Part B (Medical Insurance) and in some instances, a Medicare Advantage Plan may also include Part D (Prescription Drug coverage). **A Retiree or Dependent spouse who is enrolled in a Medicare Advantage Plan that includes Prescription Drug coverage is not eligible for the Retiree Medical Plan’s Prescription Drug benefits.**
4. Part D (Prescription Drug coverage) which helps cover prescription drugs. A monthly premium is generally required for Medicare Part D. **A Retiree or Dependent spouse who enrolls in Medicare Part D, or a Medicare Advantage Plan that includes coverage for Prescription Drugs, is not eligible for the Retiree Medical Plan’s Prescription Drug benefits, including the Mail Order Pharmacy.**

Refer to page 55 for details on enrollment in Part D.

In order to receive full Plan benefits, a Retiree and a Dependent spouse MUST enroll in Medicare Parts A and B or Plan C when eligible for that coverage. Even if COBRA is elected in lieu of Retiree Medical a Retiree and a Dependent spouse are expected to enroll in Medicare. This Plan does not provide benefits for amounts that would have been reimbursed by Medicare Part A, Part B, or Part C if a Retiree or Dependent spouse fails to enroll. Enrollment in Medicare Part B may be delayed if the Retiree or Dependent spouse is covered under a group health plan based on current employment. Please contact Medicare to verify eligibility for delayed enrollment based on Medicare's Special Enrollment Period. Plan Participants who have End-Stage Renal Disease should also enroll in Medicare when eligible.

An individual is eligible to enroll in Medicare if:

1. Age 65 or older; or
2. Under age 65 and receiving disability benefits from Social Security or the Railroad Retirement Board. (There may be a waiting period before commencement of Medicare); or
3. Has End-Stage Renal Disease ("ESRD").

Enrollment in Medicare. Plan Participants who are receiving benefits from Social Security or the Railroad Retirement Board, should be automatically enrolled in Medicare the first day of the month they turn age 65. Plan Participants who are under age 65 and disabled, should be automatically enrolled after receiving disability benefits from Social Security or the Railroad Retirement Board for 24 months (although a shorter waiting period may apply in some instances). Plan Participants who do not want Medicare Part B, must follow the instructions that come with the Medicare card. **However, if a Retiree or Dependent of a Retiree is eligible to enroll in Medicare Part B, benefits under this Plan are provided as if the Retiree or Dependent is enrolled in Medicare Part B, regardless of whether they actually enroll.** The only exception is if a Retiree or Dependent spouse has delayed enrollment in Medicare Part B because they are still covered by a group health plan based on current employment. Please contact Medicare to verify eligibility for delayed enrollment based on Medicare's Special Enrollment Period.

Plan Participants who are turning age 65 and are not receiving Social Security or Railroad Retirement benefits must apply for Medicare. Even if the Social Security age is older than age 65, eligibility for Medicare enrollment is still at age 65. Please refer to Medicare for Special Enrollment Period rules.

There is an initial enrollment period for Medicare Part B, which begins three months before the month an individual turns age 65 and ends three months after the month an individual turns age 65. However, the starting date for Medicare Part B will be delayed for individuals who do not sign up before the month they turn age 65. Please contact Medicare if you have questions.

Plan Participants who do not sign up for Medicare Part B during the initial enrollment period, may sign up during the general enrollment period which runs from January 1 through March 31 of each year. Medicare Part B will start on July 1 of the year of sign up. The cost of Medicare Part B generally increases for each 12-month period that a Plan Participant could have taken Medicare Part B but did not.

There is a special enrollment period for those who waited to enroll in Medicare Part B because they or a spouse was working and had other group health plan coverage based upon that employment. The special enrollment period is anytime the individual is still covered in the group health plan, or during the eight months following the earlier of the month that group health plan ends or employment ends.

Those under age 65 and covered by Medicare must submit proof of Medicare eligibility.

Please notify the Trust Office in writing within 30 days of receipt of notification of Medicare Eligibility. Refer to page 118 for information regarding Coordination of Benefits.

Plan Participants with End-Stage Renal Disease should also enroll in Medicare. Different enrollment rules apply. Plan Participants with End-Stage Renal Disease are encouraged to contact Social Security for information on enrollment.

To learn more about Medicare enrollment rules call Medicare at 1-800-633-4227 or visit Medicare.gov

SCHEDULE OF MEDICAL BENEFITS

This Schedule of Medical Benefits is a summary of the medical benefits provided under this Plan. **Please read the entire booklet for details on specific benefit limitations and maximums, waiting, periods and exclusions.** Prior Authorization for certain types of medical services, Durable Medical Equipment, and inpatient facility stays, may be necessary to confirm that the services are Medically Necessary and covered by the Plan. Please refer to page 44

The Plan has an arrangement with Premera Blue Cross/BlueCard PPO program to access a network of Physicians, Hospitals, and other medical providers that provide discounted pricing on medical services. These are called "In-Network Providers". Medical providers who are not in the Premera Blue Cross/BlueCard PPO program are called "Out-Of-Network Providers". The Plan will provide a higher level of benefits when "In-Network Providers" are used.

Premera Blue Cross/BlueCard PPO network provider listings are available on line at www.premera.com/sharedadmin; or by calling the Provider Locator number at 1-800-810-2583.

BENEFIT	IN-NETWORK	OUT-OF-NETWORK
ANNUAL DEDUCTIBLE*		
Individual	$ 500	$ 500
Family	$ 1,500	$ 1,500
*Deductible is a combined maximum of $500 per person per Calendar Year.		
ANNUAL OUT-OF-POCKET MAXIMUM*		
Individual	$ 4,500	Unlimited
Family	$ 4,500	Unlimited
*Includes medical Deductible, office visit Co-Pays, In-Network Co-insurance and specialty drug out-of-pocket for covered prescriptions.		
ANNUAL OVERALL OUT-OF-POCKET MAXIMUM*		
Individual	$ 6,600	Unlimited
Family	$13,200	Unlimited
*Includes the expenses recognized under the Annual Out-Of-Pocket Maximum, plus prescription and other out-of-pocket for covered expenses.		

BENEFIT	IN-NETWORK	OUT-OF-NETWORK
OFFICE VISITS & TELEMEDICINE		
$20 Co-pay will apply to the Deductible and continue to be required until the Annual Out-Of-Pocket Maximum for In-Network is met.	$20 Co-pay then 85% after Deductible	$20 Co-pay then 70% after Deductible
OUTPATIENT X-RAY & LAB		
Prior Authorization may be required	85% after Deductible	70% after Deductible
HOSPITAL SERVICES		
Prior Authorization Required	85% after Deductible	70% after Deductible
EMERGENCY ROOM		
Co-pay waived if visit is within 24 hours of an Accidental Injury, or for a Medical Emergency. Out-of-Network emergency room is paid at the In-Network benefit level when treatment is for a Medical Emergency.	$150 Co-pay then 85% after Deductible	$150 Co-pay then 70% after Deductible
TELADOC		
Medical, Behavioral Health & Dermatology	$0 Co-pay no Deductible	
Board Certified Physicians provide diagnosis and treatment via phone or video call.		
SURGERY		
Prior Authorization may be required	85% after Deductible	70% after Deductible
AMBULANCE		
To nearest Hospital only Air ambulance may require Prior Authorization	85% after Deductible	70% after Deductible
PREGNANCY		
Prenatal, postnatal care and expenses incurred at delivery	85% after Deductible	70% after Deductible
Elective abortions	Not covered	Not covered
Breast feeding support and supplies,	100% no Deductible	70% after Deductible
Contraceptives, contraceptive counseling and sterilization procedures.	100% no Deductible	70% after Deductible
BestBeginnings Maternity Resource Program		
Refer to page 46 for more information		

BENEFIT	IN-NETWORK	OUT-OF-NETWORK
ROUTINE NEWBORN CARE For covered newborns		
Routine Hospital nursery care	85% after Deductible	70% after Deductible
Routine newborn Physician care	100% no Deductible	70% after Deductible
Newborn circumcision	85% after Deductible	70% after Deductible
ROUTINE PHYSICAL BENEFIT		
Exam and related expenses 1 per Calendar Year	100% no Deductible	$20 Co-pay then 70% after Deductible
PREVENTIVE CARE		
Includes annual health and cancer screenings, well childcare, vaccines and immunizations as recommended by the Affordable Care Act. See www.healthcare.gov/coverage/preventive-care-benefits/	100% no Deductible	$20 Co-pay then 70% after Deductible
PREVENTIVE CARE FOR WOMEN		
For a list of covered services Refer to page 42 or see www.healthcare.gov/coverage/preventive-care-benefits/	100% no Deductible	70% after Deductible
HABILITATIVE THERAPY SERVICES		
Includes physical, occupational, and speech therapies to treat autism, pervasive disability disorders and other developmental disorders identified as Mental Disorders.	85% after Deductible	70% after Deductible
REHABILITATIVE THERAPY		
Includes up to 100 days of Physical, Occupational and Massage therapy after an Accident, stroke, or surgery. For all other conditions or following the first 100 days after an Accident, stroke or surgery, visits are subject to a combined limit of 30 per Calendar Year.	85% after Deductible	70% after Deductible
REHABILITATIVE SPEECH THERAPY		
Only to restore speech following Sickness or Injury	85% after Deductible	70% after Deductible

BENEFIT	IN-NETWORK	OUT-OF-NETWORK
CARDIO/PULMONARY REHABILITATION		
Medically Necessary cardiac rehabilitation. Prior Authorization required. Refer to page 37 for limitations.	85% after Deductible	70% after Deductible
SPINAL MANIPULATIONS		
Maximum 24 visits per Calendar Year - Employees or Retirees Maximum 12 visits per Calendar Year - Dependents	85% after Deductible to $25 max benefit	70% after Deductible to $25 max benefit
MENTAL HEALTH CARE		
Office Visits	$20 Co-Pay then 85% after Deductible	$20 Co-pay then 70% after Deductible
In-Patient -Prior Authorization required	85% after Deductible	70% after Deductible
SUBSTANCE USE TREATMENT		
Office Visits	$20 Co-Pay then 85% after Deductible	$20 Co-pay then 70% after Deductible
Inpatient – Prior Authorization required	85% after Deductible	70% after Deductible
CHEMO/RADIATION		
	85% after Deductible	70% after Deductible
DURABLE MEDICAL EQUIPMENT & PROSTHETICS		
Prior Authorization may be required	85% after Deductible	70% after Deductible
TEMPOROMANDIBULAR JOINT DISORDER (TMJ)		
Combined Lifetime maximum of $1000 for covered medical and dental services.	85% after Deductible	70% after Deductible
HEARING AID BENEFIT		
Hearing Aids $500 maximum per ear, each 36 consecutive month period.	85% after Deductible	70% after Deductible

BENEFIT	IN-NETWORK	OUT-OF-NETWORK
HOME HEALTH CARE		
Prescribed by a Physician and immediately following a period of Hospitalization.	100% after Deductible	100% after Deductible
Prescribed by Physician/not following a period of Hospitalization.	85% after Deductible	70% after Deductible
OUT-PATIENT HOSPICE		
Up to six months, with Hospice Care Plan Prescribed by a Physician	100% no Deductible	100% no Deductible
IN-PATIENT HOSPICE		
Prior Authorization required	100% no Deductible	100% no Deductible
SKILLED NURSING FACILITY		
Maximum of 60 days per occurrence. Prior Authorization required. Custodial Care not covered. Refer to page 42 for more information	85% after Deductible	70% after Deductible
ORGAN TRANSPLANTS		
Prior Authorization required. Refer to page 39 for Plan limitations	85% after Deductible	70% after Deductible
DONOR EXPENSES		
Donor benefits paid to a maximum of $5000. Recipient must be a Covered Person.	85% after Deductible	70% after Deductible

MEDICAL BENEFITS

Medical Benefits apply when covered medical expenses are incurred by a Covered Person for care of an Injury or Sickness and while the person is eligible for these benefits under the Plan.

Deductible

Deductible Amount. This is an amount of covered expenses for which no benefits will be paid. Before benefits can be paid in a Calendar Year, a Covered Person must meet the Deductible shown in the Schedule of Medical Benefits. The Deductible is a combined maximum of $500 per person per Calendar Year.

Family Limit. When the dollar amount shown in the Schedule of Medical Benefits has been incurred by Covered Persons in a Family toward their Calendar Year Deductibles, the Deductibles of all Covered Persons of that Family will be considered satisfied for that year.

Deductible for a Common Accident. This provision applies when two or more Covered Persons in a Family are injured in the same Accident.

These persons need not meet separate Deductibles for treatment of Injuries incurred in this Accident; instead, only one individual Deductible for the Calendar Year in which the Accident occurred will be required for them as a unit.

Benefit Payment

Each Calendar Year, benefits will be paid for the covered medical expenses of a Covered Person that are in excess of the Deductible. Payment will be made at the Co-insurance rate shown in the Schedule of Medical Benefits. No benefits will be paid in excess of the maximum benefit amount or any listed limit of the Plan.

In-Network Providers

For the purpose of determining medical benefits provided by this Plan, In-Network Providers refers to the Premera Blue Cross/BlueCard PPO network.

When covered services are provided by an In-Network Provider, the Plan generally pays a higher percentage of covered expenses than it does when services are provided by an Out-of-Network Provider. In addition, once a Family reaches the Annual Out-of-Pocket limit, or the Annual Overall Out-of-Pocket limit, covered expenses by an In-Network Provider for that Family will be payable at 100% for the rest of the Calendar Year.

Covered expenses will be paid at the In-Network Provider level when:

1. Services are provided by an In-Network Provider,
2. Services are provided or dispensed by an Out-Of-Network Provider (anesthesiologist, radiologist, pathologist, assistant surgeon or DME) at an In-Network Provider (Hospital or Physician),
3. MRI is ordered or performed by an In-Network Provider (Physician) at an Out–of-Network Provider (Hospital),

4. Medical Emergency services as defined by the Plan that are provided by In-Network or Out-of-Network Providers, or
5. Charges for lab and x-ray services are ordered by an In-Network Provider but provided by an Out-of-Network Provider.

Out of pocket amounts for covered services provided by an Out-of-Network Provider which are paid at the In-Network level in the situations described above will be applied toward the Annual Out-of-Pocket Maximum. The dollar amount applied to the Maximum will be limited to the Usual, Customary and Reasonable amount.

Out-Of-Network Providers

An Out-of-Network Provider refers to a medical provider that is not in the network of providers contracted with Premera Blue Cross/BlueCard PPO. When services are provided by an Out-of-Network Provider, the Plan generally pays a lesser percentage of covered medical expenses than it does for In-Network Providers, as shown in the Schedule of Medical Benefits. Additionally, except as described above under In-Network Providers, amounts paid to Out-of-Network Providers do not count toward the Annual Out-of-Pocket Maximum.

COVERED MEDICAL EXPENSES

Covered expenses are the expenses incurred by a Covered Person for which benefits are provided under the Plan. Covered expenses for In-Network Providers are based upon the allowed amount, which is the fee negotiated by the preferred provider network. Covered expenses for Out-of-Network Providers are based on the Usual, Customary and Reasonable charges. The following are covered expenses under the Plan. Benefits for these covered expenses are subject to the limitations, exclusions, and other provisions of this Plan. An expense is incurred on the date the service or supply is performed or furnished, unless otherwise stated.

Prior Authorization For Benefit Coverage

You must get Prior Authorization for certain types of medical services, Durable Medical Equipment, and for most inpatient facility stays. This is so Premera can confirm that these services are Medically Necessary.

Ambulance. Local Medically Necessary professional land or air ambulance service, provided the service is to the nearest Facility where treatment can be provided, unless the Trust finds a longer trip was Medically Necessary. Non-emergent Ambulance service may require Prior Authorization.

Acupuncture. When performed by a covered provider. Must be Medically Necessary and may be subject to review.

Anesthesia. The anesthesiologist’s charge for administering anesthetic during a covered surgical or medical procedure.

Cardiac Rehabilitation. Medically Necessary cardiac rehabilitation provided services are rendered:

1. Under the supervision of a Physician;
2. In connection with acute myocardial infarction, congestive heart failure, current stable angina pectoris, heart valve surgery, heart or heart lung transplantation, coronary occlusion or coronary artery bypass surgery, percutaneous transluminal coronary angioplasty, or coronary stenting;
3. Initiated within 12 weeks after the qualifying event; and
4. Performed in an outpatient medical facility.

Chemotherapy/radiation. The materials and services for technicians providing radiation or chemotherapy and treatment with radioactive substances.

Contact Lenses. Initial contact lenses or glasses required following cataract surgery.

Dental Services. Injury to or care of mouth, teeth, gums, and alveolar processes will be covered medical expenses under Medical Benefits only if that care is for the following oral surgical procedures:

1. Excision of tumors and cysts of the jaws, cheeks, lips, tongue, roof, and floor of the mouth.
2. Emergency repair due to Injury to sound natural teeth. This repair must be made within 6 months from the date of an Accident.
3. Surgery needed to correct Accidental Injuries to the jaws, cheeks, lips, tongue, floor, and roof of the mouth.
4. Excision of benign bony growths of the jaw and hard palate.
5. External incision and drainage of cellulitis.
6. Incision of sensory sinuses, salivary glands, or ducts.
7. Reduction of dislocations and excision of temporomandibular joints (TMJs).

No charge will be covered under Medical Benefits for dental and oral surgical procedures involving orthodontic care of the teeth, periodontal disease and preparing the mouth for the fitting of or continued use of dentures.

Diagnostic X-ray and Laboratory Studies. Covered medical expenses include the charge of a Physician, radiologist, pathologist or laboratory for Medically Necessary diagnostic laboratory or x-ray examination.

Dialysis for End-Stage Renal Disease (ESRD). Covered Persons diagnosed with end-stage renal disease (ESRD) may be eligible to enroll in Medicare by nature of the diagnosis. Although enrollment in Medicare is not mandatory, Plan benefits will assume that a person enrolls 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 treatment. 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.
For Covered Persons not yet eligible to enroll in Medicare (months 1-3 post diagnosis) benefits for dialysis for ESRD are subject to the annual Deductible and 85% Coinsurance for In-Network Providers and 70% Coinsurance for Out-of-Network Providers. The allowed amount is the negotiated discounted

rate for an In-Network Provider; or the Usual, Customary and Reasonable charge by an Out-of-Network Provider.

For Covered Persons enrolled in, or eligible to enroll in Medicare (months 4-34 post diagnosis) and when Medicare is the secondary payer, the allowed amount for ESRD dialysis is 150% of the current Medicare allowance, subject to the annual Deductible and 85% Coinsurance for In-Network Providers and 70% Coinsurance for Out-of-Network Providers.

For Covered Persons enrolled in Medicare when Medicare is the primary payer, the Plan pays secondary to Medicare and coordinates benefits up to 100% of the current Medicare allowed amount for out-patient dialysis treatment. Refer to claims procedures for Medicare claims listed on page 105.

Notwithstanding the above, the Trustees may, in their sole discretion, agree to a contractual arrangement for payment with a provider of ESRD services. The contract may allow for a different payment for ESRD services than listed above but in no circumstances will a contractual arrangement allow for a payment less than described above. Any contractual agreement and/or change in payment terms with a provider of ESRD services will be at the sole discretion of the Trustees.

In order to ensure the correct coordination of claim payments between the Plan and Medicare, Covered Persons with ESRD must contact the Trust Office and provide the effective date of Medicare coverage.

Durable Medical Equipment. Rental of Durable Medical Equipment if deemed Medically Necessary. May require Prior Authorization. Durable Medical Equipment means equipment that:

1. Is primarily and customarily used to serve a medical purpose;
2. Generally, is not useful to a person in the absence of a Sickness or Injury; and
3. Is appropriate for use in the home.

Habilitative Therapy. Includes physical, occupational, and speech therapies to treat autism, pervasive disability disorder and other developmental disorders identified as Mental Disorders in the current International Classification of Diseases (ICD) and or the Diagnostic and Statistical Manual of Mental Disorders (DSM).

Hearing Aids. Covered up to the benefit payment maximum shown in the Schedule of Benefits. The benefit payment maximum is allowed per ear, each 36 consecutive months. An examination must take place before obtaining the hearing aid and a written certification must be submitted to the Trust verifying the need for the hearing aid.

Home Health Care Services and Supplies. Home Health Care provides the opportunity to convalesce at home. When Home Health Care Services prescribed by a Physician begin immediately following a period of approved Hospitalization or Skilled Nursing Facility care, benefits are not subject to the Plan Deductible and charges are covered at 100% of the allowed amount for In-Network Providers or 100% of the Usual, Customary and Reasonable charges for Out-of-Network Providers.

If the period of Home Health Care Services does not follow an approved Hospitalization, care must be prescribed by a Physician and are subject to the Plan Deductible and Co-insurance. Services may be periodically reviewed for medical necessity.

Home Health Care Services must be provided by a Home Health Care Agency that is federally certified as a Home Health Care Agency; and is licensed by the state in which it is located, if licensing is required. Covered expenses include visits by a registered or licensed practical nurse, a licensed physical, occupational or speech therapist, and home health aides. The Plan also covers prescribed supplies and prescription medications obtained through the Home Health Care Agency and the rental up to the purchase price, of Durable Medical Equipment prescribed by the Physician.

Hospital Care. Inpatient room and board and Medically Necessary services and outpatient Medically Necessary medical services and supplies furnished by a Hospital, Ambulatory Surgical Center or a Birthing Center. Covered medical expenses will be payable as shown in the Schedule of Medical Benefits. After 23 observation hours, a confinement will be considered an inpatient confinement. Hospital charges for days in which the patient leaves the Hospital against medical advice are not covered. Requires Prior Authorization

In-Patient Hospice. This benefit is designed to provide in-patient Hospice care for the terminally ill. Hospice Care benefits are not subject to the Plan Deductible and charges are covered at 100% of the allowed amount for In-Network Providers and 100% of the Usual, Customary and Reasonable charge for Out-of-Network Providers. Requires Prior Authorization.

Medical Supplies. When ordered by a Physician, may include casts, dressings, splints, braces, colostomy bags and related supplies.

Mental Health Disorders and Treatment of Substance Use Disorders. Covered expenses for care, supplies and treatment of Mental Disorders and Substance Use Disorders will be considered on the same basis as any other covered Sickness or Injury.

National Suicide Prevention Lifeline (800) 273-8255

Organ Transplant. In order to be eligible for transplant coverage, the Covered Person must be eligible under the Plan for a period of at least 24 months prior to an organ transplant. Organ transplants require Prior Authorization. Charges otherwise covered under the Plan that are incurred for the care and treatment related to an organ or tissue transplant are covered.

Charges for obtaining donor organs or tissues are covered expenses under the Plan when the recipient is a Covered Person up to the limitation listed in the Schedule of Medical Benefits. When the donor has other medical coverage, the donor's plan will pay first. The benefits under this Plan will be reduced by those payable under the donor's plan. Donor charges include those for:

1. Evaluating the organ or tissue;
2. Removing the organ or tissue from the donor; and

3. Transportation of the organ or tissue from within the United States and Canada to the place where the transplant is to take place.

Orthotics. The initial purchase, fitting, repair, and replacement of orthotic appliances such as braces, splints or other appliances required for support for an injured or deformed part of the body as a result of a disabling congenital condition or an Injury or Sickness. Orthotic appliances must be prescribed by a Physician as Medically Necessary, used as prescribed, and made of durable material.

Out-patient Hospice Care Services and Supplies. This benefit is designed to provide at home care for the terminally ill. Hospice Care must be prescribed by a physician for a period of up to six months. Additional periods of Hospice Care require Physician certification. Hospice Care benefits are not subject to the Plan Deductible and charges are covered at 100% of the allowed amount for In-Network Providers and 100% of the Usual, Customary and Reasonable charge for Out-of-Network Providers. The Hospice Agency must be an organization where its main function is to provide Hospice Care Services and Supplies and it is licensed by the state in which it is located, if licensing is required.

Covered medical expenses include the services listed under the Home Health Care Benefit plus medical social services by a person with a master's degree in Social Work. Covered expenses also include prescribed supplies, prescription medications obtained through the Hospice Agency and the rental up to the purchase price of Durable Medical Equipment prescribed by a Physician. In addition the Plan may cover 100% of the allowable In-Network Provider charges or 100% of the Usual Customary and Reasonable charges by Out-of-Network Providers, for short term inpatient hospice services (respite care) up to 12 days during the six month period of care, or 120 hours every three months. The short-term inpatient respite care must be provided in a Hospital, Skilled Nursing Facility or convalescent home associated with the Hospice Agency.

Out-Patient Hospice Eligibility Requirement. To be eligible for this benefit the attending Physician must submit a written Hospice Care Plan of treatment. This Hospice Care Plan is a plan of terminal patient care that is established and conducted by a Hospice Agency and supervised by a Physician.
Benefits will be limited to six months from the initial date of the Hospice Care Plan. At the end of this period an extension of benefits may be granted if certified by the Physician.

Physician Care. The professional services of a Physician for surgical, medical, Mental and Substance Use Disorders.

