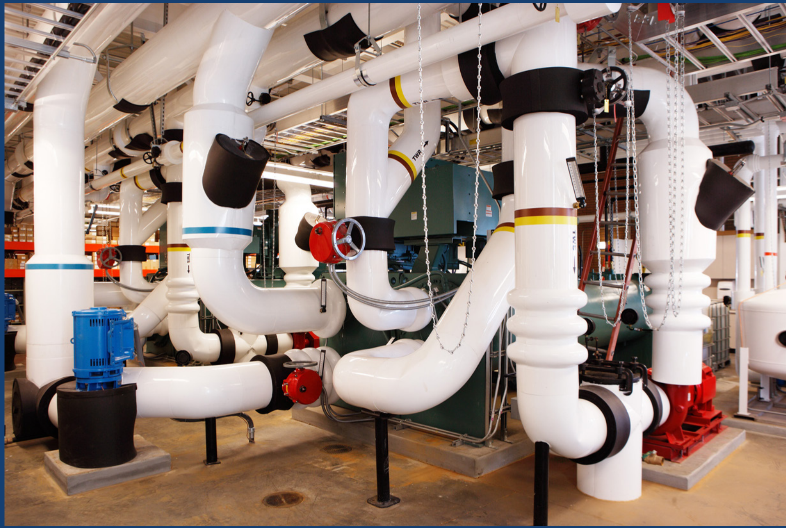

Northwest Insulation Workers Welfare Trust

Summary Plan Description

2019

Northwest Insulation Workers Welfare Trust | Summary Plan Description 2019

Northwest Insulation Workers Welfare Trust

Physical Address 7525 SE 24th Street, Suite 200, Mercer Island, WA 98040 • Mailing Address PO Box 34203, Seattle, WA 98124
Phone (844) 811-6789 • Fax (206) 505-9727 • Website www.nwinsulationtrust.com

Administered by
Welfare & Pension Administration Service, Inc.

August 8, 2019

TO: **All Plan Participants**
Northwest Insulation Workers Welfare Trust

RE: **Benefit Changes Effective October 1, 2019**

This is a Summary of Material Modification describing changes adopted by the Board of Trustees. Please be sure that you and your family read this information carefully and keep it with your Plan Booklet.

The changes described in this Summary of Material Modifications are **effective October 1, 2019.**

- **Physical Therapy Benefit Limits.** Effective October 1, 2019, the annual physical, occupational and speech therapy benefit is limited to a combined maximum of 30 visits per calendar year as medically necessary. Medically necessary therapy services for treatment of a mental health condition do not apply toward the 30 visit maximum benefit.

- **Recovery of Overpayments from Providers.** The Board of Trustees have adopted the provision regarding recovery of overpayments from in-network providers:

  Recovery of overpayments
  In the event that through mistake or inadvertence or any other circumstance, a Covered Person or other individual has been paid or credited with more than the individual is entitled to under the Plan or under the law, the payment or credit will not constitute a waiver of applicable Plan provisions, including any limitation or exclusion. The Trust may set off, recoup or recover the amount of overpayment or excess credit accrued or thereafter accruing from the Covered Person or other individual, or it may offset future benefit payments due to the Covered Person or the Covered Person's family members by the amount paid in error. The Trust may also request refunds from a provider or reduce future payments to the provider by the amount of the overpayment. The reduction or offset of future payments may involve this Plan or other health plans that are administered by the Plan's joint claim administrator/network provider - Aetna. Under this process, Aetna reduces future payments to providers by the amount of the overpayment they received, and then credit the recovered amount to the plan that overpaid the provider. Payments to providers under this Plan are subject to this same process when Aetna recovers overpayments for other plans administered by Aetna. The Trust may also take such further action as the Board shall determine.

If you have questions regarding the information outlined in this notice or benefits under the Plan, contact the Administration Office at (844) 811-6789, option 1.

Administration Office
Northwest Insulation Workers Welfare Trust

Northwest Insulation Workers Welfare Trust

Health, Dental, Vision, Weekly Disability and Life and Accidental Death Benefits

Plan Booklet and Summary Plan Description

Amended and restated January 1, 2019

NORTHWEST INSULATION WORKERS WELFARE TRUST

7525 SE 24TH ST, SUITE 200
MERCER ISLAND, WA 98040

P.O. BOX 34203
SEATTLE, WA 98124

BOARD OF TRUSTEES

EMPLOYER TRUSTEES	UNION TRUSTEES
Kenneth Gritter, Chairman	Todd Mitchell, Secretary
Matthew Loya	Nolan Olson
Britt Freel	Michael Loberg
Terry Philley (Alt. Trustee)	Gary Phillips (Alt Trustee)

LEGAL COUNSEL
McKenzie Rothwell Barlow & Coughran, P.S.

CONSULTANT
Propel Insurance

ADMINISTRATION OFFICE
Welfare & Pension Administration Service, Inc.

AUDITOR
Bjorklund & Montplaisir

NORTHWEST INSULATIONS WORKERS WELFARE TRUST

To All Concerned:

This Summary Plan Description/Plan Booklet describes the benefits available through the Northwest Insulation Workers Welfare Trust's ("Trust") Plan. This Booklet contains descriptions of Medical, Prescription Drug, Weekly Income for Disability, Dental and Vision benefits provided directly by the Trust, and constitutes the Plan document for those benefits. This Booklet also contains a summary of Life Insurance and Accidental Death and Dismemberment benefits which are provided under an insurance policy between the Trust and Aetna. This Booklet replaces all other plan Booklet/Summary Plan Descriptions previously provided to you.

The Board of Trustees has the right to amend, change or discontinue the types and amounts of Plan benefits, and the rules determining who is eligible for Plan benefits. The Board of Trustees and its Appeals Committee are granted the sole discretionary authority to make any and all determinations under the Plan, including who is eligible for benefits, the amount of benefits payable (if any), and the meaning and applicability of Plan provisions. Any such determinations shall be conclusive and binding on all parties having dealings with the Plan. No individual trustee, employer, employer association, or union, or any individual employed thereby, is authorized to change or interpret this Plan on behalf of the Board of Trustees.

The nature and amount of Plan benefits are always subject to the actual terms of the Plan as it exists at the time the product is dispensed or the services giving rise to the claim are provided, or in the case of Life Insurance or Accidental Death and Dismemberment benefits, the event giving rise to the claim occurs.

IMPORTANT INFORMATION

Northwest Insulation Workers Welfare Trust is committed to maintaining health care coverage for employees and their families at an affordable cost, however, because future conditions cannot be predicted, the Plan reserves the right to amend or terminate coverages at any time and for any reason. These are not guaranteed lifetime benefits. Also, your eligibility or right to benefits under this Plan should not be interpreted as a guarantee of employment.

As the Plan is amended from time to time, you will be sent information explaining the changes. If those later notices describe a benefit or procedure that is different from what is described here, you should rely on the later information.

We encourage you to read this Booklet carefully prior to obtaining health care. Remember, not every expense you incur for health care is covered by the Plan. If you have questions about Plan benefits, please contact the Administration Office.

Important Note: Please give special attention to the cost containment features designed by the Trustees to control costs without reducing the level of Medically Necessary care available to you. The Board of Trustees has entered into Preferred Provider arrangements with a network of health care providers that offer their services at negotiated rates to Plan participants. Contact the Administration Office for more information.

Sincerely,

Board of Trustees

WEBSITE AVAILABLE

The Trust and the Administration Office have established a website to provide you with immediate access to your Plan information. The site, located at www.nwinsulationtrust.com, includes the following Trust Fund-related material: forms, legal documents, Plan booklets, links to useful sites, and Local Union contact information.

This site also provides a link to your personal benefit information, which may be viewed through a secure location requiring the entry of a Personal Identification Number (PIN) and your WPAS ID or Social Security Number. A PIN will be assigned and mailed to you upon your written request. To request a PIN, complete a "PIN REQUEST FORM," which can be printed from the website. For security purposes, you *may not* choose your own PIN. "My Personal Benefits" information includes the following data:

- Personal Information – name, address, gender, birth date, marital status, etc.
- Health Eligibility – eligibility in the current and past seven months
- Hours/Contributions – statement showing employers reporting hours
- Dependent Enrollment Information

TABLE OF CONTENTS

QUICK REFERENCE CHART 6
ELIGIBILITY FOR ACTIVE EMPLOYEES AND THEIR DEPENDENTS 8
DEPENDENT ELIGIBILITY 11
CONTINUATION OF COVERAGE 14
COVERAGE FOR RETIRED EMPLOYEES AND THEIR DEPENDENTS 23
HOW YOUR MEDICAL PLAN WORKS 27
REQUIREMENTS FOR COVERAGE 33
WHAT THE PLAN COVERS 34
PHARMACY BENEFIT PLAN 65
VISION BENEFIT PLAN 73
DENTAL BENEFIT PLAN 75
WEEKLY DISABILITY INCOME BENEFITS 82
LIFE INSURANCE AND ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D) BENEFITS 83
COORDINATION OF BENEFITS 90
COORDINATION WITH MEDICARE 95
THIRD-PARTY REIMBURSEMENT AND OVERPAYMENTS 97
BENEFIT CLAIMS PROCESSING, DENIALS AND APPEALS 100
GLOSSARY 108
INFORMATION REQUIRED BY THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974 121
STATEMENT OF RIGHTS UNDER EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974 127
HIPAA PRIVACY DISCLOSURES AND CERTIFICATION 129
NORTHWEST INSULATION WORKERS WELFARE TRUST NOTICE OF PRIVACY PRACTICES 131

QUICK REFERENCE CHART

When you need information, please check this Booklet first. If you need further help, call the people listed in the following ***Quick Reference Chart:***

Information Needed	Whom To Contact
Claim Forms – Medical Provider Directories – Medical Plan Benefit Information - Medical, and Vision	**Administration Office** (844) 811-6789 www.nwinsulationtrust.com
Claim Forms - Prescription Drug and Dental Provider Directories – Prescription Drug and Dental Retail Network Pharmacies Plan Benefit Information - Prescription Drug and Dental	**Aetna** Aetna Pharmacy Management: (888) 792-3862 Aetna Rx Home Delivery: (800) 227-5720 Aetna Dental: (877) 238-6200 www.aetna.com
Claim Forms **Provider Directories**	**Vision Service Plan (VSP)** PO Box 385018 Birmingham, AL 35238-5018 Telephone: 800-877-7195 www.vsp.com
Administration Office Eligibility for Active Employees, Retirees, Surviving Spouses and COBRA Beneficiaries Identification Card Orders Medicare Part D Notice of Creditable Coverage Information About COBRA Coverage	**Welfare & Pension Administration Service, Inc. (WPAS)** Physical Address: 7525 SE 24th St, Suite 200 Mercer Island, WA 98040 Mailing address; P.O. Box 34203 Seattle, WA 98124-1203 (206) 441-7574 (844) 811-6789, Option 4 www.nwinsulationtrust.com
Precertification Required for inpatient admissions in a hospital, skilled nursing facility, rehabilitation facility, hospice facility, residential treatment facility for treatment of mental disorders, alcoholism or drug abuse treatment	**Aetna** (800) 370-4526 www.aetna.com

Also required for certain outpatient services. For a complete listing go to: https://www.aetna.com/health-care-professionals/precertification/precertification-lists.html	
Life and Accidental Death and Disability (for Active Employees and their Dependents) Life Insurance and Accidental Death and Disability Network and Provider Directory Administers Life Insurance and Accidental Death and Disability benefits	**Administration Office** (844) 811-6789 www.nwinsulationtrust.com
Time Loss and Short Term Disability (for Active Employees only) Administers Time Loss and Short Term Disability benefits	**Administration Office** (844) 811-6789 www.nwinsulationtrust.com
HIPAA Privacy Officer **and HIPAA Security Officer** HIPAA Notice of Privacy Practice	**Privacy Official** WPAS, Inc. P.O. Box 34203 Seattle, WA 98124 (206) 441-7574 (844) 811-6789 Fax Number: (206) 441-9110

IMPORTANT

You have a limited amount of time from the date Covered Expenses are incurred to submit claims to the Administration Office for payment.

Detailed information concerning these time limits as well as your rights to appeal denied claims can be found in the "HOW TO FILE A CLAIM" and "CLAIMS REVIEW PROCEDURE" sections of this Booklet.

ELIGIBILITY FOR ACTIVE EMPLOYEES AND THEIR DEPENDENTS

Eligibility for Employees Covered by a Collective Bargaining Agreement

Initial Eligibility Under a Collective Bargaining Agreement

If contributions are received on behalf of an Employee covered by a collective bargaining agreement, the Administration Office will set up an Hour Bank on his/her behalf. The Trust will credit to the Employee's Hour Bank all hours worked in a job classification covered by a collective bargaining agreement and contributed on by your employers.

A new Employee will become eligible for benefits after he has **440 or more hours** credited to his Hour Bank within the preceding twelve (12) month reporting period, provided however that at least three full calendar months have elapsed since the first credited hour of employment. Effective January 1, 2019, a new Employee will become eligible for benefits after he has **330 or more hours** credited to his Hour Bank within the preceding twelve (12) month reporting period, provided however that at least two full calendar months have elapsed since the first credited hour of employment.

Once the Employee has 440 hours reported to his Hour Bank (or 330 hours effective January 1, 2019) within the preceding twelve-month reporting period, coverage will begin the first day of the following month. The work month is the month the hours are actually worked, the reporting month is the following month (lag month) and the eligibility month is month of coverage. The lag month provides sufficient time for receiving and processing employer reports. The following examples illustrates how initial eligibility and the lag month work:

▪ **Example 1**							
Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Month 7	Month 8
You work 440 covered hours						Lag month	Coverage begins

▪ **Example 2**				
Month 1	Month 2	Month 3	Month 4	Month 5
You work 440 covered hours			Lag month	Coverage begins

▪ **Example 3 (Effective January 1, 2019)**			
Month 1	Month 2	Month 3	Month 4
You work 330 covered hours		Lag month	Coverage begins

Continuing Eligibility Under a Collective Bargaining Agreement

Once the Employee satisfies the initial eligibility requirements, 140 hours are deducted from his Hour Bank to provide one month of eligibility. The maximum number of hours in an Employee's Hour Bank may not exceed 840 hours (enough for six (6) months of coverage). Any hours

reported and paid above the maximum of 840 hours will not be added to the Employee's Hour Bank and will be used to fund the Plan. The Employee remains eligible as long as his Hour Bank does not fall below 140 hours.

For Example: If at the end of March, the number of hours in the Employee's Hour Bank totaled 650, 140 hours would be deducted for April's eligibility, and 510 hours would remain in the Employee's Hour Bank for future eligibility. Any additional hours reported during March would then be added to the Employee's Hour Bank, provided the total number of hours does not exceed 840.

Contributions Must Be Paid to Receive Hour Bank Credit

The Employee's Hour Bank will not be credited with hours, unless the required contributions are actually paid by the Employee's employer.

Eligibility for Employees Covered by a Contribution or Associate Agreement (non-Collectively Bargained Employees)

If the Employee's is not covered by a Collective Bargaining Agreement, the Employee's may only participate in the Plan if the Employee's employer signs a written Contribution Agreement (e.g., Associate Agreement) with the Trustees. Generally, owners, spouses of owners, and certain supervisory or management employees may only participate under a Contribution Agreement. Participation under a Contribution Agreement is subject to the terms in that agreement and the Trustees' Policy Regarding Associate Employees.

The initial and ongoing eligibility requirements for Employees participating under a Contribution Agreement are the same as for active Employees participating under a Collective Bargaining Agreement.

Termination of Hour Bank Eligibility

Your coverage ends on the earliest of:

- The last day of the month preceding the month in which the Employee's Hour Bank has less than the minimum hours required for a month of eligibility;
- On the date of the Employee's death; or
- On the date the Plan no longer provides benefits.

Following termination of the Employee's Hour Bank eligibility, there may be options for continuing coverage, as explained below under "COBRA Continuation Coverage" and "Coverage Options in Lieu of COBRA."

Reinstatement of Hour Bank Eligibility Following Termination

If Hour Bank eligibility terminates, the Employee must reinstate it, as described above, within twelve (12) months to avoid having to meet the initial eligibility requirements again.

If coverage terminates because the Employee's Hour Bank has less than the minimum required for a month of eligibility, the balance of the Employee's hours (if any) will be carried for twelve (12) months. If, during that 12-month period the Employee works and add hours to his account, his eligibility will be reinstated on the first day of the second month following the month in which the Employee's Hour Bank account has accumulated sufficient hours for a month of eligibility.

For Example**:** If the Employee works under a Collective Bargaining Agreement and his last month of coverage was in August 2015 and his Hour Bank drops below 140 hours, the last month he could be reinstated through additional hours credited to his Hour Bank would be August 2016. In this example, the 12-month period to work and add hours to the Employee's

Hour Bank account would include hours worked through June 2016. If the Employee worked enough hours in June 2016 to bring his Hour Bank up to 140 hours, then July 2016 would be the lag month and coverage would be reinstated as of August 1, 2016.

If the Employee does not reinstate his coverage during the 12-month period following termination, the balance of his hours (if any) will be forfeited and he must re-satisfy the provisions of Initial Eligibility in order to be covered by the Plan.

DEPENDENT ELIGIBILITY

Dependent Eligibility

The Employee's Dependents are eligible for coverage from the Plan. The Employee's Dependents become eligible on the effective date of the Employee's eligibility, or if later, the date the Dependent is acquired.

Definition of Dependent

Your eligible Dependents are:

- The lawful spouse of an Employee or Retired Employee (even if legally separated). The spouse must be legally married to the Employee or Retired Employee as determined under federal law, and must be treated as a spouse under the Internal Revenue Code, including a legally recognized same-sex spouse.
- A child of an Employee or Retired Employee. Children of an Employee or Retired Employee include the following:
  - A natural child, stepchild, adopted child, child "placed for adoption" or "foster child" under the age of 26. The term, "placed for adoption," means the assumption and retention by the Employee or Retired Employee of a legal obligation for total or partial support of the child in anticipation of adoption. The term "foster child" means a foster child who is placed with you by an authorized placement agency or by judgment, decree, or other order of any court of competent jurisdiction.
  - A child age 26 or older and unable to engage in any substantial gainful activity by reason of a mental or physical impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months, provided the child was an Eligible Dependent and so disabled at the time of reaching the limiting age, and remains dependent upon the Employee or Retired Employee for support and maintenance. Evidence of the child's dependency and incapacity must be filed with the Administration Office within 31 days after attaining the limiting age, and periodically thereafter. The Plan, at its own expense, has the right to designate a Physician to examine the Dependent when and as often as the Plan may reasonably require.
- You are required to inform the Plan if your child is eligible for group health coverage through his or her employer or spouse's employer.

Enrollment of Dependents

If the Employee has eligible dependents, it will be necessary to complete an enrollment form within 30 days of the Employee's enrollment in order to avoid delay in processing claims. Enrollment forms can be obtained from the Administration Office. Claims will not be paid until a completed enrollment form and all requested supporting documentation is received by the Administration Office. In no event will claims be paid more than 12 months after the claims are incurred.

If the Employee acquires new dependents while he has coverage, a new enrollment form must be completed and submitted along with the appropriate documentation. The Employee should complete a new enrollment form and supply an appropriate marriage or birth certificate within 30 days of your marriage, the birth of the child, or adoption or placement for adoption or as soon as reasonably practicable. Claims will not be paid until a completed enrollment form and all

requested supporting documentation is received by the Administration Office. In no event will claims be paid more than 12 months after the claims are incurred.

When Dependent Coverage Begins

Once all enrollment material is received and processed, eligibility for the Employee's dependents will be effective:

- On the date the Employee become covered.
- On the date of birth, adoption, placement for adoption, placement of foster child or the date legal custody is awarded.
- On the first day of the first calendar month following the date of the Employee's marriage for the Employee's new spouse and stepchildren.
- If the Employee's coverage has lapsed, your dependent's coverage will begin on the first day of the month when the Employee's eligibility is reinstated.

Although the Employee's dependents may be eligible on the dates identified above, claims for dependents will be suspended until all required enrollment documentation has been received by the Trust. If the required documentation is not received within 12 months after the date the claims were incurred, the claims will be denied.

Changes in Status

The Employee must notify the Administration Office if the Employee has a change in family status such as:

- Marriage or divorce.
- Birth of a child.
- Child no longer meets definition of an eligible dependent.
- Death of employee or eligible dependent.

Qualified Medical Child Support Orders

The Plan recognizes Qualified Medical Child Support Orders (QMCSO) and enrolls Dependent children as directed by the Order. A QMSCO is any judgment, decree or other (including a domestic relations settlement agreement) issued by a court or by an administrative agency under applicable state law which:

- Provides child support or health benefit coverage to a dependent child, or
- Enforces a state law relating to medical child support.

To be qualified, an order must clearly specify:

- The name and last known mailing address of the Employee,
- The name and mailing address of each dependent child covered by the order or the name and mailing address of the state official issuing the order,
- A description of the type of coverage to be provided by the Plan to each such dependent child,
- The period of coverage to which the order applies, and
- The name of each Plan to which the order applies.

An order will not be qualified if it requires the Plan to provide any type or form of benefit or any option not otherwise provided under this Plan.

If a proposed or final order is received, the Administration Office will notify the parties named in the order. A child may designate a representative to receive copies of notices with respect to the order. A proposed or final order will be reviewed to determine if it meets the definition of a QMSCO. A properly completed National Medical Support Notice issued by a state agency shall be deemed to be a QMSCO. Within a reasonable time, the parties named in the order will be notified of the decision.

If the order is qualified, the notice will give instructions for enrolling each child named in the order. A copy of the entire QMSCO and any required self-payments must be received prior to enrollment. Any child or children enrolled pursuant to the order will be subject to all provisions applicable to dependents under the Plan.