Pregnancy. Medically Necessary expenses for the care and treatment of Pregnancy are covered the same as any other Sickness.

1. Coverage for a Hospital stay following a normal vaginal delivery may not be limited to less than 48 hours for both the mother (if a Covered Person) and the newborn child. Coverage for a Hospital stay in connection with childbirth following a Caesarian section may not be limited to less than 96 hours for both the mother (if a Covered Person) and the newborn child. However, this will not prohibit the

mother's or newborn's attending Physician, after consulting with the mother, from discharging the mother or her newborn earlier.
2. There is no coverage for an elective abortion.

Preventive Care. Charges by a Physician for annual health and cancer screenings; well-baby care for a Dependent; and vaccines and immunizations as recommended by the Affordable Care Act. Refer to www.healthcare.gov/coverage/preventive-care-benefits/.

Private Duty Nursing Care. Charges by a licensed nurse (R.N., L.P.N. or L.V.N.) will be covered for the following:

1. Inpatient Nursing Care. Charges are covered only when care is Medically Necessary and not Custodial in nature and either the Hospital's intensive care unit is filled or the Hospital has no intensive care unit.
2. Outpatient Nursing Care. Charges are covered only when care is Medically Necessary and not Custodial in nature. The only charges covered for outpatient nursing care are those listed under Home Health Care Services and Supplies. Outpatient private duty nursing care on a 24-hour-shift basis is not covered.

Prosthetics. The initial purchase, fitting, repair, and replacement of fitted prosthetic devices which replace body parts.

Reconstructive Breast Surgery. Charges for reconstructive breast surgery of the involved breast following or coinciding with a mastectomy necessitated by Sickness or Injury. In accordance with the Women's Health and Cancer Rights Act of 1998. Such benefits include reconstruction of the breast on which the mastectomy was performed, one surgery on the other breast to produce symmetrical appearance, and prostheses and treatment of physical complications at all stages of mastectomy, including lymphedemas.

Rehabilitative Therapy. Includes the following when prescribed by a Physician and subject to the limitations in the Schedule of Medical Benefits:

1. Occupational therapy performed by a licensed occupational therapist. Therapy must be for an Injury or Sickness and improve bodily function. Covered expenses do not include recreational programs, maintenance therapy or supplies used in occupational therapy.
2. Physical therapy performed by a licensed physical therapist. Therapy must be intended to improve a bodily function.
3. Speech therapy performed by a licensed physical therapist. Therapy must be restorative in nature and follow either: surgery to correct a congenital condition of the oral cavity, throat, or nasal complex (other than frenectomy) of a person; an Injury; or Sickness.
4. Massage therapy performed by a covered provider including a licensed massage therapist. Therapy must be Medically Necessary and intended to improve bodily function.

Routine Physical Benefit. Charges for one routine physical exam and related services per Calendar Year for all Covered Persons when performed by a Physician and not for an Injury or Sickness. Refer to www.healthcare.gov/coverage/preventive-care-benefits/ for a complete listing of services.

Routine Newborn Care. Charges by a Hospital for routine newborn care that includes nursery and related services and supplies and routine newborn care provided by a Physician. This coverage is only provided if the newborn child is an eligible Dependent. If the newborn is injured or ill, benefits are provided under the Plan's medical benefit provisions for Sickness or Injury. Coverage for routine newborn care includes the following:

1. Routine nursery care.
2. Routine Physician care.
3. Circumcision.

Skilled Nursing Facility Care. The room and board and nursing care furnished by a Skilled Nursing Facility will be payable up to the limitations shown in the Schedule of Benefits. A Skilled Nursing Care Facility must be licensed and approved by Medicare and licensed to provide professional nursing services on an inpatient basis to persons convalescing from Injury or Sickness. Requires Prior Authorization

Spinal Manipulation/Chiropractic. Services by a licensed M.D., D.O., or D.C. Benefit limitations are described in the Schedule of Medical Benefits.

Teladoc. Virtual care by phone or video by Board Certified Physicians for common medical conditions like cold or flu symptoms, ear infections or allergies. Physicians are also available to diagnose and provide treatment for dermatology. Behavioral health by a licensed mental health provider to seek treatment for depression, stress and anxiety is also available for Covered Persons over 18. For questions about Teladoc call 855-332-4059 or visit Teladoc.com/premera

Temporomandibular Joint Syndrome (TMJ). Medically Necessary services for care and treatment of jaw joint conditions, including Temporomandibular Joint Syndrome (TMJ), not to exceed the combined medical and dental benefit Plan maximum shown in the Schedule of Medical Benefits.

Women's Preventive Care. In addition to the coverage provided under the Preventive Care Benefit, benefits will be paid at 100%, when services are provided by an In-Network Provider for the following preventive services for covered female Employees, Retirees and Dependents. Benefits for services provided by an Out-Of-Network Provider will be paid as shown in the Schedule of Medical Benefits.

1. Well-woman visits.
2. Screening for gestational diabetes – for pregnant women between 24 and 28 weeks of gestation and at the first prenatal visit for pregnant women identified to be a high risk for diabetes.
3. Human papillomavirus testing – beginning at age 30, no more frequently than every 3 years.
4. Counseling for sexually transmitted infections – annual.
5. Counseling and screening for human immune-deficiency virus – annual.

6. Contraceptive methods and counseling- as prescribed.
7. Breastfeeding support, supplies, and counseling- in conjunction with each birth.
8. Screening and counseling for interpersonal and domestic violence- annual.

Refer to www.healthcare.gov/coverage/preventive-care-benefits/ for a complete listing of services covered under the Women's Preventive Care benefit.

PATIENT ASSISTANCE PROGRAM

Administered by Premera Blue Cross

INTRODUCTION

This Plan Document is a description of the Northwest Laborers-Employers Health & Security Trust Fund. The Trust has an arrangement with Premera Blue Cross to administer the Patient Assistance Program that includes Prior Authorization & Utilization; Personal Health Support Programs; BestBeginnings Maternity Resource Program and a 24 Hour NurseLine.

NOTE: The following provisions do not apply to Covered Persons covered by Retiree Medical **AND** eligible for Medicare.

Prior Authorization & Utilization Review
Personal Health Support Programs
BestBeginnings Maternity Resource Program
24 Hour NurseLine

PRIOR AUTHORIZATION AND UTILIZATION REVIEW.

You must get Prior Authorization for certain types of medical services, Durable Medical Equipment, and for most inpatient facility stays.

There are two different types of Prior Authorization required:

1. **Prior Authorization for Benefit Coverage.** You must get Prior Authorization for certain types of medical services, Durable Medical Equipment, and for most inpatient facility stays. This is so that Premera can confirm that these services are Medically Necessary.
2. **Prior Authorization for In-Network Cost-Shares for Out-Of-Network Providers.** You must get Prior Authorization in order for an Out-of-Network Provider to be covered at the Plan's In-Network benefit level.

How Prior Authorization Works. Premera will make a decision on a request for services that require Prior Authorization in writing after receipt of all information necessary to make the decision. The determination will include whether the services are authorized or not, including the reasons why. If you disagree with the decision, you can appeal.

If your life or health would be in serious jeopardy if you did not receive treatment right away, you may ask for an expedited review. Premera will respond in writing as soon as possible, but no more than 72 hours after Premera receives all the information needed to make a decision.

Prior Authorization for Benefit Coverage. Medical Services, Supplies or Equipment. The Plan has a list of services, Durable Medical Equipment and facility types that require Prior Authorization. Please contact your provider before you receive a service to find out if your services require Prior Authorization.

1. **In-Network Providers** are required to request Prior Authorization for the services.

2. **Out-of-Network and out-of-area providers** should request Prior Authorization for the services. You should check with your provider to confirm the request has been submitted to Premera.

Exceptions to Prior Authorization for Benefit Coverage. The following services do not require Prior-Authorization for benefit coverage, but they have separate requirements:

1. Emergency care and emergency Hospital admissions, including emergency drug or alcohol detox in a Hospital.
2. Childbirth admission to a Hospital, or admissions for newborns who need emergency medical care at birth.

Emergency and childbirth Hospital admissions do not require Prior Authorization, but Premera must be notified as soon as reasonably possible.

Prior Authorization for Out-Of-Network Provider Coverage

Generally, non-emergent care by Out-of-Network Providers is covered at a lower benefit level. However, you may ask for a Prior Authorization to cover the Out-of-Network Provider at the In-Network benefit level if the services are Medically Necessary and are only available from an Out-of-Network Provider. You or the Out-of-Network Provider must ask for Prior Authorization before you receive the services.

NOTE: It is your responsibility to work with your Provider and confirm they have submitted the Prior Authorization request for any services that require it when you see a provider that is Out-of-Network. If you do not get a Prior Authorization, the services may not be covered at the In-Network benefit level.

The Prior Authorization request for an Out-of-Network Provider must include the following:

1. Medical records needed to support the request.

If the Out-of-Network services are authorized, the Plan will cover the service at the In-Network benefit level.

Exceptions to Prior Authorization for Out-Of-Network Providers

Out-of-Network Providers can be covered at the In-Network benefit level without Prior Authorization for emergency care and Hospital admissions for a Medical Emergency. This includes Hospital admissions for emergency drug or alcohol detox or for childbirth. Other examples of when Out-of-Network Providers can be covered at the In-Network benefit level can be found on page 35.

If you are admitted to an Out-of-Network Hospital due to an emergency condition, those services are always covered at the In-Network benefit level. The Plan will continue to cover those services until you are medically stable and can safely transfer to an In-Network Hospital. **If you choose to stay in the Out-of-Network Hospital after you are medically stable and can safely transfer to an In-Network Hospital, you may be subject to additional charges which may not be covered by your Plan.**

Out of pocket amounts for covered services provided by an Out-of-Network Provider which are paid at the In-Network level in the situations described above will be applied toward the Annual Out-of-Pocket

Maximum. The dollar amount applied to the Maximum will be limited to the Usual, Customary and Reasonable amount.

Questions?
Call the Trust Office Customer Service at 206-282-3600 or toll free at 800-826-2102.

PERSONAL HEALTH SUPPORT PROGRAMS. Need help with a chronic condition, illness, or Hospitalization? With your Health Plan, you have support at every stage of health. Premera provides Personal Health Support clinicians who can provide assistance tailored to your needs.
Learn how to:

1. Better manage a condition, such as asthma, diabetes, or heart disease
2. Take care of yourself or a loved one to prevent readmission after a Hospital stay
3. Ask the right questions about an illness or procedure

You may be contacted by a Personal Health Support clinician to offer services. If you have questions or wish to request support, call the **Personal Health Support customer service at 855-869-6775.**

BESTBEGINNINGS MATERNITY RESOURCE PROGRAM. For questions regarding Best Beginnings, contact the Trust Office customer service: 206-282-3600

BestBeginnings Maternity Resource Program provides:

1. Pregnancy support with the free BestBeginnings mobile app. Download the BestBeginnings app on Google Play or iTunes, register with the ID number found on your Northwest Laborers ID card and take the Healthy Pregnancy Survey within the first 16 weeks of Pregnancy and the $500 Deductible for the newborn will be waived for the year in which your baby is born. You may also contact the Trust Office customer service to request a paper version of the Healthy Pregnancy Survey.
2. Newborn support for babies who are covered Dependents and who need care in the neonatal intensive care unit (NICU)
3. Review customized maternity information and create a personalized birthing plan
4. Get alerts on Pregnancy-related issues
5. Set reminders for appointments, medications, exercise and more
6. Access a direct line to Premera's maternity specialists if issues arise

Special care for baby. If your baby is a covered Dependent and is admitted to the Neonatal Intensive Care Unit, BestBeginnings may provide you with a dedicated maternity clinician, depending on your situation. As your advocate, they will help you understand what is happening and help with any special needs when your baby comes home.

24-Hour NurseLine. With Premera Blue Cross you have a 24-Hour NurseLine. Advice is just a phone call away—24 hours a day, 7 days a week, 365 days a year call: 800-755-0011

When you call the 24-Hour NurseLine:

1. Your call is answered quickly by a registered nurse.

2. The nurse asks you questions and helps you decide what to do.
3. The nurse stays on the line as long as it takes to assist with your decision.
4. Your call is free and confidential

Always call 911 or your local emergency number if you have a Medical Emergency.
The phone number for the 24-hour NURSELINE can also be found on the back of your ID card.

APPEAL OF DENIED BENEFITS

Premera Blue Cross provides Prior-Authorization and Utilization Review services on behalf of the Northwest Laborers-Employers Health & Security Trust. **This appeal section describes the appeal process when you feel Premera Blue Cross has completely or partially denied a benefit to which you are entitled.**

WHAT YOU CAN APPEAL

Prior Authorization and Utilization Review for pre-service, urgent care and concurrent care	Denied	Coverage of your service, supply, device, or prescription was denied or partially denied. This includes Prior Authorization denials including pre-service procedures, urgent care, and concurrent care requests.

The rest of this section will explain the appeal process. If you still have questions, please call your Trust Office Customer Service at 206-282-3600. Contact information is also on the back of your Trust ID card.

APPEAL LEVELS

You have the right to three levels of appeals:

Appeal Level	What it means	Deadline to appeal
Level 1	This is your first appeal. Premera will review your appeal.	180 days from the date you were notified of Premera's decision.
Level 2	If Premera upholds the denial of your Level 1 Appeal, you can appeal a second time to the Northwest Laborers-Employers Health & Security Trust Board of Trustees. Refer to the General Trust Appeal section on page 109 of this Plan Booklet.	60 days from the date you were notified of your Level 1 Appeal decision.
Level 3/External Review	If the Board of Trustees upholds the denial in the Level 2 Appeal, you can ask for an Independent Review Organization (IRO) to review your appeal. Refer to the General Trust Appeal Section on page 109 of this Plan Booklet.	Four months from the date you were notified of the Board of Trustees Level 2 Appeal decision.

HOW TO SUBMIT AN APPEAL

Here are your options for submitting a Level 1 appeal to Premera Blue Cross:

Write to Premera or submit an appeal form – go to premera.com/visitor/forms to access the appeal form. You have the option of attaching additional documentation and a written statement. Send your appeal form and documentation to:

By mail:
Appeals Department
Attn: Member Appeals
P.O. Box 91102
Seattle, WA 98111-9202

Or by fax: Premera Blue Cross
425- 918-4133 or 800- 557-7581

CHOOSE SOMEONE TO APPEAL FOR YOU

You have the right to choose someone, including your doctor, to appeal on your behalf. To choose someone else, complete a Member Appeal Form with authorization located on premera.com/visitor/forms. Premera cannot release your information without this form. You do not need an authorization if your provider is contracted with Premera.

APPEAL RESPONSE TIME LIMITS

Premera will review your appeal and send a decision within the time limits below. The timeframes are based on what the appeal is about, not the appeal level. At each level, a group of people who have not reviewed the case before will review and make a decision.

Type of appeal	When to expect a response
Urgent appeals	No later than 72 hours.
Pre-service appeals (a decision made by Premera before you received services)	Within 15 days
All other appeals	Within 30 days
Level 2 and External appeals –Refer to Page 109 for complete appeal procedures	Please call your Trust Office Customer Services at 206-282-3600

WHAT HAPPENS IF YOU HAVE ONGOING CARE (CONCURRENT CARE)

Ongoing care is continuous treatment you are currently receiving, such as care for a chronic condition, inpatient care, and rehabilitation.

If the Plan reduces or terminates a course of treatment before the end of the previously approved period or number of treatments, the Plan will notify you in advance of the reduction or termination to allow you to appeal and obtain a determination on review before the benefit is reduced or terminated.

If you appeal a decision that affects ongoing care because Premera has determined the care is no longer Medically Necessary, the Plan will continue to cover your care during the appeal period. This continued coverage during the appeal period does not mean that the care is approved.

WHAT HAPPENS IF IT'S URGENT?

If your Provider believes that the situation meets the definition of urgent under the law and Premera agrees, your review will be conducted on an expedited basis. If you are currently in the Hospital, you have the right to an expedited appeal and Premera will review your case and provide you with a decision within 24-72 hours.

HOW TO ASK FOR AN EXTERNAL REVIEW

Call your Trust Office Customer Service at 206-282-3600

RESOURCES TO HELP YOU

If you have questions about understanding a denial of a claim or your appeal rights, you may contact the following:

Northwest Laborers-Employers Health & Security Trust Customer Service 206-282-3600
The Employee Benefits Security Administration of the U.S. Department of Labor 833-123-4563

Refer to page 109 for more information

PRESCRIPTION DRUG BENEFIT

The Plan contracts with a Pharmacy Benefit Manager, OptumRx, to provide prescriptions at a discounted rate through In-Network retail Pharmacies. The Plan also contracts with OptumRx to provide maintenance prescriptions through a Mail Order Pharmacy.

When using an In-Network retail Pharmacy, the Northwest Laborers ID card must be presented and the applicable Co-pay must be paid.

SCHEDULE OF PHARMACY BENEFITS

IN-NETWORK PHARMACY	GENERIC CO-PAY	BRAND CO-PAY
Up to a 30 day supply or 100 unit dose	$5	$15 + 15% of the balance
Preventive immunizations and vaccines recommended by the Affordable Care Act. Refer to www.healthcare.gov/coverage/preventive-care.	$0	$0

OUT-OF-NETWORK PHARMACY	GENERIC CO-PAY	BRAND CO-PAY
Up to a 30 day supply or 100 unit dose	$15 + 50% of the balance	$15 + 50% of the balance
Preventive immunizations and vaccines recommended by the Affordable Care Act. Refer to www.healthcare.gov/coverage/preventive-care.	$15 + 50% of the balance	$15 + 50% of the balance
For prescriptions purchased at an Out-of-Network Pharmacy full payment must be made for the prescription and a claim submitted to OptumRx for reimbursement. Visit OptumRx at www.optumrx.com or call 1-888-354-0090 to obtain a claim form.		

MAIL ORDER PHARMACY	GENERIC CO-PAY	BRAND CO-PAY
For maintenance prescriptions up to 100-day supply or 300 unit dose.	$0	$15 + 15% of the balance

SPECIALTY DRUGS	GENERIC CO-PAY	BRAND CO-PAY
Up to a 30-day supply.	$0	$15 + 15% of the balance

IN-NETWORK RETAIL PHARMACY BENEFIT OPTION – OptumRx

Covered Prescription Drugs purchased at an In-Network Pharmacy are reimbursed as shown in the Schedule of Pharmacy Benefits. To locate an In-Network Pharmacy in the OptumRx network, visit www.optum.com or call OptumRx customer service at 1-888-354-0090. Co-pays and Co-insurance are

not a covered expense under Medical Benefits but apply to the Annual Overall Out-of-Pocket Maximum.

OUT-OF-NETWORK RETAIL PHARMACY BENEFIT

Covered Prescription Drugs purchased at an Out-of-Network Pharmacy will be reimbursed at 50% of covered expenses following a $15 Co-pay. Co-pays and Co-insurance are not a covered expense under Medical Benefits and are not included in the Annual Overall Out-of-Pocket Maximum. Prescriptions must be paid at the Pharmacy and a claim form with the prescription receipt must be submitted to OptumRx for reimbursement. Claim forms can be obtained by calling OptumRx customer service at 1-888-354-0090.

MAIL ORDER PHARMACY BENEFIT OPTION

This option is available for maintenance medications (those that are taken for long periods of time, such as drugs sometimes prescribed for heart disease, high blood pressure, asthma, etc.). Covered prescriptions drugs are filled by mailing or faxing the Physician's prescription form to the OptumRx Mail Order Pharmacy. Contact OptumRx Mail Order Pharmacy at 1-888-354-0090. Payment of the Co-pay and Co-insurance is required at the time the prescription is filled. The Co-pay and Co-insurance are not a covered expense under Medical Benefits but are included in the Annual Overall Out-of-Pocket Maximum.

CO-PAYS AND CO-INSURANCE

The Co-pays and Co-insurance apply to covered prescriptions. Co-pays and Co-insurance are not covered expenses under the Medical Plan, however Co-pays and Co-insurance incurred at an In-Network Pharmacy and the Mail Order Pharmacy do apply to the Annual Overall Out-of-Pocket Maximum. Any one prescription from a retail Pharmacy is limited to the greater of a 30-day supply or a 100-unit dose. Any one prescription from the Mail Order Pharmacy is limited to the greater of a 100-day supply or a 300-unit dose.

SPECIALTY DRUGS

Covered Prescription Drugs classified as "specialty drugs" as defined by OptumRx must be purchased through the Trust's Specialty Drug Pharmacy, OptumRx Specialty Pharmacy. Specialty drugs are limited to a maximum 30 day-supply. Co-pays and Co-insurance for covered specialty drug prescriptions apply to the Annual Out-of-Pocket Maximum under Medical Benefits, and specialty drug prescriptions will be paid at 100% for the remainder of the Calendar Year once the Annual Out-of-Pocket Maximum is met. Brand Specialty will be paid at the Brand Co-pay and Generic Specialty will be paid at the Mail Order Generic Co-pay.

Specialty drugs are generally prescribed for complex or ongoing medical conditions such as multiple sclerosis, hemophilia, cancer, rheumatoid arthritis, and hepatitis. These high cost medications also typically have one or more of the following characteristics:

1. Self-injected or infused, and some are oral medications.
2. Unique storage or shipment requirements.
3. Usually not stocked at retail Pharmacies.

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Questions regarding specialty drugs and coverage confirmation should be referred to the Trust Office, or the specialty drug Pharmacy, OptumRx Specialty Pharmacy. Contact OptumRx Specialty pharmacy at 1-800-850-9122.

You must notify the Trust Office if you enroll in a Co-pay assistance program with the drug manufacturer or a third party. Any amounts paid by a drug manufacturer or a third party, as part of a Co-pay assistance program, will not apply to the annual Deductible or Out-of-Pocket.

TOBACCO CESSATION

The Plan pays 100% of the cost of nicotine replacement therapy (NRT), including all methods that have been approved by the FDA for tobacco cessation including, medications, inhalers or nicotine patches and gum.

1. The medication must be prescribed by a Physician.
2. Prior Authorization is required if a Covered Person wants to switch products after starting NRT. To obtain Prior Authorization, call OptumRx at 888-354-0090.
3. Step Therapy with generic Zyban, must be used prior to using Chantix.
4. Prescriptions approved for Zyban must be filled using the generic version.
5. Quantities are limited for 2 - 12-week cycles per Calendar Year, or a total of 24 weeks per Calendar Year.

COVERED PRESCRIPTION DRUGS

You may seek Prior Authorization for a particular drug by asking your Physician to contact OptumRx prior to dispensing the drug.

The following Prescription Drugs are covered subject to the applicable Co-pays and Co-insurance and Plan limitations and exclusions:

1. All drugs prescribed by a Physician that require a prescription either by federal or state law.
2. Insulin when prescribed by a Physician.
3. Hypodermic needles or syringes and diabetic supplies but only when dispensed upon a written prescription of a licensed Physician.
4. Newly approved drugs may be covered under this Plan if they fall within the same class or category of drugs already covered under this Plan, unless otherwise specifically excluded.
5. FDA approved contraceptive drugs, devices and barriers requiring a prescription (covered at 100%).
6. The following over the counter (OTC) medications and supplements are covered at 100% when prescribed by a Physician, and if the following requirements are satisfied:
   a) Aspirin (325mg and 81 mg) – when prescribed for prevention or treatment of cardiovascular disease for men between the ages of 45 and 79 and women between the ages of 55 and 79;
   b) Folic Acid (.04 mg and .08 mg) – for women who are childbearing age.

PRESCRIPTION PLAN LIMITATIONS

1. **Prescription drug** - benefits are only available when a Covered Person incurs a covered Prescription Drug charge. The covered drug charge for any refills is limited to the number of times specified by a Physician, up to one year from the date of order by a Physician.
2. **Compound Medications -** To be covered under the Plan, they must satisfy certain requirements. Compound drugs must not contain any ingredient otherwise excluded by the Plan. Furthermore, the allowable cost of the compound must be determined by OptumRx to be reasonable. Any compound over $300 requires a clinical Prior Authorization to ensure FDA approved indication for use.
3. **New medications released to marketplace -** Newly launched medications released by the FDA are temporarily excluded until the medication(s) can be reviewed by OptumRX Pharmacy & Therapeutics Committee to determine coverage and clinical coverage criteria.
4. **Step Therapy** – Certain medications may require step therapy, or a "step" approach to providing coverage. This means that an alternative medication must be tried, typically a Generic Drug, before the Plan will cover certain brand name medications prescribed by the Physician. Step Therapy may be waived if the healthcare provider documents clinically why the alternative drug cannot be taken. Step Therapy may be applied to the following therapeutic classes of drugs:

   a) High cholesterol.
   b) Medications to treat high blood pressure.
   c) Medications that prevent loss of bone mass or treat osteoporosis.
   d) Medications (both oral and nasal sprays) used to treat allergies.
   e) Medications used to prevent asthma.
   f) Medication used to prevent and treat ulcers, gastroesophageal reflux disease and conditions in which the stomach produces too much acid.
   g) Medications used to promote sleep, such as sedative hypnotics.
   h) Medications used to treat seizure disorders
   i) Narcotic Analgesics
   j) Medications to treat Attention Deficit Hyperactivity Disorder (ADHD)
   k) Antipsychotic agents
   l) Migraine/pain relief agents
5. **Dispense as written rule** – In-Network Pharmacies and the Mail Order Pharmacy will dispense prescriptions as written by the healthcare provider. If a brand name drug is selected in place of a Generic Drug, the Covered Person must pay the ingredient cost difference between the brand drug and the generic equivalent drug, plus the applicable brand Co-pay and Co-insurance.
6. **Quantity level limits and quantity duration management** – These limitations will apply to specific classes of drugs, such as migraine products and Tramadol/Ultram products for certain types of severe pain. In-Network Pharmacies and the Mail Order Pharmacy will dispense these prescriptions using dosing guidelines provided by the Federal Drug Administration (FDA).
7. **Specialty Oral Oncology half fill program** – This program is designed to ensure patient stability with oral oncology medication(s). This program limits the first six (6) dispensing prescriptions to a 15-day supply. The Co-payment will be half of the 30-day supply during this split program timeline. Subsequent refills are limited to a 30-day supply. This program is designed to provide for early identification and management of adverse effects of medication. If serious adverse effects are identified in the first half of the cycle, the medication can be discontinued, and it avoids potential waste associated with early therapy discontinuation. All specialty oral oncology medication must continue to be filled by the Plan's specialty Pharmacy.