If an order is not qualified, the notice will give the specific reason for the decision. The party filing the order will be given an opportunity to correct the order or appeal the decision through the claims review procedures explained in the booklet.

Termination of Dependent Eligibility

Your Dependents' eligibility terminates on the earliest of the following occurrences:

- On the date the Employee's coverage ends; or
- On the last day of the month he or she no longer qualifies as a Dependent, as defined above; or
- On the date the Dependent fails to submit to any required medical examination or provide proof of incapacity requested by the Plan;
- In the case of the Employee's death, at the end of the month following the month in which your Hour Bank totals less than 140 hours; or
- On the date the Plan no longer provides benefits.

The Employee's dependents may be eligible to extend coverage after it would otherwise end.

If you have any questions concerning your eligibility for coverage, you should contact the Administration Office or visit the Trust website.

CONTINUATION OF COVERAGE

Coverage During a FMLA Leave Of Absence

Under the Family and Medical Leave Act ("FMLA"), an Employee may be entitled to:

- Twelve workweeks of leave in a 12-month period for:
  - The birth of a child and to care for the newborn child within one year of birth;
  - The placement with the employee of a child for adoption or foster care and to care for the newly-placed child within one year of placement;
  - The care of the Employee's spouse, child, or parent who has a serious health condition;
  - To care for the Employee's own serious health condition that makes him unable to perform the essential functions of your job; or
  - Any qualifying exigency arising out of the fact that the Employee's spouse, son, daughter, or parent is a covered military member on "covered active duty" (a qualifying exigency include things such as needing to make arrangements for child or parental care, financial support or counseling, or attend ceremonies, rest and recuperate); or
- Twenty-six workweeks of leave during a single 12-month period to care for a covered servicemen with a serious injury or illness if the Employee is the service member's spouse, son, daughter, parent, or next of kin (military caregiver leave).

If the Employee thinks he is eligible for FMLA leave, he should contact his employer as soon as possible. The Employee's employer can tell him of any other obligations under the FMLA.

While the Employee is on FMLA leave, the Employee's employer is required to continue contributions for his (and his dependents') medical, dental, and vision coverage during leave.

The FMLA applies directly to employers, not to this Trust. For clarification and/or additional information on your rights under the FMLA, contact the Department of Labor, Wage and Hour Division, at http://www.wagehour.dol.gov or call 1-866-487-9243. States may provide additional entitlements and protections.

Benefits for Disabling Condition After Termination of Hour Bank Coverage

A Totally Disabled Employee's Medical, Dental, Vision and Prescription Drug benefits will continue for six months following exhaustion of the employee's Hour Bank, provided that:

- The disability must be continuous from the date of termination to the date of treatment or service; and,
- The Covered Expenses must be incurred as a result of the disabling Injury or Illness existing on the date of termination.

For the purpose of this continuation coverage, **"Totally Disabled,"** with respect to an Employee, means the Employee is unable to perform any and every duty of the employee's occupation, is not engaged in any activity for wages or profit, and is unable to engage in any employment which the employee may be able to perform based on the employee's training, experience and abilities.

Benefits for Total Disability will be terminated at the earlier the following events:

- The Employee is no longer Totally Disabled, or becomes covered under another group health plan; or
- The Plan ceases to provide benefits.

At the end of the six-month period, the Employee may be able to elect COBRA Continuation (see the Continuation of Coverage section). The six-month period will run concurrently with any COBRA coverage.

Continuation of Eligibility for Dependents in the Event of the Death of an Active Employee

In the event an active Employee dies while covered under this Plan, the surviving Dependents of a deceased Employee may continue Medical, Vision, Prescription Drug, Dental, Life Insurance, and AD&D Insurance benefits for the duration of the Employee's Hour Bank eligibility, for up to six months.

Coverage for the Employee's Dependents will terminate sooner in the event of one of the following occurrences:

- Remarriage of the Employee's surviving spouse; or
- The Employee's Dependent ceases to be a Dependent as defined under this Plan.

When the Employee's Hour Bank eligibility has been exhausted or the surviving Dependents are no longer eligible under the Plan as a Dependent, the surviving Dependents may choose to continue certain health benefits under COBRA Continuation Coverage. The Cobra Continuation of Coverage shall be reduced by the time the surviving Dependents received hour bank eligibility. Please refer to the **Continuation of Coverage** section of this Booklet for more information.

COBRA Continuation Coverage

Pursuant to a federal law known as COBRA, and under the circumstances described below, the Employee, the Employee's lawful Dependent spouse and Dependent children each have an independent right to elect to continue Trust health coverage beyond the time coverage would ordinarily have ended. The Employee or his spouse may elect COBRA on behalf of other eligible family members. A parent or legal guardian may elect COBRA on behalf of a minor child.

Notices to Trust Concerning COBRA

The Administration Office for the Northwest Insulation Workers Welfare Trust is responsible for administering COBRA continuation rights for the Trust. All communications must be made in writing, and identify the participant and the individual requesting COBRA, the Trust's name (Northwest Insulation Workers Welfare Trust), and the qualifying event. Communications must be sent to the Administration Office at the following address:

Northwest Insulation Workers Welfare Trust
P.O. Box 34203
Seattle, WA 98124

Qualifying Events

COBRA coverage is available if the Employee or the Employee's Dependents lose coverage because of specific qualifying events. You have the right to elect continuation coverage if you would otherwise lose eligibility because of a reduction in hours of employment or termination of employment.

Your lawful Dependent spouse has the right to choose continuation coverage if he or she would otherwise lose eligibility for any of the following reasons:

- The Employee's termination of employment or reduction in hours of employment;
- Death of the Employee or Retiree; or
- Divorce from the Employee or Retiree.

A Dependent child has the right to elect continuation coverage if eligibility would otherwise be lost for any of the following reasons:

- The Employee's termination of employment or reduction in hours of employment;
- Death of the Employee or Retiree;
- Divorce of a lawful spouse from the Employee or Retiree; or
- The child no longer qualifying as an eligible Dependent under the Plan.

A child of the participating employee who is covered under the Trust's health plan pursuant to a qualified medical child support order (QMCSO) received during the Employee's period of covered employment is entitled to the same rights to elect continuation coverage as an eligible dependent child of the Employee.

<u>COBRA Notification Responsibilities</u>

The Trust offers COBRA coverage only after it has been notified of a qualifying event. The Employee or the Employee's Dependents have the responsibility to inform the Administration Office of a loss of coverage resulting from a divorce or a child losing Dependent status. The Employee or the Employee's Dependents must provide this notice to the Administration Office in writing within 60 days of the later of: the date of the qualifying event; the date coverage would be terminated as the result of the qualifying event; or the date you are first provided this notice, or another notice describing the procedure for electing COBRA. Notice of the qualifying event must identify the individual who has experienced the qualifying event; your name, if different; the qualifying event that occurred; and the Trust. Even after you have made a written election with the Administration Office you may later revoke, change or modify your election notice with a follow-up written election notice made and forwarded to the Administration Office any time before the 60 days has expired. Elections, changes or revocations must be sent to the Administration Office in writing within the 60-day period to the address listed above under "Notices to Trust Concerning COBRA."

Failure to provide timely notice will result in the Employee's coverage ending as it normally would under the terms of the Plan, and the Employee and the Employee's Dependents will lose the right to elect continuation coverage.

Your employer is responsible for informing the Trust of a qualifying event which is a termination of employment, reduction in hours or your death. The Board of Trustees reserves the right to determine whether coverage has in fact been lost due to a qualifying event.

<u>Election of COBRA</u>

Once the Administration Office has received proper notice that a qualifying event has occurred, it will notify the Employee or the Employee's Dependents of the right to elect COBRA and provide an election form. A written election must be sent to the Administration Office at the address listed above under "Notices to Trust Concerning COBRA," 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.

Failure to elect COBRA within this 60-day period will cause eligibility to end as it normally would under the terms of the Plan, and the Employee or the Employee's Dependents will lose the right to elect continuation coverage.

Available Coverage

The Employee or the Employee's or Retiree's Dependents may elect the following coverage options:

- Medical and Prescription Drug
- Medical, Prescription Drug, Dental and Vision
- Medical, Prescription Drug, Dental, Vision, Life Insurance and Accidental Death and Dismemberment Insurance.

Once the coverage option is selected, and the 60-day window for making the selection closes, the selection cannot be changed. COBRA coverage is not available for time loss benefits.

Adding New Dependents

COBRA is available to individuals who were covered under the Plan at the time of the qualifying event. However, if you elect COBRA and acquire a new Dependent through marriage, birth, adoption or placement for adoption, you may add the new Dependent to your COBRA coverage by providing written notice to the Administration Office at the address indicated above under "Notices to Trust Concerning COBRA," within 31 days of acquiring the new Dependent. The written notice must identify the Employee or Retiree, the new Dependent, and the date the new Dependent was acquired. A copy of the marriage certificate, birth certificate or adoption papers must be included with the written notice. If timely written notice is not provided to the Administration Office, you will not be entitled to add a new Dependent.

Children acquired through birth, adoption or placement for adoption who are timely enrolled in continuation coverage are entitled to extend their COBRA coverage if a second qualifying event occurs, as discussed below. Spouses and stepchildren acquired after a qualifying event are not eligible for 36 months of coverage due to a second qualifying event.

Continuous Coverage Required

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

Cost

There is a cost for COBRA. The cost for the coverage available through the Trust is set annually. The Trust can charge up to 102% of the total plan premium for COBRA coverage. If you or your Dependents are eligible for a disability extension of continuation coverage, as discussed below, the cost of the coverage may be 150% of the COBRA self-payment rate for the additional 11 months of coverage provided. Information regarding the cost will be sent with the election forms.

Monthly Self-Payments Required

You or your Dependents are responsible for the full cost of COBRA. All payments must be sent to the Administration Office at the address printed on the payment coupons. The first payment is due 45 days from the date the election form is sent to the Administration Office. The first payment must cover all months since the date coverage would have otherwise terminated. Eligibility for COBRA will not commence, nor will claims be processed until the initial payment has been made. You or your Dependents will lose the right to COBRA if the initial payment is not postmarked or received by the Administration Office by the due date.

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

<u>Length of Continuation Coverage</u>

Continuation coverage may last for up to 18 months following loss of coverage that results from a termination of employment or reduction in hours. If Hour Bank coverage was provided under the provisions for "Extended Coverage in Case of Disability," the maximum continuation period will be 18 months less the number of months of the extended disability coverage. The 18-month period may be extended as provided below for "Disabled Individuals," "Second Qualifying Event," and "Medicare Entitlement."

For all other qualifying events (death of the participant, divorce from the participant or a child no longer qualifying as a Dependent under the Plan) COBRA coverage may last for up to 36 months.

Continuation coverage will end on the last day of the monthly payment period if any one of the following occurs before the maximum available continuation period:

- A required self-payment is not postmarked or received by the Administration Office on a timely basis for the next monthly coverage period;
- You or your Dependent becomes covered under any other group health plan after the date of your COBRA election (unless the other group health plan limits or excludes coverage for a pre-existing condition of the individual seeking COBRA). You are required to notify the Administration Office when you become eligible under another group health plan;
- You or your Dependent provide written notice that you wish to terminate your coverage;
- You or your Dependent become entitled to Medicare after the date of the election of COBRA;
- The Plan terminates, or
- 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 that formerly participated in the Trust.

<u>Length of Continuation Coverage – Disabled Individuals</u>

If you or your Dependent is determined by the Social Security Administration to be disabled either before an 18-month qualifying event, or within the first 60 days of COBRA coverage, you and your Dependents can extend COBRA for up to an additional 11 months beyond the original 18 months, up to a maximum of 29 months. To obtain the additional months of coverage, you must notify the Administration Office in writing prior to the end of your initial 18-month period of COBRA coverage. A copy of the Social Security Disability Determination must be included with the written notice. Failure to give notice and provide the Social Security Disability Determination prior to the end of the initial 18-month period will cause you and your Dependents to lose the right to extend COBRA. If the disabled individual is subsequently found not to be disabled, you must notify the Administration Office within 30 days of this determination.

Continuation coverage will end on the earlier of 29 months from the loss of coverage, or the month that begins more than 30 days after the final determination has been made that the disabled individual is no longer disabled.

Length of Continuation Coverage – Second Qualifying Event

Dependents who are entitled to COBRA as the result of a participant's termination of employment or reduction of hours can extend their coverage up to a total of 36 months if a second qualifying event occurs which is the participant's death, a divorce from the participant, or a child losing Dependent status.

If a Dependent wants extended coverage as a result of a second qualifying event, he or she must notify the Administration Office in writing within 60 days of the second qualifying event. The notice must identify the qualifying event that occurred. Failure to give such timely written notice of a second qualifying event will cause the individual to lose the right to extend COBRA. In no event will COBRA extend beyond a total of 36 months.

Length of Continuation Coverage – Medicare Entitlement

If you have an 18-month qualifying event after becoming entitled to Medicare, your Dependents may continue COBRA coverage until the later of:

- 18 months from the date coverage would normally end due to the termination of employment or reduction of hours; or
- 36 months from the date you become entitled to Medicare.

Relationship Between COBRA and Medicare or Other Health Coverage

Your COBRA coverage will terminate if you become entitled to Medicare or other group health coverage after your COBRA election. If your Medicare or other group health coverage already existed when you elected COBRA, however, you can be eligible for both.

If you have Trust coverage based on COBRA and you are entitled to Medicare based on age or disability and no longer have current employment status, Medicare will pay first and the Trust will only pay secondary and coordinate with Medicare. Current employment status means you are still at work or have received short-term disability benefits for six months or less. If you have Medicare coverage based on end stage renal disease and have Trust coverage (based on COBRA or otherwise), the Trust will pay primary during the 30-month coordination period provided for by statute.

Retirees and their spouses are expected to enroll in Medicare Part A and Part B when first eligible. Even if you retire and elect COBRA in lieu of Retiree benefits, you must enroll in Medicare Part A and Part B. If you are eligible to enroll in Medicare Part A and Part B, benefits are provided by the Plan as if you are enrolled, regardless of whether you actually did enroll.

If you have other group health coverage, it will pay primary and the Trust's COBRA coverage will be secondary.

Continued Coverage While in Uniformed Service ("USERRA")

Under the Uniform Services Employment and Reemployment Rights Act ("USERRA"), you have certain rights to continue coverage if you enter military service. If you are an active Employee and you leave employment with a contributing employer for military service, you have the following options:

- You may elect to run-out your Hour Bank. When hours in your Hour Bank are less than the number required for one month of eligibility, you may elect to extend coverage by making self-payments for USERRA continuation coverage.

- You may elect to freeze your Hour Bank until you return from military service. If you freeze your Hour Bank, you still have the option of electing to self-pay for USERRA continuation coverage for up to 24 months.

Notice of Military Service

You are responsible for notifying the Administration Office that you are entering military service. If you want to freeze your Hour Bank, you must notify the Administration Office within 60 days of beginning military service. If you do not provide timely notice, your Hour Bank will continue to be used for updating eligibility each month until it is run out.

If you want to run-out your Hour Bank, and then elect USERRA continuation coverage, you must notify the Administration Office of your military service within 60 days of termination of your Hour Bank coverage. If you fail to notify the Administration Office within the 60-day time period, you will not be entitled to elect USERRA continuation coverage.

Election of USERRA Continuation Coverage

After timely notification to the Administration Office of military service, you will be sent an election form to affirmatively elect USERRA continuation coverage. Your completed election form must be sent to the Administration 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. If you do not return your election forms by the due date, you will not be allowed to elect USERRA continuation coverage.

Length of USERRA Continuation Coverage

If the Employee provides timely notice and properly elect to freeze his Hour Bank, it will be frozen the first of the month following the month in which he begins military service.

If you properly elect to freeze your Hour Bank and elect USERRA continuation coverage, the USERRA continuation coverage will begin on the first day of the month following the month in which you begin military service, provided the required self-payments are made.

If you decide to run-out your Hour Bank before commencing USERRA continuation coverage, USERRA continuation coverage will begin immediately following the date Hour Bank coverage ended, provided you properly elect USERRA continuation coverage and the required self-payments are made.

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

- 24 months following the date in which your Hour Bank coverage ended or was frozen because of your entry into military service.
- The last day of the month in which you fail to return to employment or apply for a position of reemployment within the time required by USERRA.
- The last day of the month for which a timely self-payment is not received or postmarked.

Available Coverage

The Employee may elect to self-pay for USERRA continuation coverage for himself, Employee and Dependents, or only the Employee's Dependents. The Employee may elect the following coverage options:

- Medical and Prescription Drug
- Medical, Prescription Drug, Life and AD&D
- Medical, Prescription Drug, Dental, Vision

- Medical, Prescription Drug, Dental, Vision, Life and AD&D

USERRA continuation coverage is not available for time loss benefits. Once you elect 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 Active Employees. If the Trust changes its benefits, USERRA continuation coverage will also change.

Monthly Self-Payments

If the Employee's military leave is less than 31 days, coverage is continued at no cost. The Employee will be credited with the hours necessary to keep coverage in effect as if he worked in covered employment with a contributing employer during the period of service.

If the Employee's USERRA military leave is for 31 days or more, a monthly self-payment is required for USERRA continuation coverage. The Administration Office will notify the Employee of the self-payment amount when it sends him 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 Administration 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 Administration 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 your Hour Bank coverage ended (or was frozen).

Reinstatement of Eligibility Following Military Service

If the Employee properly elected to freeze his Hour Bank when he entered military service, the balance in the Employee's Hour Bank will be carried over until he has an USERRA qualifying discharge from military service. The Employee's Hour Bank eligibility will be reinstated the first of the month of the discharge, provided he has sufficient hours for a month of coverage. Following reinstatement, Hour Bank eligibility will terminate the first day of any month the Employee's Hour Bank has less than the number of hours required for one month of eligibility at the current Hour Bank deduction rate, unless the Employee returns to employment with a contributing employer within the time period required by USERRA, as explained below.

If the Employee returns to employment with a contributing employer immediately following a qualifying discharge from military service and within the time period required by USERRA, the Employee's Hour Bank will be credited with the maximum number of hours allowed by the Plan (prior to deduction for the current month of eligibility), and eligibility will be reinstated the first of the month in which he returns to employment. If the Employee elected to freeze his Hour Bank, the frozen hours that remain on the date of reemployment, together with the credited hours, will not exceed the maximum number of hours allowed by the Plan (prior to deduction for the current month of eligibility). Hour Bank eligibility will terminate the first day of any month the Employee's Hour Bank has less than a month of eligibility. However, the Employee may be able to qualify for COBRA coverage.

If the Employee is on the out-of-work list at the local union, it is considered a return to employment with a contributing employer for purposes of reinstatement of eligibility.

The Employee is responsible for immediately notifying the Administration Office of his discharge from military service so that frozen hours can be reinstated on a timely basis. The Employee should also notify the Administration Office if he is reemployed within the time required by USERRA, so that his Hour Bank can be credited and eligibility reinstated without waiting periods.

Relationship of USERRA Continuation Coverage to COBRA

The 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. See the COBRA Continuation Coverage section.

COVERAGE FOR RETIRED EMPLOYEES AND THEIR DEPENDENTS

Retiree Eligibility

A former Employee must satisfy conditions 1) through 3) or 4) to be eligible for coverage from the Plan as a Retired Employee:

- The Employee has attained age 55 or older, or has 30 years of credited service under the Western States Asbestos Pension Fund, or the Employee is eligible for disability retirement benefits under the Western States Asbestos Pension Fund;
- The Employee is vested under the Western States Asbestos Pension Fund;
- You are not engaged in any occupation for remuneration or profit; or
- The Employee had 7,000 (6,000 for Employees retiring on or after Jan. 1, 1988) Credited Hours or Employment (as defined herein) during the 72-month period immediately preceding the date of your disability, or the effective date of disability as determined by the Social Security Administration.

Your self-pay retiree coverage will begin on the later of:

- The first of the month following your retirement date, or
- The first of the month following termination of eligibility as an Active Employee under this Plan.

If you elect Retiree coverage, you and your eligible Dependents will be covered for Medical, Prescription Drug, Vision, Life Insurance, and AD&D. Weekly Income and Dental Care benefits described in this Summary Plan Description cease when your eligibility as an active Employee terminates.

As an alternative, Retirees have the option to continue active eligibility for a limited time period of 18 months for themselves and their Dependents on a self-pay basis under COBRA Continuation Coverage. Upon exhaustion of COBRA, the Retiree and any eligible Dependents may enroll in Retiree coverage provided coverage is continuous. Refer to the COBRA continuation coverage section of this Booklet.

Enrollment and Self-Payments for Coverage

You must apply for Retiree coverage and agree to submit the monthly premiums for coverage. Premiums must be received by the Administration Office by the 15th of the month prior to the month of coverage. Please note: self-payment rates are subject to change as required by the Plan.

Coverage for disability Retirees will commence on the 1st of the month following the Administration Office's receipt of the Retiree's application for Retiree coverage, or the date of disability established by the Social Security Administration, if later.

MEDICARE ENROLLMENT–IMPORTANT! PLEASE READ

All participants, including retired participants, spouses, and dependents, regardless of age, who are otherwise eligible and entitled to participate in the federal Medicare program for benefits, are required to enroll and participate in both Parts A and B of the Medicare program. **You are required to notify the Trust Office within 60 days of becoming eligible for Medicare. If you, your spouse or your dependent fail to enroll in Medicare, benefits will be paid as if**

you were enrolled in Medicare. As a result, it is important for you and your dependent(s) to enroll in Medicare on a timely basis. You should contact your local Social Security Office regarding enrollment in Medicare before your or your dependent's 65th birthday, or if you are disabled.

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

Delay or Opt-Out of Enrollment for Retirees and Dependents

There are two exceptions to the timely enrollment requirements for retiree coverage.

First, retirees and their dependents who are not eligible for Medicare may delay applying for coverage in the Northwest Insulation Workers Retiree Plan if the retiree or the retiree's dependent has other group or individual coverage, including coverage offered through a State Health Care Exchange. To be eligible for this exception you must show that you or your Dependent had continuous coverage for the lesser of:

- 12 consecutive months prior to the application for enrollment; or
- The period between your retirement date and the date you or your dependent apply for enrollment.

Second, non-Medicare retirees and their dependents may delay enrollment or opt out of this Plan and later enroll in this Plan when the retiree or dependent becomes eligible for Medicare.

These exceptions apply on a one time basis. A non-Medicare or Medicare eligible retiree or dependent who late enrolls or re-enrolls in the Plan coverage and then drops coverage may not re-enroll in the Plan at a later date.

If a retiree or dependent initially enrolled on the date they became eligible for coverage, the retiree or dependent may, on a one time basis, opt-out of coverage in the Plan. The retiree or dependent may then re-enroll coverage when the retiree or dependent is Medicare eligible or before the retiree or dependent is Medicare eligible if the retiree or dependent is able to show that he or she has other group or individual coverage from the first day of the month following the date of the opt-out through the date of the application for re-enrollment.

If the retiree or retiree's dependents decide to delay enrollment, the retiree and retiree's dependents must meet the following requirements:

- The retiree and retiree's dependents must enroll within 30 days after the other health coverage ends or 30 days after becoming eligible for Medicare.
- The retiree and retiree's dependent must meet the eligibility requirements of this plan on the date enrollment is sought.
- For the retiree's dependents' late enrollment, the retiree must be enrolled and participating in the plan on the date enrollment is sought.
- If the retiree and retiree's dependents' other coverage was under COBRA, the COBRA coverage must be exhausted to be eligible for delayed enrollment. COBRA coverage is not considered exhausted if the COBRA coverage is lost solely because the applicable COBRA premium was not paid on a timely basis.

Coverage or late enrolled or re-enrolled retirees or dependents will be effective on the first day of the month, following the date of a completed application provided that the appropriate premium is received and all other plan conditions are satisfied.

Enrollment of Dependents of Retirees

Eligible dependents under the Retiree Plan are the same as those under the Active Plan.

Your eligible dependents may enroll when you first become eligible by completing an enrollment form within 30 days of your eligibility date. If an enrollment form is not on file at the Administration Office, claims for that dependent will not be paid until a completed enrollment form is returned to the Administration Office.

If an eligible dependent does not enroll when first eligible, the dependent will not be able to enroll at a later date unless you or your dependent has a right to delay enrollment.

Coverage for your eligible dependents will generally begin the later of the date your coverage begins or the first day of the month following the date a completed application and premium is received. Dependents you acquire after your coverage is effective may be covered on the date they become an eligible dependent.

You and your dependents must be enrolled for the same health care benefits including, as applicable, medical, prescription drug, life insurance, and AD&D, except as provided by law. No dependent coverage is available for Weekly Income Coverage (Time Loss) which covers only the active Employees. Enrollment forms are available from the Administration Office.

Changes in Status

You must notify the Administration Office if you have a change in family status such as:

- Marriage or divorce.
- Birth of a child.
- Child no longer meets definition of an eligible dependent.
- Death of retiree or covered spouse.
- Remarriage of surviving spouse of a retiree.
- Retiree returns to work or returns to retired status after a period of working.
- Retiree becomes eligible for Medicare and cancels his or her coverage, but wishes to continue coverage for a spouse until the spouse is eligible for Medicare.

Accurate and efficient claims processing depends on the Administration Office having current information. Remember to advise the Administration Office promptly of these changes by completing a revised enrollment form.

Termination of Retiree Eligibility

Coverage for a Retired Employee and his Dependents ends on the earliest of:

- The last day of the month for which no self-payment is received on your behalf;
- The last day of the month in which the Retired Employee dies (subject to continuation of Dependent eligibility, below);
- On the date the Plan no longer provides benefits for Retired Employees; or
- The Plan no longer provides benefits.

Once Retiree coverage ends it cannot be reinstated.

Continuation of Eligibility for Dependents in the Event of Death of a Retired Employee

In the event of the Retiree's death, the surviving spouse and Dependents may apply to self-pay for Retiree coverage for six months following the death of the Retired Employee and for COBRA coverage. Retiree Coverage will run concurrent with COBRA. See the Continuation of Coverage Section on page 14. Coverage includes the same benefits as provided to the Retiree: Medical, and Prescription Drug. Premiums must be received by the Administration Office on the 15th of the month prior to the month of coverage. Contact the Administration Office for information regarding self-payments.

Coverage will end if the required monthly self-payment is not made by the 15th of the month before the month of coverage.

Notice of Death of Dependent

If your Dependent dies, it is your responsibility to notify the Administration Office. The notice must be in writing, and sent to the address listed in the Quick Reference Guide. If you fail to notify the Administration Office, and self-payments for Retiree Coverage continue to be made on behalf of the Plan, any refund of self-payments will be limited to six months of payments.

Notice of Medicare Eligibility

If you or your Dependent becomes eligible for Medicare, it is your responsibility to send a copy of your Medicare card to the Administration Office to the address listed in the Quick Reference Guide. Your amount of the self-payments for Retiree Coverage will then be adjusted to take into account your Medicare eligibility. If you fail to notify the Administration Office, and as a result your self-payments are not adjusted, any refunds will be limited to six months of overpayments.

HOW YOUR MEDICAL PLAN WORKS

About Your Medical Plan

This plan provides coverage for a wide range of medical expenses for the treatment of illness or injury. The plan also provides coverage for certain preventive and wellness benefits. Coverage is subject to all of the terms, policies and procedures outlined in this Booklet. Not all medical expenses are covered under the plan. Exclusions and limitations apply to certain medical services, supplies and expenses. Refer to the *What the Plan Covers* and the *Exclusions, Limitations* sections to determine if medical services are covered, excluded or limited.

The following are important terms and components of this Plan and discussed more fully in the following sections:

- Annual Deductible
- Copays
- Coinsurance
- Annual Out-of-Pocket Maximum
- PPO Network
- Precertification

Annual Deductible

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

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

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

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

The following services are not subject to the annual deductible:

- Immunizations
- Preventive care services performed by a PPO provider
- Physical exams (including well baby exams)

Copays

The plan requires you to pay a copay for each physician office visit, emergency room visit and non-emergency inpatient stay as follows:

Copay	Per Office Visit/ Specialist Visit	Urgent Care Visit	Per ER Visit	Per Inpatient Stay
PPO providers	$30 (no deductible, no coinsurance)	$50	$100	$200

The copays set-forth above generally apply to all PPO provider visits and non-PPO provider visits; however, the copays may be different than what is set forth above, depending on the nature of the services and where they are received. See the Plan's Summaries of Benefits and Coverage for additional copay information.

For both PPO and non-PPO office and specialist visits in Alaska, the Plan charges a $30 copay (no deductible, no coinsurance).

For PPO office and specialist visits in all other States, the Plan charges a $30 copay (no deductible, no coinsurance). For non-PPO physician and specialists visits in all other States, the Plan charges 70% coinsurance after deductible, (no copay).

Coinsurance

Once you have met the deductible and any applicable copays, the plan typically covers 80% of the Recognized Charge for covered services and 70% of non-PPO providers' usual and customary (U & C) charges for covered services.

PPO providers	80% of the Recognized Charge
Non-PPO providers	70% of the Recognized Charge

The coinsurance set-forth above generally apply to all PPO provider visits and non-PPO provider visits; however, the coinsurance may be different than what is set forth above, depending on the nature of the services and where they are received. See the Plan's Summaries of Benefits and Coverage for additional coinsurance information.

Annual Out-of-Pocket Maximum (applies to PPO and Non-PPO Providers)

Once your total out-of-pocket expenses (including deductibles, coinsurance and copays) reaches the amounts below, all deductibles, coinsurance and copays are waived for the remainder of the calendar year.

	Medical Out-Of-Pocket Max	Prescription Out-Of-Pocket Max
Per person/calendar year	$2,000	$2,000
Per family/calendar year	$6,000	$6,000

For example, if one individual in a family reaches the medical out-of-pocket maximum of $2,000, then the Plan will pay the rest of individual's claims incurred in the calendar year at 100%. If three or more individuals in a family reach the family medical out-of-packet maximum of $6,000, then the Plan will pay the rest of the family's claims incurred in the calendar year at 100%.

PPO Network

The Trust has contracted with Aetna to provide a Preferred Provider Organization (PPO) network to the plan. Pursuant to this PPO network contract, the plan pays benefits based on the Recognized Charge for both network "PPO" providers and out-of-network "non-PPO" providers.

Recognized Charge for PPO Providers: The Recognized Charge is the provider's discounted charge which it has contractually agreed to in its contract with the Plan's PPO network: This is the amount the preferred provider has agreed to accept as full payment for covered health care services or supplies.

Recognized Charge for Non-PPO Providers: The Recognized Charge is the Usual, Customary and Reasonable (UCR) charge determined by the Plan.

Your coinsurance will generally be lower when you use PPO providers and facilities. You always have the choice to access all licensed providers and facilities; however, your out-of-pocket costs will generally be higher when you use non-PPO provider because expenses billed in excess of the Recognized Charge do not apply to the annual out-of-pocket maximum. Additionally, non-PPO providers have not agreed to accept the negotiated charge and may bill you for charges over the Recognized Charge.

A service or supply will be treated as a covered expense under the Other Health Care benefits category when Aetna determines that a network provider is not available to provide the service or supply. This includes situations in which you are admitted to a network hospital and non-network physicians, who provide services to you during your stay, bill you separately from the network hospital. In those instances, the Recognized Charge for that service or supply is the lesser of:

- What the provider bills or submits for that service or supply; or
- For professional services the 90th percentile of the Prevailing Charge Rate for the geographic area where the service is furnished.

If Aetna has an agreement with a provider (directly, or indirectly through a third party) which sets the rate that Aetna will pay for a service or supply, then the Recognized Charge is the rate established in such agreement.

Aetna may also reduce the Recognized Charge by applying Aetna Reimbursement Policies. Aetna Reimbursement Policies address the appropriate billing of services, taking into account factors that are relevant to the cost of the service such as:

- the duration and complexity of a service;
- whether multiple procedures are billed at the same time, but no additional overhead is required;
- whether an assistant surgeon is involved and necessary for the service;
- if follow up care is included;
- whether there are any other characteristics that may modify or make a particular service unique; and

- when a charge includes more than one claim line, whether any services described by a claim line are part of or incidental to the primary service provided.

Aetna Reimbursement Policies are based on Aetna's review of: the policies developed for Medicare; the generally accepted standards of medical and dental practice, which are based on credible scientific evidence published in peer- reviewed literature generally recognized by the relevant medical or dental community or which is otherwise consistent with physician or dental specialty society recommendations; and the views of physicians and dentists practicing in the relevant clinical areas. Aetna uses a commercial software package to administer some of these policies.

Accessing Network Providers and Benefits

You may select any network provider from the Aetna provider directory or by logging on to Aetna’s website at www.aetna.com/docfind. You can search Aetna’s online directory, DocFind® Choice POS II (Open Access) option, for names and locations of physicians, hospitals and other health care providers and facilities. You can change your health care provider at any time.

If a service or supply you need is covered under the plan but not available from a network provider, please contact Member Services at the toll-free number on your ID card for assistance.

Precertification

See the most current Pre-Certification requirements at the following link:

https://www.aetna.com/health-care-professionals/precertification/precertification-lists.html.

The following services and supplies require precertification by Aetna:

- Stays in a hospital
- Stays in a skilled nursing facility
- Stays in a rehabilitation facility
- Stays in a hospice facility
- Outpatient hospice care
- Stays in a residential treatment facility for treatment of mental disorders, alcoholism or drug abuse treatment
- Private duty nursing care

You or a member of your family, a hospital staff member, or the attending physician, must notify Aetna to pre-certify the admission or medical services and expenses prior to receiving any of the services or supplies that require precertification pursuant to this plan.

Precertification should be secured within the timeframes specified below. To obtain precertification, call Aetna at the telephone number listed on your ID card. This call must be made:

For non-emergency admissions:	Your physician or the facility will need to call and request precertification at least 21 days before the date you are scheduled to be admitted.

For an emergency outpatient medical condition:	Your physician or the facility should call prior to the outpatient care, treatment or procedure if possible; or within 48 hours.
For an emergency admission:	Your physician or the facility must call within 24 hours or as soon as reasonably possible after you have been admitted.
For an urgent admission:	Your physician or the facility will need to call before you are scheduled to be admitted. An urgent admission is a hospital admission by a physician due to the onset of or change in an illness; the diagnosis of an illness; or an injury.
For outpatient non-emergency medical services requiring precertification:	Your physician must call at least 21days before the outpatient care is provided, or the treatment or procedure is scheduled.

Aetna will provide a written notification to you, your physician and facility of the precertification decision. If your precertified expenses are approved the approval is good for 60 days as long as you remain enrolled in the plan.

If precertification determines that the stay or services and supplies are not covered expenses, the notification will explain why and how Aetna's decision can be appealed. You or your provider may request a review of the precertification decision pursuant to the Claims and Appeals section included with this Booklet.

How Failure to Precertify Affects Your Benefits

A precertification benefit reduction of **$400** will be applied to the benefits paid if you fail to obtain a required precertification prior to incurring medical expenses. This means the Plan will reduce the amount paid towards your coverage, or your expenses may not be covered. You will be responsible for the unpaid balance of the bills.

It is your responsibility to ensure that your Provider obtains the necessary precertification from Aetna prior to receiving services from an out- of-network provider. Your provider may precertify your treatment for you; however, you should verify with the Administration Office prior to the procedure, that the provider has obtained precertification from Aetna. If your treatment is not precertified by your provider, the benefit payable may be significantly reduced or your expenses may not be covered.

How Your Benefits are Affected

The chart below illustrates the effect on your benefits if necessary precertification is not obtained.

If precertification is:	then the expenses are:
▪ requested and approved by Aetna.	covered.
▪ requested and denied.	not covered, may be appealed.

If precertification is:	then the expenses are:
▪ not requested, but would have been covered if requested.	covered after a precertification benefit reduction of $400 is applied.
▪ not requested, would not have been covered if requested.	not covered, may be appealed.

It is important to remember that any additional out-of-pocket expenses incurred because your precertification requirement was not met will not count toward your deductible or payment limit or maximum out-of-pocket limit.

REQUIREMENTS FOR COVERAGE

To be covered by the plan, services, supplies and prescription drugs must meet the following requirements:

1. The service, supply or prescription must:
   - Be included as a covered expense in this Booklet;
   - Not be an excluded expense under this Booklet. Refer to the *Exclusions* sections of this Booklet for a list of services and supplies that are excluded;
   - Not exceed the maximums and limitations outlined in this Booklet. Refer to the *What the Plan Covers* section for information about certain expense limits; and
   - Be obtained in accordance with all the terms, policies and procedures outlined in this Booklet.
2. The service or supply or prescription drug must be provided while coverage is in effect.
3. The service or supply or prescription drug must be medically necessary. To meet this requirement, the medical services, supply or prescription drug must be provided by a physician, or other health care provider, exercising prudent clinical judgment, to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms. The provision of the service or supply must be:
   - In accordance with generally accepted standards of medical practice;
   - Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease;
   - Not primarily for the convenience of the patient, physician or other health care provider; and
   - Not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury, or disease.

For these purposes "generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, or otherwise consistent with physician specialty society recommendations and the views of physicians practicing in relevant clinical areas and any other relevant factors.

Preventive Care

The Plan coverers the preventive care listed in this section at 100% without copays if provided by a PPO provider. Preventive care provided by Non-PPO providers is subject to the Plan's normal copays and coinsurance. All preventive benefits may be subject to frequency and visit limits.

Routine Physical Exams

Covered expenses include charges made by your physician for routine physical exams. This includes routine vision and hearing screenings given as part of the routine physical exam. A routine exam is a medical exam given by a physician for a reason other than to diagnose or treat a suspected or identified illness or injury, and also includes:

- Evidence-based items that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force.
- Screenings and counseling services as provided for in the comprehensive guidelines recommended by the Health Resources and Services Administration. These services may include but are not limited to:
  - Screening and counseling services, such as:
    - Interpersonal and domestic violence;
    - Sexually transmitted diseases; and
    - Human Immune Deficiency Virus (HIV) infections.
  - Screening for gestational diabetes for women.
  - High risk Human Papillomavirus (HPV) DNA testing for women age 30 and older.
- X-rays, lab and other tests given in connection with the exam.
- For covered newborns, an initial hospital check-up.

Unless specified above, not covered under this Preventive Care benefit are charges for:

- Services which are for diagnosis or treatment of a suspected or identified illness or injury;
- Exams given during your stay for medical care.

Preventive Care Immunizations

Covered expenses include charges made by your physician or a facility for immunizations for infectious diseases; and the materials for administration of immunizations that have been recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.

Not covered under this Preventive Care benefit are charges incurred for immunizations that are not considered Preventive Care such as those required due to your employment or travel.

Well Woman Preventive Visits

Covered expenses include charges made by your physician for a routine well woman preventive exam office visit, including Pap smears, in accordance with the recommendations by the Health Resources and Services Administration. A routine well woman preventive exam is a medical

exam given by a physician for a reason other than to diagnose or treat a suspected or identified illness or injury.

Unless specified above, not covered under this Preventive Care benefit are charges for:

- Services which are for diagnosis or treatment of a suspected or identified illness or injury;
- Exams given during your stay for medical care.

Routine Cancer Screenings

Covered expenses include, but are not limited to, charges incurred for routine cancer screening as follows:

- Mammograms;
- Fecal occult blood tests;
- Digital rectal exams;
- Prostate specific antigen (PSA) tests;
- Sigmoidoscopies;
- Double contrast barium enemas (DCBE); and
- Colonoscopies.

These benefits will be subject to any age; family history; and frequency guidelines that are:

- Evidence-based items or services that have in effect a rating of A or B in the recommendations of the United States Preventive Services Task Force; and
- Evidence-informed items or services provided in the comprehensive guidelines supported by the Health Resources and Services Administration.

Screening and Counseling Services

Covered expenses include charges made by your physician in an individual or group setting for the following:

- Obesity screening and counseling services to aid in weight reduction due to obesity.
- Screening and counseling services to aid in the prevention or reduction of the use of an alcohol agent or controlled substance. Coverage includes preventive counseling visits, risk factor reduction intervention and a structured assessment.
- Screening and counseling services to aid in the cessation of the use of tobacco products. Tobacco product means a substance containing tobacco or nicotine including: cigarettes, cigars; smoking tobacco; snuff; smokeless tobacco and candy-like products that contain tobacco.

Prenatal Care

Prenatal care will be covered as Preventive Care for services received by a pregnant female in a physician's, obstetrician's, or gynecologist's office but only to the extent described below.

Coverage for prenatal care under this Preventive Care benefit is limited to pregnancy-related physician office visits including the initial and subsequent history and physical exams of the pregnant woman (maternal weight, blood pressure and fetal heart rate check).

Comprehensive Lactation Support and Counseling Services

Covered expenses include comprehensive lactation support (assistance and training in breast feeding) and counseling services provided to females during pregnancy and in the postpartum period by a certified lactation support provider. The "postpartum period" means the one-year period directly following the child's date of birth. Covered expenses incurred during the postpartum period also include the rental or purchase of breast feeding equipment as described below. Lactation support and lactation counseling services are covered expenses when provided in either a group or individual setting.

Breast Feeding Durable Medical Equipment

Coverage includes the rental or purchase of breast feeding durable medical equipment for the purpose of lactation support (pumping and storage of breast milk). Covered expenses include the following:

- The rental of a hospital-grade electric breast pump for a newborn child when the newborn child is confined in a hospital.
- The purchase of:
  - An electric breast pump (non-hospital grade). A purchase will be covered once every three years; or
  - A manual breast pump. A purchase will be covered once every three years.
- If an electric breast pump was purchased within the previous three-year period, the purchase of an electric or manual breast pump will not be covered until a three-year period has elapsed from the last purchase of an electric pump.
- Breast pump supplies

Limitations: Coverage is limited to only one purchase per pregnancy in any year where a covered female would not qualify for the purchase of a new pump.

Coverage for the purchase of breast pump equipment is limited to one item of equipment, for the same or similar purpose, and the accessories and supplies needed to operate the item. You are responsible for the entire cost of any additional pieces of the same or similar equipment you purchase or rent for personal convenience or mobility.

Family Planning Services - Female Contraceptives

For females with reproductive capacity, covered expenses include those charges incurred for services and supplies that are provided to prevent pregnancy. All contraceptive methods, services and supplies covered under this Preventive Care benefit must be approved by the U.S. Food and Drug Administration (FDA).

Coverage includes counseling services on contraceptive methods provided by a physician, obstetrician or gynecologist. Such counseling services are covered expenses when provided in either a group or individual setting.

The following contraceptive methods are covered expenses under this Preventive Care benefit:

- Voluntary Sterilization - Covered expenses include charges billed separately by the provider for female voluntary sterilization procedures and related services and supplies including, but not limited to, tubal ligation and sterilization implants.

- Contraceptives - charges made by a physician for female contraceptives that are brand name and generic prescription drugs or female contraceptive devices, including the related services and supplies needed to administer the device.

Family Planning Services - Other

Covered expenses include charges for certain family planning services, even though not provided to treat an illness or injury.

- Voluntary sterilization for males
- Voluntary termination of pregnancy

Not covered are:

- Reversal of voluntary sterilization procedures, including related follow-up care;
- Charges for services which are covered to any extent under any other part of this Plan or any other group plans sponsored by the Trust; and
- Charges incurred for family planning services while confined as an inpatient in a hospital or other facility for medical care.

Preventive Vision Care Services

Covered expenses include charges made by a legally qualified ophthalmologist or optometrist for the following preventive services:

Routine eye exam: The plan covers expenses for a complete routine eye exam that includes refraction and glaucoma testing. The plan covers charges for one routine eye exam in any 24-consecutive month period.