8. **Brand name drugs to treat acid reflux** - Benefits for prescriptions for proton pump inhibitors (PPIs) and acid reducers will be limited to generic prescriptions.

PRESCRIPTION PLAN EXCLUSIONS

Prescription drug benefits are not available for any of the following:

1. **Administration.** Any charge for the administration of a covered Prescription Drug.
2. **Analgesic/pain management patches.** A charge for analgesic/pain management patches to treat acute and chronic pain.
3. **Bulk chemicals and compound kits.** As may be used in a compound drug.
4. **Consumed on premises.** Any drug or medicine that is consumed or administered at the place where it is dispensed except for covered preventive immunizations and vaccines when administered by a qualified Pharmacy staff member.
5. **Cosmetic Agents**. Any drug, agent or articles intended to be rubbed, poured, sprinkled, or sprayed on, introduced into, or otherwise applied to any part of the body to improve the patient's appearance and/or self-esteem and is not intended to substantially improve or restore a bodily function.
6. **Devices.** Devices of any type, even though such devices may require a prescription. These include (but are not limited to) therapeutic devices, artificial appliances, braces, support garments, or any similar device. Devices may be covered as a Medical Supply item under the Medical Benefit portion of this Plan.
7. **Dietary supplements or vitamins.** Dietary supplements or vitamins except those mandated by the Affordable Care Act. Refer to www.healthcare.gov/preventive-care-benefits.
8. **Experimental or Investigational.** Experimental or Investigational drugs and medicines, even though a charge is made to the Covered Person.
9. **FDA.** Any drug not approved by the Food and Drug Administration.
10. **Infertility.** A charge for infertility medication.
11. **Medical exclusions.** A charge excluded under Plan Exclusions and Limitations. This includes medical specialty medications administered at inpatient facilities
12. **No charge.** A charge for Prescription Drugs that may be properly received without charge under local, state, or federal programs.
13. **No prescription.** A drug or medicine that can legally be bought without a written prescription. This does not apply to injectable insulin, tobacco cessation products and over the counter pharmaceuticals approved by the FDA and mandated by the Affordable Care Act under the Preventive Care or Women's Preventive Care.
14. **Sexual Dysfunction.** A charge for Viagra or other medications prescribed to enhance sexual desire or function.
15. **Medications that are essentially the same** as effective drugs already available on the market and approved by the FDA. These drugs have minor differences but are just as clinically effective as what is already available.
16. **Non-Essential Drugs/Products** excludes non-FDA-approved products deemed unnecessary.
17. **High Cost Brand with Generic Available:** excludes higher-cost brand products when a lower-cost generic equivalent is available.
18. **High Cost Generic:** excludes higher-cost generic products when an FDA approved therapeutically equivalent lower-cost generic is available.

APPEAL OF DENIED PRESCRIPTION DRUG BENEFITS

If your claim for Prescription Drug Benefits has been completely or partially denied, you have the right to request a review or an appeal of the decision. A review or an appeal must be submitted in writing within 180 days of the denial.

Refer to page 109 for more information.

MEDICARE PART D PRESCRIPTION DRUG COVERAGE FOR COVERED PERSONS WITH MEDICARE

Individuals who are entitled to Medicare Part A or enrolled in Medicare Part B or a Medicare Advantage Plan, Part C, are also eligible to enroll for Medicare Part D Prescription Drug benefits. It has been determined that the Prescription Drug coverage offered by the Plan is "creditable." This means that this Plan's Prescription Drug coverage is, on average for all Plan Participants, expected to pay out as much as standard Medicare Prescription Drug coverage pays and is therefore considered "creditable coverage".

Because the existing coverage is "creditable coverage," Medicare eligible individuals **do NOT need to enroll** in a Medicare Part D Prescription Drug plan in order to avoid a late penalty under Medicare.

If a Medicare eligible individual goes 63 continuous days or longer without Prescription Drug coverage that is "creditable coverage," the monthly Medicare premium will go up at least 1% for every month that they did not have that coverage. For example, if a Medicare eligible individual goes nineteen months without coverage, the premium may be at least 19% higher than the base Medicare premium. A Medicare eligible individual may have to pay this higher premium (a penalty) as long as they have Medicare Prescription Drug coverage. In addition, they may have to wait until the following October to join.

Medicare eligible individuals may enroll in a Medicare Prescription Drug plan when they first become eligible for Medicare and each year from October 15th to December 7th. However, if a Medicare eligible individual loses the current creditable Prescription Drug coverage, through no fault of his own, he will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

IMPORTANT NOTICE

If a Medicare covered Retiree enrolls in a Medicare Part D Plan, or in a Medicare Part C, Medicare Advantage Plan that includes Medicare Part D, Prescription Drug coverage, the covered Retiree and any covered Dependents will lose their current Prescription Drug coverage under the Northwest Laborers-Employers Health & Security Plan and they may not be able to get this coverage back.

More detailed information about Medicare plans that offer Prescription Drug coverage is in the "Medicare & You" handbook. Medicare eligible individuals will get a copy of the handbook in the mail every year from Medicare. For more information about Medicare Prescription Drug coverage or Medicare Part C, Medicare Advantage Plans that include Prescription Drug coverage:

1. Visit www.medicare.gov
2. Call your State Health Insurance Assistance Program (see your copy of the "Medicare & You" handbook for their telephone number) for personalized help,
3. Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

Please contact the Trust Office before enrolling in any Medicare Part D Prescription Drug plan.

VISION BENEFITS
Covered Employees and their Dependents

The Trust has an agreement with Vision Service Plan (VSP) to provide vision benefits to Covered Employees and Dependents who meet the eligibility requirements for vision benefits. Refer to the Eligibility Section on page 7 for initial eligibility requirements for vision benefits. Covered Employees and Dependents may use any licensed vision provider, however, if a VSP In-Network Provider is used, the Plan allows a higher benefit and the Provider will automatically file claims with VSP. For questions about vision benefits, contact VSP at 1-800-877-7195.

VISION SCHEDULE OF BENEFITS

COVERED EXPENSES	IN-NETWORK	OUT-OF-NETWORK
Exams (once each Calendar Year)	100%, after $10 Co-pay	Up to $55, after $10 Co-pay
Lenses (once each Calendar Year)		
Single vision	100%	up to $50
Bifocal – lined	100%	up to $80
Trifocal – lined	100%	up to $130
Lenticular	100%	up to $100
Polycarbonate lenses for children	100%	No coverage
Frames (once each two Calendar Years)	up to $130	up to $50
Contacts (once each Calendar Year in place of eyeglass lenses and frames)		
Elective**	100%, up to $130	up to $105
Necessary***	100%	up to $250

*Refer to limitations and exclusions on page 59.
**Allowance applies to the cost of the contact lenses and the contact lens evaluation and fitting.
***Covered (with prior VSP approval) following cataract surgery, to correct extreme visual acuity problems that cannot be corrected with spectacle lenses, for certain conditions of anisometropia and for keratoconus.

In addition, VSP In-Network Providers agree to:

1. 30% savings on additional glasses and sunglasses, including lens enhancements, from the same VSP provider on the same day as exam. Or get 20% off from any VSP provider within 12 months of your last exam.
2. A 15% discount for a contact lens fitting and evaluation. This benefit is available in conjunction with the VSP contact lens allowance or can be used to purchase contacts if glasses are already received.

LOW VISION COVERAGE

Low vision benefits are available (with prior VSP approval) for severe visual problems that are not correctable with regular lenses when care is provided by a VSP In-Network Provider.
Low vision coverage includes:

1. Supplemental Care Aids: 75% of cost (25% Co-pay). Must be visually necessary and appropriate.
2. Supplemental testing: 100% of cost for a complete low vision analysis and diagnosis which includes a comprehensive examination of visual functions, including the prescription of corrective eyewear or vision aids where indicated.

Low vision coverage has a benefit maximum of $1,000 each two Calendar Years excluding the Co-pay.

Low vision care from an Out-of-Network Provider is subject to the same time limits and Co-pays as described above for a VSP In-Network Provider. Charges by an Out-of-Network Provider must be paid at the time of service and then submitted to VSP for reimbursement. See “To receive service from an Out-of-Network Provider” below.

OBTAINING VISION COVERAGE

To receive eye care services or eyewear from a VSP In-Network Provider:

1. Contact VSP by calling 1-800-877-7195 or by visiting www.vsp.com to determine if the provider is in the VSP network or to locate a VSP In-Network Provider.
2. Make an appointment and provide the VSP In-Network Provider with the Employee’s name, social security number, and date of birth. VSP will verify eligibility and available benefits.
3. Pay the $10 Co-pay and the cost of any cosmetic options at the time of service. In most cases the Plan then pays 100% for covered services.
4. There is no need to file a claim; the VSP In-Network Provider will do this.

To receive service from an Out-of-Network Provider:

1. Make an appointment with any vision care provider;
2. Pay the Out-of-Network Provider the full amount of the bill and request an itemized copy of the bill.

The bill should detail the charges for the eye exam and materials, including lens type; and should include the following information:

a) The name, address and phone number of the Out-of-Network Provider.
b) The Covered Employee’s Social Security or other member ID number found on the Northwest Laborers ID card
c) The Covered Employee’s name, address and phone number.
d) The name of the group (Northwest Laborers Employers Health & Security Trust).
e) The patient’s name, date of birth, address and phone number.
f) The patient’s relationship to the Covered Employee (such as self, spouse or child).

Employees can simply write the above information on the bill, obtain a claim form available at the Trust Office or use the printable form available on www.vsp.com and click on the “view benefits information” option.

Send a copy of the itemized bill(s) with the above information or a fully completed claim form to VSP at:

VSP
P.O. Box 385018
Birmingham, AL 35238-5018

NOTE: Claims for reimbursement must be filed within twelve months of the date of service. Covered Employees will be reimbursed according to the Out-of-Network reimbursement schedule. Reimbursement is made directly to the Covered Employee and is not assignable to the provider.

VISION LIMITATIONS AND EXCLUSIONS

VSP includes an additional charge for:

1. Blended lenses.
2. Coated or laminated lenses.
3. Contact lenses (except as noted above).
4. Cosmetic lenses and optional processes.
5. Frames that cost more than the Plan allowance.
6. Oversize lenses (61 mm or larger).
7. Progressive multifocal lenses.
8. UV (ultraviolet) protected lenses.

VSP does not cover:

1. Claims received after the 12-month filing limit.
2. Experimental procedures or lenses.
3. Eye exam or corrective eyewear required by an employer as a condition of employment.
4. Medical or surgical treatment of the eyes.
5. Orthoptics or vision training or any associated supplemental testing.
6. Plano lenses.
7. Replacement of lost or broken lenses or frames furnished under this Plan (except at the normal intervals).
8. Two pair of glasses in place of bifocals.

APPEAL OF DENIED VISION BENEFIT

If your claim for Vision Benefits has been completely or partially denied, you have the right to request a review of the decision by VSP. After review, if the denial is upheld, you have a right to appeal the decision to the Board of Trustees. A review or an appeal must be submitted in writing within 180 days of the denial.

Refer to page 109 for more information

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DENTAL BENEFITS
Covered Employees and Their Dependents

A CHOICE OF DENTAL PLANS

Covered Employees who are eligible for benefits under the active eligibility provision of the Plan and who meet the eligibility requirement for dental must choose between Dental Plan A and Dental Plan B. Covered Employees will be given an opportunity to make a selection once eligibility is established, by completing an enrollment form and selecting a Dental Plan. If a selection is not made within 90 days of initial Eligibility, Covered Employees will automatically be enrolled in Dental Plan B.

A change in dental plans will not be allowed until the next open enrollment period. Each year the Plan will hold an open enrollment period during which time a new dental plan option may be selected**.**
Refer to page 7 for Eligibility requirements for dental coverage.

DENTAL A

Dental Plan A is a managed dental care plan offered by Willamette Dental Group. This Plan offers a network of dental clinics in Washington, Oregon and Idaho that provide dental care to covered, enrolled Employees and their Dependents. A list of Co-pays, limitations and exclusions can be found on pages 62-65. If Dental Plan A is selected, dental care must be received at one of the Willamette Dental Group clinics. Co-pays are due at the time of each visit. All dental appointments are scheduled by calling the Willamette Dental Appointment Center. Family members do not have to use the same Willamette Dental Group clinic, but all covered Family members must use a clinic in the Willamette Dental Group network. Willamette Dental Group will verify eligibility at the time an appointment is made. For appointments or customer service contact Willamette Dental Group Toll Free – 1-855-433-6825. For a list of dental offices, visit them on the web at www.willamettedental.com.

DENTAL PLAN B

Dental Plan B is administered by Delta Dental of Washington (DDWA). Dental Plan B allows covered, enrolled Employees and their Dependents to use the dentist of their choice, however if the dentist participates in the Delta Dental network, the charges will be at the Delta Dental discounted rates. All claims for dental services must be submitted directly to Delta Dental for processing. A Covered Employee or Dependent must be eligible when treatment is received and dental benefits for covered services will be paid based on the Schedule of Allowances and limitations and exclusions listed on pages 77-81, up to a Plan maximum of $2,000 per covered Family member per Calendar Year. The $2,000 Calendar Year maximum does not apply to Orthodontia or Preventive and Minor Restorations for Dependent children under the age of 18. For questions and customer service contact Delta Dental of Washington Toll Free – 1-800-554-1907 or visit them on the web at www.deltadentalwa.com.

DENTAL PLAN A
WILLAMETTE DENTAL GROUP

How to Obtain Treatment

All dental appointments are scheduled by calling the Willamette Dental Group Appointment Center. Family members do not have to use the same Willamette Dental Group office. The list of dental offices can be found on www.willamettedental.com.

The dental office will verify eligibility when an appointment is scheduled. Payment of the office visit charge and any Co-pays are due the same day treatment is received.

Willamette Dental Group reserves the right to terminate coverage under Dental Plan A on the last day of the month following at least thirty days advance written notice that the provider has documented an inability to establish or maintain a patient/provider relationship between the patient and a participating dentist at locations reasonably accessible to the patient.

Appointment Center

Most Willamette Dental Group offices are open for appointments, Monday through Friday and select Saturdays. To schedule an appointment, contact the appointment center at 1-855-433-6825.
A complete listing of Willamette Dental Offices in Washington, Oregon and Idaho can be found at www.willamettedental.com.

Emergency Care

A condition is considered an emergency if it causes acute pain, swelling or bleeding, and is treated within 48 hours of its onset. Willamette Dental Group provides emergency dental care during regular office hours. In the event of a dental emergency, call the Appointment Center toll free at 1-855-433-6825. After hours, a dentist is available for emergency consultation over the telephone at no cost. In the event of an emergency 50 miles or more from a Willamette Dental office, any licensed dentist can provide emergency treatment. Emergency dental treatment may be eligible for reimbursement up to $100. Upon arriving home, contact Willamette Dental Group Member Services at 1-855-433-6825 for reimbursement. Follow-up care **must** be provided by a Willamette Dental Group primary care dentist.

DENTAL PLAN A
WILLAMETTE DENTAL GROUP
Schedule of Co-Pays

BENEFIT	CO-PAY
ANNUAL MAXIMUM	No Annual Maximum
DEDUCTIBLE	No Deductible
GENERAL OFFICE VISIT – Each Visit	$15
DIAGNOSTIC SERVICES AND PREVENTIVE SERVICES	
Routine and emergency exams	Covered at 100%
X-rays	Covered at 100%
Teeth Cleaning	Covered at 100%
Fluoride Treatment	Covered at 100%
Sealants	Covered at 100%
Head and Neck Cancer Screening	Covered at 100%
Oral Hygiene Instruction	Covered at 100%
Periodontal Charting	Covered at 100%
Periodontal Evaluation	Covered at 100%
RESTORATIVE & PROSTHODONTICS	
Fillings (amalgam)	Covered at 100%
Porcelain-Metal Crowns	$ 250 Co-pay
Complete Upper Denture	$ 300 Co-pay
Complete Lower Denture	$ 300 Co-pay
Bridge – per tooth	$ 250 Co-pay
ENDODONTICS AND PERIODONTICS	
Root Canal Therapy – anterior	$ 75 Co-pay
Root Canal Therapy – bicuspid	$ 150 Co-pay
Root Canal Therapy – molar	$ 225 Co-pay
Osseous Surgery – per quadrant	$ 55 Co-pay
Root Planning –per quadrant	$ 55 Co-pay
ORAL SURGERY	
Routine Extraction – single tooth	Covered at 100%
Surgical Extraction	$ 100 Co-pay
MISCELLANEOUS	
Missed Appointments (w/o 24 Hour notice)	$ 20 Co-pay
Dental Lab Fees	Covered at 100%
Nitrous Oxide (per visit)	$ 20 Co-pay
Specialty or Emergency Office Visit – each visit	$ 15 Co-pay

BENEFIT	CO-PAY
ORTHODONTICS	
Pre-Orthodontia Treatment	$ 150 Co-pay
Comprehensive Orthodontia Treatment	$2,800 Co-pay

PRE-ORTHODONTIC SERVICES: A Co-pay of $150 will be charged for pre-orthodontic services. However, if the patient elects to receive comprehensive orthodontic treatment, the Co-pay will be applied to the comprehensive orthodontic treatment Co-pay.

ORTHODONTIC SERVICES: The orthodontic benefit includes both Covered Employees and Dependents. There is no waiting period. In addition to the comprehensive orthodontia treatment Co-pay, the Covered Person must pay a General Office Visit Co-pay at each visit.

EMERGENCY TREATMENT: If the Covered Person is 50 miles or more from a Willamette Dental office and requires emergency treatment, Willamette Dental Group will reimburse up to $100 toward the cost of the emergency treatment. Follow-up care must be scheduled with a Willamette Dental Group primary care dentist.

DENTAL PLAN A
WILLAMETTE DENTAL GROUP

Limitations

All benefits provided under Dental Plan A are subject to the following limitations:

1. If alternative services can be used to treat a condition, the service recommended by the Willamette Dental Group dentist is covered.
2. Services or supplies which are provided to correct congenital or developmental malformations which impair functions of the teeth and supporting structures, will be covered for Dependent children if dental necessity has been established.
3. Orthognathic surgery is covered when the Willamette Dental Group dentist determines it is dentally necessary and authorizes the orthognathic surgery for treatment of a Dependent, under age 19, with congenital or developmental malformation.
4. Crowns, casts, or other indirect fabricated restorations are covered only if dentally necessary and if recommended by the Willamette Dental Group dentist.
5. When initial root canal therapy is performed by a Willamette Dental Group dentist, the retreatment of such root canal therapy will be covered as part of the initial treatment for the first 24 months. When the initial root canal therapy was performed by an Out-of-Network Provider, the retreatment of such root canal therapy by a Willamette Dental Group dentist will be subject to the applicable Co-pays.
6. General anesthesia is covered with the Co-pays specified when it is performed in a dental office; provided in conjunction with a covered service; and dentally necessary because the Dependent is under the age of 7, developmentally disabled or physically handicapped.
7. Services provided by a dentist in a Hospital setting are covered if Medically Necessary; pre-authorized in writing by a Willamette Dental Group dentist; the services provided are the same services that would be provided in a dental office; and the applicable Co-pay are paid.
8. The replacement of an existing denture, crown, inlay, onlay or other prosthetic appliance or restoration denture is covered if the appliance is more than 5 years old and replacement is dentally necessary.

Exclusions

No benefits will be allowed for any of the following:

1. Bridges, crowns, dentures, or any prosthetic devices requiring multiple treatment dates or fittings if the prosthetic item is installed or delivered more than 60 days after termination of coverage.
2. The completion or delivery of treatments, services, or supplies initiated prior to the effective date of coverage.
3. Dental implants, including attachment devices and their maintenance.
4. Endodontic services, prosthetic services, and implants that were provided prior to the effective date of coverage.
5. Endodontic therapy completed more than 60 days after termination of coverage.
6. Exams or consultations needed solely in connection with a service or supply not listed as covered.
7. Experimental or Investigational services or supplies and related exams or consultations.
8. Full mouth reconstruction, including the extensive restoration of the mouth with crowns, bridges, or implants; and occlusal rehabilitation, including crowns, bridges, or implants used for the purpose of

splinting, altering vertical dimension, restoring occlusions, or correcting attrition, abrasion, or erosion.

9. Hospital care or other care outside of a dental office for dental procedures, Physician services, or facility fees.
10. Maxillofacial prosthetic services.
11. Night guards.
12. Personalized restorations.
13. Plastic, reconstructive, or cosmetic surgery and other services or supplies, which are primarily intended to improve, alter, or enhance appearance.
14. Prescription and over-the-counter drugs and pre-medications.
15. Provider charges for a missed appointment or appointment cancelled without 24 hours prior notice.
16. Replacement of lost, missing, or stolen dental appliances; replacement of dental appliances that are damaged due to abuse, misuse, or neglect.
17. Replacement of sound restorations.
18. Services or supplies and related exams or consultations that are not within the prescribed treatment plan and/or are not recommended and approved by a Willamette Dental Group dentist.
19. Services or supplies and related exams or consultations to the extent they are not necessary for the diagnosis, care, or treatment of the condition involved.
20. Services or supplies by any person other than a licensed dentist, denturist, hygienist, or dental assistant.
21. Services or supplies for treatment of injuries sustained while practicing for or competing in a professional athletic contest.
22. Services or supplies for the treatment of an occupational Injury or disease, including an Injury or disease arising out of self-employment or for which benefits are available under workers' compensation or similar law.
23. Services or supplies for treatment of intentionally self-inflicted injuries.
24. Services or supplies for which coverage is available under any federal, state, or other governmental program, unless required by law.
25. Services or supplies not listed as covered.
26. Services or supplies where there is no evidence of pathology, dysfunction, or disease other the covered preventive service.

APPEAL OF DENIED DENTAL PLAN A BENEFITS. If your claim for Dental Plan A benefits has been completely or partially denied, you have the right to request a review of the decision by Willamette Dental Group. After review, if the denial is upheld you have a right to appeal the decision to the Board of Trustees. An appeal must be submitted in writing within 180 days of the denial.

Refer to page 109 for more information

DENTAL PLAN B
Delta Dental of Washington – Program #03839
Scheduled Benefit Plan

Introduction
This Plan Document is a description of the Northwest Laborers-Employers Health & Security Trust Fund. The Trust has an arrangement with Delta Dental of Washington (DDWA) to administer Dental Plan B benefits. DDWA is a member of the nationwide Delta Dental Plans Association.

In addition to the description of Dental Plan B, Dental benefits covered by this Plan are also subject to all of the terms and conditions of the Northwest Laborers-Employers Health & Security Trust provisions set forth in this Plan Document. Including but not limited to Eligibility & Termination; COBRA; Appeals; Coordination of Benefits; Third Party Recovery Provision; HIPAA Privacy Disclosures; and Notice of Privacy Practices.

How to Use the Plan
The best way to take full advantage of Dental Plan B is to understand its features. Please read this section describing the Plan *before* going to the dentist. For questions about Dental Plan B benefits or Delta Dental of Washington call a DDWA customer service representative at 206-522-2300 or 1-800-554-1907. Be sure to provide the Northwest Laborers ID number and DDWA Program #03839. *Consult the provider regarding any charges that may not be covered by the Plan before treatment begins.*

Choosing a Dentist
With Dental Plan B, any licensed dentist may be selected; however, out-of-pocket expenses may be lower when choosing a participating Delta Dental dentist.