Hearing Exam

Covered expenses include charges for an audiometric hearing exam if the exam is performed by:

A physician certified as an otolaryngologist or otologist; or

An audiologist who is legally qualified in audiology; or holds a certificate of Clinical Competence in Audiology from the American Speech and Hearing Association (in the absence of any applicable licensing requirements); and performs the exam at the written direction of a legally qualified otolaryngologist or otologist.

The plan will not cover expenses for charges for more than one hearing exam for any 24-month period.

Physician Services

Physician Visits

Covered medical expenses include charges made by a physician during a visit to treat an illness or injury. The visit may be at the physician's office, in your home, in a hospital or other facility during your stay or in an outpatient facility. Covered expenses also include:

- Immunizations for infectious disease, but not if solely for your employment;
- Allergy testing, treatment and injections; and
- Charges made by the physician for supplies, radiological services, x-rays, and tests provided by the physician.

Surgery

Covered expenses include charges made by a physician for:

- Performing your surgical procedure;
- Pre-operative and post-operative visits; and
- Consultation with another physician to obtain a second opinion prior to the surgery.

Anesthetics

Covered expenses include charges for the administration of anesthetics and oxygen by a physician, other than the operating physician, or Certified Registered Nurse Anesthetist (C.R.N.A.) in connection with a covered procedure.

Alternatives to Physician Office Visits

Walk-In Clinic Visits

Covered expenses include charges made by walk-in clinics for:

- Unscheduled, non-emergency illnesses and injuries;
- The administration of certain immunizations administered within the scope of the clinic's license; and
- Individual screening and counseling services to aid you to stop the use of tobacco products or in weight reduction due to obesity.

Unless specified above, not covered under this benefit are charges incurred for services and supplies furnished on a group setting for screening and counseling services.

Not all services are available at all Walk-In Clinics. The types of services offered will vary by the provider and location of the clinic.

E-Visits

Covered expenses include charges made by your network physician for a routine, non-emergency, medical consultation. You must make your E-visit through an Aetna authorized internet service vendor. You may have to register with that internet service vendor. Information about providers who are signed up with an authorized vendor may be found in the provider Directory or online in DocFind on www.aetna.com/docfind or by calling the number on your identification card.

Hospital Expenses

Room and Board

Covered expenses include charges for room and board provided at a hospital during your stay. Private room charges that exceed the hospital's semi-private room rate are not covered unless a private room is required because of a contagious illness or immune system problem.

Room and board charges also include:

- Services of the hospital's nursing staff;
- Admission and other fees;
- General and special diets; and
- Sundries and supplies.

Other Hospital Services and Supplies

Covered expenses include charges made by a hospital for services and supplies furnished to you in connection with your stay. Covered expenses include hospital charges for other services and supplies provided, such as:

- Ambulance services.
- Physicians and surgeons.
- Operating and recovery rooms.
- Intensive or special care facilities.
- Administration of blood and blood products, but not the cost of the blood or blood products.
- Radiation therapy.
- Speech therapy, physical therapy and occupational therapy.
- Oxygen and oxygen therapy.
- Radiological services, laboratory testing and diagnostic services.
- Medications.
- Intravenous (IV) preparations.
- Discharge planning.

Emergency Medical Conditions

Covered expenses include charges made by a hospital or a physician for services provided in an emergency room to evaluate and treat an emergency medical condition.

The emergency care benefit covers:

- Use of emergency room facilities;
- Emergency room physician services;
- Hospital nursing staff services; and
- Radiologist and pathologist services.

Please contact a network provider after receiving treatment for an emergency medical condition.

With the exception of Urgent Care described below, if you visit a hospital emergency room for a non-emergency condition, the plan will not cover your expenses. No other plan benefits will pay for non-emergency care in the emergency room.

Urgent Care

Covered expenses include charges made by a hospital or urgent care provider to evaluate and treat an urgent condition.

Your coverage includes:

- Use of emergency room facilities when network urgent care facilities are not in the service area and you cannot reasonably wait to visit your physician;
- Use of urgent care facilities;
- Physicians services;

- Nursing staff services; and
- Radiologists and pathologists services.

Please contact a network provider after receiving treatment of an urgent condition.

If you visit an urgent care provider for a non-urgent condition, the plan will not cover your expenses.

Outpatient Surgery and Physician Surgical Services

Covered expenses include charges for services and supplies furnished in connection with outpatient surgery made by:

- A physician or dentist for professional services;
- A surgery center; or
- The outpatient department of a hospital.

The surgery must meet the following requirements:

- The surgery can be performed adequately and safely only in a surgery center or hospital and
- The surgery is not normally performed in a physician's or dentist's office.

Birthing Center

Covered expenses include charges made by a birthing center for services and supplies related to your care in a birthing center for:

- Prenatal care;
- Delivery; and
- Postpartum care within 48 hours after a vaginal delivery and 96 hours after a Cesarean delivery.

Home Health Care

Covered expenses include charges for home health care services when ordered by a physician as part of a home health plan and provided you are:

- Transitioning from a hospital or other inpatient facility, and the services are in lieu of a continued inpatient stay; or
- Homebound

Covered expenses include only the following:

- Skilled nursing services that require medical training of, and are provided by, a licensed nursing professional within the scope of his or her license. These services need to be provided during intermittent visits of 4 hours or less, with a daily maximum of 3 visits. Intermittent visits are considered periodic and recurring visits that skilled nurses make to ensure your proper care, which means they are not on site for more than four hours at a time. If you are discharged from a hospital or skilled nursing facility after an inpatient stay, the intermittent requirement may be waived to allow coverage for up to 12 hours (3 visits) of continuous skilled nursing services. However, these services must be provided for within 10 days of discharge.

- Home health aide services, when provided in conjunction with skilled nursing care, that directly support the care. These services need to be provided during intermittent visits of 4 hours or less, with a daily maximum of 3 visits.
- Medical social services, when provided in conjunction with skilled nursing care, by a qualified social worker.
- Skilled behavioral health care services provided in the home by a behavioral health provider when ordered by a physician and directly related to an active treatment plan of care established by the physician. All of the following must be met:
  - The skilled behavioral health care is appropriate for the active treatment of a condition, illness or disease to avoid placing you at risk for serious complications.
  - The services are in lieu of a continued confinement in a hospital or residential treatment facility, or receiving outpatient services outside of the home.
  - You are homebound because of illness or injury.
  - The services provided are not primarily for comfort, convenience or custodial in nature.
  - The services are intermittent or hourly in nature.
  - The services are not for Applied Behavior Analysis.

Benefits for home health care visits are payable up to the Home Health Care Maximum. Each visit by a nurse, behavioral health provider or therapist is 1 visit.

In figuring the Calendar Year Maximum Visits, each visit of a:

- Nurse or Therapist, up to 4 hours is 1 visit and
- behavioral health provider, of up to 1 hour, is 1 visit.

This maximum will not apply to care given by an R.N. or L.P.N. when:

- Care is provided within 10 days of discharge from a hospital or skilled nursing facility as a full-time inpatient; and
- Care is needed to transition from the hospital or skilled nursing facility to home care.

When the above criteria are met, covered expenses include up to 12 hours of continuous care by an R.N. or L.P.N. per day.

Coverage for Home Health Care services is not determined by the availability of caregivers to perform them. The absence of a person to perform a non-skilled or custodial care service does not cause the service to become covered. If the covered person is a minor or an adult who is dependent upon others for non-skilled care (e.g. bathing, eating, toileting), coverage for home health services will only be provided during times when there is a family member or caregiver present in the home to meet the person’s non-skilled needs.

Note: Home short-term physical, speech, or occupational therapy is covered when the above home health care criteria are met. Services are subject to the conditions and limitations listed herein.

Limitations - Unless specified above, *not* covered under this benefit are charges for:

- Services or supplies that are not a part of the Home Health Care Plan.
- Services of a person who usually lives with you, or who is a member of your or your spouse’s or your domestic partner's family.

- Services of a certified or licensed social worker.
- Services for physical, occupational and speech therapy. Refer to Short Term Rehabilitation Therapies section for coverage information.
- Services for Infusion Therapy.
- Transportation.
- Services or supplies provided to a minor or dependent adult when a family member or caregiver is not present.
- Services that are custodial care.

Skilled Nursing Care

Covered expenses include charges by an R.N., L.P.N., or nursing agency for outpatient skilled nursing care. This is care by a visiting R.N. or L.P.N. to perform specific skilled nursing tasks.

Limitations - Unless specified above, not covered under this benefit are charges for:

- Nursing care that does not require the education, training and technical skills of a R.N. or L.P.N.
- Nursing care, including care in a skilled nursing facility, is limited to 60 days per calendar year.
- Nursing care assistance for daily life activities, such as:
  - Transportation;
  - Meal preparation;
  - Vital sign charting;
  - Companionship activities;
  - Bathing;
  - Feeding;
  - Personal grooming;
  - Dressing;
  - Toileting; and
  - Getting in/out of bed or a chair.
- Nursing care provided for skilled observation.
- Nursing care provided while you are an inpatient in a hospital or health care facility.
- A service provided solely to administer oral medicine, except where law requires a R.N. or L.P.N. to administer medicines.

Skilled Nursing Facility

Covered expenses include charges made by a skilled nursing facility during your stay for the following services and supplies, including:

- Room and board, up to the semi-private room rate. The plan will cover up to the private room rate if it is needed due to an infectious illness or a weak or compromised immune system;
- Use of special treatment rooms;
- Radiological services and lab work;
- Physical, occupational, or speech therapy;
- Oxygen and other gas therapy;
- Other medical services and general nursing services usually given by a skilled nursing facility (this does not include charges made for private or special nursing, or physician's services); and
- Medical supplies.

Admissions to a skilled nursing facility must be precertified by Aetna. Refer to *Using Your Medical Plan* for details about precertification.

Nursing care, including both skilled nursing facility and outpatient care, is limited to 60 days per calendar year.

Hospice Care

Covered expenses include charges made by the following furnished to you for hospice care when given as part of a hospice care program.

<u>Facility Expenses</u>

The charges made by a hospital, hospice or skilled nursing facility for:

- Room and Board and other services and supplies furnished during a stay for pain control and other acute and chronic symptom management; and
- Services and supplies furnished to you on an outpatient basis.

<u>Outpatient Hospice Expenses</u>

Covered expenses include charges made on an outpatient basis by a hospice care agency for:

- Part-time or intermittent nursing care by a R.N. or L.P.N. for up to eight hours a day;
- Part-time or intermittent home health aide services to care for you up to eight hours a day.
- Medical social services under the direction of a physician. These include but are not limited to:
- Assessment of your social, emotional and medical needs, and your home and family situation;
- Identification of available community resources; and
- Assistance provided to you to obtain resources to meet your assessed needs.
- Physical and occupational therapy; and
- Consultation or case management services by a physician;
- Medical supplies;

- Prescription drugs;
- Dietary counseling; and
- Psychological counseling.

Charges made by the providers below if they are not a participant of a hospice care agency; and such Agency retains responsibility for your care:

- A physician for a consultation or case management;
- A physical or occupational therapist;
- A home health care agency for:
  - Physical and occupational therapy;
  - Part time or intermittent home health aide services for your care up to eight hours a day;
  - Medical supplies;
  - Prescription drugs;
  - Psychological counseling; and
  - Dietary counseling.

Other Covered Health Care Expenses

Acupuncture

The plan covers up to 15 visits for medically necessary acupuncture treatments provided by an appropriately licensed Covered Provider. In order to obtain additional acupuncture services, the participant must demonstrate meaningful improvement and treatment notes are required for medical necessity review.

Acupuncture treatments are limited to the following conditions:

- Chronic low back pain (Maintenance treatment are not medically necessary when the patient's symptoms are neither progressing nor improving. Re-evaluate the treatment plan if no clinical benefits are appreciated after 4 weeks)
- Migraine headache
- Nausea from pregnancy
- Pain from osteoarthritis of the knee or hip (adjunctive therapy; re-evaluate the treatment plan if no clinical benefits appreciate after 4 weeks)
- Post-operative and chemotherapy-induced nausea and vomiting
- Post-operative dental pain
- Temporomandibular disorders (TMD)

The Plan does not cover acupuncture for any other conditions.

Ambulance Service

Ground Ambulance Covered expenses include charges for professional ambulance transportation:

- To the first hospital where treatment is given in a medical emergency.
- From one hospital to another hospital in a medical emergency when the first hospital does not have the required services or facilities to treat your condition.
- From hospital to home or to another facility when other means of transportation would be considered unsafe due to your medical condition.
- From home to hospital for covered inpatient or outpatient treatment when other means of transportation would be considered unsafe due to your medical condition. Transport is limited to 100 miles.
- When during a covered inpatient stay at a hospital, skilled nursing facility or acute rehabilitation hospital, an ambulance is required to safely and adequately transport you to or from inpatient or outpatient medically necessary treatment.

Air or Water Ambulance Covered expenses include charges for transportation to a hospital by professional air or water ambulance when:

- Ground ambulance transportation is not available; and
- Your condition is unstable, and requires medical supervision and rapid transport; and
- In a medical emergency, transportation from one hospital to another hospital; when the first hospital does not have the required services or facilities to treat your condition and you need to be transported to another hospital; and the two conditions above are met.

Air or Water Ambulance coverage is limited to the nearest facility equipped to treat the condition.

Chiropractic Care

The plan covers up to 20 visits per year for chiropractic care.

Diagnostic Complex Imaging Expenses

The plan covers charges made on an outpatient basis by a physician, hospital or a licensed imaging or radiological facility for complex imaging services to diagnose an illness or injury, including:

- C.A.T. scans;
- Magnetic Resonance Imaging (MRI);
- Nuclear medical imaging, including positron emission tomography (PET) Scans; and
- Other medically necessary outpatient diagnostic imaging service.

Outpatient Diagnostic Lab Work and Radiological Services

Covered expenses include charges for radiological services (other than diagnostic complex imaging), lab services, and pathology and other tests provided to diagnose an illness or injury. You must have definite symptoms that start, maintain or change a plan of treatment prescribed by a physician. The charges must be made by a physician, hospital or licensed radiological facility or lab.

Outpatient Preoperative Testing

Prior to a scheduled covered surgery, covered expenses include charges made for tests performed by a hospital, surgery center, physician or licensed diagnostic laboratory provided the charges for the surgery are covered expenses and the tests are:

- Related to your surgery, and the surgery takes place in a hospital or surgery center;
- Completed within 14 days before your surgery;
- Performed on an outpatient basis;
- Covered if you were an inpatient in a hospital;
- Not repeated in or by the hospital or surgery center where the surgery will be performed.

Test results should appear in your medical record kept by the hospital or surgery center where the surgery is performed. If your tests indicate that surgery should not be performed because of your physical condition, the plan will pay for the tests, however surgery will not be covered.

Durable Medical and Surgical Equipment (DME)

Covered expenses include charges by a DME supplier for the rental of equipment or, in lieu of rental:

The initial purchase of DME if:

- Long term care is planned; and
- The equipment cannot be rented or is likely to cost less to purchase than to rent.
- Repair of purchased equipment. Maintenance and repairs needed due to misuse or abuse are not covered.

Replacement of purchased equipment if:

- The replacement is needed because of a change in your physical condition; and
- It is likely to cost less to replace the item than to repair the existing item or rent a similar item.

The plan limits coverage to one item of equipment, for the same or similar purpose and the accessories needed to operate the item. You are responsible for the entire cost of any additional pieces of the same or similar equipment you purchase or rent for personal convenience or mobility.

Covered Durable Medical Equipment includes those items covered by Medicare unless excluded in the Exclusions section of this Booklet. The plan reserves the right to limit the payment of charges up to the most cost efficient and least restrictive level of service or item which can be safely and effectively provided.

Clinical Trials - *Clinical Trial Therapies (*Experimental or Investigational)

Covered expenses include charges made for experimental or investigational drugs, devices, treatments or procedures "under an approved clinical trial" only when you have cancer or a terminal illness, and all of the following conditions are met:

- Standard therapies have not been effective or are inappropriate;
- The Plan, or its designee, determines, based on published, peer-reviewed scientific evidence that you may benefit from the treatment; and
- You are enrolled in an approved clinical trial that meets these criteria.

An “approved clinical trial” is a clinical trial that meets these criteria:

- The FDA has approved the drug, device, treatment, or procedure to be investigated or has granted it investigational new drug (IND) or group c/treatment IND status. This requirement does not apply to procedures and treatments that do not require FDA approval.
- The clinical trial has been approved by an Institutional Review Board that will oversee the investigation.
- The clinical trial is sponsored by the National Cancer Institute (NCI) or similar federal organization.
- The trial conforms to standards of the NCI or other, applicable federal organization.
- The clinical trial takes place at an NCI-designated cancer center or takes place at more than one institution.
- You are treated in accordance with the protocols of that study.

Covered expenses include charges made by a provider for “routine patient costs” furnished in connection with your participation in an “approved clinical trial” for cancer or other life-threatening disease or condition, as those terms are defined in the federal Public Health Service Act, Section 2709.

Limitations - Not covered under this Plan are:

- Services and supplies related to data collection and record-keeping that is solely needed due to the clinical trial (i.e. protocol-induced costs);
- Services and supplies provided by the trial sponsor without charge to you; and
- The experimental intervention itself (except medically necessary Category B investigational devices and promising experimental or investigational interventions for terminal illnesses in certain clinical trials in accordance with Aetna’s claim policies).

Pregnancy Related Expenses

Covered expenses include charges made by a physician for pregnancy and childbirth services and supplies at the same level as any illness or injury. This includes prenatal visits, delivery and postnatal visits.

For inpatient care of the mother and newborn child, covered expenses include charges made by a Hospital for a minimum of:

- 48 hours after a vaginal delivery; and
- 96 hours after a cesarean section.
- A shorter stay, if the attending physician, with the consent of the mother, discharges the mother or newborn earlier.

Covered expenses also include charges made by a birthing center as described under Alternatives to Hospital Care.

Note: Covered expenses also include services and supplies provided for circumcision of the newborn during the stay.

Prosthetic Devices

Covered expenses include charges made for internal and external prosthetic devices and special appliances, if the device or appliance improves or restores body part function that has

been lost or damaged by illness, injury or congenital defect. Covered expenses also include instruction and incidental supplies needed to use a covered prosthetic device.

The plan covers the first prosthesis you need that temporarily or permanently replaces all or part of a body part lost or impaired as a result of disease or injury or congenital defects as described in the list of covered devices below for an:

- Internal body part or organ; or
- External body part.

Covered expenses also include replacement of a prosthetic device if:

- The replacement is needed because of a change in your physical condition; or normal growth or wear and tear; or
- It is likely to cost less to buy a new one than to repair the existing one; or
- The existing one cannot be made serviceable.

The list of covered devices includes but is not limited to:

- An artificial arm, leg, hip, knee or eye;
- Eye lens;
- An external breast prosthesis and the first bra made solely for use with it after a mastectomy;
- A breast implant after a mastectomy;
- Ostomy supplies, urinary catheters and external urinary collection devices;
- Speech generating device;
- A cardiac pacemaker and pacemaker defibrillators; and
- A durable brace that is custom made for and fitted for you.

The plan will not cover expenses and charges for, or expenses related to:

- Orthopedic shoes, therapeutic shoes, foot orthotics, or other devices to support the feet; unless required for the treatment of or to prevent complications of diabetes; or if the orthopedic shoe is an integral part of a covered leg brace; or
- Trusses, corsets, and other support items; or
- Devices designed for solely for activities such as sports or exercise
- Any item listed in the *Exclusions* section.

<u>Short-Term Rehabilitation Therapy Services- Cardiac and Pulmonary Rehabilitation Benefits</u>

Cardiac rehabilitation benefits are available as part of an inpatient hospital stay. A limited course of outpatient cardiac rehabilitation is covered when following angioplasty, cardiovascular surgery, congestive heart failure or myocardial infarction. The plan will cover charges in accordance with a treatment plan as determined by your risk level when recommended by a physician. This course of treatment is limited to a maximum of 36 sessions in a 12-week period.

Pulmonary rehabilitation benefits are available as part of an inpatient hospital stay. A limited course of outpatient pulmonary rehabilitation is covered for the treatment of reversible pulmonary disease states. This course of treatment is limited to a maximum of 36 hours or a six-week period.

The services have to be performed by a licensed or certified therapist; a hospital, skilled nursing facility, or hospice facility; or a physician.

Habilitative and Rehabilitation Therapy Services - Outpatient Cognitive Therapy, Physical Therapy, Occupational Therapy and Speech Therapy Rehabilitation Benefits.

Covered expenses include charges for short-term therapy services when prescribed by a physician as described below.

The services have to be performed by a licensed or certified physical, occupational or speech therapist; a hospital, skilled nursing facility, or hospice facility; or a physician.

Habilitative therapy services, include occupational therapy, speech therapy, physical therapy and related therapies to improve a mental health condition or congenital birth defect.

Rehabilitative therapy services include occupational therapy, speech therapy and physical therapy, to the extent that the therapy will significantly restore or improve a lost function(s) following a severe illness, injury or surgery.

Habilitative and rehabilitative services are subject to the following conditions:

- The service must be necessary to improve function or to maintain function where significant deterioration in function would result without the therapy;
- The services must be prescribed by the attending physician and administered by a physician or covered licensed therapist. The Plan may periodically request a review of the services by a physician and the patient must continue under the care of the attending physician during the time the therapy is being provided; and
- The services must not be custodial in nature.

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

Inpatient rehabilitation benefits for the services listed will be paid as part of your Inpatient Hospital and Skilled Nursing Facility benefits provision in this Booklet.

Habilitative and rehabilitative benefits do not include education training or services designed to develop physical function.

A "visit" consists of no more than one hour of therapy. Covered expenses include charges for two therapy visits of no more than one hour in a 24-hour period.

The therapy should follow a specific treatment plan that:

- Details the treatment, and specifies frequency and duration; and
- Provides for ongoing reviews and is renewed only if continued therapy is appropriate.

Reconstructive or Cosmetic Surgery and Supplies

Covered expenses include charges made by a physician, hospital, or surgery center for reconstructive services and supplies, including:

- Surgery needed to improve a significant functional impairment of a body part.
- Surgery to correct the result of an accidental injury, including subsequent related or staged surgery, provided that the surgery occurs no more than 24 months after the original injury. For a covered child, the time period for coverage may be extended through age 18.

- Surgery to correct the result of an injury that occurred during a covered surgical procedure provided that the reconstructive surgery occurs no more than 24 months after the original injury.
- Surgery to correct a gross anatomical defect present at birth or appearing after birth (but not the result of an illness or injury) when the defect results in severe facial disfigurement, or the defect results in significant functional impairment and the surgery is needed to improve function.

Reconstructive Breast Surgery

Covered expenses include reconstruction of the breast on which a mastectomy was performed, including an implant and areolar reconstruction. Also included is surgery on a healthy breast to make it symmetrical with the reconstructed breast and physical therapy to treat complications of mastectomy, including lymphedema.

Chemotherapy

Covered expenses include charges for chemotherapy treatment. Coverage levels depend on where treatment is received. In most cases, chemotherapy is covered as outpatient care. Inpatient hospitalization for chemotherapy is limited to the initial dose while hospitalized for the diagnosis of cancer and when a hospital stay is otherwise medically necessary based on your health status.

Radiation Therapy Benefits

Covered expenses include charges for the treatment of illness by x-ray, gamma ray, accelerated particles, mesons, neutrons, radium or radioactive isotopes.

Outpatient Infusion Therapy Benefits

Covered expenses include infusion therapy received from an outpatient setting including, but not limited to:

- A free-standing facility;
- The outpatient department of a hospital; or
- A physician in his/her office or in your home.

The list of preferred infusion locations can be found by contacting Aetna by logging onto your Aetna Navigator® secure member website at www.aetna.com or calling the number on the back of your ID card.

Certain infused medications may be covered under the prescription drug plan. You can access the list of specialty care prescription drugs by contacting Aetna or by logging onto your Aetna Navigator® secure member website at www.aetna.com or calling the number on the back of your ID card to determine if coverage is under the prescription drug plan or this booklet.

Infusion therapy is the intravenous or continuous administration of medications or solutions that are a part of your course of treatment. Charges for the following outpatient Infusion Therapy services and supplies are covered expenses:

- The pharmaceutical when administered in connection with infusion therapy and any medical supplies, equipment and nursing services required to support the infusion therapy;
- Professional services;
- Total parenteral nutrition (TPN);

- Chemotherapy;
- Drug therapy (includes antibiotic and antivirals);
- Pain management (narcotics); and
- Hydration therapy (includes fluids, electrolytes and other additives).

Not included under this infusion therapy benefit are charges incurred for:

- Enteral nutrition;
- Blood transfusions and blood products;
- Dialysis; and
- Insulin.

Coverage for inpatient infusion therapy is provided under the Inpatient Hospital and Skilled Nursing Facility Benefits sections of this booklet.

Specialty Care Prescription Drugs

Covered expenses include specialty care prescription drugs when they are purchased by your provider, listed on our specialty care prescription drug list as covered under this booklet and injected or infused by your provider in an outpatient setting such as:

- A free-standing outpatient facility
- The outpatient department of a hospital
- A physician in his/her office
- A home care provider in your home

Certain infused medications may be covered under the prescription drug plan. You can access the list of specialty care prescription drugs by contacting Member Services or by logging onto your Aetna Navigator® secure member website at www.aetna.com or calling the number on the back of your ID card to determine if coverage is under the prescription drug plan of this booklet.

Diabetic Equipment, Supplies and Education

Covered expenses include charges for the following services, supplies, equipment and training for the treatment of insulin and non-insulin dependent diabetes and for elevated blood glucose levels during pregnancy:

- External insulin pumps;
- Blood glucose monitors without special features unless required due to blindness;
- Alcohol swabs;
- Glucagon emergency kits;
- Self-management training provided by a licensed health care provider certified in diabetes self-management training; and
- Foot care to minimize the risk of infection.

Treatment of Infertility

Covered expenses include basic infertility charges made by a physician to diagnose and to surgically treat the underlying medical cause of infertility.

Spinal Manipulation Treatment

Covered expenses include charges made by a physician on an outpatient basis for manipulative (adjustive) treatment or other physical treatment for conditions caused by (or related to) biomechanical or nerve conduction disorders of the spine.

Jaw Joint Disorder Treatment

The plan covers charges made by a physician, hospital or surgery center for the diagnosis and surgical treatment of jaw joint disorder. A jaw joint disorder is defined as a painful condition:

- Of the jaw joint itself, such as temporomandibular joint dysfunction (TMJ) syndrome; or
- Involving the relationship between the jaw joint and related muscles and nerves such as myofascial pain dysfunction (MPD).

Transplant Services

Covered expenses include charges incurred during a transplant occurrence. The following will be considered to be one transplant occurrence once it has been determined that you or one of your dependents may require an organ transplant. Organ means solid organ; stem cell; bone marrow; and tissue.

- Heart;
- Lung;
- Heart/Lung;
- Simultaneous Pancreas Kidney (SPK);
- Pancreas;
- Kidney;
- Liver;
- Intestine;
- Bone Marrow/Stem Cell;
- Multiple organs replaced during one transplant surgery;
- Tandem transplants (Stem Cell);
- Sequential transplants;
- Re-transplant of same organ type within 180 days of the first transplant;
- Any other single organ transplant, unless otherwise excluded under the plan. The following will be considered to be *more than one* Transplant Occurrence:
  - Autologous blood/bone marrow transplant followed by allogenic blood/bone marrow transplant (when not part of a tandem transplant);
  - Allogenic blood/bone marrow transplant followed by an autologous blood/bone marrow transplant (when not part of a tandem transplant);
  - Re-transplant after 180 days of the first transplant;
  - Pancreas transplant following a kidney transplant;

- A transplant necessitated by an additional organ failure during the original transplant surgery/process;
- More than one transplant when not performed as part of a planned tandem or sequential transplant, (e.g., a liver transplant with subsequent heart transplant).

The network level of benefits is paid only for a treatment received at a facility designated by the plan as an Institute of Excellence™ (IOE) for the type of transplant being performed. Each IOE facility has been selected to perform only certain types of transplants.

Services obtained from a facility that is not designated as an IOE for the transplant being performed will be covered as out-of-network services and supplies, even if the facility is a network facility or IOE for other types of services.

The plan covers:

- Charges made by a physician or transplant team.
- Charges made by a hospital, outpatient facility or physician for the medical and surgical expenses of a live donor, but only to the extent not covered by another plan or program.
- Related supplies and services provided by the facility during the transplant process. These services and supplies may include: physical, speech and occupational therapy; bio-medicals and immunosuppressants; home health care expenses and home infusion services.
- Charges for activating the donor search process with national registries.
- Compatibility testing of prospective organ donors who are immediate family members. For the purpose of this coverage, an “immediate” family member is defined as a first-degree biological relative. These are your biological parents, siblings or children.
- Inpatient and outpatient expenses directly related to a transplant.

If you are a participant in the IOE program, the program will coordinate all solid organ and bone marrow transplants and other specialized care you need. Any covered expenses you incur from an IOE facility will be considered network care expenses.

Unless specified above, *not* covered under this benefit are charges incurred for:

- Outpatient drugs including bio-medicals and immunosuppressants not expressly related to an outpatient transplant occurrence;
- Home infusion therapy after the transplant occurrence;
- Harvesting or storage of organs, without the expectation of immediate transplantation for an existing illness;
- Harvesting and/or storage of bone marrow, tissue or stem cells, without the expectation of transplantation within 12 months for an existing illness;
- Cornea (Corneal Graft with Amniotic Membrane) or Cartilage (autologous chondrocyte or autologous osteochondral mosaicplasty) transplants, unless otherwise authorized.

Treatment of Mental Disorders

Covered expenses include charges made for the treatment of mental disorders by behavioral health providers. Benefits are payable for charges incurred in a hospital, psychiatric hospital, residential treatment facility or behavioral health provider's office for the treatment of mental disorders as follows:

- Inpatient Treatment - Covered expenses include charges for room and board at the semi-private room rate, and other services and supplies provided during your stay in a hospital, psychiatric hospital or residential treatment facility. Inpatient benefits are payable only if your condition requires services that are only available in an inpatient setting.
- Partial Confinement Treatment - Covered expenses include charges made for partial confinement treatment provided in a facility or program for the intermediate short-term or medically-directed intensive treatment of a mental disorder. Such benefits are payable if your condition requires services that are only available in a partial confinement treatment setting.
- Outpatient Treatment - Covered expenses include charges for treatment received while not confined as a full-time inpatient in a hospital, psychiatric hospital or residential treatment facility. The plan covers partial hospitalization services (more than 4 hours, but less than 24 hours per day) provided in a facility or program for the intermediate short-term or medically-directed intensive treatment. The partial hospitalization will only be covered if you would need inpatient care if you were not admitted to this type of facility. Outpatient mental health treatment also includes:
  - Electro-convulsive therapy (ECT); and
  - Substance use disorder injectables.

Important Reminder - Inpatient care, partial hospitalizations and outpatient treatment must be precertified by Aetna. Refer to *How Your Medical Plan Works* for more information about precertification.

Treatment of Substance Abuse

Covered expenses include charges made for the treatment of substance abuse by behavioral health providers. Benefits are payable as follows:

- Inpatient Treatment - This Plan covers room and board at the semi-private room rate and other services and supplies provided during your stay in a psychiatric hospital or residential treatment facility, appropriately licensed by the state Department of Health or its equivalent. Coverage includes:
  - Treatment in a hospital for the medical complications of substance abuse.
  - “Medical complications” include detoxification, electrolyte imbalances, malnutrition, cirrhosis of the liver, delirium tremens and hepatitis.
  - Treatment in a hospital is covered only when the hospital does not have a separate treatment facility section.
- Outpatient Treatment - Outpatient treatment includes charges for treatment received for substance abuse while not confined as a full-time inpatient in a hospital, psychiatric hospital or residential treatment facility. This Plan covers partial hospitalization services (more than 4 hours, but less than 24 hours per day) provided in a facility or program for the intermediate short-term or medically-directed intensive treatment of alcohol or drug abuse. The partial hospitalization will only be covered if you would need inpatient treatment if you were not admitted to this type of facility.
- Partial Confinement Treatment - Covered expenses include charges made for partial confinement treatment provided in a facility or program for the intermediate short-term or medically-directed intensive treatment of substance abuse. Such benefits are payable if

your condition requires services that are only available in a partial confinement treatment setting.

Important Reminder - Inpatient care, partial hospitalizations and outpatient treatment must be precertified by Aetna. Refer to *How Your Medical Plan Works* for more information about precertification.

Oral and Maxillofacial Treatment (Mouth, Jaws and Teeth)

Covered expenses include charges made by a physician, a dentist and hospital for non-surgical treatment of infections or diseases of the mouth, jaw joints or supporting tissues. Covered expenses also include charges made by a physician, a dentist and hospital for services and supplies for treatment of, or related conditions of, the teeth, mouth, jaws, jaw joints or supporting tissues, (this includes bones, muscles, and nerves), for surgery needed to:

- Treat a fracture, dislocation, or wound.
- Cut out cysts, tumors, or other diseased tissues.
- Cut into gums and tissues of the mouth. This is only covered when not done in connection with the removal, replacement or repair of teeth.
- Alter the jaw, jaw joints, or bite relationships by a cutting procedure when appliance therapy alone cannot result in functional improvement.
- To remove, repair, restore or reposition: (a) natural teeth damaged, lost, or removed; or (b) other body tissues of the mouth fractured or cut due to injury.

If crowns, dentures, bridges, or in-mouth appliances are installed due to injury, covered expenses only include charges for:

- The first denture or fixed bridgework to replace lost teeth;
- The first crown needed to repair each damaged tooth; and
- An in-mouth appliance used in the first course of orthodontic treatment after the injury.

Limitations:

- Any such teeth must have been free from decay or in good repair, and are firmly attached to the jaw bone at the time of the injury; and
- If treatment if related to an accident, the treatment must be completed in the Calendar Year of the accident or in the next Calendar Year.

Medical Plan Exclusions

Not every medical service or supply is covered by the plan, even if prescribed, recommended, or approved by your physician or dentist. The plan covers only those services and supplies that are medically necessary. Charges made for the following, including complications resulting from such services or supplies, are not covered except to the extent otherwise provided for in this booklet:

1. Acupuncture, acupressure and acupuncture therapy.
2. Allergy: Specific non-standard allergy services and supplies, including but not limited to, skin titration (Rinkel method), cytotoxicity testing (Bryan’s Test) treatment of non-specific candida sensitivity, and urine autoinjections.
3. Any charges in excess of the benefit, dollar, day, visit or supply limits stated in this plan.

4. Any non-emergency charges incurred outside of the United States if you traveled to such location to obtain medical services, prescription drugs, or supplies, even if otherwise covered under this plan. This also includes prescription drugs or supplies if:
   - such prescription drugs or supplies are unavailable or illegal in the United States; or
   - the purchase of such prescription drugs or supplies outside the United States is considered illegal.
5. Applied Behavioral Analysis, the LEAP, TEACCH, Denver and Rutgers programs, except as otherwise covered by the plan.
6. Behavioral Health Services, except as otherwise covered by the Plan:
   - Treatment of impulse control disorders such as pathological gambling, kleptomania, pedophilia, or caffeine use.
   - Treatment of antisocial personality disorder.
   - Treatment in programs that do not otherwise meet the Plan's requirements.
7. Blood, blood plasma, synthetic blood, blood products or substitutes, including but not limited to, the provision of blood, other than blood derived clotting factors. Any related services including processing, storage or replacement costs, and the services of blood donors, apheresis or plasmapheresis are not covered. For autologous blood donations, only administration and processing costs are covered.
8. Charges for a service or supply furnished by a network or out-of-network provider in excess of the Recognized Charge.
9. Charges submitted for services that are not rendered or rendered to a person not eligible for coverage under the plan.
10. Charges for services or supplies which are not provided or billed in accordance with generally accepted professional standards and/or medical practice, including up-coding, unbundling, duplication, excessive or improperly coded billing charges.
11. Charges that are not permitted by the provider's network agreement or applicable claims payment policies or charges made in violation of the provider's network agreement or applicable claims payment policies.
12. Charges for claims that are submitted or completed more than one year from the later of the date of service or discharge.
13. Any services or supplies that are contrary to guidelines adopted by the Trust or the Trust's Preferred Provider Organization, including guidelines concerning industry standards for diagnosis, treatment, prescription or billing practices.
14. Charges submitted for services by an unlicensed hospital, physician or other provider or not within the scope of the provider's license.
15. Contraception, except as otherwise covered by the plan.
16. Cosmetic services and plastic surgery, except as otherwise covered by the plan, for: any treatment, surgery (cosmetic or plastic), service or supply to alter, improve or enhance the shape or appearance of the body whether or not for psychological or emotional reasons including:

- Face lifts, body lifts, tummy tucks, liposuctions, removal of excess skin, removal or reduction of non-malignant moles, blemishes, varicose veins, cosmetic eyelid surgery and other surgical procedures;
- Procedures to remove healthy cartilage or bone from the nose (even if the surgery may enhance breathing) or other part of the body;
- Chemical peels, dermabrasion, laser or light treatments, bleaching, creams, ointments or other treatments or supplies to alter the appearance or texture of the skin;
- Insertion or removal of any implant that alters the appearance of the body (such as breast or chin implants); except removal of an implant will be covered when medically necessary;
- Removal of tattoos (except for tattoos applied to assist in covered medical treatments, such as markers for radiation therapy); and
- Repair of piercings and other voluntary body modifications, including removal of injected or implanted substances or devices;
- Surgery to correct Gynecomastia;
- Breast augmentation;
- Otoplasty.

17. Counseling: services and treatment for marriage, religious, family, career, social adjustment, pastoral, or financial counselor.
18. Court ordered services, including those required as a condition of parole or release.
19. Custodial care.
20. Dental Services: any treatment, services or supplies related to the care, filling, removal or replacement of teeth and the treatment of injuries and diseases of the teeth, gums, and other structures supporting the teeth. This includes but is not limited to:
    - services of dentists, oral surgeons, dental hygienists, and orthodontists including apicoectomy (dental root resection), root canal treatment, soft tissue impactions, removal of bony impacted teeth, treatment of periodontal disease, alveolectomy, augmentation and vestibuloplasty and fluoride and other substances to protect, clean or alter the appearance of teeth;
    - dental implants, false teeth, prosthetic restoration of dental implants, plates, dentures, braces, mouth guards, and other devices to protect, replace or reposition teeth; and
    - non-surgical treatments to alter bite or the alignment or operation of the jaw, including treatment of malocclusion or devices to alter bite or alignment.
21. Disposable outpatient supplies: Any outpatient disposable supply or device, including sheaths, bags, elastic garments, support hose, bandages, bedpans, syringes, blood or urine testing supplies, and other home test kits; and splints, neck braces, compresses, and other devices not intended for reuse by another patient.
22. Drugs, medications and supplies:
    - Over-the-counter drugs, biological or chemical preparations and supplies that may be obtained without a prescription including vitamins except as otherwise covered;
    - Any services related to the dispensing, injection or application of a drug, except as otherwise covered;

- Any prescription drug purchased illegally outside the United States, even if otherwise covered under this plan within the United States;
- Immunizations related to work;
- Needles, syringes and other injectable aids, except as covered for diabetic supplies;
- Drugs related to the treatment of non-covered expenses;
- Performance enhancing steroids;
- Injectable drugs if an alternative oral drug is available;
- Outpatient prescription drugs;
- Self-injectable prescription drugs and medications;
- Any expenses for prescription drugs, and supplies covered under an Aetna Pharmacy plan will not be covered under this medical expense plan. Prescription drug exclusions that apply to the Aetna Pharmacy plan will apply to the medical expense coverage; and
- Charges for any prescription drug for the treatment of erectile dysfunction, impotence, or sexual dysfunction or inadequacy.

23. Educational services:
    - Any services or supplies related to education, training or retraining services or testing, including: special education, remedial education, job training and job hardening programs;
    - Evaluation or treatment of learning disabilities, minimal brain dysfunction, developmental, learning and communication disorders, behavioral disorders, (including pervasive developmental disorders) training or cognitive rehabilitation, regardless of the underlying cause, except as otherwise covered by the plan; and
    - Services, treatment, and educational testing and training related to behavioral (conduct) problems, learning disabilities and delays in developing skills, except as otherwise covered by the plan.
24. Examinations. Any health examinations required:
    - by a third party, including examinations and treatments required to obtain or maintain employment, or which the Trust is required to provide under a labor agreement;
    - by any law of a government;
    - for securing insurance, school admissions or professional or other licenses;
    - to travel; or
    - to attend a school, camp, or sporting event or participate in a sport or other recreational activity.
25. Experimental or investigational drugs, devices, treatments or procedures, except as otherwise covered by the plan.
26. Facility charges for care services or supplies provided in:
    - rest homes;
    - assisted living facilities;

- similar institutions serving as an individual's primary residence or providing primarily custodial or rest care;
- health resorts;
- spas, sanitariums; or
- infirmaries at schools, colleges, or camps.

27. Food items: Any food item, including infant formulas, nutritional supplements, vitamins, including prescription vitamins, medical foods and other nutritional items, even if it is the sole source of nutrition. This exclusion does not apply to specialized medical foods delivered enterally (only when delivered via a tube directly into the stomach or intestines) or parenterally.
28. Foot care: Any services, supplies, or devices to improve comfort or appearance of toes, feet or ankles, including but not limited to:
    - Routine treatment of calluses, bunions, toenails, hammer-toes, subluxations, fallen arches, weak feet, chronic foot pain or conditions caused by routine activities such as walking, running, working or wearing shoes; and
    - shoes (including orthopedic shoes), foot orthotics, arch supports, shoe inserts, ankle braces, guards, protectors, creams, ointments and other equipment, devices and supplies, even if required following a covered treatment of an illness or injury.
29. Growth/Height: Any treatment, device, drug, service or supply (including surgical procedures, devices to stimulate growth and growth hormones), solely to increase or decrease height or alter the rate of growth.
30. Hearing:
    - Any hearing service or supply that does not meet professionally accepted standards;
    - Hearing exams given during a stay in a hospital or other facility; and
    - Any tests, appliances, and devices for the improvement of hearing (including hearing aids and amplifiers), or to enhance other forms of communication to compensate for hearing loss or devices that simulate speech.
31. Home and mobility: Any addition or alteration to a home, workplace or other environment, or vehicle and any related equipment or device, such as exercise equipment, air purifiers, water purifiers, waterbeds, swimming pools; stair-glides, elevators, wheelchair ramps, or other additions or alterations to your home, workplace or other environment, including room additions, changes in cabinets, countertops, doorways, lighting, wiring, or furniture.
32. Home births: Any services and supplies related to births occurring in the home or in a place not licensed to perform deliveries.
33. Infertility: except as otherwise covered by the plan, any services, treatments, procedures or supplies that are designed to enhance fertility or the likelihood of conception, including but not limited to:
    - Injectable infertility medications, including but not limited to menotropins, hCG, GnRH agonists, and IVIG;
    - Artificial Insemination;

- Any advanced reproductive technology (“ART”) procedures or services related to such procedures, including but not limited to in vitro fertilization (“IVF”), gamete intra-fallopian transfer (“GIFT”), zygote intra-fallopian
- transfer (“ZIFT”), and intra-cytoplasmic sperm injection (“ICSI”); Artificial Insemination for covered females attempting to become pregnant who are not infertile as defined by the plan;
- Infertility services for couples in which 1 of the partners has had a previous sterilization procedure;
- Infertility services for females with FSH levels 19 or greater mIU/ml on day 3 of the menstrual cycle;
- Sperm or egg donors or any charges related to sperm or egg donation;
- Surrogacy; or
- Charges associated with cryopreservation or storage of cryopreserved eggs and embryos (e.g., office, hospital, ultrasounds, laboratory tests, etc.).