Delta Dental Participating Dentists
When selecting a dentist who is a Delta Dental participating provider, that dentist has agreed to provide treatment for enrolled persons covered by DDWA plans. Participating dentists will complete claim forms and submit them directly to DDWA. Payment will be based on the Schedule of Allowances and payment will be sent directly to the dentist by DDWA. The Covered Person is responsible for paying the amount over the scheduled allowance, any amount over the Plan maximum and any elective care received outside the Schedule of Allowances. The Covered Person will not be charged more than the participating dentist's approved fee or the fee that the participating dentist has filed with DDWA.

Delta Dental PPO Dentists
PPO dentists must be Delta Dental Premier® dentists in order to participate in the PPO network. PPO dentists receive payment based on the Schedule of Allowances. The Covered Person is responsible for paying the amount over the scheduled allowance, any amount over the Plan maximum and for any elective care received outside the covered dental benefits. If care is received by a PPO dentist, the out-of-pocket expenses may be lower.

Delta Dental Premier® Dentists (non-PPO)

Premier dentists also have contracts with DDWA, but they may not be part of the PPO network. Premier dentists will submit claim forms for you and receive payment directly from DDWA.

Nonparticipating Dentists

If a Covered Person selects a dentist who is not a Delta Dental participating dentist, the Covered Person is responsible for having the dentist complete and sign an appropriate claim form. DDWA accepts any American Dental Association approved claim form that the dentist may provide. A claim form can also be downloaded at www.deltadental.com. It is up to the Covered Person to ensure that the claim is sent to DDWA. Payment by DDWA to a nonparticipating dentist for services will be based on the Schedule of Allowances. The Covered Person will be responsible for any balance remaining. DDWA has no control over nonparticipating dentists' charges or billing practices.

Finding a Dentist

A current listing of participating dentists within the state of Washington is available by going online to the Delta Dental of Washington website at www.deltadentalwa.com. Click on the *Patients* tab and then on the *Find a Dentist* tab to begin the search. Be sure to click on the *Delta Dental PPO Plan* and follow the prompts.

Claim Submission

DDWA is not obligated to pay for treatment performed for which claim forms are not submitted within 12 months from the date of treatment unless the Covered Person is legally incapacitated throughout the year.

Confirmation of Treatment and Cost (Confirmation) A dentist may complete and submit a request for an estimate, sometimes called a "Confirmation of Treatment and Cost." This will allow the Covered Person to know in advance what procedures may be covered, the amount DDWA may pay and the Covered Person's expected financial responsibility.

A Confirmation is not an authorization for services but a notification of covered dental benefits available at the time the Confirmation is made and is not a guarantee of payment.

In the event coverage terminates, the Confirmation of Treatment and Cost is voided. DDWA will make payments based on available benefits subject to the applicable Plan provisions when the treatment is provided.

Dental Plan B Benefits Covered by your Plan

The following are the Covered Dental Benefits under this Plan and are subject to the limitations and exclusions (refer also to "General Exclusions" section) contained in Dental Plan B section of this benefit booklet. Such benefits (as defined) are available only when provided by a licensed dentist or other licensed professional when appropriate and necessary as determined by the standards of generally accepted dental practice and DDWA.

Note: Please be sure to consult your provider before treatment begins regarding any charges that may be your responsibility.

The amounts payable by DDWA for Covered Dental Benefits are described in the Schedule of Allowances section of this benefit booklet.

Class I Diagnostic

Covered Dental Benefits

1. Comprehensive, or detailed and extensive oral evaluation
2. Diagnostic evaluation for routine purposes (dental exam)
3. X-rays

Limitations

1. Comprehensive, or detailed and extensive oral evaluation is covered once in the patient's Lifetime by the same dentist. Subsequent comprehensive or detailed and extensive oral evaluations from the same dentist are paid as a periodic oral evaluation.
2. Routine evaluation is covered twice in Calendar Year. Routine evaluation includes all evaluations except limited problem-focused evaluations.
3. A complete series is covered once in twelve month period.
   a) Any number or combination of X-rays, billed for the same date of service, which equals or exceeds the allowed fee for a complete series, is considered a complete series for payment purposes.

Exclusions

1. Diagnostic services and X-rays related to temporomandibular joints (jaw joints) are not a Class I paid Covered Dental Benefit.

Please also see:

"Temporomandibular Joint Benefits" section for information on X-rays related to temporomandibular joint benefits.

Class I Preventive

Covered Dental Benefits

1. Prophylaxis (cleaning)
2. Topical application of fluoride including fluoridated varnishes
3. Sealants
4. Space maintainers
5. Amalgam, anterior composite, and posterior composite restorations (one or two surfaces) - *For three or four surface posterior composites See Class II Restorative*

Limitations

1. Any combination of prophylaxis and periodontal maintenance is covered twice in a Calendar Year.
2. For any combination of adult prophylaxis (cleaning) and periodontal maintenance, third and fourth occurrences may be covered if the dentist determines the patient meets periodontal Case Type III or IV (Pocket depth readings of 5mm or greater).*
3. Topical application of fluoride is limited to two covered procedures in a Calendar Year through age 18.
4. The application of a sealant to an unrestored molar is covered once in a Lifetime per tooth through age 18.
5. Benefit coverage for application of sealants is limited to permanent molars that have no restorations (includes preventive resin restorations) on the occlusal (biting) surface.
6. Amalgam, anterior composite, and posterior composite restorations (one or two surface) on the same surface(s) of the same tooth are covered once in a twenty-four month period from the date of service
7.

*Note: These benefits are available only under certain conditions of oral health. It is strongly recommended that you have your dentist submit a Confirmation of Treatment and Cost request to determine if treatment is a covered dental benefit. A Confirmation of Treatment and Cost is not a guarantee of payment. See the "Confirmation of Treatment and Cost" section for additional information.

Exclusions

1. Plaque control program (oral hygiene instruction, dietary instruction, and home fluoride kits)

Please also see:

"Class II Periodontics" for Periodontal Maintenance Benefits.

Class II Sedation

Covered Dental Benefits

1. General Anesthesia
2. Intravenous Sedation

Limitations

1. General Anesthesia or Intravenous Sedation are Covered Dental Benefits only when administered by a licensed dentist or other Licensed Professional who meets the educational, credentialing and privileging guidelines established by the Dental Quality Assurance Commission of the state of Washington or as determined by the state in which the services are provided.
2. General Anesthesia is a Covered Dental Benefit only in conjunction with certain covered surgery procedures, as determined by DDWA, or when Medically Necessary, for children through age six, or for a physically or developmentally disabled person, when in conjunction with Class I, II, III, TMJ or Orthodontic Covered Dental Benefits.*
3. Intravenous Sedation is covered in conjunction with certain covered oral surgery procedures, as determined by DDWA.*
4. Sedation, which is either General Anesthesia or Intravenous Sedation, is a Covered Dental Benefit only once per day.

*Note: These benefits are available only under certain conditions of oral health. It is strongly recommended that you have your dentist submit a Confirmation of Treatment and Cost request to

determine if the treatment is a covered dental benefit. A Confirmation of Treatment and Cost is not a guarantee of payment. See the "Confirmation of Treatment and Cost" section" for additional information.

Exclusions

1. General Anesthesia or Intravenous Sedation for routine post-operative procedures is not a paid Covered Dental Benefit except as described above for children through the age of six or a physically or developmentally disabled person.

Class II Palliative Treatment

Covered Dental Benefits

1. Limited problem-focused evaluations
2. Palliative treatment for pain

Limitations

1. Limited problem-focused evaluations are covered twice in a benefit period.
2. Postoperative care and treatment of routine post-surgical complications are included in the initial cost for surgical treatment if performed within 30 days.

Class II Restorative

Covered Dental Benefits

1. Posterior composites - (three or four surfaces) - *For one or two surface posterior composites See Class I Preventive*
2. Stainless steel crowns
3. Diagnostic Casts
4. Consultation

Limitations

1. Restorations on the same surface(s) of the same tooth are covered once in a two-year period from the date of service.
2. Restorations are covered for the following reasons:
   a) Treatment of carious lesions (visible destruction of hard tooth structure resulting from the process of dental decay)
   b) Fracture resulting in significant loss of tooth structure (missing cusp)
   c) Fracture resulting in significant damage to an existing restoration
3. Stainless steel crowns are covered once in a two-year period from the date of service.
4. A diagnostic cast is covered once in a Lifetime.

Exclusions

1. Overhang removal
2. Copings
3. Re-contouring or polishing of a restoration
4. Restorations necessary to correct vertical dimension or to alter the morphology (shape) or occlusion

Please also see:

"Class III Restorative" for more information regarding coverage for crowns (other than stainless steel), inlays, veneers or onlays.

Class II Oral Surgery

Covered Dental Benefits

1. Removal of teeth
2. Preparation of the mouth for insertion of dentures
3. Treatment of pathological conditions and traumatic injuries of the mouth

Exclusions

1. Bone replacement graft for ridge preservation
2. Bone grafts, of any kind, to the upper or lower jaws not associated with periodontal treatment of teeth
3. Orthognathic surgery or treatment
4. Tooth transplants
5. Materials placed in tooth extraction sockets for the purpose of generating osseous filling

Please also see:

"Class II Sedation "section for additional information.

Class II Periodontics

Covered Dental Benefits

1. Surgical and nonsurgical procedures for treatment of the tissues supporting the teeth
2. Periodontal Maintenance
3. Periodontal scaling/root planing*
4. Periodontal surgery
5. Limited adjustments to occlusion (eight teeth or fewer)
6. Gingivectomy

Limitations

1. Periodontal scaling/root planing is covered once in a 36-month period from the date of service.
2. Limited occlusal adjustments are covered once in a 12-month period from the date of service.
3. Any combination of prophylaxis (See Class I Preventive) and periodontal maintenance is covered twice in Calendar Year.
4. Periodontal maintenance procedures are covered only if a patient has completed active periodontal treatment.
5. For any combination of adult prophylaxis and periodontal maintenance, third and fourth occurrences may be covered if the patient meets periodontal Case Type III or IV.*
6. Periodontal surgery (per site) is covered once in a three-year period from the date of service.
7. Gingivectomy is covered once in a three-year period from the date of service for two or more teeth.

*Note: Some benefits are available only under certain conditions of oral health. It is strongly recommended that you have your dentist submit a Confirmation of Treatment and Cost request to determine if the treatment is a Covered Dental Benefit. A Confirmation of Treatment and Cost is not a guarantee of payment. See the "Confirmation of Treatment and Cost "section for additional information.

Please also see:

1. "Class II Sedation" section for additional information.
2. "Class III Periodontics" section for complete occlusal equilibration or occlusal guard

Class II Endodontics

Covered Dental Benefits

1. Procedures for pulpal and root canal treatment, including pulp exposure treatment, pulpotomy, and apicoectomy

Limitations

1. Root canal treatment on the same tooth is covered once in a 24-month period from the date of service.
2. Re-treatment of the same tooth is allowed only when performed by a dentist other than the dentist who performed the original treatment and only if the re-treatment is performed in a dental office other than the office where the original treatment was performed.

Exclusions

1. Bleaching of teeth

Please also see:

"Class II Sedation" section for additional information.

Class III Periodontics

Covered Dental Benefits

1. Occlusal guard (nightguard) for any reason
2. Repair and relines of occlusal guard
3. Complete occlusal equilibration

Class III Restorative

Covered Dental Benefits

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

Limitations

1. A crown, veneer, or onlay on the same tooth is covered once in a 60-month period from the seat date.
2. An implant-supported crown on the same tooth is covered once in a 60-month period from the original seat date of a previous crown on the same tooth.
3. An inlay (as a single tooth restoration) will be considered as elective treatment and an amalgam allowance will be made, with any difference in cost being the responsibility of the Covered Person, once in a 24-month period from the seat date.
4. Payment for a crown, veneer, inlay, or onlay shall be paid based upon the date that the treatment or procedure is completed.
5. A crown buildup is a Covered Dental Benefit when more than 50 percent of the natural coronal tooth structure is missing or there is less than 2mm of vertical height remaining for 180 degrees or more of the tooth circumference and there is evidence of decay or other significant pathology.
6. A crown buildup is covered once in a 60-month period on the same tooth from the date of service.
7. A post and core is covered once in a 60-month period on the same tooth from the date of service.

8. Crown buildups or post and cores are not a paid Covered Dental Benefit within two years of a restoration on the same tooth from the date of service.
9. A crown used for purposes of re-contouring or repositioning a tooth to provide additional retention for a removable partial denture is not a paid Covered Dental Benefit unless the tooth is decayed to the extent that a crown would be required to restore the tooth whether or not a removable partial denture is part of the treatment.
10. Ceramic substrate/porcelain or cast metal crowns and onlays are not a paid Covered Dental Benefit for children under 12 years of age.

Exclusions

1. Copings
2. A crown or onlay is not a paid Covered Dental Benefit when used to repair micro-fractures of tooth structure when the tooth is asymptomatic (displays no symptoms) or there is an existing restoration with no evidence of decay or other significant pathology.
3. A crown or onlay placed because of weakened cusps or existing large restorations

Class III Prosthodontics

Covered Dental Benefits

1. Dentures
2. Fixed partial dentures (fixed bridges)
3. Inlays when used as a retainer for a fixed partial denture (fixed bridge)
4. Removable partial dentures
5. Adjustment or repair of an existing prosthetic appliance
6. Surgical placement or removal of implants or attachments to implants
7. Tissue Conditioning

Limitations

1. Replacement of an existing prosthetic appliance is covered once every five years from the delivery date and only then if it is unserviceable and cannot be made serviceable.
2. Fixed prosthodontics for children less than 16 years of age are not a paid Covered Dental Benefit.
3. Payment for dentures, fixed partial dentures (fixed bridge), inlays (only when used as a retainer for a fixed bridge), and removable partial dentures shall be paid upon the seat/delivery date.
4. Implants and superstructures are covered once every five years.
5. Temporary Denture - DDWA will allow the amount of a reline toward the cost of an interim partial or full denture. After placement of the permanent prosthesis, an initial reline will be a benefit after six months.
6. Stayplate dentures are a benefit only when replacing anterior teeth during the healing period or in children 16 years of age or under for missing anterior permanent teeth.
7. Full and immediate dentures – DDWA will allow the cost of a full or immediate denture toward the cost of an elective procedure such as an overdenture, a personalized restoration, or a specialized treatment.*
8. Denture adjustments and relines – Denture adjustments and relines done more than six months after the initial placement are covered two times in a 12-month period. Subsequent relines or rebases (but not both) will be covered once in a 12-month period from the date of service.

Exclusions

1. Crowns in conjunction with overdentures
2. Duplicate dentures

3. Personalized dentures
4. Copings
5. Maintenance or cleaning of a prosthetic appliance
6. Root canals in conjunction with overdentures

NOTE: Some benefits are available only under certain conditions of oral health. It is strongly recommended that you have your dentist submit a Confirmation of Treatment and Cost request to determine if the treatment is a Covered Dental Benefit. A Confirmation of Treatment and Cost is not a guarantee of payment. See the "Confirmation of Treatment and Cost" section for additional information.

Other Benefits

Temporomandibular Joint Benefits (TMJ)

For the purpose of Dental Plan B, Temporomandibular Joint (TMJ) treatment is defined as dental services provided by a licensed dentist for the treatment of disorders associated with the temporomandibular joint. TMJ disorders shall include those disorders that have one or more of the following characteristics: pain in the musculature associated with the temporomandibular joint, internal derangements of the temporomandibular joint, arthritic problems with the temporomandibular joint, or an abnormal range of motion or limitation of motion of the temporomandibular joint.
"Dental Services" are those that are:

1. Appropriate, for the treatment of a disorder of the temporomandibular joint;
2. Effective for the control or elimination of one or more of the following, caused by a disorder of the temporomandibular joint: pain, infection, disease, difficulty in speaking, or difficulty in chewing or swallowing food;
3. Recognized as effective, according to the professional standards of good dental practice; and
4. Not Experimental or primarily for cosmetic purposes.

Both surgical and non-surgical procedures are covered. Non-surgical procedures include, but are not limited to:

1. TMJ examination
2. X-rays (including TMJ film and arthrogram)
3. Temporary repositioning splint
4. Occlusal orthotic device
5. Removable metal overlay stabilizing appliance
6. Fixed stabilizing appliance
7. Occlusal equilibration
8. Arthrocentesis
9. Manipulation under anesthesia

Services related to treatment of Temporomandibular Join Syndrome (TMJ) are limited to a combined Medical/Dental Plan Lifetime maximum of $1,000. The amounts payable for TMJ benefits shall not be applied to the covered person's annual Plan Maximum.
It is strongly suggested that a TMJ treatment Plan be submitted to, and a Confirmation of Treatment and Cost request be completed prior to commencement of treatment. A Confirmation of Treatment and Cost is not a guarantee of payment. *See the "Confirmation of Treatment and Cost" section for additional*

information. If you have any questions about your Covered Dental Benefits or Plan Maximums please contact DDWA's Customer Service.

Orthodontic Benefits for Covered Adults and Children

Orthodontic treatment is the appliance therapy necessary for the correction of teeth or jaws that are positioned improperly.

The Lifetime maximum amount payable by DDWA for orthodontic benefits provided to a Covered Person shall be $2,000. Not more than $1,000 of the maximum, or one-half of DDWA's total responsibility shall be payable at the time of initial banding. Subsequent payments of DDWA's responsibility shall be made on a monthly basis throughout the length of treatment submitted.

Additionally, payment for orthodontic benefits is based upon eligibility. If individuals lose eligibility prior to the payment of benefits, subsequent payment is not made.

Covered Dental Benefits

1. Fixed or removable appliance therapy for the treatment of teeth or jaws.
2. Orthodontic records: exams (initial, periodic, comprehensive, detailed, and extensive), X-rays (intraoral, extraoral, diagnostic radiographs, panoramic), diagnostic photographs, diagnostic casts (study models) or cephalometric films.

Limitations

1. Payment is limited to:
   a) Completion of the treatment plan, or any treatment that is completed while you are eligible for the Orthodontic Benefit, whichever occurs first.
   b) Treatment received after coverage begins (claims must be timely submitted to DDWA). For orthodontia claims, the initial banding date is the treatment date considered in the timely filing.
2. Treatment that began prior to the start of coverage will be prorated. Allowable payment will be calculated based on the balance of treatment costs remaining on the date of eligibility.
3. In the event of termination of the treatment plan prior to completion of the case, or termination of this plan, no subsequent payments will be made for treatment incurred after such termination date.

Exclusions

1. Charges for replacement or repair of an appliance
2. Self-Administered Orthodontics
3. No benefits shall be provided for services considered inappropriate and unnecessary, as determined by DDWA.

It is strongly suggested that an orthodontic treatment plan be submitted to, and a Confirmation of Treatment and Cost be made by, DDWA prior to commencement of treatment. A Confirmation of Treatment and Cost is not a guarantee of payment. Additionally, payment for orthodontic benefits is based upon your eligibility. If you become ineligible prior to the subsequent payment of benefits, subsequent payment is not covered. If you have any questions about your Covered Dental Benefits or Plan Maximums contact DDWA's Customer Service.

Accidental Injury

DDWA and the Medical portion of this Plan will coordinate benefits for charges related to Accidental Injuries to natural teeth for necessary diagnosis and treatment incurred within 180 days following the

date of the accident. DDWA will pay 100 percent of the scheduled allowance for Class I, Class II, and Class III Covered Dental Benefit expenses arising as a direct result of an accidental bodily Injury. However, payment for accidental Injury claims will not exceed the unused Plan Maximum. A bodily Injury does not include teeth broken or damaged during the act of chewing or biting on foreign objects. DDWA will pay Dental benefits first and a copy of the bill and the DDWA EOB must be submitted to the Trust Office in order for the Medical portion of the Plan to provide secondary coverage.

DENTAL PLAN B
Delta Dental of Washington – Program #03839
Schedule of Allowances

Dental expenses are reimbursed according to the Schedule of Allowances listed below **(up to a maximum benefit of $2,000 per Calendar Year)** regardless of whether services are provided by a participating or nonparticipating dentist. The $2,000 Calendar Year maximum does not apply to Orthodontia or Preventive and Minor Restorations for Dependent children under the age of 18. The Covered Person is responsible for paying the amount over the scheduled allowance, any amount over the Plan maximum and for any elective care received outside the covered dental benefits. A complete Schedule of Allowances is on file with Delta Dental of Washington.

PROCEDURE		ALLOWANCE
Diagnostic		
D0120	Periodic Oral Exam	$ 45
D0140	Problem Focus Evaluation	$ 66
D0150	Comprehensive Oral Evaluation	$ 66
X-rays		
D0210	Full mouth x-rays	$ 104
D0330	Panoramic single film	$ 81
D0220	Intraoral - single film	$ 21
D0230	Intraoral –each additional film	$ 16
D0272	Bitewings – 2 films	$ 35
D0274	Bitewings – 4 films	$ 47
Preventive		
D1110	Prophylaxis - age 14 and over	$ 89
D1120	Prophylaxis - to age 14	$ 61
D1206	Topical application of fluoride	$ 38
D1351	Sealant, each tooth	$ 40
Restorative		
D2140	Amalgam – 1 surface	$ 88
D2150	Amalgam – 2 surfaces	$ 120
D2160	Amalgam - 3 surfaces	$ 145
D2161	Amalgam – 4 or more surfaces	$ 171
D2330	Composite/resin – 1 surface	$ 107
D2331	Composite/resin – 2 surface	$ 138
D2332	Composite/resin – 3 surface	$ 172
D2335	Composite/resin – 4 surface	$ 205
D2391	Resin based composite – 1 surface	$ 120

PROCEDURE	ALLOWANCE
D2392 Composite – 2 surface, posterior	$ 162
D2393 Resin based composite – 3 surface	$ 199
D2394 Composite – 4 or more surfaces, posterior	$ 231
Crowns-Single Restorations	
D2750 Porcelain to high noble	$ 658
D2790 Full cast high noble	$ 651
Crowns-Single Restorations	
D2930 Prefab stainless steel crown	$ 160
D2950 Crown buildups	$ 148
D2954 Prefabricated post and core	$ 186
Endodontics	
D3220 Pulpotomy	$ 103
D3310 Root Canal Therapy - Anterior	$ 559
D3320 Root Canal Therapy - Bicuspid	$ 663
D3330 Root Canal Therapy - Molar	$ 853
Periodontics	
D4910 Periodontal maintenance	$ 118
D4341 Periodontal scaling per quad	$ 148
D4342 Periodontal scaling and root planning	$ 105
D4260 Osseous surgery	$ 966
D4211 Gingivectomy – 1-3 teeth	$ 227
Oral Surgery	
Extractions (includes local anesthesia and routine post-operative care)	
D7140 Single tooth	$ 106
D7210 Surgical removal erupted tooth	$ 201
D7220 Removal of impacted tooth - soft tissue	$ 205
D7230 Removal of impacted tooth- partially bony	$ 264
D7240 Removal of impacted tooth - completely bony	$ 321
Prosthodontics	
Dentures	
D5110 Complete upper	$1,121
D5120 Complete lower	$1,015
D5213 Upper partial	$ 975
D5214 Lower partial	$ 975
Related Denture Services	

PROCEDURE	ALLOWANCE
D5750 Reline complete denture	$ 273
D5760 Reline Partial denture	$ 300
Bridge Pontics	
D6240 Porcelain to high noble	$ 667
D6241 Porcelain to base	$ 673
D6242 Porcelain to noble	$ 694
Bridge Abutment-Crowns	
D6750 Porcelain to high noble	$ 685
D6751 Porcelain to base	$ 659
D6752 Porcelain to noble	$ 617
Other Dental Procedures	
D9223 General Anesthesia	$ 138
D9110 Palliative (emergency) treatment	$ 116
Orthodontics –	**$ 2,000**

50% of the allowable cost, up to a Lifetime maximum of $2,000.
Benefits paid under the Orthodontic benefit do not apply to the annual maximum of $2,000

A complete Schedule of Allowances is on file with Delta Dental of Washington. Benefit allowances for other procedures are available by calling DDWA at 1-800-554-1907.

DENTAL PLAN B
LIMITATIONS AND EXCLUSIONS

In addition to the Plan's General Limitations and Exclusions listed on pages 100-103, the following Dental Limitations and Exclusions shall apply to the Dental Plan B benefits covered under this Plan.

Limitations

The benefits covered under this Plan are subject to limitations and exclusions which affect the type or frequency of procedures which will be covered. Refer to the section for "Dental Plan B Covered Benefits under the Plan" section for the list of limitations and some exclusions.

General Exclusions

Additionally, this Plan does not cover every aspect of dental care. There are exclusions to the type of services that are covered, which are detailed here. Please read all limitations and exclusions carefully. These items are not Covered Dental Benefits under this Plan.