34. Maintenance Care, except as otherwise covered by the plan.
35. Medicare: Payment for that portion of the charge for which Medicare or another party is the primary payer, whether or not You enrolled for Medicare upon entitlement.
36. Miscellaneous charges for services or supplies including:
    - Annual or other charges to be in a physician’s practice;
    - Charges to have preferred access to a physician’s services such as boutique or concierge physician practices;
    - Cancelled or missed appointment charges or charges to complete claim forms;
    - Charges the recipient has no legal obligation to pay; or the charges would not be made if the recipient did not have coverage (to the extent exclusion is permitted by law) including:
        - Care in charitable institutions;
        - Care for conditions related to current or previous military service;
        - Care while in the custody of a governmental authority;
        - Any care a public hospital or other facility is required to provide; or
        - Any care in a hospital or other facility owned or operated by any federal, state or other governmental entity, except to the extent coverage is required by applicable laws.
37. Nursing and home health aide services provided outside of the home (such as in conjunction with school, vacation, work or recreational activities).
38. Non-medically necessary services, including but not limited to, those treatments, services, prescription drugs and supplies which are not medically necessary, as determined by the plan, for the diagnosis and treatment of illness, injury, restoration of physiological functions, or covered preventive services. This applies even if they are prescribed, recommended or approved by your physician or dentist.

39. Personal comfort and convenience items: Any service or supply primarily for your convenience and personal comfort or that of a third party, including: telephone, television, internet, barber or beauty service or other guest services; housekeeping, cooking, cleaning, shopping, monitoring, security or other home services; and travel, transportation, or living expenses, rest cures, recreational or diversional therapy.
40. Private duty nursing during your stay in a hospital, and outpatient private duty nursing services, except as otherwise covered by the plan.
41. Reports: Any special medical reports not directly related to treatment except when provided as part of a covered service.
42. Routine physical exams, routine eye exams, routine dental exams, routine hearing exams and other preventive services and supplies, except as otherwise covered by the plan.
43. Sex change: Any treatment, drug, service or supply related to changing sex or sexual characteristics, including:
    - Surgical procedures to alter the appearance or function of the body;
    - Hormones and hormone therapy;
    - Prosthetic devices; and
    - Medical or psychological counseling.
44. Services provided by a spouse, domestic partner, parent, child, step-child, brother, sister, in-law or any household member.
45. Services of a resident physician or intern rendered in that capacity.
46. Services provided where there is no evidence of pathology, dysfunction, or disease; except as specifically provided in connection with covered routine care and cancer screenings.
47. Sexual dysfunction/enhancement: Any treatment, drug, service or supply to treat sexual dysfunction, enhance sexual performance or increase sexual desire, including:
    - Surgery, drugs, implants, devices or preparations to correct or enhance erectile function, enhance sensitivity, or alter the shape or appearance of a sex organ; and
    - Sex therapy, sex counseling, marriage counseling or other counseling or advisory services.
48. Services that are not covered under this Booklet.
49. Services and supplies provided in connection with treatment or care that is not covered under the plan.
50. Speech therapy for treatment of delays in speech development, except as otherwise covered by the plan.
51. Spinal disorder, including care in connection with the detection and correction by manual or mechanical means of structural imbalance, distortion or dislocation in the human body or other physical treatment of any condition caused by or related to biomechanical or nerve conduction disorders of the spine including manipulation of the spine treatment, except as otherwise covered by the plan.
52. Strength and performance: Services, devices and supplies to enhance strength, physical condition, endurance or physical performance, including:

- Exercise equipment, memberships in health or fitness clubs, training, advice, or coaching;
- Drugs or preparations to enhance strength, performance, or endurance; and
- Treatments, services and supplies to treat illnesses, injuries or disabilities related to the use of performance- enhancing drugs or preparations.

53. Therapies for the treatment of delays in development, unless resulting from acute illness or injury, or congenital defects amenable to surgical repair (such as cleft lip/palate), are not covered, except as otherwise covered by the plan.
54. Therapies and tests: Any of the following treatments or procedures:
    - Aromatherapy;
    - Bio-feedback and bioenergetic therapy;
    - Carbon dioxide therapy;
    - Chelation therapy (except for heavy metal poisoning);
    - Computer-aided tomography (CAT) scanning of the entire body;
    - Educational therapy;
    - Gastric irrigation;
    - Hair analysis;
    - Hyperbaric therapy, except for the treatment of decompression or to promote healing of wounds;
    - Hypnosis, and hypnotherapy, except when performed by a **physician** as a form of anesthesia in connection with covered surgery;
    - Lovaas therapy;
    - Massage therapy;
    - Megavitamin therapy;
    - Primal therapy;
    - Psychodrama;
    - Purging;
    - Recreational therapy;
    - Rolfing;
    - Sensory or auditory integration therapy;
    - Sleep therapy; or
    - Thermograms and thermography.
55. Third-Party Injuries: Any expense or charge for injuries or illness caused by the act or omission of another person (known as a third-party) for which there is a potential opportunity to recover from the third-party, the third-party's insurer or any other liability policy including but not limited to an automobile policy, commercial premises policy, homeowner's policy, medical malpractice policy, renter's policy, or any other liability policy, including first-party uninsured or underinsured motorist policy. The plan may agree to

advance benefits if the participant agrees to reimburse the plan as set forth in the plan's provisions.

56. Tobacco Use: Any treatment, drug, service or supply to stop or reduce smoking or the use of other tobacco products, except as otherwise covered by the plan.
57. Transplant-The transplant coverage does not include charges for:
    - Outpatient drugs including bio-medicals and immunosuppressants not expressly related to an outpatient transplant occurrence;
    - Services and supplies furnished to a donor when recipient is not a covered person;
    - Home infusion therapy after the transplant occurrence;
    - Harvesting and/or storage of organs, without the expectation of immediate transplantation for an existing illness;
    - Harvesting and/or storage of bone marrow, tissue or stem cells without the expectation of transplantation within 12 months for an existing illness;
    - Cornea (corneal graft with amniotic membrane) or cartilage (autologous chondrocyte or autologous osteochondral mosaicplasty) transplants, unless otherwise precertified.
58. Transportation costs, including ambulance services for routine transportation to receive outpatient or inpatient services except as otherwise covered by the plan.
59. Unauthorized services, including any service obtained by or on behalf of a covered person without precertification when required. This exclusion does not apply in a Medical Emergency or in an Urgent Care situation.
60. Vision-related services and supplies, except as otherwise covered by the plan. The plan does not cover:
    - Special supplies such as non-prescription sunglasses and subnormal vision aids;
    - Vision service or supply which does not meet professionally accepted standards;
    - Eye exams during your stay in a hospital or other facility for health care;
    - Eye exams for contact lenses or their fitting;
    - Eyeglasses or duplicate or spare eyeglasses or lenses or frames;
    - Replacement of lenses or frames that are lost or stolen or broken;
    - Acuity tests;
    - Eye surgery for the correction of vision, including radial keratotomy, LASIK and similar procedures;
    - Services to treat errors of refraction.
61. Weight: Any treatment, drug service or supply intended to decrease or increase body weight, control weight or treat obesity, including morbid obesity, regardless of the existence of comorbid conditions; except as specifically provided in the *What the Plan Covers* section, including but not limited to:
    - Liposuction, banding, gastric stapling, gastric by-pass and other forms of bariatric surgery; surgical procedures medical treatments, weight control/loss programs and other services and supplies that are primarily intended to treat, or are related to the treatment of obesity, including morbid obesity;

- Drugs, stimulants, preparations, foods or diet supplements, dietary regimens and supplements, food or food supplements, appetite suppressants and other medications;
- Counseling, coaching, training, hypnosis or other forms of therapy; and
- Exercise programs, exercise equipment, membership to health or fitness clubs, recreational therapy or other forms of activity or activity enhancement.

62. Work related: Any illness or injury related to employment or self-employment including any illness or injury that arises out of (or in the course of) any work for pay or profit, unless no other source of coverage or reimbursement is available to you for the services or supplies. Sources of coverage or reimbursement may include the Trust, Workers' Compensation, or an occupational illness or similar program under local, state or federal law. A source of coverage or reimbursement will be considered available to you even if you waived your right to payment from that source. If you are also covered under a Workers' Compensation law or similar law, and submit proof that you are not covered for a particular illness or injury under such law, that illness or injury will be considered "non-occupational" regardless of cause.
63. Conditions caused by or arising from an act of war, armed invasion of aggression.
64. Injury sustained while committing or attempting to commit a felony.

PHARMACY BENEFIT PLAN

What the Plan Covers

This pharmacy benefit plan covers charges for certain prescription drugs and supplies described below. You are responsible for any copays and cost-sharing amounts up to your out-of-pocket maximum.

Accessing Network Pharmacies and Benefits

This plan provides access to covered benefits through a network of pharmacies, vendors or suppliers. Aetna has contracted for these network pharmacies to provide prescription drugs and other supplies to you. You also have the choice to access state licensed pharmacies outside the network for covered expenses.

Obtaining your benefits through network pharmacies has many advantages. Your out-of-pocket costs may vary between network and out-of-network benefits. There is no coinsurance when you use network pharmacies. Network pharmacies include retail, mail order and specialty pharmacies. You may select a network pharmacy from the Aetna Network Pharmacy Directory or by logging on the Aetna's website at www.aetna.com. You can search Aetna's online directory, DocFind, for names and locations of network pharmacies. If you cannot locate a network pharmacy in your area call Member Services.

You must present your ID card to the network pharmacy every time you get a prescription filled to be eligible for network benefits. The network pharmacy will calculate your claim online. You will pay any deductible, copayment or payment percentage directly to the network pharmacy.

You do not have to complete or submit claim forms. The network pharmacy will take care of claim submission.

When You Use an Out-of-Network Pharmacy

You can also access an out-of-network pharmacy to obtain covered prescription drugs. If you use an out-of-network pharmacy you will be responsible for paying coinsurance in the amount of 30% of the negotiated charges. You will pay the pharmacy for your prescription drugs at the time of purchase and submit a claim form to receive reimbursement from the plan. You are responsible for completing and submitting claim forms for reimbursement of covered expenses you paid directly to an out-of-network pharmacy. The plan will reimburse you for a covered expense up to the Recognized Charge, less any cost sharing required by you.

Cost Sharing

You share in the cost of your benefits. You will be responsible for the copayment for each prescription or refill. The copayment is payable directly to the network pharmacy at the time the prescription is dispensed.

After you pay the applicable copayment, you will be responsible for any applicable payment percentage for covered expenses that you incur. Your payment percentage is determined by applying the applicable payment percentage to the negotiated charge if the prescription is filled at a network pharmacy or the Recognized Charge if purchased at an out-of-network pharmacy charges. Please see the table below for a summary of your costs.

What the Plan Covers

Your prescription drug benefit coverage is based on Aetna's preferred drug formulary. The preferred drug formulary includes both brand-name prescription drugs and generic prescription

drugs. Your out-of-pocket expenses may be higher if your physician prescribes a covered prescription drug not appearing on the preferred drug formulary.

Prescriptions must be written by a prescriber licensed to prescribe federal legend prescription drugs.

Generic prescription drugs may be substituted by your pharmacist for brand-name prescription drugs. You may minimize your out-of-pocket expenses by selecting a generic prescription drug when available.

Coverage for prescription drugs and supplies is limited to the supply limits as described below.

Coverage of prescription drugs may be subject to precertification, step therapy or other Aetna requirements or limitations described below. Prescription drugs covered by this plan are subject to drug utilization review by Aetna and/or your provider and/or your network pharmacy.

Retail Pharmacy Benefits

Outpatient prescription drugs are covered when dispensed by a network retail pharmacy. Each prescription is limited to a maximum 30 day supply when filled at a network retail pharmacy. Prescriptions for more than a 30 day supply are not eligible for coverage when dispensed by a network retail pharmacy. All prescriptions and refills over a 30 day supply must be filled at a mail order pharmacy.

Drug Tier	Your Cost (30 day Supply Retail)	
	In Network	Out of Network
Preferred Generic Prescription Drugs	$5 copay	$5 copay and 30% coinsurance
Preferred Brand-Name Prescription Drugs	Greater of $5 or 20% of the negotiated charge, not to exceed $80	Copay of the greater of $5 or 20% of the negotiated charge, not to exceed $80 and 30% coinsurance of the negotiated charges
Non- Preferred Generic Prescription Drugs	$5 copay	$5 copay and 30% coinsurance
Non- Preferred Brand-Name Prescription Drugs	Greater of $5 or 35% of the negotiated charge, not to exceed $140	Copay of the greater of $5 or 35% of the negotiated charge, not to exceed $140 and 30% coinsurance of the negotiated charges

Mail Order Pharmacy Benefits

Outpatient prescription drugs are covered when dispensed by a network mail order pharmacy. The Plan does not provide out-of-network mail order pharmacy benefits. Each prescription is limited to a maximum 90 day supply when filled at a network mail order pharmacy. Prescriptions for less than a 30 day supply or more than a 90 day supply are not eligible for coverage when dispensed by a network mail order pharmacy.

Drug Tier	Your Cost (90 day Supply Mail Order)
Preferred Generic Prescription Drugs	$5 copay
Preferred Brand-Name Prescription Drugs	Greater of $5 or 20% of the negotiated charge, not to exceed $80
Non- Preferred Generic Prescription Drugs	$5 copay
Non- Preferred Brand-Name Prescription Drugs	Greater of $5 or 35% of the negotiated charge, not to exceed $140

Other Covered Expenses

Off-Label Use

FDA approved prescription drugs may be covered when the off-label use of the drug has not been approved by the FDA for that indication. The drug must be recognized for treatment of the indication in one of the standard compendia (the United States Pharmacopoeia Drug Information, the American Medical Association Drug Evaluations, or the American Hospital Formulary Service Drug Information). Or, the safety and effectiveness of use for this indication has been adequately demonstrated by at least one study published in a nationally recognized peer review journal. Coverage of off label use of these drugs may, in Aetna's sole discretion, be subject to precertification, step-therapy or other Aetna requirements or limitations.

Diabetic Supplies

The following diabetic supplies are covered upon prescription by a physician:

- Diabetic needles and syringes.
- Test strips for glucose monitoring and/or visual reading.
- Diabetic test agents.
- Lancets/lancing devices.
- Alcohol swabs.

Contraceptives

Covered expenses include charges made by a network pharmacy for the following contraceptive methods when prescribed and the prescription is submitted to the pharmacist for processing:

- Female contraceptives that are generic prescription drugs and brand-name prescription drugs.
- Female contraceptive devices.
- FDA-approved female generic emergency contraceptives.

The plan's copay or deductible are waived for contraceptives covered as a preventive benefit. The copay and deductible waiver does not apply to contraceptive methods that are:

- brand-name prescription drugs;

- FDA approved female brand-name emergency contraceptives.

However, the copay and deductible Waiver does apply when:

- such contraceptive methods are not available within the same therapeutic drug class; or
- a generic equivalent, or generic alternative, within the same therapeutic drug class is not available; and
- you are granted a medical exception.

Oral and Self-Injectable Infertility Drugs

Certain prescription drugs used for the purpose of treating infertility may be covered, including, but not limited to urofollitropin, menotropin, human chorionic gonadotropin and progesterone.

Precertification

Precertification is required for certain outpatient prescription drugs. Prescribers must contact Aetna or an affiliate to request and obtain coverage for such prescription drugs. The list of drugs requiring precertification is subject to periodic review and modification by Aetna. An updated copy of the list of drugs requiring precertification is available upon request or may be accessed on line and can be found in the Aetna preferred drug guide available online at www.aetna.com/formulary.

Failure to request precertification will result in reduction of benefits or denial of coverage, so be sure to ask your prescriber or pharmacist if the drug being considered requires precertification.

How to Obtain Precertification

If an outpatient prescription drug requires precertification and you use a network pharmacy the prescriber is required to obtain precertification for you.

When you use an out-of-network pharmacy, you can begin the precertification process by having the prescriber call Aetna at the number on your ID card. Aetna will let your prescriber know if the prescription drug is precertified. If precertification is denied Aetna will notify you how the decision can be appealed.

Step-Therapy

Step-therapy is another form of precertification. With step-therapy, certain medications will be excluded from coverage unless one or more “prerequisite therapy” medications are tried first or unless the prescriber obtains a medical exception. The plan will not cover the step-therapy drug if your prescriber does not prescribe a prerequisite drug first or fails to obtain a medical exception. Lists of the step-therapy drugs and prerequisite drugs are included in the Aetna preferred drug guide available upon request or online at www.aetna.com/formulary. The list of step therapy drugs are subject to change by Aetna.

Medical Exceptions

Your prescriber may seek a medical exception to obtain coverage for drugs for which coverage is denied through Precertification or Step Therapy. The prescriber must submit such exception requests to Aetna. Coverage granted as a result of a medical exception shall be based on an individual, case by case medical necessity determination and coverage will not apply or extend to other covered persons.

Pharmacy Benefit Limitations

A network pharmacy may refuse to fill a prescription order or refill when in the professional judgment of the pharmacist the prescription should not be filled.

The plan will not cover expenses for any prescription drug for which the actual charge to you is less than the required copayment or deductible, or for any prescription drug for which no charge is made to you.

You will be charged the out-of-network prescription drug cost sharing for prescription drugs recently approved by the FDA, but which have not yet been reviewed by the Aetna Health Pharmacy Management Department and Therapeutics Committee.

Aetna retains the right to review all requests for reimbursement and in its sole discretion make reimbursement determinations subject to the Complaint and Appeals section(s) of the Booklet.

The number of copayments/deductibles you are responsible for per vial of Depo-Provera, an injectable contraceptive, or similar type contraceptive dispensed for more than a 30 day supply, will be based on the 90 day supply level. Coverage is limited to a maximum of 5 vials per calendar year.

The plan will not pay charges for any prescription drug dispensed by a mail order pharmacy for the treatment of erectile dysfunction, impotence or sexual dysfunction or inadequacy.

Pharmacy Benefit Exclusions

Not every health care service or supply is covered by the plan, even if prescribed, recommended, or approved by your physician or dentist. These prescription drug exclusions are in addition to the exclusions listed under your medical coverage. The plan does not cover the following expenses:

1. Administration or injection of any drug.
2. Any charges in excess of the benefit, dollar, day, or supply limits stated in this Booklet.
3. Allergy sera and extracts.
4. Any non-emergency charges incurred outside of the United States 1) if you traveled to such location to obtain prescription drugs, or supplies, even if otherwise covered under this Booklet, or 2) such drugs or supplies are unavailable or illegal in the United States, or 3) the purchase of such prescription drugs or supplies outside the United States is considered illegal.
5. Any drugs or medications, services and supplies that are not medically necessary, as determined by Aetna, for the diagnosis, care or treatment of the illness or injury involved. This applies even if they are prescribed, recommended or approved by your physician or dentist.
6. Biological sera, blood, blood plasma, blood products or substitutes or any other blood products.
7. Contraception. Over the counter contraceptive supplies including but not limited to:
   - condoms;
   - contraceptive foams;
   - jellies;
   - ointments; or
   - services associated with the prescribing, monitoring and/or administration of contraceptives.
8. Cosmetic drugs, medications or preparations used for cosmetic purposes or to promote hair growth, including but not limited to:

- health and beauty aids;
- chemical peels;
- dermabrasion;
- treatments;
- bleaching;
- creams; or
- ointments or other treatments or supplies, to remove tattoos, scars or to alter the appearance or texture of the skin.

9. Drugs given or entirely consumed at the time and place it is prescribed or dispensed.
10. Drugs or supplies used for the treatment of erectile dysfunction, impotence or sexual dysfunction or inadequacy in oral, injectable and topical forms or any other form used internally or externally (including but not limited to gels, creams, ointments and patches). Any prescription drug in oral, topical or any other form that is in a similar or identical class, has a similar or identical mode of action or exhibits similar or identical outcomes including but not limited to:
    - Sildenafil citrate;
    - Phentolamine;
    - Apomorphine;
    - Alprostadil; or
    - Any other prescription drug that is in a similar or identical class; or has a similar or identical mode of action or exhibits similar or identical outcomes.
11. Drugs which do not, by federal or state law, need a prescription order (i.e. over-the-counter (OTC) drugs), even if a prescription is written.
12. Drugs given by, or while the person is an inpatient in, any healthcare facility; or for any drugs provided on an outpatient basis in any such institution to the extent benefits are payable for it.
13. Drugs used primarily for the treatment of infertility, or for or related to artificial insemination, in vitro fertilization, or embryo transfer procedures, except as described in the *What the Plan Covers* section.
14. Drugs used for the purpose of weight gain or reduction, including but not limited to:
    - stimulants;
    - preparations;
    - foods or diet supplements;
    - dietary regimens and supplements;
    - food or food supplements;
    - appetite suppressants; and
    - other medications.
15. Drugs used for the treatment of obesity.