1. Dentistry for cosmetic reasons.
2. Restorations or appliances necessary to correct vertical dimension or to restore the occlusion, which include restoration of tooth structure lost from attrition, abrasion or erosion, and restorations for malalignment of teeth.
3. Services for injuries or conditions that are compensable under Worker's Compensation or Employers' Liability laws, and services that are provided to the covered person by any federal, state or provincial government agency or provided without cost to the covered person by any municipality, county, or other political subdivision, other than medical assistance in this state, under medical assistance RCW 74.09.500, or any other state, under 42 U.S.C., Section 1396a, section 1902 of the Social Security Act.
4. Application of desensitizing agents (treatment for sensitivity or adhesive resin application).
5. Experimental services or supplies. This includes:
   a) Procedures, services, or supplies are those whose use and acceptance as a course of dental treatment for a specific condition is still under investigation/observation. In determining whether services are Experimental, DDWA, in conjunction with the American Dental Association, will consider them if:
      i. The services are in general use in the dental community in the state of Washington;
      ii. The services are under continued scientific testing and research;
      iii. The services show a demonstrable benefit for a particular dental condition; and
      iv. They are proven to be safe and effective.
      v. Any individual whose claim is denied due to this Experimental exclusion clause will be notified of the denial within 20 working days of receipt of a fully documented request.
      vi. Any denial of benefits by DDWA on the grounds that a given procedure is deemed Experimental may be appealed to DDWA. DDWA will respond to such an appeal within 20 working days after receipt of all documentation reasonably required to make a decision. The 20-day period may be extended only with written consent of the covered person.

vii. Whenever DDWA makes an adverse determination and delay would jeopardize the covered person's life or materially jeopardize the covered person's health, DDWA shall expedite and process either a written or an oral appeal and issue a decision no later than 72 hours after receipt of the appeal. If the treating Licensed Professional determines that delay could jeopardize the covered person's health or ability to regain maximum function, DDWA shall presume the need for expeditious determination in any independent review. Please refer to Appeals on pages 82 and 109.

6. Analgesics such as nitrous oxide, conscious sedation, euphoric drugs, or injections of anesthetic not in conjunction with a dental service; or injection of any medication or drug not associated with the delivery of a covered dental service.
7. Prescription drugs.
8. Hospitalization charges and any additional fees charged by the dentist for Hospital treatment.
9. Charges for missed appointments.
10. Behavior management.
11. Completing claim forms.
12. Habit-breaking appliances which are, fixed or removable device(s) fabricated to help prevent potentially harmful oral health habits (e.g., chronic thumb sucking appliance, tongue thrusting appliance etc.), this does not include Occlusal Guard, see "Class III Periodontics" for benefit information.
13. This Plan does not provide benefits for services or supplies to the extent that those services and supplies are payable under any motor vehicle medical, motor vehicle no-fault, uninsured motorist, underinsured motorist, personal injury protection (PIP), commercial liability, homeowner's policy, or other similar type of coverage.
14. All other services not specifically included in this Plan as Covered Dental Benefits.

DDWA shall determine whether services are Covered Dental Benefits in accordance with a standard dental practice and the Limitations and Exclusions shown in this benefits booklet. Should there be a disagreement regarding the interpretation of such benefits, the Covered Person shall have the right to appeal the determination in accordance with the appeals process in this benefit booklet.

Necessary vs. Not Covered Treatment

Your dentist may recommend a treatment plan that includes services which may not be covered by this Plan. DDWA does not specify which treatment should be performed, only which treatment will be paid for under your Plan. While a treatment may be appropriate for managing a specific condition of oral health, it must still meet the provisions of the dental Plan in order to be a paid Covered Dental Benefit. Prior to treatment, you and your dentist should discuss which services may not be covered as well as any fees that are your responsibility. For further information see the "Confirmation of Treatment and Cost" section.

APPEAL OF DENIED DENTAL PLAN B BENEFITS

APPEAL LEVELS

You have the right to three levels of appeals:

Appeal Level	What it means	Deadline to appeal
Level 1	This is a request for in informal review of the denial. Delta Dental of WA will review the request.	180 days from the date of the denial
Level 2	If Delta Dental upholds the denial of your Level 1 Appeal, you can appeal a second time to the Northwest Laborers-Employers Health & Security Trust Board of Trustees. Refer to the General Trust Appeal section on page 109 of this Plan Booklet.	60 days from the date you were notified of your Level 1 informal review decision, or no later than 180 days from the date of the original denial.
Level 3/External Review	If the Board of Trustees upholds the denial in the Level 2 Appeal, you can ask for an Independent Review Organization (IRO) to review your appeal. Refer to the General Trust Appeal Section on page 109 of this Plan Booklet.	Four months from the date you were notified of the Board of Trustees Level 2 Appeal decision.

HOW TO CONTACT US

We will accept notice of an Urgent Care, Grievance, or Appeal if made by you, your covered Dependent, or an authorized representative of your covered Dependent.
You may include any written comments, documents or other information that you believe supports your claim. For more information please call 800-554-1907.

Customer Service for Dental Claims and Level 1 Appeals:
Delta Dental of Washington
PO Box 75983
Seattle, WA 98175-0983
Customer Service toll-free 1-800-554-1907

Customer Service for Eligibility & Level 2 Appeals:
Northwest Laborers-Employers Health & Security Trust
11724 NE 195th St. Suite 300
Bothell, WA 98011-3145
206-282-3600 or toll free 1-800-826-2102

Authorized Representative

You may authorize another person to represent you or your Dependent and receive communications from Delta Dental of WA regarding you or your Dependent's specific appeal. The authorization must be in writing and signed by you. If an appeal is submitted by another party without this authorization, a request will be made to obtain a completed authorized representative form. The appeal process will not commence until this form is received. Should the form, or any other document confirming the right of the individual to act on your behalf, i.e., power of attorney, not be returned, the appeal will be closed.

LEVEL 1 APPEAL- Dental Plan B

Informal Review

If your claim for dental benefits has been completely or partially denied, or you have received any other adverse benefit determination, you have the right to request an Informal Review. Either you, or your authorized representative (see the "Authorized Representative" section), must submit your request for a review within 180 days from the date of the adverse benefit determination (please see your Explanation of Benefits form). A request for a review may be made orally or in writing and must include the following information:

1. Your name and ID number
2. The group name and number
3. The claim number (from your explanation of benefits form)
4. The name of the dentist
5. Any written comments, document or other information that you believe supports your claim

DDWA will review your request and send you a notice within 14 days of receiving your request. This notice will either be the determination of our review or a notification that we will require an additional 16 days, for a total of 30 days. When our review is completed, DDWA will send you a written notification of the review decision and provide you information regarding any further appeal rights available should the result be unfavorable to you. Upon request, you will be granted access to, and copies of, all relevant information used in making the review decision. Informal reviews of wholly or partially denied claims are conducted by persons not involved in the initial claim determination.

LEVEL 1 URGENT Appeal- Dental Plan B

Whenever DDWA makes an adverse determination and delay would jeopardize the covered person's life or materially jeopardize the covered person's health, DDWA shall expedite and process either a written or an oral appeal and issue a decision no later than seventy-two hours after receipt of the appeal. If the treating Licensed Professional determines that delay could jeopardize the covered person's health or ability to regain maximum function, DDWA shall presume the need for expeditious review, including the need for an expeditious determination in any independent review.

Please submit your request for a Level 1 Appeal - Informal Review to:
Delta Dental of Washington
Attn: Appeals Coordinator
P.O. Box 75983
Seattle, WA 98175-0983

LEVEL 2 APPEAL – Dental Plan B

If you disagree with the outcome of your Level 1 Informal Review, you may submit a Level 2 Appeal directly to the Northwest Laborers-Employers Health & Security Trust, Board of Trustees at the following address:

Northwest Laborers-Employers Health & Security Trust
Appeals Committee
11724 NE 195th Street Suite 300
Bothell, WA 98011-3145

Refer to page 109 for more information

SHORT TERM DISABILITY BENEFITS
Covered Employees Only

The Short Term Disability Benefit applies when a Covered Employee who meets the initial eligibility requirements for Short Term Disability coverage has a Total Disability that meets all of the criteria listed below. Please refer to the Eligibility section on pages 7-9 for the initial eligibility requirements for Short Term Disability.

1. The Total Disability starts while the Employee is eligible for benefits under the Active eligibility provisions of the Plan;
2. The Total Disability is being continuously treated by a Physician; and
3. The Total Disability is due to an Injury or Sickness that, in either case, is non-occupational and does not arise from work for wage or profit.

Total Disability (Totally Disabled) means the complete inability to perform any and every duty of the Employee's occupation or the inability to engage in any occupation for wage or profit as a result of Injury or Sickness.

The Plan has the right to request periodic physical examinations from either the current Physician on the case or a Physician of the Plan's choice. Failure to provide requested Physicians' statements will result in termination of benefits. Employees are responsible for providing the following information in a clearly understandable format:

1. History regarding when symptoms first appeared or Accident happened;
2. Diagnosis;
3. Dates of treatment, nature of treatment, progress, and prognosis;
4. Physician's signature and tax I.D. number; and
5. Additional information required based upon the individual Injury or Sickness.

Benefit Payment

For non-occupational Sickness and Injuries
Weekly benefit limit………………………………..$134 per week

Benefits are payable:
For Injury…………………………………………...first day of Total Disability
For Sickness ………………………………………..eighth day of Total Disability
Maximum period payable…………………………..13 weeks

Note: Disability must commence during a month in which the Employee is eligible for Short Term Disability benefits under the Active Eligibility provisions of the Plan.

Period of Total Disability

Period of Total Disability is the period of time that an Employee is Totally Disabled. Successive periods due to the same or related causes not separated by return to active work for at least two weeks in a row will be considered as one period of disability. When benefits have been paid for the maximum period,

benefits will stop. However, the Employee will again be eligible for benefits as soon as they have returned to or have been available for active work for a period of two weeks, provided that the new period of disability commences while coverage is in force.

Income and FICA Taxes

Short term disability benefits provided by the Plan are subject to federal income tax. Employees may, upon their written request, have income tax withheld by the Trust Office. To request income tax to be withheld, contact the Trust Office for a withholding application and other details. Please note, federal regulations mandate withholding of at least $20 from each of the weekly benefit payments, if withholding is requested.

Income tax will be withheld from short term disability benefits payable eight or more days after receipt by the Plan of a written request to withhold. Termination of withholding of income tax will take effect with short term disability benefits payable eight or more days after receipt of a written notice to terminate withholding.

Short term disability benefits paid by the Plan within the first six months after employment ceases are also subject to Social Security (FICA) taxation. The Plan is required by federal law to withhold and deposit with the appropriate depository, the Employee's share of the tax from each weekly short term disability benefit payment that is made during the six month period after the Employee ceases work due to disability.

Exceptions

Short term disability benefits are not provided for:

1. Injury or Sickness arising out of or in the course of any employment for wage or profit and for which benefits are recovered or recoverable through payment, adjudication or settlement of a claim under a workers' compensation law, occupational disease law, or similar law, even if the Covered Employee fails to make timely application for or waives the right to such benefits, or even if workers' compensation insurance was not purchased;
2. War or any act of war (declared or undeclared) or service in the Armed Forces in any country;
3. Any day on which the Covered Employee is not under the direct care of a Physician;
4. Any day on which the Covered Employee is performing work of any kind, anywhere, for compensation or profit; or
5. Any disability that begins during a month in which the Covered Employee has no eligibility from hours worked.

APPEAL OF DENIED SHORT TERM DISABILITY BENEFITS

If your claim for Short Term Disability benefits has been completely or partially denied, you have the right to request an informal review or Level 1 appeal of the decision. Additional information about appeals rights begin on page 109. A review or an appeal must be in writing and filed within 180 days of the denial.

Refer to page 109 for more information

LIFE and ACCIDENTAL DEATH & PERSONAL LOSS COVERAGE
Covered Employees and their Covered Dependents

Life and Accidental Death & Personal Loss benefits are provided through this Trust for the life of the Covered Employee, the life of the covered Dependent spouse and covered Dependent children who are not otherwise eligible as Employees or in the Armed Forces. The following is a summary of Life and Accidental Death & Personal Loss Coverage features provided by the Plan. Please refer to the Eligibility Section on pages 8-9 for the initial eligibility requirements for Life and Accidental Death & Personal Loss Coverage.

SUMMARY OF LIFE BENEFITS

Benefit Amount Employee	$5,000 – Death of a Covered Employee. This benefit will be paid for the death of a Covered Employee, for any cause, provided the death occurs while eligible for benefits under this Plan.
Benefit Amount Dependent	$2,000 – Death of a covered Dependent spouse and/or unmarried child from live birth to age 26. This benefit will be paid for the death of a covered Dependent, provided the death occurs while the Covered Employee is eligible for benefits under this Plan.

SUMMARY OF ACCIDENTAL DEATH AND PERSONAL LOSS COVERAGE
Covered Employee only

Accidental Death and
Personal Loss Coverage Principal Sum - $5,000

The Plan pays a benefit in addition to the Life Benefit described above if, while covered, the Covered Employee suffers a bodily Injury caused by an Accident; and if, within 365 days after the Accident and as a direct result of the Injury, the Covered Employee suffers the following:

1. Loss of life.
2. Loss of a hand, by actual severance at or above the wrist joint.
3. Loss of a foot, by actual severance at or above the ankle joint.
4. Loss of an eye, involving irrecoverable and complete loss of sight in the eye.
5. Loss of speech or hearing; the loss must be total and deemed permanent.
6. A total loss of speech or hearing will be deemed permanent if the loss has been present for 12 consecutive months, unless an attending Physician states otherwise.
7. Loss of thumb and index finger of same hand, by actual severance of entire digit. Loss of thumb and index finger means complete severance through or above the metacarpophalangeal joint of both digits.

Disappearance will be deemed an Accident if:

1. The Covered Employee disappears as a direct result of the Accidental disappearance, wrecking, or sinking of the conveyance in which the Covered Employee was an occupant; and
2. There is no contrary evidence about the circumstances of the disappearance within 365 days of the Accident.

This Plan also pays a benefit if:

1. The Covered Employee suffers a bodily Injury in an Accident and if, as a direct result of the Accident, suffers a full thickness **third degree burn** caused by a direct contact with a chemical, fire, steam, water or heat (except sunburns) or,
2. Within 365 days after the Accident and as a direct result of the Injury, the Covered Employee is stricken with one of the following forms of paralysis:

   a) Quadriplegia – the entire and irrecoverable paralysis of both upper and lower limbs.
   b) Paraplegia – the entire and irrecoverable paralysis of both lower limbs.
   c) Hemiplegia – the entire and irrecoverable paralysis of the upper and lower limbs on one side of the body.
   d) Uniplegia – the entire and irrecoverable paralysis of one limb. A limb means the entire arm or leg.

Loss of life due to exposure to natural or chemical elements will be deemed to be accidental if the exposure was a direct result of an Accident.

BENEFIT

1. The full Principal Sum is payable for loss of life.
2. The full Principal Sum is payable for loss of both hands, both feet or both eyes.
3. The full Principal Sum is payable for loss of both hearing and speech.
4. The full Principal Sum is payable for quadriplegia.
5. The full Principal Sum is payable for third degree burns covering 75% or more of the body.
6. Half the Principal Sum is payable for loss of a hand, loss of a foot, or loss of an eye.
7. Half the Principal Sum is payable for paraplegia or for hemiplegia.
8. Half the Principal Sum is payable for third degree burns covering 50% to 74% of the body.
9. One quarter of the Principal Sum is payable for the loss of the thumb and index finger of the same hand.
10. One quarter of the Principal Sum is payable for uniplegia.

No more than the full Principal Sum is payable for all losses listed above resulting from one Accident.

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ADDED FEATURES – The following features are available when a Covered Employee suffers the loss due to an Accident.

Coma Benefit	If the Covered Employee suffers an Accident and as a direct result becomes comatose, there is a monthly benefit of 5% of the Principal Sum if the Covered Employee remains in a coma for more than 30 days the benefit is payable for up to 12 months.
Repatriation of Remains	If a covered loss of life of the Covered Employee occurs at least 200 miles from home, as a direct result of an Accident, a benefit of $5,000 will be payable for the preparation and transportation of the body to a hometown mortuary.
Passenger Restraint And Airbag	If a loss of life of the Covered Employee occurs as a direct result of a motor vehicle Accident and the Covered Employee was properly using a passenger restraint and if the driver is properly licensed, a benefit will be payable. If an airbag is activated as a result of the same Accident, an additional benefit will be payable. Passenger restraint and airbag usage will require verification. The benefit provides for $10,000 for use of a passenger restraint and an additional $5,000 if an airbag is activated.
Education Benefit	If a loss of life of the Covered Employee occurs as a direct result of an Accident, an education benefit will be payable on behalf of each covered Dependent child and/or covered surviving Dependent spouse for a maximum of 4 years from the date of death, with verification of continued enrollment. The benefit provides for 5% of the Covered Employee's Principle Sum per month not to exceed $5,000 per year.
Child Care	If a loss of life of the Covered Employee occurs as a direct result of an Accident, a benefit will be payable to the guardian of the estate of the covered Dependent child, or to the custodian, or adult caretaker, to cover expenses associated with the covered Dependent child's enrollment in a legally licensed child care center as of the date of the Accident or subsequently enrolled within 90 days of the Accident. The benefit is payable for a maximum of 4 years from the date of death, with verification of continued enrollment. The benefit provides for 3% of the Principal Sum per month to a maximum of $2,000 per covered Dependent child per year.
Medical Coverage Funding Benefit	If loss of life of the Covered Employee occurs as a direct result of an Accident, this benefit will offset out-of-pocket expenses that surviving covered Dependents may incur as a result of having to continue medical expenses coverage in accordance COBRA. The benefit payable is $300 per month/$3,600 per year for a maximum of 36 months.
Monthly Hospital Benefits	If the Covered Employee is injured in an Accident and that Accident results in the person being confined to a Hospital and or convalescent facility for at least 30 successive days, a monthly Hospital benefit will be payable. Thereafter, additional monthly benefits will be payable for each period of confinement lasting 30 days. The benefit payable is $2,500 per month for a maximum of 12 months not to exceed $30,000.

ADDED FEATURES – The following features are available when a Covered Employee suffers the loss due to an Accident.

Rehabilitation Training Benefit	Pays for out-of-pocket expenses that are incurred by the Covered Employee as a result of entering a rehabilitation training program that has been designed to help the person return to work with their employer. The benefit pays a maximum of $2,500 for expenses that are incurred within 2 years from the date of the loss.
Accidental Death And Personal Loss Limitations	This coverage is only for losses caused by Accidents. No benefits are payable for a loss caused or contributed to by: 1. A bodily or mental infirmity. 2. A disease, ptomaine, or bacterial infection*. 3. Medical or surgical treatment*. 4. Suicide or attempted suicide (while sane or insane.) 5. An intentionally self-inflicted Injury. 6. A war or any act of war (declared or not declared). 7. Voluntary inhalation of poisonous gases. 8. Commission of or attempt to commit a criminal act. 9. Use of alcohol, intoxicants, or drugs, except as prescribed by a Physician. 10. An Accident in which the blood alcohol level of the operator of a motor vehicle meets or exceeds the level at which intoxication would be presumed under the law of the state where the accident occurred, shall be deemed to be caused by the use of alcohol. 11. Intended or accidental contact with nuclear or atomic energy by explosion and/or release. 12. Air or space travel. This does not apply if a person is a passenger with no duties at all, on an aircraft being used only to carry passengers (with or without cargo). *These do not apply if the loss is caused by: 1. An infection which results directly from the Injury 2. Surgery needed because of the Injury.

DESIGNATION OF BENEFICIARY

Life and Accidental Death & Personal Loss benefits that are payable due to the Covered Employee's death will be paid to the beneficiary or beneficiaries named in writing by the Covered Employee. A Covered Employee may change the beneficiary designation. However, if the Covered Employee is married and selects a beneficiary other than the spouse, the spouse must consent to such designation. An enrollment form with designation of beneficiary is available at the Trust Office for this purpose. Any change will be binding only upon receipt of a written request by the Trust Office.

Any amount payable to a beneficiary will be paid to those designated. Unless stated to the contrary, if more than one beneficiary is named, they will share on equal terms.

If a named beneficiary dies before the Covered Employee, his or her share will be payable in equal shares to any other named surviving beneficiaries.

If there is no surviving beneficiary or if no beneficiary has been named, payment will be made as follows:

1. The spouse, if any.
2. If there is no spouse, in equal shares to the children.
3. If there is no spouse or child, to the parents, equally or to the survivor.
4. If there is no spouse, child, or parent, in equal shares to brothers and sisters.
5. If none of the above survives, to executors or administrators of the Covered Employee's estate.

If the Covered Employee designates a person who is or subsequently becomes the Covered Employee's spouse, the designation is automatically revoked if the marriage is subsequently dissolved or invalidated, unless the Covered Employee re-designates the former spouse following the dissolution or invalidation of marriage.

If the named beneficiary is a minor or legally unable to give a valid release for payment of any benefit, the benefit will be payable to the legal guardian of the estate of the minor, or to the custodian under the Uniform Transfer to Minors Act, or an adult caretaker, when permitted under applicable state law.

APPEAL OF LIFE AD&D OR PERSONAL LOSS BENEFITS

If your claim for Life AD&D or Personal Loss benefits has been completely or partially denied, you have the right to request a review or an appeal of this decision. A review or an appeal must be filed within 180 days of the denial.

Refer to page 109 for more information.

DEFINED TERMS

The following terms have special meanings and when used in this Plan will be capitalized**:**

Accident means an event that happens unintentionally, unexpectedly and is unusual and unforeseen. Lifting, bending and simple exercise are not in themselves Accidents.

Ambulatory Surgical Center is a licensed facility that is used mainly for performing outpatient surgery, has a staff of Physicians, has continuous Physician and nursing care by registered nurses (R.N.s) and does not provide for overnight stays.

Annual Out-of-Pocket Maximum is the total amount a Covered Person will have to pay out-of-pocket, for covered In-Network expenses in a Calendar Year, before the Plan starts to pay 100% for covered In-Network expenses. This includes medical and specialty drug Deductibles, Co-pays and Co-insurance. It does not include cost sharing for or amounts paid to Out-of-Network Providers (except when treated as In-Network Providers), In-Network and Out-of-Network Prescription Drug Co-pays or Co-insurance or any non-covered expenses. It also does not include out-of-pocket amounts for dental or vision.

Annual Overall Out-of-Pocket Maximum is in addition to the Annual Out-of-Pocket Maximum shown above. This “Overall” maximum includes all amounts listed in the prior section, in addition to In-Network Prescription Drug Co-pays and Co-insurance and other In-Network out of pocket expenses for services determined to be essential health benefits pursuant to the Affordable Care Act. It does not include cost sharing or out-of-pocket amounts for Out-of-Network Providers, or dental, vision or any non-covered expenses. If a Covered Person has combined Out-of-Pocket expenses that reach the “Overall” maximum in a Calendar Year, the Plan will pay 100% for applicable covered In-Network expenses for the remainder of the Calendar Year.

Birthing Center is a facility that provides obstetrical delivery and short-term recovery after delivery under the full-time supervision of a Physician and either a registered nurse (R.N.) or a licensed nurse-midwife and has a written agreement with a Hospital in the same locality for immediate acceptance of patients who develop complications or require pre or post-delivery confinement. Birthing Center must be licensed and operated in accordance with the laws pertaining to Birthing Centers in the jurisdiction where the facility is located.

Calendar Year means January 1st through December 31st of the same year.

Co-insurance is the reimbursement percentage the Plan pays for covered expenses after the Deductible is met.

Co-pay/Co-payments are fixed dollar amounts (for example, $20) paid for covered expenses, usually at the time services are received.

Confirmation of Treatment and Cost a dentist may submit a request for an estimate, sometimes called a "Confirmation of Treatment and Cost." This will allow the Covered Person to know in advance what procedures may be covered, the amount DDWA may pay and the Covered Person's expected financial responsibility.

Covered Employee is an Employee that is eligible for benefits under the Active Eligibility provisions of the Plan.

Covered Employer or Employer is an employer participating in the Plan by virtue of being signatory to a collective bargaining agreement requiring contributions to the Trust, or signatory to an associate agreement requiring contributions to the Trust.

Covered Employment is work covered by a collective bargaining agreement or associate agreement that requires contributions to the Northwest Laborers-Employers Health & Security Trust. When the term is used in reference to the Retiree Medical Eligibility, the definition may also include work covered by a collective bargaining agreement or associate agreement that requires contributions to the Western Washington Laborers-Employers Pension Trust, Washington-Idaho Laborers-Employers Pension Trust, or a pension plan approved by the Board of Trustees.

Covered Person or Covered Participant is an Employee or eligible Retiree or Dependent who is covered under this Plan.

Custodial Care is care (including room and board needed to provide that care) that is given principally for personal hygiene or for assistance in daily activities and can, according to generally accepted medical standards, be performed by persons who have no medical training. Examples of Custodial Care are help in walking and getting out of bed; assistance in bathing, dressing, feeding; or supervision of medication administration that could normally be self-administered.

Deductible is the amount paid for covered expenses each Calendar Year before the Plan starts to pay benefits.

Dependent is defined under the **Dependent Eligibility** section beginning on page 10.

Durable Medical Equipment means equipment which (a) can withstand repeated use, (b) is primarily and customarily used to serve a medical purpose, (c) generally is not useful to a person in the absence of an Sickness or Injury and (d) is appropriate for use in the home.