16. Durable medical equipment, monitors and other equipment.
17. Experimental or investigational drugs or devices, except as described in the *What the Plan Covers* section. This exclusion will not apply with respect to drugs that:
    - Have been granted treatment investigational new drug (IND); or Group c/treatment IND status; or
    - Are being studied at the Phase III level in a national clinical trial sponsored by the National Cancer Institute; and
    - Aetna determines, based on available scientific evidence, are effective or show promise of being effective for the illness.
18. Food items: Any food item, including infant formulas, nutritional supplements, vitamins, medical foods and other nutritional items, even if it is the sole source of nutrition.
19. Genetics: Any treatment, device, drug, or supply to alter the body's genes, genetic make-up, or the expression of the body's genes except for the correction of congenital birth defects.
20. Immunization or immunological agents. Implantable drugs and associated devices.
21. Injectables:
    - Any charges for the administration or injection of prescription drugs or injectable insulin and other injectable drugs covered by the Plan;
    - Needles and syringes, except for diabetic needles and syringes;
    - Injectable drugs if an alternative oral drug is available;
    - For any refill of a designated self-injectable drug not dispensed by or obtained through the specialty pharmacy network. An updated copy of the list of self-injectable drugs designated by this plan to be refilled by or obtained through the specialty pharmacy network is available upon request or may be accessed at the Aetna website at www.aetna.com.
22. Insulin pumps or tubing or other ancillary equipment and supplies for insulin pumps.
23. Prescription drugs for which there is an over-the-counter (OTC) product which has the same active ingredient and strength even if a prescription is written.
24. Prescription drugs, medications, injectables or supplies provided through a third-party vendor contract with the contract holder.
25. Prescription orders filled prior to the effective date or after the termination date of coverage under this Booklet.
26. Prophylactic drugs for travel.
27. Refills in excess of the amount specified by the prescription order. Before recognizing charges, Aetna may require a new prescription or evidence as to need, if a prescription or refill appears excessive under accepted medical practice standards.
28. Refills dispensed more than one year from the date the latest prescription order was written, or as otherwise permitted by applicable law of the jurisdiction in which the drug is dispensed.
29. Replacement of lost or stolen prescriptions.
30. Drugs, services and supplies provided in connection with treatment of an occupational injury or occupational illness.

31. Strength and performance: Drugs or preparations, devices and supplies to enhance strength, physical condition, endurance or physical performance, including performance enhancing steroids.
32. Sexual dysfunction/enhancement: Any drug, or supply to treat sexual dysfunction, enhance sexual performance or increase sexual desire, including:
    - Drugs, implants, devices or preparations to correct or enhance erectile function, enhance sensitivity, or change the shape or appearance of a sex organ.
    - Supplies, devices or equipment of any type, except as specifically provided in the *What the Plan Covers* section.
33. Test agents except diabetic test agents.

VISION BENEFIT PLAN

What the Plan Covers

This plan covers charges for certain vision care supplies described below. The plan limits coverage to a maximum benefit amount per benefit period. You are responsible for any cost-sharing amounts, and any expenses you incur in excess of the benefit maximum. You may also have vision benefits under the medical plan. Please see the medical plan portion of this booklet for more details on this benefit.

Vision Network

Effective January 1, 2019, The Plan has contracted with Vision Service Plan (VSP) to provide you a vision network. For maximum benefits, it is to your advantage to see a VSP network provider. When you go to a VSP network provider, there are no claim forms for you to file. When you go to a non-VSP provider, you must pay for the vision services at the time you receive them and then file a claim with VSP. The Plan does not cover out-of-network exams.

To locate a VSP doctor, contact VSP at www.vsp.com or call (800) 877-7195.

Vision Supplies and Exam Benefits

The plan covers 100% of the usual, customary and reasonable charges for one exam from an in-network, legally qualified ophthalmologist, optometrist or optician every two calendar years. Out of network exams are not covered by the plan.

This plan also covers charges for lenses (single, bifocal, trifocal and lenticular), frames, or prescription contact lenses when prescribed by a legally qualified ophthalmologist or optometrist, up to the Vision Supply Maximum, per benefit period. The Vision Supply Maximum is up to $200 per calendar year.

Limitations

All covered expenses are subject to the vision expense exclusions in this Booklet and are subject to the deductible(s), copayments or payment percentage listed herein.

Coverage is subject to the exclusions listed in the Vision Expense Plan section of this Booklet.

Benefits for Vision Care Supplies After Your Coverage Terminates

If your coverage under the plan terminates while you are not totally disabled, the plan will cover expenses you incur for eyeglasses and contact lenses, up to the Vision Supply Maximum, within 30 days after your coverage ends if:

- A complete eye exam was performed in the 30 days before your coverage ended, and the exam included refraction; and
- The exam resulted in lenses being prescribed for the first time, or new lenses ordered due to a change in prescription.

Vision Plan Exclusions

Not every vision care service or supply is covered by the plan, even if prescribed, recommended, or approved by your physician. The plan covers only those services and supplies that are medically necessary. In addition to those exclusions set forth in the medical section above, charges made for the following vision expenses are not covered:

1. Any charges in excess of the benefit, dollar, or supply limits stated in this Booklet.

2. Any exams given during your stay in a hospital or other facility for medical care.
3. An eye exam, or any part of an eye exam, performed for the purpose of the fitting of contact lenses.
4. Eye surgery for the correction of vision, including radial keratotomy, LASIK and similar procedures.
5. For prescription sunglasses or light sensitive lenses in excess of the amount which would be covered for non-tinted lenses.
6. For an eye exam which:
   - Is required as a condition of employment; or
   - Is required under a labor agreement; or
   - Is required by any law of a government.
7. Prescription or over-the-counter drugs or medicines.
8. Special vision procedures, such as orthoptics, vision therapy or vision training.
9. Vision service or supply which does not meet professionally accepted standards.
10. Anti-reflective coatings.
11. Tinting of eyeglass lenses.
12. Duplicate or spare eyeglasses or lenses or frames for them.
13. Lenses and frames furnished or ordered because of an eye exam that was done before the date the person becomes covered.
14. Replacement of lost, stolen or broken prescription lenses or frames.
15. Special supplies such as nonprescription sunglasses and subnormal vision aids.
16. Vision services that are covered in whole or in part under any Workers' Compensation law or any other law of like purpose.

DENTAL BENEFIT PLAN

What the Plan Covers

This plan covers charges for certain dental care described below, subject to the annual deductible and coinsurance. The dental plan limits coverage to a calendar year maximum benefit. You are responsible for any cost-sharing amounts, and any expenses you incur in excess of the calendar year maximum benefit.

Obtaining Benefits

If you are an enrollee with Aetna Dental coverage, you don't need an ID card. When visiting a dentist, simply provide your name, date of birth and Member ID# (or social security number). The dental office can use that information to verify your eligibility and benefits. You can also access your benefits information when you're on the go. To learn more, visit www.aetna.com/mobile or call Aetna at 1-877-238-6200.

The plan is a Preferred Provider Organization (PPO) that covers a wide range of dental services and supplies. You can visit the dental provider of your choice when you need dental care. You can choose a dental provider who is in the dental network. You may pay less out of your own pocket when you choose a network provider. You have the freedom to choose a dental provider who is not in the dental network. You may pay more if you choose an out-of-network provider.

Annual Dental Deductible

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

Each person/calendar year	$50
Each family/calendar year	$150

Coinsurance

Once you have met the deductible, the plan typically pays the following coinsurance amounts based on the type of services received.

Type A Expenses	100% of the Recognized Charge
Type B Expenses	80% of the Recognized Charge
Type C Expenses	50% of the Recognized Charge

Examples of Type A, B and C Expenses are set forth in subsequent sections.

Calendar Year Maximum

Once your total out-of-pocket expenses (including deductibles, coinsurance and copays) reaches $1,250 no additional benefits will be paid.

Advance Claim Review

The purpose of the advance claim review is to determine, in advance, the benefits the plan will pay for proposed services. Knowing ahead of time which services are covered by the plan, and the benefit amount payable, helps you and your dentist make informed decisions about the care you are considering.

An advance claim review is recommended whenever a course of dental treatment is likely to cost more than $350. Ask your dentist to write down a full description of the treatment you need, using either an Aetna claim form or an ADA approved claim form. Then, before actually treating you, your dentist should send the form to Aetna. Aetna may request supporting x-rays and other diagnostic records. Once all of the information has been gathered, Aetna will review the proposed treatment plan and provide you and your dentist with a statement outlining the benefits payable by the plan. You and your dentist can then decide how to proceed. The advance claim review is voluntary. It is a service that provides you with information that you and your dentist can consider when deciding on a course of treatment. It is not necessary for emergency treatment or routine care such as cleaning teeth or check-ups. In determining the amount of benefits payable, Aetna will take into account alternate procedures, services, or courses of treatment for the dental condition in question in order to accomplish the anticipated result.

Type A Expenses: Diagnostic and Preventive Care

- Office visit during regular office hours, for routine comprehensive or recall examination (limited to 2 visits every year) or problem-focused examination (limited to 2 visits every year)
- Prophylaxis (cleaning) (limited to 2 treatments per year)
- Topical application of fluoride, (limited to one course of treatment per year and to children under age 16)
- Sealants, per tooth (limited to one application every 3 years for permanent molars only, and to children under age 16)
- Bitewing X-rays (limited to 1 set per year)
- Complete X-ray series, including bitewings if necessary, or panoramic film (limited to 1 set every 3 years)
- Vertical bitewing X-rays (limited to 1 set every 3 years)
- Periapical x-rays (single films up to 13)
- Space Maintainers Only when needed to preserve space resulting from premature loss of primary teeth. (Includes all adjustments within 6 months after installation.)

Type B Expenses: Basic Restorative Care

- Professional visit after hours (payment will be made on the basis of services rendered or visit, whichever is greater)
- Emergency palliative treatment, per visit
- Intra-oral, occlusal view, maxillary or mandibular
- Upper or lower jaw, extra-oral
- Biopsy and histopathologic examination of oral tissue
- Oral Surgeries, including extractions (erupted tooth/exposed root), impacted teeth (soft tissue), removal of odontogenic cysts and neoplasms
- Other Surgical Procedures:

Alveoplasty, in conjunction with extractions - per quadrant
Alveoplasty, in conjunction with extractions, 1 to 3 teeth or tooth spaces - per quadrant
Alveoplasty, not in conjunction with extraction - per quadrant
Alveoplasty, not in conjunction with extractions, 1 to 3 teeth or tooth spaces - per quadrant
Sialolithotomy: removal of salivary calculus
Closure of salivary fistula
Excision of hyperplastic tissue
Removal of exostosis
Transplantation of tooth or tooth bud
Closure of oral fistula of maxillary sinus
Sequestrectomy
Crown exposure to aid eruption
Removal of foreign body from soft tissue
Frenectomy
Suture of soft tissue injury

- Periodontics and Endodontics:
  Occlusal adjustment (other than with an appliance or by restoration)
  Root planing and scaling, per quadrant (limited to 4 separate quadrants every 2 years)
  Root planing and scaling – 1 to 3 teeth per quadrant (limited to once per site every 2 years)
  Gingivectomy, per quadrant (limited to 1 per quadrant every 3 years)
  Gingivectomy, 1 to 3 teeth per quadrant, limited to 1 per site every 3 years
  Gingival flap procedure - per quadrant (limited to 1 per quadrant every 3 years)
  Gingival flap procedure – 1 to 3 teeth per quadrant (limited to 1 per site every 3 years)
  Periodontal maintenance procedures following active therapy (limited to 2 per year)
  Localized delivery of antimicrobial agents
  Pulp capping
  Pulpotomy
  Apexification/recalcification
  Apicoectomy
  Root canal therapy including necessary X-rays
  Anterior
  Bicuspid
- Restorative Dentistry (Multiple restorations in 1 surface will be considered as a single restoration.):
  Amalgam restorations
  Resin-based composite restorations (other than for molars)
  Pins: Pin retention—per tooth, in addition to amalgam or resin restoration
  Crowns (when tooth cannot be restored with a filling material) - prefabricated stainless steel or resin crown (excluding temporary crowns)
  Recementation – inlay, crown and bridge

Type C Expenses: Major Restorative Care

- Oral Surgery - removal of impacted teeth (bony)
- Periodontics and Endodontics
  Osseous surgery (including flap and closure), 1 to 3 teeth per quadrant, limited to 1 per site, every 3 years
  Osseous surgery (including flap and closure), per quadrant, limited to 1 per quadrant, every 3 years
  Soft tissue graft procedures

Clinical crown lengthening, hard tissue
Full mouth Debridement once per lifetime
Root canal therapy Including necessary X-rays
Molar

- Restorative, not covered as Type B above
- Prosthodontics
  First installation of dentures and bridges is covered only if needed to replace teeth extracted while coverage was in force and which were not abutments to a denture or bridge less than 8 years old.
  Replacement of existing bridges or dentures is limited to 1 every 8 years.
  Bridge Abutments (See Inlays and Crowns)
  Pontics
  Removable Bridge (unilateral)
  Dentures and Partials (Fees for dentures and partial dentures include relines, rebases and adjustments within 6 months after installation. Fees for relines and rebases include adjustments within 6 months after installation. Specialized techniques and characterizations are not eligible.)
  Full and partial denture repairs
  Adding teeth to existing partial denture
  Repairs: crowns and bridges
  Occlusal guard (for bruxism only), limited to 1 every 3 years
- General Anesthesia and Intravenous Sedation (only when medically necessary and only when provided in conjunction with a covered surgical procedure)

Replacement Rule

Crowns, inlays, onlays and veneers, complete dentures, removable partial dentures, fixed partial dentures (bridges) and other prosthetic services are subject to the plan's replacement rule. That means certain replacements of, or additions to, existing crowns, inlays, onlays, veneers, dentures or bridges are covered only when you give proof to Aetna that:

- While you were covered by the plan, you had a tooth (or teeth) extracted after the existing denture or bridge was installed. As a result, you need to replace or add teeth to your denture or bridge.
- The present crown, inlay and onlay, veneer, complete denture, removable partial denture, fixed partial denture (bridge), or other prosthetic service was installed at least 8 years before its replacement and cannot be made serviceable.
- You had a tooth (or teeth) extracted while you were covered by the plan. Your present denture is an immediate temporary one that replaces that tooth (or teeth). A permanent denture is needed, and the temporary denture cannot be used as a permanent denture. Replacement must occur within 12 months from the date that the temporary denture was installed.

Tooth Missing but Not Replaced Rule

The first installation of complete dentures, removable partial dentures, fixed partial dentures (bridges), and other prosthetic services will be covered if:

- The dentures, bridges or other prosthetic services are needed to replace one or more natural teeth that were removed while you were covered by the plan; and
- The tooth that was removed was not an abutment to a removable or fixed partial denture installed during the prior 8 years. The extraction of a third molar does not qualify. Any

such appliance or fixed bridge must include the replacement of an extracted tooth or teeth.

Alternate Treatment Rule

Sometimes there are several ways to treat a dental problem, all of which provide acceptable results. When alternate services or supplies can be used, the plan's coverage will be limited to the cost of the least expensive service or supply that is:

- Customarily used nationwide for treatment, and
- Deemed by the dental profession to be appropriate for treatment of the condition in question. The service or supply must meet broadly accepted standards of dental practice, taking into account your current oral condition.

You should review the differences in the cost of alternate treatment with your dental provider. Of course, you and your dental provider can still choose the more costly treatment method. You are responsible for any charges in excess of what the plan will cover.

Coverage for Dental Work Begun Before You Are Covered by the Plan

The plan does not cover dental work that began before you were covered by the plan. This means that the following dental work is not covered:

- An appliance, or modification of an appliance, if an impression for it was made before you were covered by the plan;
- A crown, bridge, or cast or processed restoration, if a tooth was prepared for it before you were covered by the plan; or
- Root canal therapy, if the pulp chamber for it was opened before you were covered by the plan.

Coverage for Dental Work Completed After Termination of Coverage

Your dental coverage may end while you or your covered dependent is in the middle of treatment. The plan does not cover dental services that are given after your coverage terminates. There is an exception. The plan will cover the following services if they are ordered while you were covered by the plan, and installed within 30 days after your coverage ends:

- Inlays;
- Onlays;
- Crowns;
- Removable bridges;
- Cast or processed restorations;
- Dentures;
- Fixed partial dentures (bridges); and
- Root canals.

"Ordered" means:

- For a denture: the impressions from which the denture will be made were taken.
- For a root canal: the pulp chamber was opened.

- For any other item: the teeth which will serve as retainers or supports, or the teeth which are being restored:
- Must have been fully prepared to receive the item; and
- Impressions have been taken from which the item will be prepared.

Dental/Medical Integration

This plan provides additional dental expenses as covered expenses for you and your covered dependent if you have medical coverage administered by Aetna and are pregnant, have coronary artery disease/cardiovascular disease, cerebrovascular disease, or diabetes. These additional covered dental expenses are:

- One additional prophylaxis (cleaning) per year.
- Scaling and root planing, (4 or more teeth); per quadrant;
- Scaling and root planing (limited to 1-3 teeth); per quadrant;
- Full mouth debridement;
- Periodontal maintenance (one additional treatment per year); and
- Localized delivery of antimicrobial agents. (Not covered for pregnancy)

The additional prophylaxis benefit is payable the same as other prophylaxis under the plan.

The payment percentage applied to the other covered dental expenses above will be 100% for network expenses and 100% for out-of-network expenses. These additional benefits are not subject to any frequency limits except as shown above or any calendar year maximum.

Aetna will reimburse the provider directly, or you may pay the provider directly and then submit a claim for reimbursement for covered expenses.

Dental Plan Exclusions

Not every dental care service or supply is covered by the plan, even if prescribed, recommended, or approved by your dentist. The plan covers only those services and supplies that are medically necessary. In addition to those exclusions set forth in the medical section above, charges made for the following dental expenses are not covered:

1. Any charges in excess of the benefit, dollar, or supply limits stated in this Booklet.
2. Cosmetic services and supplies including plastic surgery, reconstructive surgery, cosmetic surgery, personalization or characterization of dentures or other services and supplies which improve alter or enhance appearance, augmentation and vestibuloplasty, and other substances to protect, clean, whiten bleach or alter the appearance of teeth; whether or not for psychological or emotional reasons; except to the extent coverage is specifically provided in the *What the Plan Covers* section. Facings on molar crowns and pontics will always be considered cosmetic.
3. Crown, inlays and onlays, and veneers unless:
   - It is treatment for decay or traumatic injury and teeth cannot be restored with a filling material; or
   - The tooth is an abutment to a covered partial denture or fixed bridge.
4. Dental implants, braces, mouth guards, and other devices to protect, replace or reposition teeth and removal of implants.

5. Dental services and supplies that are covered in whole or in part:
   - Under any other part of this plan; or
   - Under any other plan of group benefits.
6. Dentures, crowns, inlays, onlays, bridges, or other appliances or services used for the purpose of splinting, to alter vertical dimension, to restore occlusion, or correcting attrition, abrasion, or erosion.
7. Except as otherwise covered in this booklet, treatment of any jaw joint disorder and treatments to alter bite or the alignment or operation of the jaw, including temporomandibular joint disorder (TMJ) treatment, orthognathic surgery, and treatment of malocclusion or devices to alter bite or alignment.
8. First installation of a denture or fixed bridge, and any inlay and crown that serves as an abutment to replace congenitally missing teeth or to replace teeth all of which were lost while the person was not covered.
9. General anesthesia and intravenous sedation, unless specifically covered and only when done in connection with another necessary covered service or supply.
10. Orthodontic treatment except as covered in the *What the Plan Covers* section.
11. Pontics, crowns, cast or processed restorations made with high noble metals (gold or titanium).
12. Prescribed drugs; pre-medication; or analgesia.
13. Replacement of a device or appliance that is lost, missing or stolen, and for the replacement of appliances that have been damaged due to abuse, misuse or neglect and for an extra set of dentures.
14. Services and supplies done where there is no evidence of pathology, dysfunction, or disease other than covered preventive services.
15. Services and supplies provided for your personal comfort or convenience, or the convenience of any other person, including a provider.
16. Services and supplies provided in connection with treatment or care that is not covered under the plan.
17. Space maintainers except when needed to preserve space resulting from the premature loss of deciduous teeth. Surgical removal of impacted wisdom teeth only for orthodontic reasons.
18. Treatment by other than a dentist. However, the plan will cover some services provided by a licensed dental hygienist under the supervision and guidance of a dentist. These are:
   - Scaling of teeth;
   - Cleaning of teeth; and
   - Topical application of fluoride.

WEEKLY DISABILITY INCOME BENEFITS

If you are an actively working employee and become disabled because of a non-occupational injury or sickness, you may be eligible for weekly disability income benefits. To qualify for benefits, you must have been employed by a contributing employer for at least 30 days, your disability must commence while you are eligible for this benefit and you must be under continuous care and treatment of a physician or other covered provider. This benefit is not available to dependents.

Benefit

Effective January 1, 2019, the maximum benefit is $325 per week, net after FICA (Social Security) taxes have been withheld. However, the benefit will not exceed 70% of the employee's weekly earnings, minus the total amount of benefits, if any, the employee receives or is entitled to receive, for the same period of time from Federal Social Security Disability Benefits.

Benefits begin on the first day of disability due to an accidental injury or hospitalization, and on the fourth day of disability due to illness. Benefits are paid for a maximum of 26 weeks of a continuous disability.

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

A continuous disability includes all periods of disability due to the same or related causes separated by less than 30 days of full-time active work.

Taxation of Benefits

Weekly disability income benefit payments are subject to both federal income tax and FICA taxes. The Plan will automatically withhold the appropriate FICA tax from your weekly check and the Plan will pay the corresponding employer portion. The Plan will withhold federal income tax from your weekly check. The Plan will provide you a W-2 form at year-end for use in filing your federal income tax return.

Exclusions

1. Conditions caused by or arising from an act of war, armed invasion of aggression.
2. Disability beginning prior to the effective date of coverage.
3. Disease or injury arising out of, caused by, contributed to by, or arising out of, any employment, self-employment or occupation for compensation or profit. No benefits are available under this plan for any accident or sickness covered under any Workers' Compensation law or act, whether or not enrolled. Labor & Industries claims are excluded.
4. Injury sustained while committing or attempting to commit a felony

LIFE INSURANCE AND ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D) BENEFITS

This is only a summary of the Plan's life insurance and accidental death and personal loss benefits. If you would like more information about this Plan's benefits, please contact the Administration Office or Aetna. Their contact information is located on page 6 of this booklet.