Employee means a person who is an Employee of a Covered Employer and on whose behalf contributions are required to the Trust by a collective bargaining agreement or other written agreement between the Covered Employer and the Trust. The term shall also include a former Employee who is still eligible under the Active Eligibility provisions of the Plan.
ERISA is the Employee Retirement Income Security Act of 1974, as amended.

Experimental and/or Investigational means a Prescription Drug or medical service, supply, care or treatment which does not constitute accepted medical practice properly within the range of appropriate medical practice under the standards of the case and by the standards of a reasonably substantial, qualified, responsible, relevant segment of the medical community or government oversight agencies at the time services were rendered. The following guidelines will be used in determining whether a drug or medical service, supply, care, or treatment is Experimental or Investigational:

1. Whether the Prescription Drug or medical service, supply, care, or treatment has not received the required approval by the Food and Drug Administration or other agency of the United States for general public use for treatment of a condition; or
2. Whether the Prescription Drug or medical service, supply, care or treatment, or the patient informed consent document utilized with the Prescription Drug or medical service, supply, care or treatment, was reviewed and approved by the treating facility's Institutional Review Board or other body serving a similar function, or if federal law requires such review or approval; or
3. Whether reliable evidence shows that the Prescription Drug or medical service, supply, care or treatment is the subject of on-going phase I or phase II clinical trials, or is the research, Experimental, study or Investigational arm of on-going phase III clinical trials, or is otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis; or
4. Whether reliable evidence shows that the prevailing opinion among experts regarding the Prescription Drug or medical service, supply, care or treatment is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis.

"Reliable evidence" means only published reports and articles in peer reviewed authoritative medical and scientific literature; the written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same drug or medical service, supply, care or treatment; or the written informed consent used by the treating facility or by another facility studying substantially the same drug, device, medical treatment or procedure.

Notwithstanding the foregoing, routine patient costs for items and services furnished in connection with an approved clinical trial will not be considered Experimental or Investigational if the item or service would otherwise be a covered charge for a Covered Person who is *not* enrolled in the clinical trial. 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. The Covered Person must be eligible to participate in the approved clinical trial according to the trial protocol. The following are not covered:

1. The actual clinical trial or the Investigational team;
2. Items and services solely for data collection that are not directly used in the clinical management of the patient; or
3. Services that are clearly inconsistent with widely accepted and established standards of care for a particular condition.

The Plan will investigate claims that might be considered Experimental or Investigational. The Plan may consult with medical professionals to determine whether the treatment is excluded as Experimental or Investigational, or whether it is covered as part of an approved clinical trial.

Family is the Covered Employee or Retiree and the Family members who are covered as Dependents.

Generic Drug means a Prescription Drug that has the equivalency of the brand name drug with the same use and metabolic disintegration. This Plan will consider as a Generic Drug any Food and Drug Administration approved generic pharmaceutical dispensed according to the professional standards of a licensed pharmacist and clearly designated by the pharmacist as being generic.

Home Health Care Agency is an organization that meets all of these tests: its main function is to provide Home Health Care Services and Supplies; it is federally certified as a Home Health Care Agency; and it is licensed by the state in which it is located, if licensing is required.

Home Health Care provides an opportunity to convalesce at home and must be prescribed by a Physician.

Home Health Care Services and Supplies Covered expenses include visits by a registered or licensed practical nurse, a licensed physical, occupational or speech therapist, and home health aides. The Plan also covers prescribed supplies and prescription medications obtained through the Home Health Care Agency and the rental up to the purchase price, of Durable Medical Equipment prescribed by the Physician.

Hospice Agency is an organization where its main function is to provide Hospice Care Services and Supplies and it is licensed by the state in which it is located, if licensing is required.

Hospice Care Plan is a plan of terminal patient care that is established and conducted by a Hospice Agency and supervised by a Physician.

Hospice Care Services and Supplies are those provided through a Hospice Agency and under a Hospice Care Plan and include inpatient care in a Hospice Unit or other licensed facility and Home Health Care Services and Supplies listed above.

Hospital is an institution which is engaged primarily in providing medical care and treatment of sick and injured persons on an inpatient basis at the patient's expense and which fully meets these tests: it is accredited as a Hospital by the Joint Commission on Accreditation of Healthcare Organizations; it is approved by Medicare as a Hospital; it maintains diagnostic and therapeutic facilities on the premises for surgical and medical diagnosis and treatment of sick and injured persons by or under the supervision of a staff of Physicians; it continuously provides on the premises 24-hour-a-day nursing services by or under the supervision of registered nurses (R.N.s); and it is operated continuously with organized facilities for operative surgery on the premises.
The definition of "Hospital" also includes the following:

1. A facility operating legally as a psychiatric Hospital or residential treatment facility for mental health and licensed as such by the state in which the facility operates.
2. A facility operating primarily for the treatment of Substance Use Disorders if it meets these tests: maintains permanent and full-time facilities for bed care and full-time confinement of at least 15 resident patients; has a Physician in regular attendance; provides 24-hour a day nursing service by a registered nurse (R.N.); has a full-time psychiatrist or psychologist on the staff; and is primarily engaged in providing diagnostic and therapeutic services and facilities for treatment of Substance Use Disorders.

Injury means physical injury to the body sustained as a direct result of a non-occupational Accident caused by external means and which happens unintentionally, unexpectedly, and is unusual and unforeseen, and all related symptoms and recurrent conditions resulting from the same Accident.

In-Network Provider (Dental) for Dental Plan A, means a dentist or clinic that participates in the Willamette Dental Group. For **Dental Plan B**, it means a dentist that participates in the Delta Dental of Washington provider network.

In-Network Provider (Medical) means a medical provider that participates in the Premera Blue Cross/BlueCard PPO Program.

In-Network Provider (Prescription Drug) means a retail Pharmacy that participates in the OptumRx network of Pharmacies. It also means OptumRx Home Delivery for mail order prescriptions and OptumRx Specialty Drug for specialty drugs

In-Network Provider (Vision) means a vision care provider that participates in the Vision Service Plan (VSP) network of providers.

Lifetime is a word that appears in this Plan in reference to benefit maximums and limitations. Lifetime is understood to mean while covered under the Plan.

Medical Emergency means any medical condition of recent onset and severity, including but not limited to severe pain that would lead a prudent layperson, possessing an average knowledge of medicine and health, to believe that his or her condition, Sickness, or Injury is of such a nature that failure to obtain immediate medical care could result in:

1. Placing the patient’s health in serious jeopardy;
2. Serious impairment to bodily functions; or
3. Serious dysfunction of any bodily organ or part.

Medically Necessary means care and treatment recommended or approved by a Physician; is consistent with the patient’s condition or accepted standards of good medical practice; is medically proven to be effective treatment of the condition; is not performed mainly for the convenience of the

patient or provider of medical services; is not conducted for research purposes; and is the most appropriate level of services which can be safely provided to the patient.

All of these criteria must be met. Merely because a Physician recommends or approves certain care does not mean that it is Medically Necessary. The Trustees have the discretionary authority to decide whether care or treatment is Medically Necessary.

Medicare is a Health Insurance program for the Aged and Disabled under Title XVIII of the Social Security Act, as amended.

Mental Disorder means any disease or condition, regardless of whether the cause is organic, that is classified as a Mental Disorder in the current edition of International Classification of Diseases, published by the U.S. Department of Health and Human Services or is listed in the current edition of Diagnostic and Statistical Manual of Mental Disorders, published by the American Psychiatric Association.

Out-of-Network Provider means a provider that is not an In-Network Provider.

Outpatient Care is treatment including services, supplies and medicines provided and used at a Hospital under the direction of a Physician to a person not admitted as a registered bed patient; or services rendered in a Physician's office, laboratory or x-ray facility, an Ambulatory Surgical Center, or the patient's home.

Pharmacy means a licensed establishment where covered Prescription Drugs are filled and dispensed by a pharmacist licensed under the laws of the state where he or she practices.

Physician means a Doctor of Medicine (M.D.), Doctor of Osteopathy (D.O.), Doctor of Dental Surgery (D.D.S., D.M.D.), Doctor of Podiatry (D.P.M.), Doctor of Chiropractic (D.C.), Audiologist, Certified Nurse Anesthetist, Licensed Professional Physical Therapist (L.P.T or D.P.T), Midwife, Optician, Physician Assistant (P.A.), Occupational Therapist, Optometrist (O.D.), Physiotherapist, Psychiatrist (M.D.), Psychologist (Ph.D.), Speech Language Pathologist.
Other licensed providers may also be covered by this definition if, under the scope of their license or certification they provide a service that is covered by this Plan (e.g. Acupuncturist for acupuncture, Naturopathic Doctor (N.D.) for physical exam, Licensed Massage Therapist (LMT) for massage therapy). All providers must be licensed and regulated by a state or federal agency and acting within the scope of his or her license. Services must be Medically Necessary and may be subject to review.
For the purpose of Mental Health and Substance Use Disorders, a Physician also means a Certified Clinical Social Worker (CCSW), Certified Mental Health Counselor (CMHC), Certified Masters Social Worker (CMSW), Masters in Social Work (M.S.W)., Education Doctorate (Ed.D.), Masters in Psychology (M.A.) and Master of Education (MED) who is certified and/or licensed by the State to provide counseling and who is practicing within the scope of his or her license.

Physician or Office Visit means a personal interview where the Physician sees the patient or a real-time interactive telephone or audio/video consultant (telehealth/telemedicine). To be covered, the telehealth/telemedicine consultation must be diagnostic and treatment focused via a live discussion or

video exchange with ongoing participation by the patient and the provider throughout the visit. Medical records or chart notes must be submitted when requested. Telehealth/telemedicine services described in this definition are separate from the services provided through Teladoc.

Plan means Northwest Laborers Employers Health & Security Plan.

Plan Participant is any Employee, Retiree or Dependent who is covered under this Plan.

Plan Year is April 1 through March 31 of the following year.

Prior Authorization or Preapproval is a request for determination of Medical Necessity for a particular procedure, treatment, Hospital stay or Prescription Drug.

Pregnancy is childbirth and conditions associated with Pregnancy, including complications.

Prescription Drug means a Medically Necessary drug in the treatment of a Sickness or Injury that meets any of the following: a Food and Drug Administration approved drug or medicine which, under federal law, is required to bear the legend: "Caution: federal law prohibits dispensing without prescription;" injectable insulin; hypodermic needles or syringes, but only when dispensed upon a written prescription of a licensed Physician.

Retiree is one who meets the eligibility requirements for Retiree Medical coverage as set forth on page 23 and pays the required Retiree Medical premium.

Sickness means illness, disease or Pregnancy.

Skilled Nursing Facility is a facility that fully meets all these tests:

1. Licensed to provide professional nursing services on an inpatient basis to persons convalescing from Injury or Sickness. The service must be rendered by a registered nurse (R.N.) or by a licensed practical nurse (L.P.N.) under the direction of a registered nurse.
2. Services to help restore patients to self-care in essential daily living activities must be provided.
3. Services are provided for compensation and under the full-time supervision of a Physician.
4. Provides 24 hour per day nursing services by licensed nurses, under the direction of a full-time registered nurse.
5. Maintains a complete medical record on each patient.
6. Has an effective utilization review Plan.
7. It is not, other than incidentally, a place for rest, the aged, drug addicts, alcoholics, mentally handicapped, Custodial, or educational care or care of Mental Disorders.
8. Approved and licensed by Medicare.

This term also applies to charges incurred in a facility referring to itself as an extended care facility, convalescent nursing home or any other similar nomenclature used to describe a facility that meets the criteria set forth above.

Spinal Manipulation/Chiropractic Care means skeletal adjustments, manipulation, or other treatment in connection with the detection and correction by manual or mechanical means of structural imbalance or subluxation in the human body. Such treatment is done by a Physician to remove nerve interference resulting from, or related to, distortion, misalignment, or subluxation of, or in, the vertebral column.

Substance Use Disorder is the condition caused by regular excessive compulsive drinking of alcohol and/or physical habitual use of drugs that result in an acute or chronic disorder affecting physical health and/or personal or social functioning. This does not include dependence on tobacco and ordinary caffeine-containing drinks.

Temporomandibular Joint Syndrome (TMJ) means jaw joint disorders including conditions of structures linking the jawbone and skull and the complex of muscles, nerves and other tissues related to the temporomandibular joint. Care and treatment shall include, but are not limited to orthodontics, crowns, inlays, physical therapy, injections, and any appliance that is attached to or rests on the teeth.

Total Disability (Totally Disabled) means in the case of a Covered Employee, the complete inability to perform any and every duty of the Employee's occupation or unable to engage in any occupation for wage or profit as a result of Injury or Sickness.

Total Disability (Totally Disabled) means in the case of a Dependent, the complete inability as a result of Injury or Sickness to perform the normal activities of a person of like age and sex in good health.

Uniformed Service means the United States Armed Forces, the Army National Guard and the Air National Guard when engaged in active duty for training, inactive duty training, or full-time National Guard duty, the commissioned corps of the Public Health Service, and any other category of persons designated by the President in a time of war or emergency.

Usual, Customary and Reasonable means the fees that fall within the customary range charged in a geographic area by most providers with similar training and experience for performing a similar service or procedure. This provision recognizes there will be differences in charges because of factors such as geographic location, provider skill and service complexity. The Trust uses the 90th percentile of the Usual, Customary and Reasonable charge as determined by a national vendor. Geographic location is determined by the Providers' billing zip code. The Trustees will make the final determination of whether a fee is Usual, Customary and Reasonable.

PLAN EXCLUSIONS AND LIMITATIONS

In addition to the other exclusions and limitations listed throughout this booklet, benefits are not provided under the Plan for the following:

Abortion. Services, supplies, care, or treatment in connection with an abortion unless the life of the mother is endangered.

Complications of non-covered treatments. Care, services, or treatment required as a result of complications from a treatment not covered under the Plan.

Cosmetic Services. Services performed or treatment to any part of the body to improve the patient's appearance and/or self-esteem and is not intended to substantially improve or restore a bodily function.

Custodial Care. Services or supplies provided mainly as a rest cure, maintenance or as defined by the Plan.

Dental care. Dental care services are not provided under Medical Benefits, except for tumors and injuries to natural teeth as provided for in the Plan. Please refer to the Dental Plan sections for limitations and exclusions for dental care, or contact Willamette Dental group for Dental Plan A or Delta Dental of Washington for Dental Plan B.

Educational or vocational testing. Services or supplies that are primarily educational in nature and vocational testing or training.

Excess charges. The part of an expense for care and treatment of an Injury or Sickness that is in excess of the Usual, Customary and Reasonable charge.

Exercise programs. Exercise programs for treatment of any condition, except for Physician supervised cardiac rehabilitation, occupational or physical therapy covered by this Plan.

Experimental, Investigational or not Medically Necessary. Care and treatment that is deemed either Experimental, Investigational or not Medically Necessary except for approved clinical trials, as provided in the Plan.

Eye care. Radial keratotomy or other eye surgery to correct near-sightedness. Also, routine eye examinations, including refractions, lenses for the eyes and exams for their fitting except as provided for under the Vision Care Benefits of this Plan. This exclusion does not apply to aphakic patients and soft lenses or sclera shells intended for use as corneal bandages.

Gender Reassignment. Gender reassignment surgery and related services, diagnosis, and treatment to change the gender you were born with.

Government coverage. Care, treatment or supplies furnished by a program or agency funded by any government. This does not apply to Medicaid or when otherwise prohibited by law.

Hair loss. Care and treatment for hair loss including wigs, hair transplants or any drug that promises hair growth, whether or not prescribed by a Physician, except for up to one wig following the loss of hair due to chemotherapy.

Hearing aids and exams. Charges for services or supplies in connection with hearing aids except as provided for in the Schedule of Medical Benefits.

Hospital Employees. Professional services billed by a Physician or nurse who is an Employee of a Hospital or Skilled Nursing Facility and paid by the Hospital or facility for the service.

Illegal acts. Charges for services or supplies received as a result of Injury or Sickness sustained while engaging in, or when contributed to by engaging in, an assault, battery, gross misdemeanor (including driving while under the influence of intoxicating liquors or any drug), or felony, regardless of whether prosecuted or not.

Infertility. Care and treatment for infertility, artificial insemination or in vitro fertilization.

Marriage and/or Family counseling. Marriage and/or Family counseling, except as provided for under the Affordable Care Act, Women's Preventive Services, refer to www.healthcare.gov/preventive-care-benefits/.

No charge. Care and treatment for which there would not have been a charge if no coverage had been in force.

Non-emergency Hospital admissions. Care and treatment billed by a Hospital for non-Medical Emergency admissions on a Friday or a Saturday. This does not apply if surgery is performed within 24 hours of admission.

No obligation to pay. Charges incurred for which the Plan has no legal obligation to pay.

No Physician recommendation. Care, treatment, services or supplies not recommended and approved by a Physician; or treatment, services or supplies when the Covered Person is not under the regular care of a Physician. Regular care means ongoing medical supervision or treatment which is appropriate care for the Injury or Sickness.

Not specified as covered. Services, treatments and supplies which are not specified as covered under this Plan.

Obesity. Care and treatment of obesity, weight loss or dietary control whether or not it is, in any case, a part of the treatment plan for an Injury or another Sickness, except for obesity screening and counseling provided for under the Affordable Care Act. Refer to www.healthcare.gov/preventive-care-benefits/.

Occupational. Charges for an Injury or Sickness arising out of or occurring in the course of any employment for wage or profit, including self-employment, and for which benefits are recovered or recoverable through payment, adjudication or settlement of a claim under a workers' compensation law, occupational disease law, or similar law, even if the Covered Person fails to make timely application for or waives the right to such benefits, or even if workers' compensation insurance was not purchased.

Personal comfort items. Personal comfort items or other equipment, such as, but not limited to, air conditioners, air-purification units, humidifiers, electric heating units, orthopedic mattresses, blood pressure instruments, scales, elastic bandages or stockings, nonprescription drugs and medicines, and first-aid supplies and non-Hospital adjustable beds.

Plan design exclusions. Charges excluded by the Plan design as mentioned in this document.

Relative giving services. Professional services performed by a person who ordinarily resides in the Covered Person's home or is related to the Covered Person as a spouse, parent, child, brother or sister, whether the relationship is by blood or exists in law.

Replacement braces. Replacement of braces of the leg, arm, back, neck, or artificial arms or legs, unless there is sufficient change in the Covered Person's physical condition to make the original device no longer functional.

Service in Armed Forces. Any treatment of any individual while the individual is on active duty in the U.S. Armed Forces if the active duty exceeds 30 days, subject to the individual's right to USERRA Continuation Coverage.

Services before or after coverage. Care, treatment or supplies for which a charge was incurred before a person was covered under this Plan or after coverage ceased under this Plan.

Sexual dysfunctions. Diagnosis and treatment of sexual dysfunction, regardless of origin or cause; surgical, medical, or psychological treatment of impotence or frigidity, including drugs, medications or penile or other implants.

Surgical sterilization reversal. Care and treatment for reversal of surgical sterilization.

Third Party Claims. Medical and Prescription Drug benefits for any Injury or Sickness caused by the act or omission of another person (known as a "third party"), and where a potential opportunity for recovery exists from the third party and/or under an automobile (including first party coverage such as uninsured and underinsured motorist policies), homeowners, commercial premises, renter's, medical malpractice, or other insurance or liability policy.

Travel or accommodations. Charges for travel or accommodations, whether or not recommended by a Physician, except for Ambulance charges as defined as a covered expense.

War. Any loss that is due to declared or undeclared act of war.

CLAIMS PROCEDURES

HOW TO SUBMIT A CLAIM

A Covered Person must be eligible for benefits on the date the medical care or services are received, before a claim can be considered for payment. Refer to the Eligibility Section in this booklet.

A Covered Person MUST show the Northwest Laborers ID card to the provider each time services are received.

Medical Claims

When a Covered Person receives medical care, both In-Network and Out-of-Network Providers must submit the claims directly to Premera Blue Cross. Premera Blue Cross may review for medical necessity and will then apply the appropriate discounts and forward the claims to the Trust Office for processing. Benefit payments will be paid directly to the provider. If medical care is provided outside of Washington or Alaska, Providers must submit claims to their local Blue Cross Blue Shield office. The local Blue Cross Blue Shield office will forward the claim to Premera Blue Cross for processing as described above.

Short Term Disability, Life and Accidental Death and Personal Loss Coverage

Claim forms are required for Short Term Disability and Life and Accidental Death and Personal Loss Coverage. Claim forms may be obtained by contacting the Trust Office. Claim forms and supporting documentation must be submitted to the Trust Office. When submitting a claim to the Trust Office, be sure to complete all applicable areas of the claim form. This will expedite processing of the claim.

Dental Plan A Claims

Dental Plan A is administered by Willamette Dental Group, and claim forms are not required. For questions about Dental Plan A and Willamette Dental Group, please call 1-855-433-6825.

Dental Plan B Claims

Dental Plan B is administered by Delta Dental of Washington (DDWA). Charges for services provided by a dentist who participates in the Delta Dental network will be billed at the DDWA discounted rates and claims are submitted by the provider directly to DDWA for processing.

If services are provided by a dentist who is not a DDWA participating dentist, then the Covered Person is responsible for having the dentist complete and sign an appropriate claim form. DDWA will accept any American Dental Association approved claim form that a dentist may provide. Covered Persons may also download a claim form from the DDWA website at www.deltadentalwa.com. It is up to each Covered Person to ensure that the claim is sent to DDWA. Payment for services will be based on the Schedule of Allowances. If services are provided by a non DDWA participating dentist, out-of-pocket expenses will be greater. For questions about Delta Dental of Washington please contact 1-800-554-1907.

Vision Claims

All vision claims are administered by Vision Service Plan (VSP). Claims for services received from a VSP provider are submitted directly to VSP by the provider and claim forms are not required. If care is provided by a non-VSP provider, the out-of-pocket will be greater. Before seeing a non-VSP provider, call 1-800-877-7195 for more details. VSP will provide the necessary claim form when using a non-VSP provider. A Covered Person must submit the claim form to VSP for reimbursement of services received from a non-VSP provider.

Prescription Drug Claims

Prescription Drugs purchased at an OptumRx participating retail Pharmacy or the mail order Pharmacy OptumRx Home Delivery, do not require a claim form to be submitted. If a Covered Person purchases a prescription at a non-participating Pharmacy, the Covered Person must pay the full retail price for the prescription, obtain a prescription claim form from the Trust Office or OptumRx and submit the claim form with the itemized prescription receipt to OptumRx to receive benefit payment. For questions about OptumRx or to find a participating Pharmacy, visit www.OptumRx.com or call 1-888-354-0090.

Medicare Claims

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

NO WAIVER OF CLAIM PAID IN ERROR – RECOVERY BY TRUST

If a claim is paid erroneously, or if payment is made because of incomplete or inaccurate information furnished to the Plan, or if payment is made in an incorrect amount due to an error, payment of the claim will not constitute a waiver of applicable Plan eligibility requirements, or any Plan limitation or exclusion. The Plan may recoup the erroneous payment from the provider or Covered Person or the Plan may offset future benefit payments of the affected Covered Person or of that Covered Person's Family members by the amount of the claim paid in error. The Plan may also take appropriate legal action to recover the amount of an overpayment.

MISREPRESENTATION

An individual who knowingly presents a false or fraudulent claim for payment or knowingly misrepresents facts relating to the eligibility for benefits will be subject to liability for reimbursement of the claim, for audit fees, attorney fees, and costs incurred by the Plan on account of such misrepresentation, as well as potential criminal liability.

ASSIGNMENT

The Trust and benefits payable in accordance with the Plan, shall not be subject in any manner to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance or charge by any person, provided that the Trustees may recognize assignments of benefits from a Covered Person to a Physician, Hospital, or other person or institution that has treated or cared for, or provided services or goods to, the Covered Person; and shall recognize a Qualified Medical Child Support Order (QMSCO) as provided on page 11.

TIME PERIOD FOR FILING CLAIMS

Claims must be filed within 12 months of the date charges for the services were incurred, or in the case of short term disability or life and accidental death and personal loss coverage, within 12 months of the date the disability commences or death occurs. Claims filed later than that date may be declined or reduced, unless: it was not reasonably possible to submit the claims in that time; and or the claimant is not legally capable of submitting the claims.

Benefits are based upon the Plan provisions at the time charges were incurred.

Processing of Claims

Pre-Service Health Claims; Post-Service Health Claims; Urgent Care Health Claims and Concurrent Care Health Claims described below may be subject to the Premera Blue Cross Prior Authorization and Utilization Review requirements set forth on page 44, and subject to the time period filing guidelines set forth below. Claims that are properly filed will be processed in accordance with the following guidelines:

Pre-Service Health Claims

A pre-service health claim is a properly filed claim for medical benefits that must be pre-approved (Prior Authorized) to receive full benefits from the Plan. **Failing to obtain Prior Authorization for a pre-service claim may result in reduced benefits.** Pre-service claims include non-emergency admission to a Hospital, or a Skilled Nursing Facility, or In-Patient Hospice Care. Prior Authorization is also required for many out-patient services. See page 44. A pre-service claim will generally be processed within 15 days of receipt. This period may be extended for up to 15 days if the Plan determines an extension is necessary due to matters beyond the control of the Plan, and notifies the claimant within the initial 15-day period of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision.

If an extension is necessary due to the claimant's failure to submit the information necessary to process the claim, the notification of the extension will describe the necessary information, and the claimant will be provided at least 45 days from receipt of the notification to submit the additional information. The period for making a determination will be tolled from the date on which the notification of the extension is sent to the claimant until the date on which the claimant responds to the request for additional information.

If services that require Prior Authorization have been provided and the only issue is what payment, if any, will be made, the claim will be processed as a post-service claim.

Post-Service Health Claims

A post-service health claim is any properly filed claim for medical, dental, vision, or Prescription Drug benefits that is not a pre-service claim and does not involve urgent care. A post-service claim will generally be processed within 30 days of receipt. This period may be extended for up to 15 days if the Plan determines an extension is necessary due to matters beyond the control of the Plan, and notifies the claimant within the initial 30-day period of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision. If an extension is necessary due to the claimant's failure to submit the information necessary to process the claim, the notification of the extension will describe the necessary information, and the claimant will be provided at least 45 days from receipt of the notification to submit the additional information. The period for making a determination will be tolled from the date on which the notification of the extension is sent to the claimant until the date on which responds to the request for additional information.

Urgent Care Health Claims

Urgent care health claims are pre-service claims with respect to which the normal time frames for review of a claim could seriously jeopardize the life or health of the claimant, or expose the claimant to severe pain that could not adequately be managed without the care or treatment that is the subject of the claim.

Urgent care claims may be filed, orally or in writing, by the claimant or by the health care provider with knowledge of the claimant's medical condition. A decision on an urgent care claim will generally be made within 72 hours after receipt of a claim that is complete when submitted. Claimants will be notified within 24 hours if additional information is required to process the claim and will be provided at least 48 hours to submit the additional information. If additional information is required to process the claim, a determination will be made within 48 hours of the earlier of the Plan's receipt of the requested information, or the end of the period afforded the claimant to provide the additional information.

A determination involving urgent care may be provided orally within the time frames in this section, with a written notification furnished not later than three days after the oral notification.

Concurrent Care Claims

Concurrent care health claims are pre-service claims involving an ongoing course of treatment to be provided over a period of time or for a number of treatments. Except in the case of urgent care, a claim to extend a course of treatment beyond the period of time or number of treatments previously approved, will be treated as a new claim and processed within the timeframes appropriate to the type of claim. A claim to extend a course of treatment that involves urgent care will be processed within 24 hours after receipt of the claim, provided the claim is made to the Plan at least 24 hours prior to the expiration of the prescribed period of time or number of treatments. If the claim is not made at least 24 hours prior to the expiration of the prescribed period of time or number of treatments, the request will be treated as a claim involving urgent care.

If the Plan reduces or terminates a course of treatment before the end of the previously approved period or number of treatments, the Plan will notify the claimant in advance of the reduction or termination to allow the claimant to appeal and obtain a determination on review before the benefit is reduced or terminated.

Short Term Disability Claims

Claimants will be notified of a determination on a claim for short term disability benefits within 45 days after receipt of the claim by the Plan. This period may be extended for up to 30 days (to a total of 75 days) if the Plan determines that an extension of time for making the determination is necessary due to matters beyond the control of the Plan, and notifies the claimant prior to the expiration of the initial 45-day period of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision. If the Plan determines that an additional extension of time for making the benefit determination is necessary due to matters beyond the control of the Plan, and notifies the claimant prior to the expiration of the first 30-day extension period of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision, then the period for making a benefit determination may be extended by the Plan for an additional 30 days (to a total of 105 days).

If an extension is necessary due to the claimant's failure to submit information necessary to process the claim, the notification of the extension will describe the necessary information, and the claimant will be provided at least 45 days from receipt of the notification to submit the additional information. The period for making a determination will be tolled from the date on which the notification of the extension is sent to the claimant until the date on which the claimant responds to the request for additional information.

Life and Accidental Death and Personal Loss Claims. A determination on a claim for life or accidental death and personal loss coverage will be made within a reasonable period of time. If the Plan needs additional information to make a decision, the claimant will be notified as to what information must be submitted.

NOTIFICATION OF A PRIOR AUTHORIZATION OR CLAIM DENIAL. If a Prior Authorization or claim is denied or partly denied, the claimant will be notified in writing and given an opportunity for review. This written denial may be in the form of a letter from Premera Blue Cross or Delta Dental of WA; or an Explanation of Benefits (EOB) from Delta Dental of WA or the Northwest Laborers-Employers Health & Security Trust. The written denial will give:

1. The specific reasons for the denial.
2. Specific reference to pertinent Plan provisions on which the denial is based.
3. A description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary.
4. If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion, or a statement that such a rule, guideline, protocol, or other criterion was relied upon in making the determination, a copy of the same will be provided free of charge to the claimant upon request.
5. If the denial is based on medical necessity, or Experimental or Investigational treatment, or a similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances, or a statement that such an explanation will be provided free of charge upon request.
6. An explanation of the Plan's claim review procedure, including a statement of the claimant's right to bring a civil action under ERISA §502(a).
7. In the case of an adverse determination of a claim for urgent care, a description of the expedited review process.

GENERAL TRUST APPEAL PROCEDURES
HOW TO APPEAL A DENIAL OF BENEFITS

APPEAL LEVELS

You have the right to three levels of appeals:

Appeal Level	What it means	Deadline to appeal
Level 1	This is your first appeal. **Premera Blue Cross** will review your appeal for a denial of Prior Authorization of medical services, Medical Necessity, or concurrent review. **DDWA** will review your Informal Review/appeal for Dental Plan B services. The Trust Office and/or Appeal Committee will review your appeal for Eligibility, denial of Medical benefit provisions, Prescription, Vision, Short Term Disability and Life and Accidental Death	180 days from the date you were notified of the denial. This written denial may be in the form of a letter from **Premera Blue Cross, DDWA**; or an Explanation of Benefits (EOB) from **DDWA** or the Northwest Laborers-Employers Health & Security Trust.
Level 2	If **Premera Blue Cross or DDWA** or the Appeal Committee upholds the denial of your Level 1 Appeal, you can appeal a second time to the Northwest Laborers-Employers Health & Security Trust Board of Trustees.	60 days from the date you were notified of the Level 1 Appeal decision.
Level 3/External Review **Only available for Medical appeals**	If the Board of Trustees upholds the denial in the Level 2 Appeal, you can ask for an Independent Review Organization (IRO) to review your appeal.	Four months from the date you were notified of the Board of Trustees Level 2 Appeal decision.

Medical Level 1 Appeal. For denial of Prior Authorization of medical services, Medical Necessity, or concurrent review. Medical benefits denied by Premera Blue Cross shall be handled through Premera's appeal process. Appeals must be filed within 180 days of denied or partially denied benefits and sent to:

Premera Blue Cross
Attn: Member Appeals
P.O. Box 91102
Seattle, WA 98111-9202

Medical Level 1 Urgent Appeal. Whenever Premera makes an adverse determination and delay would jeopardize the covered person's life or materially jeopardize the covered person's health, Premera shall expedite and process either a written or an oral appeal and issue a decision no later than seventy-two hours after receipt of the appeal.
Refer to page 49 for more information

Dental Level 1 Appeal. Denied dental benefits under Dental Plan B shall be handled through DDWA's appeal process. Appeals must be filed within 180 days of denied or partially denied benefits and sent to:

Delta Dental of Washington
Attn: Appeals Coordinator
P.O. Box 75983
Seattle, WA 98175-0983

Dental Level 1 Urgent Appeal. Whenever DDWA makes an adverse determination and delay would jeopardize the covered person's life or materially jeopardize the covered person's health, DDWA shall expedite and process either a written or an oral appeal and issue a decision no later than seventy-two hours after receipt of the appeal. If the treating Licensed Professional determines that delay could jeopardize the covered person's health or ability to regain maximum function, DDWA shall presume the need for expeditious review, including the need for an expeditious determination in any independent review.
Refer to page 83 for more information

Level 1 Appeal for Eligibility, Medical Benefit provisions, Pharmacy, Dental Plan A, Vision, Life and Accidental Death and Short Term Disability benefits.
If your claim for Pharmacy, medical benefit provisions, Dental Plan A, vision, Life and Accidental Death or Short Term Disability benefits has been completely or partially denied, or your claim has been denied based on eligibility and you believe you did not receive the full amount of benefits to which you are entitled, you have the right to request a review or an appeal of this decision. A review or an appeal must be filed within 180 days of the denial to the following address:

Northwest Laborers-Employers Health & Security Trust
Appeals Committee
11724 N.E. 195th Street Suite 300
Bothell, WA 98011-3145

Or fax: 206-352-6975

Level 2 Appeal. If following a Level 1 appeal the denial is upheld and you still believe you have been denied benefits to which you are entitled, you have the right to request a Level 2 appeal. Any Employee, Retiree, Dependent or other beneficiary (hereafter "claimant") who applies for benefits and is ruled ineligible following a Level 1 appeal by Premera Blue Cross, DDWA or the Board of Trustees or Appeal committee, or who believes he did not receive the full amount of benefits to which he is entitled, or who is otherwise adversely affected by any action of the Trustees, will have the right to a Level 2 appeal to request review of the matter by the Board of Trustees, provided that such a request, in writing, is filed within 60 days after the Level 1 Appeal decision or within 180 days after receipt of the original denial. Notwithstanding the foregoing, the appeal of a claim involving the reduction or termination of a previously approved concurrent care claim must be made within the time prescribed by the Plan in the notice of denial. The appeal of a claim for urgent care may be made orally or in writing. A request for an appeal should be submitted to the Trust Office. A failure to file a notice of appeal within the applicable time period will serve as a waiver of and bar the further right to appeal the adverse determination.

A Level 2 appeal will be conducted by the Board of Trustees, or by the Appeals Committee of the Board of Trustees, which has been given the authority for making a final decision in connection with the appeal.

Scheduling of Level 2 Appeal. Except for claims involving pre-service and urgent care, the Trustees will review a properly filed appeal at the next regularly scheduled quarterly meeting of the Appeals Committee, unless the request for review is received by the Trustees within 30 days preceding the date of such meeting or there are special circumstances requiring an extension of time. In such case, the appeal will be reviewed no later than the date of the second quarterly meeting following the Trustee's receipt of the notice of appeal, unless there are special circumstances requiring a further extension of time, in which case a benefit determination will be rendered not later than the third quarterly meeting of the Appeals Committee following the Trustee's receipt of the notice of appeal. If such an extension of time for review is required because of special circumstances, such as a request for a hearing on the appeal, then prior to the commencement of the extension, the Plan will notify the claimant in writing of the extension, describe the special circumstances and the date as of which the benefit determination will be made.

The Trustees will review a properly filed Level 2 appeal of a pre-service claim within 30 days after receipt of the appeal, provided that review may be expedited if the claim involves the reduction or termination of a previously approved claim for concurrent care. The Trustees will review a properly filed Level 2 appeal of an urgent care claim within 72 hours after receipt of the appeal. All necessary information on a claim for urgent care may be transmitted between the Plan and the claimant by telephone, facsimile, or other available expeditious method.

Level 2 Appeal Procedures The claimant is generally entitled to present his position and any evidence in support thereof, at an appeal hearing. Notwithstanding the foregoing, in order to expedite review, the appeal of a pre-service, concurrent care, or urgent care claim may be held telephonically by the Trustees, and unless the participation of the claimant or his representative is necessary to develop an

adequate record, may be based upon the written record. The claimant may request postponement of the Trustees' review if the claimant wishes to appear in person at a hearing.

The claimant may be represented by an attorney or by any other representative of his choosing at his own expense. In the case of an appeal involving urgent care, a health care professional with knowledge of the claimant's medical condition may act as an authorized representative of the claimant without a prior written authorization.

The claimant will be provided upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to his or her claim for benefits.

The claimant must introduce enough credible evidence on appeal to establish, prima facie, entitlement to the relief from the decision or other action from which the appeal is taken. The claimant will have the burden of proving his right to relief from the decision or action appealed, by a preponderance of evidence. The Trustees will review all comments, documents, records, and other information submitted by the claimant related to the claim, regardless of whether such information was submitted or considered in the initial benefit determination. The Trustees will not afford deference to the initial adverse benefit determination.

When deciding an appeal of a claim that is based in whole or in part on a medical judgment, the Trustees will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. Any medical or vocational expert whose advice was obtained on behalf of the Plan in connection with the adverse benefit determination will be identified to the claimant. Any health care professional engaged for the purpose of a consultation on a claim will not be an individual who was consulted in connection with the initial adverse benefit determination that is the subject of the appeal, nor the subordinate of any such individual.

Modifications to Level 2 Appeal Procedures for Urgent Care Claims. Level 1 Appeal urgent care claims procedures are set forth on page 110. The following modifications will be made in the Level 2 appeal procedures set forth above for urgent care claims:

Urgent Care Claims Level 2 Appeals involving denial of urgent care will be subject to the rules set forth above with the following modifications:

1. An initial decision will be made within 72 hours if the initial claim was complete when submitted or an additional 48 hours after receiving additional information if it was necessary to process the claim;
2. An appeal may be made orally or in writing;
3. A health care professional with knowledge of the individual's medical condition may act as an authorized representative of the claimant without a prior written authorization;
4. Information will be provided to the claimant or authorized representative via a telephone, facsimile, or other expedited method; and
5. A decision will be issued within 72 hours of a Level 2 appeal of a Level 1 denial.

Level 2 Appeal - Decision after Appeal Hearing. The Trustees will issue a written decision on review of a claim (other than a pre-service or urgent care claim) as soon as possible, but not later than five days following the conclusion of the Appeals Committee meeting. Where necessary, the Trustees may issue a more detailed explanation of the reasons for an adverse decision within 30 days of the conclusion of the Appeals Committee meeting. Notwithstanding the foregoing, a decision on review of a pre-service claim or concurrent care claim will be made within 30 days after receipt of the appeal, and a decision on review of an urgent care claim will be made within 72 hours after receipt of the appeal. In the case of an adverse benefit determination, the written denial will indicate:

1. The specific reasons for the adverse benefit determination and a specific reference to pertinent Plan provisions on which the denial is based.
2. A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of all documents, records, and other information relevant to the claimant's claim for benefits.
3. A statement of the claimant's right to bring a civil action under ERISA §502(a).
4. If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion, or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the determination and that a copy of the same will be provided free of charge to the claimant upon request.

Level 3 Appeal - External Review. If a claimant remains dissatisfied after the Board of Trustees issues its decision on appeal, he or she may request an external review with an Independent Review Organization or bring a civil action under ERISA § 502(a). If the claimant requests an external review, such request is subject to the following:

1. The Plan's claim appeal process must be exhausted before external or judicial review can be sought.
2. External reviews are only available for appeals involving medical judgment or the retroactive rescission of coverage. There is no external review for dental, prescription, vision, short term disability, accidental death and personal loss or life benefits.
3. A claimant has four months from the date of the final adverse benefit determination to file a request for external review. Failure to request an external review within the four-month period will end the claimant's ability to seek external review.
4. Requests for external review should be sent to the Trust Office at the following address:

Northwest Laborers-Employers Trust Office
Appeals Committee
11724 NE 195th St. Suite 300
Bothell, WA 98011

Preliminary Review of External Review Request

Within five business days of receipt of a request for external review, the Plan will complete a preliminary review of the external review request. The preliminary review will be expedited if the request satisfies the requirements for an expedited external review. Within one business day after

completion of this review, the Plan will notify the claimant of its decision. If the request is not eligible for external review, the Plan will notify the claimant. If the request for external review is incomplete, the Plan will identify what is needed and the claimant will have the longer of 48 hours or the remaining portion of the four-month external review request period to provide the information. If the external review request is complete and eligible for external review, the Plan will refer the matter to an Independent Review Organization.

Expedited External Review

A claimant may request an expedited external review if the claimant received:

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

Review by Independent Review Organization

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

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

Judicial Review of Appeal. If a claimant remains dissatisfied after the issuance of the Trustees' decision on appeal, or issuance of the Independent Review Organization's decision, the claimant may bring a civil action under ERISA § 502(a). Any civil action must be brought no later than one year after the date of issuance of the Trustees' decision on an appeal or an external review decision, if later. The question on review will be whether the Trustees' decision was an abuse of discretion.

Sole and Exclusive Procedures. A claimant must exhaust his remedies under the foregoing procedures as a condition precedent to commencement of any suit. The claim and appeal procedures are the sole and exclusive procedures available to a claimant who is dissatisfied with an eligibility determination, benefit award, or who is adversely affected by any action of the Trustees.

COORDINATION OF BENEFITS

Coordination of Benefits (COB). The coordination of benefits (COB) provision applies when a person has health care coverage under more than one benefit plan. Plan is defined below.

The order of benefit determination rules governs the order in which each plan will pay a claim for benefits. The plan that pays first is called the primary plan. The primary plan must pay benefits as if there were no other plan involved. The secondary and subsequent plans may pay the balance due up to 100% of the total allowable expense. If the other plan is primary, the Covered Person must submit the claim to the other plan first, then submit a copy of the explanation of benefits along with the itemized bill to Premera Blue Cross for medical claims and DDW for Dental Plan B claims.

Annual verification of Family coverage. Many families have more than one Family member working and are covered by more than one benefit plan. This Plan requires that Family coverage information be updated at least annually.

Plan. The term benefit plan means this Plan or any one of the following that provides benefits or services for medical or dental care or treatment:

1. Group or group-type plans, including franchise or blanket benefit plans or health care programs issued by insurance companies, health care services contractors and health maintenance organizations.
2. Labor-management trustee, labor organization, employer organization or employer benefit organization plans.
3. Government plans or programs, including Medicare.
4. Plans or programs required or provided by law. This does not include Medicaid or any benefit plans like it that, by its terms, does not allow coordination.

Allowable Expense. An allowable expense for an In-Network Provider, is the negotiated fee for a health care expense that is covered at least in part by this Plan. An allowable expense for an Out-of-Network Provider, is a Usual, Customary and Reasonable charge for a health care expense that is covered at least in part by this Plan.

If a Covered Person is covered by two or more plans that compute their benefits payment on the basis of a Usual, Customary and Reasonable charge or relative value schedule reimbursement method or other similar reimbursement method, any amount in excess of the highest reimbursement amount for a specific benefit is not an allowable expense.

If a Covered Person is covered by two or more plans that provide benefits or services on the basis of negotiated fees, an amount in excess of this Plan's negotiated fees is not an allowable expense.

In the case of HMO (Health Maintenance Organization) plans: This Plan will not consider any charges in excess of what an HMO provider has agreed to accept as payment in full. Also, when an HMO pays its benefits first, this Plan will not consider as an allowable expense any charge that would have been covered by the HMO had the Covered Person used the services of an HMO provider.

In the case of service type plans where services are provided as benefits, the reasonable cash value of each service will be the allowable expense and a benefit paid.

Credit Savings. When this Plan does not have to pay its full benefits because of coordination of benefits, any savings will be credited to the Covered Person for the Calendar Year. The savings will only be applied to any unpaid covered expenses during that Calendar Year.

Order of Benefit Determination. When a Covered Person is covered by two or more plans, the rules for determining the order of benefit payment are as follows:

1. A plan that does not contain a coordination of benefits provision is always primary.
2. Plans with a coordination of benefits provision will pay their benefits by the following rules up to the allowable expense:
    a) Plans covering non-Dependents. A plan, including this Plan, that covers a person other than as a Dependent, for example as an Employee, member, policyholder, subscriber, or Retiree is primary over plans that cover a person as a Dependent. However, if the Covered Person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the plan covering the person as a Dependent, and primary to the plan covering the person as other than a Dependent (i.e. a retired Employee), then the order of benefits between the two plans is reversed so that the plan covering the person as an Employee, member, policyholder, subscriber or Retiree is secondary and the plan covering the person as a Dependent is primary.
    b) Plans covering a Dependent child. Unless there is a court decree stating otherwise, when a Dependent child is covered by more than one plan, the order of benefits is determined as follows:
        (i) For a Dependent child, whose parents are married or are living together, whether or not they have ever been married:
            (A) The plan of the parent whose birthday falls earlier in the Calendar Year is the primary plan**;** or
            (B) If both parents have the same birthday, the plan that has covered the parent the longest is the primary plan**.**
        (ii) For a Dependent child, whose parents are divorced or separated or not living together, whether or not they have ever been married:
            (A) If a court decree states that one of the parents is responsible for the Dependent child's health care expenses or health care coverage and the plan of that parent has actual knowledge of those terms, that plan is primary. This rule applies to claim determination periods commencing after the plan is given notice of the court decree;
            (B) If a court decree states one parent is to assume primary financial responsibility for the Dependent child but does not mention responsibility for health care expenses, the plan of the parent assuming financial responsibility is primary;
            (C) If a court decree states that both parents are responsible for the Dependent child's health care expenses or health care coverage, the provisions of subparagraph 2.b (i) above determine the order of benefits;
            (D) If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the

Dependent child, the provisions of subsection 2 (b) (i) above determine the order of benefits; or

(E) If there is no court decree allocating responsibility for the Dependent child's health care expenses or health care coverage, the order of benefits for the child are as follows:

- The plan covering the custodial parent, first;
- The plan covering the spouse of the custodial parent, second;
- The plan covering the noncustodial parent, third; and then
- The plan covering the spouse of the noncustodial parent, last.

(iii) For a Dependent child covered under more than one plan of individuals who are not the parents of the child, the provisions of subsections 2.b) (i) and (ii) above determine the order of benefits as if those individuals were the parents of the child.

(iv) In the event the Dependent child is covered as an Employee under another plan, that plan shall be primary.

c) Covered Employee. The plan that covers a person as a Covered Employee is primary over a plan that covers a person as a Retiree regardless of which plan has covered the person longest.

d) If a person is under a disability extension from a previous benefit plan, that benefit plan will pay first and this Plan will pay second.

e) COBRA or state continuation coverage. If a person whose coverage is provided under COBRA or under a right of continuation provided by state or other federal law is covered under another plan, the plan covering the person as an Employee, member, subscriber or Retiree or covering the person as a Dependent of an Employee, member, subscriber or Retiree is the primary plan and the COBRA or state or other federal continuation coverage is the secondary plan. If the other plan does not have this rule, and as a result, the plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule under paragraph 2.a can determine the order of benefits.

f) Longer or shorter length of coverage. The plan that covered the person as a Covered Employee, member, policyholder, or subscriber longer is the primary plan and the plan that covered the person the shorter period of time is the secondary plan.

g) If the preceding rules do not determine the order of benefits, the allowable expenses must be shared equally between the plans meeting the definition of plan. In addition, this plan will not pay more than it would have paid had it been the primary plan.

Claims determination period. Benefits will be coordinated on a Calendar Year basis.

Right to receive or release necessary information. To make this provision work, this Plan may give or obtain needed information from another insurer or any other organization or person. This information may be given or obtained without the consent of or notice to any other person. A Covered Person will give this Plan the information it asks for about other plans and their payment of allowable charges.

Facility of payment. This Plan may repay other plans for benefits paid that the Trust determines it should have paid. That repayment will count as a valid payment under this Plan.

Right of recovery. This Plan may pay benefits that should be paid by another benefit plan. In this case this Plan may recover the amount paid from the other benefit plan or the Covered Person. That repayment will count as a valid payment under the other benefit plan. Further, this Plan may pay benefits that are later found to be greater than the allowable charge. In this case, this Plan may recover the amount of the overpayment from the source to which it was paid.

Coordination with Medicare. In certain situations, the Plan for active Employees and their Dependents is primary to Medicare. This means that when the Participant is enrolled in Medicare and this Plan at the same time, this Plan pays benefits for Covered Expenses first and Medicare pays second. Those situations are:

1. When the Employee or spouse is age 65 or over and by law Medicare is secondary to the employer group health plan;
2. When the Participant incurs Covered Expenses for a kidney transplant or kidney dialysis and when by law Medicare is secondary to the employer group health plan; and
3. When the Participant is entitled to benefits under Section 226(b) of the Social Security Act (Medicare disability) and by law Medicare is secondary to the Participant's employer group health plan.

In all other instances, the Plan will not pay benefits toward any part of a Covered Expense to the extent the Covered Expense is actually paid or would have been paid under Medicare Part A or B or a Medicare Advantage Plan (Part C) and the Participant properly applied for and maintained Medicare coverage.

Accordingly, it is important that the Participants eligible for Medicare in Parts A, B or C evaluate whether Medicare Parts A and B or Part C should be chosen.

Importance of Enrollment in Medicare Part B: **Medicare Part A (Hospital Charges) is generally automatic on the attainment of age 65 while Medicare Part B (Physicians Charges) and Medicare Part C (Medicare Advantage) requires enrollment and monthly premium payments.** If Medicare Part B or C coverage is maintained, it may cover certain expenses not paid by the Plan. If you subsequently enroll in the Trust's Retiree Plan or continue your coverage through COBRA after you are Medicare-eligible, Medicare can be primary instead of your Trust coverage. If Medicare is primary, the Trust will provide as if Medicare Parts A and B are in place even if the individual has failed to obtain these coverages. If you are Medicare eligible and participating in an active plan, you should contact Medicare to determine the rules that will apply when your active coverage ends.

Refer to page 28 for more information.

THIRD PARTY RECOVERY PROVISION

The Plan excludes medical and Prescription Drug benefits for any Injury or Sickness caused by the act or omission of another person (known as a "third party"), and where a potential opportunity for recovery exists from the third party and/or under an automobile (including first party coverage such as uninsured and underinsured motorist policies), homeowners, commercial premises, renter's, medical malpractice, or other insurance or liability policy. If a Covered Person has the potential right of recovery for which a third party or insurer may have legal responsibility, the Plan, as a convenience to the Covered Person, may advance benefits pending the resolution of the claim upon the following conditions:

1. By accepting or claiming benefits, the Covered Person agrees that the Plan is entitled to reimbursement from any judgment, settlement, disputed claim settlement, or other recovery, up to the full amount of all benefits provided by the Plan, but not to exceed the amount of the recovery. In other words, by this agreement, the Plan shall have an equitable lien in the Covered Person's recovery. The Plan is entitled to reimbursement, regardless of whether the Covered Person is made whole by the recovery, and regardless of the characterization of the recovery, except that the Plan will make the following reductions if the Covered Person complies with the terms of the Plan and the agreement to reimburse:
    a) the Plan will deduct a pro rata share of the Covered Person's attorney's fees and costs from the reimbursement amount;
    b) if application of this general rule results in the Plan receiving more than the Covered Person, the Plan will reduce its claim so that it does not exceed 50% of the amount payable to or on behalf of the Covered Person.
2. Prior to advancing benefits the Plan can require a Covered Person and the Covered Person's attorney or legal representative to execute an agreement acknowledging the Plan's reimbursement right, including the obligation to hold an amount sufficient to reimburse the Plan in a trust account or escrow until the Plan's claims are resolved by mutual agreement or court order. Also, prior to advancing benefits, the Plan can require the Covered Person to execute and deliver instruments and papers, disclose the circumstances resulting from the Injury or Sickness, and do whatever else is necessary to secure the Plan's right to reimbursement (including an assignment of rights). In no event, will the Trust advance benefits greater than $15,000 without a properly executed agreement acknowledging the Trust's reimbursement rights.
3. A Covered Person must do nothing after payment of benefits to prejudice the Plan's right of reimbursement.
4. When any recovery is obtained from a third party or insurer, whether by direct payment, settlement, judgment, or any other way, the Covered Person or Covered Person's attorney or legal representative must immediately notify the Plan. No funds may be distributed to any party prior to notification to and written agreement by the Plan. An amount sufficient to satisfy the Plan's reimbursement amount must be paid by the Covered Person or the Covered Person's attorney or legal representative into an escrow or trust account and held there until the Plan's claim is resolved by mutual agreement, arbitration or court order. If the funds necessary to satisfy the Plan's reimbursement amount are not placed in an escrow or trust account, the Covered Person or the person named to hold the funds will be personally liable for any loss the Trust suffers as a result.
5. If the Plan is forced to bring a legal action to enforce the terms of the Plan's provisions or the reimbursement agreement, it shall be entitled to its reasonable attorney fees, costs of collection and court costs.

6. The Plan may deny coverage or seek reimbursement from providers if there is a reasonable basis to determine this provision or any agreement to reimburse the Plan is not enforceable, or if there is a reasonable basis for believing that the parties involved will not honor the terms of this provision or any agreement to reimburse the Plan or the Board of Trustees modify this provision related to advancing benefits when a third party recovery is anticipated. Pursuant to this exclusion, the Plan may continue to exclude expenses incurred after judgment or settlement of the claim, if such expenses are related to the third party recovery. In addition, the Plan may offset future benefits, including those of Family members, by denying such payments until it is reimbursed for the benefits provided that are related to the third party recovery.
7. The Covered Person expressly affirms the Plan's right to: bring a breach of contract action in state court to enforce the Plan's right to reimbursement under this Plan provision; seek a constructive trust in federal court under ERISA 502(a)(3) to recover the funds received by the Covered Person from a third party according to this Plan provision; and recover the reimbursement amount by requesting provider refunds, offsetting future benefit payments of the affected Covered Person or the affected Covered Person’s Family members, or recovery from the source to which benefits were paid.
8. Venue for any enforcement action of this Plan provision will be in King County Superior Court in the State of Washington or the U.S. District Court for the Western District of Washington. The Plan may bring an action in an appropriate court to enforce the Plan provisions or the agreement to reimburse, or to enforce the requirement that funds be placed in trust or to seek other appropriate relief.

HIPAA PRIVACY DISCLOSURES AND CERTIFICATION

The Trust's privacy practices were effective April 14, 2003 and are administered in accordance with regulations adopted by the Department of Health and Human Services at 45, CFR §Part 164. The Board of Trustees has adopted the following provisions:

Protected Health Information. The term "Protected Health Information" (PHI) has the same meaning as in 45 CFR § 164.501.

Request, Use and Disclosure of PHI by Trustees. The Trustees are permitted to receive PHI from the Plan and to use and/or disclose PHI only to the extent necessary to perform the following administrative functions:

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

Trustee Certification. The Plan will only disclose PHI to a Trustee upon receipt of a certification that has been adopted and the Trustees, as Plan sponsor:

1. The Trustees will not use or disclose any PHI received from the Plan, except as permitted in this amendment or required by law.
2. The Trustees will ensure that any of their subcontractors or agents to whom they may provide PHI that was received from the Plan, agree to written contractual provisions that impose at least the same obligations to protect PHI as are imposed on the Trustees.
3. The Trustees will not use or disclose PHI for employment related actions and decisions or in connection with any other benefit or Employee benefit plan of the Trustees.

4. The Trustees will report to the Plan any known impermissible or improper use or disclosure of PHI not authorized by this amendment of which they become aware.
5. The Trustees will make their internal practices, books, and records relating to the use and disclosure of PHI received from the Plan available to the Department of Health and Human Services (DHHS) or its designee for the purpose of determining the Plan's compliance with HIPAA.
6. When the PHI is no longer needed for the purpose for which disclosure was made, the Trustees must, if feasible, return to the Plan or destroy all PHI that the Trustees received from or on behalf of the Plan. This includes all copies in any form, including any compilations derived from the PHI. If return or destruction is not feasible, the Trustees agree to restrict and limit further uses and disclosures to the purposes that make the return or destruction infeasible.

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

Trustee Certification as to Participant Rights. The Board of Trustees also certifies it will observe the following in regard to Plan Participants and their PHI:

1. The Board of Trustees will make PHI available to the Plan to permit Participants to inspect and copy their PHI contained in a designated record set.
2. The Board of Trustees will make a Participant's PHI available to the Plan to permit Participants to amend or correct PHI contained in a designated record set that is inaccurate or incomplete and the Trustees will incorporate amendments provided by the Plan.
3. The Board of Trustees will make a Participant's PHI available to permit the Plan to provide an accounting of disclosures.

Adequate Separation. The Trustees represent that adequate separation exists between the Plan and the Trustees so the PHI will be used only for Plan administration. The Trustees certify that they have no Employees, or other persons under their control, that will have access to PHI.

Effective Mechanism for Resolving Issues of Noncompliance. The Trustees certify that any individual or entity who suspects an improper use or disclosure of PHI may report that occurrence to the Plan Privacy Official.

NORTHWEST LABORERS-EMPLOYERS HEALTH & SECURITY TRUST
NOTICE OF PRIVACY PRACTICES

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

Pursuant to regulations issued by the federal government, the Trust is providing you this Notice about the possible uses and disclosures of your health information. Your health information is information that constitutes protected health information as defined in the Privacy Rules of the Administrative Simplification provision of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). As required by law, the Trust has established a policy to guard against unnecessary disclosure of your health information. This Notice describes the circumstances under which and the purposes for which your health information may be used and disclosed and your rights in regard to such information.

PROTECTED HEALTH INFORMATION

Protected health information generally means information that: (1) is created or received by a health care provider, health plan, employer, or health care clearinghouse; and (2) relates to the past, present, or future physical or mental health or condition of an individual, the provision of health care to an individual, or the past, present, or future payment for the provision of health care to an individual; and (3) identifies the individual, or there is a reasonable basis to believe the information can be used to identify the individual.

USE AND DISCLOSURE OF HEALTH INFORMATION

Your health information may be used and disclosed without an authorization for the purposes listed below. The health information used or disclosed will be limited to the "minimum necessary," as defined under the Privacy Rules.

To Make or Obtain Payment. The Trust may use or disclose your health information to make payment to or collect payment from third parties, such as other health plans or providers, for the care you receive. For example, the Trust may use your health information to pay claims, or share information regarding your coverage or health care treatment with other health plans to coordinate payment of benefits.

To Facilitate Treatment. The Trust may disclose information to facilitate treatment which involves the provision, coordination or management of health care or related services. For example, the Plan may disclose the name of your treating Physician to another treating Physician for the purpose of obtaining x-rays.

To Conduct Health Care Operations. The Trust may use or disclose health information for its own operations to facilitate the administration of the Trust and as necessary to provide coverage and services to all of the Trust's Participants. Health care operations include such activities as: contacting health care providers; providing Participants with information about health-related issues or treatment

alternatives; developing clinical guidelines and protocols; conducting case management, medical review and care coordination; handling claim appeals; reviewing health information to improve health or reduce health care costs; participating in drug or disease management activities; conducting underwriting, premium rating or related functions to create, renew or replace health insurance or health benefits; and performing the general administrative activities of the Trust (such as providing customer service, conducting compliance reviews and auditing, responding to legal matters and compliance inquiries, including cost management and planning related analyses and formulary development, and accreditation, certification, licensing or credentialing activities).

In Connection with Judicial and Administrative Proceedings. If required or permitted by law, the Trust may disclose your health information in the course of any judicial or administrative proceeding in response to an order of a court or administrative tribunal as expressly authorized by such order or in response to a subpoena, discovery request or other lawful process. The Trust will make reasonable efforts to either notify you about the request or to obtain an order protecting your health information.

When Legally Required for Law Enforcement Purposes. The Trust will disclose your health information when it is required to do so by any federal, state, or local law. Additionally, as permitted or required by law, the Trust may disclose your health information to a law enforcement official for certain law enforcement purposes, including, but not limited to, if the Trust has a suspicion that your death was the result of criminal conduct or in an emergency to report a crime.

To Conduct Health Oversight Activities. The Trust may disclose your health information to a health oversight agency for authorized activities including audits, civil, administrative, or criminal investigations, inspections, licensure or disciplinary action. The Trust, however, may not disclose your health information if you are the subject of an investigation and the investigation does not arise out of or is not directly related to your receipt of health care or public benefits.

In the Event of a Serious Threat to Health or Safety. The Trust may, consistent with applicable law and ethical standards of conduct, disclose your health information if the Trust, in good faith, believes that such disclosure is necessary to prevent or lessen a serious and imminent threat to your health or safety or to the health and safety of the public.

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

To Your Personal Representative. The Trust may disclose your health information to an individual who is considered to be your personal representative under applicable law.

To Individuals Involved in Your Care or Payment for Your Care. The Trust may disclose your health information to immediate Family members, or to other individuals who are directly involved in your care or payment for your care.

To Business Associates. The Trust may disclose your health information to its Business Associates, which are entities or individuals not employed by the Trust, but which perform functions for the Trust involving protected health information, such as claims processing, utilization review, or legal, consulting, accounting or administrative services. The Trust's Business Associates are required to safeguard the confidentiality of your health information.

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

For Disclosure to the Plan Trustees. The Trust may disclose your health information to the Board of Trustees (which is the Plan sponsor) and to necessary advisors for Plan administration functions, such as those listed in this summary, or to handle claim appeals, solicit bids for services, or modify, amend or terminate the Plan. The Trust may also disclose information to the Trustees regarding whether you are participating or enrolled in the Plan.

AUTHORIZATION TO USE OR DISCLOSE HEALTH INFORMATION

Other than as stated above, the Trust will not disclose your health information without your written authorization. Authorization forms are available from the Privacy Office, listed below. If you have authorized the Trust to use or disclose your health information, you may revoke that authorization in writing at any time. The revocation should be in writing, include a copy of or reference your authorization and be sent to the Privacy Office, listed below.

Your written authorization will generally be required before the Plan will use or disclose psychotherapy notes. Psychotherapy notes are separately filed notes about your observations with your mental health professional during a counseling session. They do not include summary information about your mental health treatment. The Plan may use and disclose such notes when needed to defend against litigation filed by you.

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

RIGHTS WITH RESPECT TO YOUR HEALTH INFORMATION

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

Right to Request Restrictions. You may request restrictions on certain uses and disclosures of your health information. You have the right to request a limit on the Trust's disclosure of your health information to someone involved in the payment of your care. However, the Trust is not required to agree to your request unless the disclosure is to another health plan for the purpose of carrying out payment or health care operations and your health care provider has been paid out of pocket in full. If

you wish to request restrictions, please make the request in writing to the Trust's Privacy Office listed below.

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

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

Right to Amend Your Health Information. If you believe that your health information records are inaccurate or incomplete, you may request that the Trust amend the records. That request may be made as long as the information is maintained by the Trust. A request for an amendment of records must be made in writing to the Trust's Privacy Office, listed below. The Trust may deny the request if it does not include a reasonable reason to support the amendment. The request also may be denied if your health information records were not created by the Trust, if the health information you are requesting be amended is not part of the Trust's records, if the health information you wish to amend falls within an exception to the health information you are permitted to inspect and copy, or if the Trust determines the records containing your health information are accurate and complete.

If the Trust denies a request for amendment, you may write a statement of disagreement. The Trust may write a rebuttal statement and provide you with a copy. If you write a statement of disagreement, then your request for amendment, your statement of disagreement, and the Trust's rebuttal will be included with any future release of the disputed health information.

Right to an Accounting. You have the right to request a list of disclosures of your health information made by the Trust. The request must be made in writing to the Privacy Office listed below. The request should specify the time period for which you are requesting the information but may not start earlier than April 14, 2003 when the Privacy Rules became effective. Accounting requests may not be made for periods of time going back more than six (6) years. An accounting will not include disclosure made to carry out treatment, payment, and health care operations; disclosures that were made to you; disclosures that were incident to a use or disclosure that is otherwise permitted by the Privacy Rules; disclosures made pursuant to an authorization; or in other limited situations. The Trust will provide the first accounting you request during any 12-month period without charge. Subsequent

accounting requests may be subject to a reasonable cost-based fee. The Trust will inform you in advance of the fee, if applicable.

Right to Opt Out of Fundraising Communications. If the Trust participates in fund raising, you have the right to opt-out of all fund raising communications.

Right to a Paper Copy of this Notice. You have a right to request and receive a paper copy of this Notice at any time, even if you have received this Notice previously or agreed to receive the Notice electronically. To obtain a paper copy, please contact the Privacy Office, listed below. You will also be able to obtain a copy of the current version of the Trust's Notice at its website, www.zenith-american.com.

Privacy Office/Privacy Contact. To exercise any of these rights related to your health information you should contact the Privacy Office listed below, which also serves as the Privacy Contact under the Privacy Rules:

Privacy Office/Privacy Contact
Zenith American Solutions, Inc.
11724 NE 195th St. Suite 300
Bothell, WA 98011

Phone No.: 866-277-3927
Fax No.: 206-285-1701
E-mail:contactperson@zenith-american.com

DUTIES OF THE TRUST

The Trust is required by law to maintain the privacy of your health information as set forth in this Notice, to provide to you this Notice of its duties and privacy practices, and to notify you following a breach of unsecured protected health information. The Trust is required to abide by the terms of this Notice, which may be amended from time to time. The Trust reserves the right to change the terms of this Notice and to make the new Notice provisions effective for all health information that it maintains. If the Trust changes its policies and procedures, the Trust will revise the Notice and will provide a copy of the revised Notice to you within 60 days of the change. You have the right to express complaints to the Trust and to the Secretary of the Department of Health and Human Services if you believe that your privacy rights have been violated. Any complaints to the Trust should be made in writing to the Privacy Office identified above. The Trust encourages you to express any concerns you may have regarding the privacy of your health information. You will not be retaliated against in any way for filing a complaint. The Trust is prohibited by law from using or disclosing genetic health information for underwriting purposes.

SUMMARY PLAN DESCRIPTION

TYPE OF PLAN

The Plan is a self-funded welfare plan providing medical, dental, vision, Prescription Drug, short term disability, life, and accidental death and personal loss benefits. Dental Plan A benefits are insured by Willamette Dental Group. The administration is provided through a contract administrative agent, Zenith American Solutions.

PLAN NAME

The name of the Plan is the Northwest Laborers-Employers Health and Security Plan. The trust fund through which the Plan is funded is the Northwest Laborers-Employers Health & Security Trust Fund.

TAX ID NUMBER

91-1283260

PLAN NUMBER

501

HEALTH PLAN IDENTIFICATION NUMBER

7164425069

PLAN YEAR ENDS

March 31st

CONTRACT ADMINISTRATIVE AGENT

This Plan is administered by the Board of Trustees, with the assistance of a contract administrative organization, Zenith American Solutions Inc., 11724 NE 195th St. Suite 300, Bothell, WA 98011. Telephone number is 206-282-3600 or toll free 1-800-826-2102.

AGENT FOR SERVICE OF LEGAL PROCESS

The Board of Trustees has designated Zenith American Solutions, Inc. as agent for the purpose of accepting service of legal process on behalf of the Trust Fund. Each member of the Board of Trustees is also an agent for the purposes of accepting service of legal process on behalf of the Trust Fund.

NAMES AND ADDRESS OF THE BOARD OF TRUSTEES

Employer Trustees

Andrew Ledbetter, Chairman
Associated General Contractors
1200 Westlake Ave. North, Ste. 301
Seattle, WA 98198

Anissa Lindren
Sellen Construction
227 Westlake Ave. North
Seattle, WA 98109

Carl Stewart
Frank Gurney
P.O. Box 11557
Spokane Valley, WA 99211

Dan Kuney
Max J. Kuney Company
102 N. Ralph Street
Spokane, WA 99220

Mark Horton
Anderson Construction
6712 N. Cutter Circle
Portland, OR 97217

Kari Shiflett
Lakeside Industries
P.O. Box 7016
Issaquah, WA 98027

Labor Trustees

Jermaine Smiley, Secretary
Washington and Northern Idaho
District Council of Laborers
12101 Tukwila International Blvd.
Ste. 300 Seattle, WA 98168

Dale Cannon
LiUNA Local 242
22323 Pacific Hwy. South
Des Moines, WA 9819

Brian Belarde
LiUNA Local 252
4803 South M Street
Tacoma, WA 9408

Stacy Martin
LiUNA Local 292
2810 Lombard Avenue, Ste.100
Everett, WA 98201

Kayne Segura
LiUNA Local 348
P.O. Box 1349
Richland, WA 99352

Shannon Stull
LiUNA Local 335
2212 NE Andresen Rd.
Vancouver, WA 98661

Upon written request to the Trustees, Participants and beneficiaries may receive information as to whether a particular Employer or Employee organization sponsors the Plan and the sponsor's address.

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DESCRIPTION OF COLLECTIVE BARGAINING AGREEMENT

This Plan is maintained pursuant to more than one collective bargaining agreement. A copy of such agreements may be obtained by Participants and beneficiaries upon written request to the Trustees. Such agreements are also available for examination by Participants and beneficiaries at the Trust Office or at the local union offices upon ten (10) days advance written request. The Trustees may impose a reasonable charge to cover the cost of furnishing the agreements. Participants and beneficiaries may wish to inquire as to the amount of charges before requesting copies.

PARTICIPATION, ELIGIBILITY AND BENEFITS

Those Employees whose employer is signatory to a collective bargaining agreement or written participation agreement requiring contributions to the Trust on behalf of the Employee and whose employer makes the required contribution to the Trust Fund are eligible to participate in the Plan. The eligibility rules that determine which Employees and their Dependents are entitled to the benefits are set forth under the Eligibility Section of this Booklet. Certain Retirees and their Dependents are also eligible for Retiree Medical and prescription coverage under this Plan. Eligibility rules that determine which Retirees and their Dependents are entitled to this coverage are set forth in the Retiree Eligibility section of this booklet. You may obtain, without charge from the Trust Office, additional copies of the Plan booklet, including eligibility rules and schedules of benefits.

SOURCE OF CONTRIBUTIONS

The source of contributions to the Plan is employer contributions paid pursuant to negotiated collective bargaining agreements, or employer contributions paid pursuant to associate agreements with the Board of Trustees. Self-payments are also permitted for COBRA, USERRA, and Retiree eligibility, as outlined in this booklet.

ENTITIES USED FOR ACCUMULATIONS OF ASSETS AND PAYMENTS OF BENEFITS

Contributions paid into the Plan to obtain benefits are received and held in trust by the Board of Trustees pending payment of benefits, administrative expenses, and premiums. The Board of Trustees pays benefits directly from the Trust Fund, with the exception of Dental Plan A benefits which are provided by Willamette Dental Group, Inc.

THE FOLLOWING ARE THE NAMES AND ADDRESSES OF ISSUERS UNDER CONTRACT WITH THE PLAN:

Delta Dental of Washington P.O. Box 759830 Seattle, WA 98175	Administers Dental Plan B benefits and provides a network of participating dentists that charge discounted rates for dental services.
Willamette Dental Group 15025 SW Farmington Beaverton, Oregon 97005	Administers Dental Plan A benefits through a network of dental clinics.
OptumRx 1600 McConnor Parkway Schaumburg, Il 60173-6801	A prescription benefit manager that provides Pharmacy network management, mail order and specialty drug services.
Vision Service Plan, Inc. (VSP) 6120 Capitol Blvd. NE Tumwater, WA 98501	Administers vision care services and provides a network of vision care providers
Premera Blue Cross 7001 220th St. S.W. Building 3, M.S. 323 Mountlake Terrace, WA. 98053-2124	Provides a network of medical providers that provide discounts for medical services; Prior Authorization for certain medical services; Personal Health Services; 24-Hour NurseLine; BestBeginnings and Teladoc
Advantria 255 N. Sierra St., Suite 1207 Reno, NV 89501	Administers re-pricing services for dialysis

STATEMENT OF ERISA RIGHTS

As a Participant in the Northwest Laborers-Employers Health and Security Trust, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan Participants shall be entitled to:

Receive Information about Your Plan and Benefits

1. Examine, without charge, at the Trust Office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
2. Obtain, upon written request to the Plan administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective 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.
3. 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 Group Health Plan Coverage

Continue health care 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 on the rules governing your COBRA continuation coverage rights.

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

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

Under ERISA, there are steps you can take to enforce the above rights. For instance:

1. If you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator.

2. If you have a claim for benefits which is denied or ignored, in whole or in part, you may request a hearing before the Board of Trustees. If you are dissatisfied with the determination of the Trustees, you may file suit in a state or Federal court. In addition, if you disagree with the Plan decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in Federal court.
3. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your Plan, you should contact the 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 Department of Labor at one of the following addresses:

Employee Benefits Security Administration
U.S. Department of Labor
Seattle District Office
300 Fifth Avenue, Suite 1110
Seattle, WA 98104
Phone - 206-757-6781

Division of Technical Assistance and Inquiries
Employee Benefits Security Administration
U.S. Department of Labor
200 Constitution Ave. NW
Washington, D.C. 20210

You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

Amendment and Termination

In order that the Plan may carry out its obligation to maintain, within the limits of its resources, a program dedicated to providing the maximum possible benefits for all Participants, the Board of Trustees expressly reserves the right, in its sole discretion at any time and from time to time, upon a non-discriminatory basis, to:

1. Terminate or amend the Plan;
2. Alter or postpone the method of payment of any benefit;
3. Construe the provisions of the Plan and determine any and all questions pertaining to administration, eligibility, and benefit entitlement, including the right to remedy possible ambiguities and inconsistencies or omissions. Any construction or determination by the Trustees made in good faith shall be conclusive on all persons affected thereby;
4. Reduce or eliminate any Plan subsidy; and

5. Amend or rescind any other provision of this Plan.

The Trust may be terminated by the Employers and union by an instrument in writing executed by mutual consent at any time, subject, however, to all the requirements and procedures for Plan termination under ERISA and all regulations issued there under. Upon voluntary termination of the Trust, all assets remaining in the Trust after payment of all expenses shall be used for the continuance of benefits provided in the Plan until such assets have been depleted. Any such voluntary termination shall be performed in accordance with ERISA and applicable governmental regulations.

Benefits Not Guaranteed

None of the benefits provided by this Plan are insured by any contract of insurance, except the dental benefits provided by Willamette Dental Group. There is no liability on the Board of Trustees or any other individual or entity to provide payments over and beyond the amount in the Trust that was collected and available for such purpose. No Employee, Retiree, or Dependent shall have any accrued or vested rights to benefits under this Plan.