What the Plan Covers

This Plan provides life insurance, in the event you or your dependent(s) die while covered by the Plan. It also provides accidental death and personal loss (ADPL) benefits for losses you suffer solely and as a direct result of accidental bodily injury that occurs while you are covered by the Plan.

Maximum Benefit

The maximum benefit payable by the Plan for Life Insurance or Accidental Death and Personal Loss is $3,000.

Life Insurance

The Plan's life insurance benefit is payable if you lose your life or a covered dependent loses his or her life while covered by the Plan. You, your spouse, and your dependent children, up to 19 years of age, can be covered by the Plan's life insurance benefit.

The Plan's life insurance benefit provides a benefit of up to the benefit maximum to your named beneficiary if you die while covered by the Plan. You must elect life insurance coverage within 31 days of coverage by the Plan and submit evidence of good health. If you fail to elect coverage and submit evidence of good health, you will not be eligible for life insurance coverage under the Plan.

In the event one of your dependents die while covered by the Plan's life insurance benefit, the plan will provide the following benefits:

Dependents Schedule

Classification	**Amount***
Wife or husband	$1,000
Unmarried child, age Live Birth to 6 months	$100
6 months to 2 years	$200
2 years but less than 3 years	$400
3 years but less than 4 years	$600
4 years but less than 5 years	$800
5 years and older	$1,000

*but not more than 50% of the amount of your life insurance under this plan.

Accelerated Death Benefits

This benefit provides a partial life insurance benefit if you or your spouse are diagnosed with a terminal illness and not expected to survive longer than 24 months. Please note: you or your spouse will not be eligible for this benefit if you, or your spouse, have assigned your life insurance benefits, or your spouse's life insurance benefits.

Accidental Death and Personal Loss

The accidental death and personal loss benefit provides benefits if the following events occur while you are covered by the Plan:

- Loss of life;
- Loss of a hand by actual and permanent severance at or above the wrist joint;
- Loss of a foot by actual and permanent severance at or above the ankle joint;
- Complete and irrevocable loss of sight in the eye;
- Total and permanent loss of speech or hearing in both ears;
- Loss of the thumb and index finger of the same hand by actual and permanent severance at or above the metacarpophalangeal joint of both fingers;
- Loss of speech or hearing that has lasted 12 months, unless a physician states otherwise;
- Paralysis, including quadriplegia, paraplegia, hemiplegia, and uniplegia, resulting from an accidental bodily injury;
- Coma, if you suffer bodily injury and are in a coma solely and as a direct result of an accident, the coma begins within 30 days of the accident, and you remain continually comatose for at least 30 days;
- Disappearance, if your body is not found, and no contrary evidence about the circumstances of your disappearance arise within one year of the disappearance, sinking, or wrecking of a conveyance you occupied.

Accidental Death and Personal Loss Benefits Payable

The Plan's benefits are expressed as a percentage of the maximum benefit payable by the Plan.

Covered Loss	Percentage of Maximum Benefit Payable by Plan
Loss of life	100% of Maximum Benefit
Loss of both feet, both hands, or the sight in both eyes	100% of Maximum Benefit
Loss of both speech and hearing in both ears	100% of Maximum Benefit
Quadriplegia	100% of Maximum Benefit
Loss of one hand, one foot or the sight in one eye	50% of Maximum Benefit
Loss of speech or hearing in both ears	50% of Maximum Benefit
Paraplegia or hemiplegia	50% of Maximum Benefit
Loss of thumb and index finger of the same hand	25% of Maximum Benefit

Covered Loss	Percentage of Maximum Benefit Payable by Plan
Uniplegia	25% of Maximum Benefit
Coma – 11 months	5% of Maximum Benefit/month payable for up to 11 months
Coma – 12 months	45% of Maximum Benefit if still comatose in 12th month
Third degree burns – 75% or more of body	100% of Maximum Benefit
Third degree burns – 50% to 74% of body	50% of Maximum Benefit

Naming Your Beneficiary

Your beneficiary is the individual or individuals you designate to receive your life insurance benefits in the event you die while covered. If you name more than one beneficiary, the life insurance benefits will be paid out equally to your beneficiaries, unless you designate otherwise on the form.

In order to designate your beneficiary or beneficiaries, you must complete the beneficiary designation form, which you can request from the Trust Office. You may change your beneficiaries at any time. No other person can change your beneficiary designation.

If you have not named any beneficiaries, or if you named a beneficiary and they die before you, payment will be made as follows to those who survive you:

- Your spouse, if any;
- If no spouse, then in equal shares to your children;
- If you have no spouse or children, to your parents, equally or to the survivor;
- If you have no spouse, children or living parents, to your brothers and sisters in equal shares;
- If you have none of the above, then to your executors or administrators.

When Coverage Ends

Life insurance and accidental death and personal loss coverage ends when you retire. Please see the Plan's eligibility section for other questions regarding eligibility.

When Coverage Ends for Members

Your coverage under the plan will end if:

- The plan is discontinued;
- You voluntarily stop your coverage;
- The group policy ends;
- You are no longer eligible for coverage;
- You do not make any required contributions;
- You become covered under another plan offered by the Trust; or
- Your employment stops for any reason, including job elimination or being placed on severance. This will be either the date you stop active work, or the day before the first

premium due date that occurs after you stop active work. However, if premium payments are made on your behalf, the Plan may deem your employment to continue, for purposes of remaining eligible for coverage under this Plan, as described below:

- If you are not **actively at work** due to **illness or injury**, your coverage may continue until stopped by the Trust, but not beyond 12 months from the start of the absence.
- If you are not **actively at work** due to temporary lay-off or leave of absence, your coverage may continue until stopped by the Trust. Your coverage will not continue beyond the end of the policy month after the policy month in which your absence started. A "policy month" is defined in the group policy on file with the Trust.
- If you are eligible as a permanently and totally disabled member, your coverage may be deemed to continue for Life Insurance while you remain eligible.

It is your or your employer's responsibility to let the Plan know when your employment ends. The limits above may be extended only if the Plan agrees, in writing, to extend them.

When Coverage Ends for Dependents

Coverage for your dependents will end if:

- You are no longer eligible for dependents' coverage;
- You do not make your contribution for the cost of dependents' coverage;
- Your own coverage ends for any of the reasons listed under *When Coverage Ends* for Members;
- Your dependent is no longer eligible for coverage. Coverage ends at the end of the calendar month when your dependent does not meet the plan's definition of a dependent;
- As permitted under applicable federal and state law, your dependent becomes eligible for like benefits under this or any other group plan offered by the Trust as a member; or
- Your life insurance is being extended under this Plan as a permanently and totally disabled member.
- A "domestic partner" will no longer be considered to be a defined dependent on the date of termination of the domestic partnership. In that event, you should provide the Plan with a completed and signed Declaration of Termination of Domestic Partnership.

Coverage for dependents may continue for a period after your death. Life Insurance for your fully handicapped dependent child may be continued past the maximum age for a dependent child, provided that the child has not been issued an individual life conversion policy and that the child's age had not exceeded the maximum age for dependent children under this plan when you became eligible.

Converting to an Individual Life Insurance Policy

You may be eligible to apply for an individual life insurance policy, called a conversion policy, if the group plan coverage for you or your dependents ends because:

- Your employment was terminated;
- You are no longer in an eligible class; or
- Your coverage amount has been reduced because of the group policy age, pension or retirement reductions.

You may also convert your covered dependent's life insurance to an individual policy, if:

- You are no longer in an eligible class that is eligible for dependent coverage; or
- Your dependent no longer qualifies as a covered dependent due to age.

Your dependents may convert their coverage as an individual policy if their coverage ends because:

- Your marriage ends in divorce or annulment; or
- You die.

In these circumstances, an application for conversion can be completed and submitted to **Aetna** without providing proof of good health. You or your dependents will need to apply for an individual policy with Aetna within 31 days after your group life insurance coverage ends or is reduced. Aetna will set the premium cost for the converted policy at the customary rates in effect at the time the policy is issued. You will be responsible for making premium payments on a timely basis.

The amount of coverage in the conversion policy will be determined at the time of application. The policy will take into consideration:

- Your age or the age of your dependents,
- The group plan's policy value in force in the prior 5-year period and the current entitlement under the group plan,
- Aetna's available products at the time of application.

The provisions of the conversion policy may not be the same as the provisions of the group plan. The conversion policy may not be a term policy, may not include disability or other supplementary benefits, it may contain exclusions, or may have exclusions that are different from those in the group policy. Once your individual policy becomes effective it will replace the benefits and privileges of your former group plan. If you or your dependent die during the 31-day conversion period and before the individual policy becomes effective, benefits to your beneficiary will be paid through your group plan.

If You Are Totally Disabled

You may be entitled to certain rights or benefits under the life insurance portion of this plan if you are or become permanently and totally disabled. If you exercise your conversion privilege, and it is later determined that you are eligible for life insurance under this plan because you were permanently and totally disabled at the time your Life Insurance ended, please contact Aetna or the Trust's administrative office for more information.

Reporting of Life Insurance Claims and Accidental Death & Personal Loss Claims

A claim must be submitted to Aetna **in writing** within 90 days after the date of the loss for coverage. All claims must give proof of the nature and extent of the loss. You must furnish true and correct information as Aetna may reasonably request. Please contact the Trust Administrative Office for claim forms.

If, through no fault of your own, you are not able to meet the deadline for filing claim, your claim will still be accepted if you file as soon as possible. Unless you are legally incapacitated, late claims for Accidental Death and Personal Loss Coverages will not be covered if they are filed more than 2 years after the deadline.

Payment of Benefits

Benefits will be paid as soon as the necessary proof to support the claim is received. Written proof must be provided for all benefits. Any death benefit payable under the Life Insurance and Accidental Death and Personal Loss Plan for the loss of life will be paid in accordance with the beneficiary designation. Payment will be made in one sum.

If your beneficiary is a minor or, in Aetna's opinion, legally unable to give a valid release for payment of any life insurance benefit or accidental death and personal loss coverage, the benefit will be payable to the 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.

Any unpaid balance will be paid within 30 days of receipt by Aetna of the due written proof. This paragraph does not apply to Life Insurance. Aetna may pay up to $1,000 of any other benefit to any of your relatives whom it believes are fairly entitled to it. This can be done if the benefit is payable to you and you are a minor or not able to give a valid release. It can also be done if a benefit is payable to your estate. This paragraph does not apply to Life Insurance.

Contacting the Trust

If you have questions, would like a copy of the Plan Booklet, or have concerns about your medical, vision, or weekly time-loss benefits or coverage, you may contact the Trust at:

Welfare & Pension Administration Service, Inc. (WPAS)
Physical Address:
7525 SE 24th St, Suite 200
Mercer Island, WA 98040
Mailing Address:
P.O. Box 34203
Seattle, WA 98124-1203
(206) 441-7574
(844) 811-6789, Option 4
www.nwinsulationtrust.com

Contacting Aetna

If you have questions, comments or concerns about your prescription drug plan, dental benefits, life insurance, accidental death or personal loss benefits or coverage, or if you are required to submit information to Aetna, you may contact Aetna's Home Office at:

Aetna Life Insurance Company
151 Farmington Avenue
Hartford, CT 06156
www.aetna.com.

Exclusions

No benefits are payable for a loss caused or contributed by:

- 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).
- Bodily or mental infirmity.
- Commission of or attempted commission of a criminal act.
- Illness, ptomaine or bacterial infection*.

- Inhalation of poisonous gases.
- Intended or accidental contact with nuclear or atomic energy by explosion and/or release.
- Ligature strangulation resulting from auto-erotic asphyxiation.
- Intentionally self-inflicted injury.
- Medical or surgical treatment*.
- 3rd degree burns resulting from sunburn.
- Use of alcohol.
- Use of drugs, except as prescribed by a physician.
- Use of intoxicants.
- Use of alcohol or intoxicants or drugs while operating any form of a motor vehicle whether or not registered for land, air or water use. A motor vehicle accident will be deemed to be caused by the use of alcohol, intoxicants or drugs if it is determined that at the time of the accident you or your covered dependent were:
  - Operating the motor vehicle while under the influence of alcohol is a level which meets or exceeds the level at which intoxication would be presumed under the laws of the state where the accident occurred. If the accident occurs outside of the United States, intoxication will be presumed if the person's blood alcohol level meets or exceeds .08 grams per deciliter; or
  - Operating the motor vehicle while under the influence of an intoxicant or illegal drug; or
  - Operating the motor vehicle while under the influence of a prescription drug in excess of the amount prescribed by the physician; or
  - Operating the motor vehicle while under the influence of an over the counter medication taken in an amount above the dosage instructions.
- Suicide or attempted suicide (while sane or insane).
- War or any act of war (declared or not declared).

*These do not apply if the loss is caused by:

- An infection which results directly from the injury.
- Surgery needed because of the injury.

COORDINATION OF BENEFITS

This Coordination of Benefits (COB) provision applies to This Plan when you or your covered dependent has health coverage under more than one plan. “Plan” and “This Plan” are defined herein. The Order of Benefit Determination Rules below determines which plan will pay as the primary plan. The primary plan pays first without regard to the possibility that another plan may cover some expenses. A secondary plan pays after the primary plan and may reduce the benefits it pays so that payments from all group plans do not exceed 100% of the total allowable expense.

Getting Started - Important Terms

Allowable Expense means a health care service or expense, including, coinsurance and **copayments** and without reduction of any applicable **deductible**, that is covered at least in part by any of the Plans covering the person. When a Plan provides benefits in the form of services (for example an HMO), the reasonable cash value of each service will be considered an allowable expense and a benefit paid. An expense or service that is not covered by any of the Plans is not an allowable expense. Any expense that a health care provider by law or in accordance with a contractual agreement is prohibited from charging a covered person is not an allowable expense. The following are examples of expenses and services that are not allowable expenses:

1. If a covered person is confined in a private **hospital** room, the difference between the cost of a semi-private room in the **hospital** and the private room is not an allowable expense. This does not apply if one of the Plans provides coverage for a private room.
2. If a person is covered by 2 or more Plans that compute their benefit payments on the basis of reasonable or Recognized Charges, any amount in excess of the highest of the reasonable or Recognized Charges for a specific benefit is not an allowable expense.
3. If a person is covered by 2 or more Plans that provide benefits or services on the basis of negotiated charges, an amount in excess of the highest of the negotiated charges is not an allowable expense.
4. The amount a benefit is reduced or not reimbursed by the primary Plan because a covered person does not comply with the Plan provisions is not an allowable expense. Examples of these provisions are second surgical opinions, precertification of admissions, and preferred provider arrangements.
5. If all Plans covering a person are high deductible Plans and the person intends to contribute to a health savings account established in accordance with section 223 of the Internal Revenue Code of 1986, the primary high deductible Plan’s deductible is not an allowable expense, except as to any health expense that may not be subject to the deductible as described in section 223(c)(2)(C) of the Internal Revenue Code of 1986.

If a person is covered by one Plan that computes its benefit payments on the basis of reasonable or Recognized Charges and another Plan that provides its benefits or services on the basis of negotiated charges, the primary plan’s payment arrangements shall be the allowable expense for all the Plans. However, if the secondary plan has a negotiated fee or payment amount different from the primary plan and if the provider contract permits, that negotiated fee will be the allowable expense used by the secondary plan to determine benefits.

When a plan provides benefits in the form of services, the reasonable cash value of each service rendered shall be deemed an allowable expense and a benefit paid.

Closed Panel Plan(s). A plan that provides health benefits to covered persons primarily in the form of services through a panel of providers that have contracted with or are employed by the plan, and that limits or excludes benefits for services provided by other providers, except in cases of emergency or referral by a panel member.

Custodial Parent. A parent awarded custody by a court decree. In the absence of a court decree, it is the parent with whom the child resides more than one half of the calendar year without regard to any temporary visitation.

Plan. Any Plan providing benefits or services by reason of health care or treatment, which benefits or services are provided by one of the following:

- Group or nongroup, blanket, or franchise health insurance policies issued by insurers, including health care service contractors;

  Other prepaid coverage under service Plan contracts, or under group or individual practice;
- Uninsured arrangements of group or group-type coverage;
- Labor-management trustee Plans, labor organization plans, employer organization Plans, or employee benefit organization Plans;
- Medical benefits coverage in a group, group-type, and individual automobile “no-fault” and traditional automobile “fault” type contracts;
- Medicare or other governmental benefits;
- Other group-type contracts. Group type contracts are those which are not available to the general public and can be obtained and maintained only because membership in or connection with a particular organization or group.

If the Plan includes medical, prescription drug, dental, vision and hearing coverage, those coverages will be considered separate plans. For example, Medical coverage will be coordinated with other Medical plans, and dental coverage will be coordinated with other dental plans.

This Plan is any part of the contract that provides benefits for health care expenses.

Primary Plan/Secondary Plan. The order of benefit determination rules state whether This Plan is a Primary Plan or Secondary Plan as to another Plan covering the person. When This Plan is a primary Plan, its benefits are determined before those of the other Plan and without considering the other Plan’s benefits. When This Plan is a Secondary Plan, its benefits are determined after those of the other Plan and may be reduced because of the other Plan’s benefits. When there are more than two Plans covering the person, this Plan may be a Primary Plan as to one or more other Plans, and may be a Secondary Plan as to a different Plan or Plans.

Which Plan Pays First

When two or more plans pay benefits, the rules for determining the order of payment are as follows:

- The primary plan pays or provides its benefits as if the secondary plan or plans did not exist.
- A plan that does not contain a coordination of benefits provision that is consistent with this provision is always primary. There is one exception: coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package

of benefits may provide that the supplementary coverage shall be excess to any other parts of the plan provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base plan hospital and surgical benefits, and insurance type coverages that are written in connection with a closed panel plan to provide out-of-network benefits.

- A plan may consider the benefits paid or provided by another plan in determining its benefits only when it is secondary to that other plan.
- The first of the following rules that describes which plan pays its benefits before another plan is the rule to use:

1. Non-Dependent or Dependent. The plan that covers the person other than as a dependent, for example as an employee, member, subscriber or retiree is primary and the plan that covers the person as a dependent is secondary. However, if the 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 (e.g. 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, subscriber or retiree is secondary and the other plan is primary.
2. Child Covered Under More than One Plan. The order of benefits when a child is covered by more than one plan is:

A. The primary plan is the plan of the parent whose birthday is earlier in the year if:

- The parents are married or living together whether or not married;
- A court decree awards joint custody without specifying that one party has the responsibility to provide health care coverage or if the decree states that both parents are responsible for health coverage, the plan that covers the parent whose birthday falls earlier in the calendar year pays first, and the plan covers the parent whose birthday falls later in the calendar year pays second. If both parents have the same birthday, the plan that covered either of the parents longer is primary.

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

C. If the parents are separated or divorced or are not living together whether or not they have ever been married and there is no court decree allocating responsibility for health coverage, the order of benefits is:

- The plan of the custodial parent;
- The plan of the spouse of the custodial parent;
- The plan of the noncustodial parent; and then
- The plan of the spouse of the noncustodial parent.

D. If there is no custodial parent (i.e. the child is over age 18), the plan that covers the parent whose birthday falls earlier in the calendar year pays first, and the plan that covers the parent whose birthday falls later in the calendar year pays second.

For a dependent child covered under more than one plan of individuals who are not the parents of the child, the order of benefits should be determined as outlined above as if the individuals were the parents.

The word “birthday” refers only to the month and day in the calendar year, not the year in which the person was born.

3. Active Employee or Retired or Laid off Employee. The plan that covers a person as an active employee who is neither laid off nor retired or as a dependent of an active employee, is the primary plan. The plan covering that same person as a retired or laid off employee or as a dependent of a retired or laid off employee is the secondary plan. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored. If a person is covered as a laid-off or retired employee under one plan and as a dependent of an active employee under another plan, the order of benefits is determined by the Non-Dependent or Dependent rules listed above.
4. Continuation Coverage. If a person whose coverage is provided under a right of continuation provided by federal or state law also is covered under another plan, the plan covering the person as an employee, member, subscriber or retiree (or as that person’s dependent) is primary, and the continuation coverage is secondary. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored. If a person is covered other than as a dependent (that is, as an employee, former employee retiree, member or subscriber) under a right of continuation of coverage under federal or state law under one plan and as a dependent of an active employee under another plan, the order of benefits is determined by the Non-Dependent or Dependent rules above.
5. If none of the four previous rules determines the order of benefits, the plan that covered the person for the longer period of time pays first; and the plan that covered the person for the shorter period of time pays second.

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

   B The start of a new plan does not include a change:

   - In the amount or scope of a plan’s benefits;
   - In the entity that pays, provides or administers the plan; or
   - From one type of plan to another (such as from a single employer plan to a multiple employer plan).

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

6. If the other coverage has not Coordination of Benefit rules, this Plan will always pay secondary.

How Coordination of Benefits Works

In determining the amount to be paid when this plan is secondary on a claim, the secondary plan will calculate the benefits that it would have paid on the claim in the absence of other health insurance coverage and apply that amount to any allowable expense under this plan that was unpaid by the primary plan. The amount will be reduced so that when combined with the amount paid by the primary plan, the total benefits paid or provided by all plans for the claim do not exceed 100 percent of the total allowable expense.

In addition, a secondary plan will credit to its plan deductible any amounts that would have been credited in the absence of other coverage.

Under the COB provision of this plan, the amount normally reimbursed for covered benefits or expenses under this plan is reduced to take into account payments made by other plans. The general rule is that the benefits otherwise payable under this plan for all covered benefits or expenses will be reduced by all other plan benefits payable for those expenses. When the COB rules of this plan and another plan both agree that this plan determines its benefits before such other plan, the benefits of the other plan will be ignored in applying the general rule above to the claim involved. Such reduced amount will be charged against any applicable benefit limit of this coverage.

If a covered person is enrolled in two or more closed panel plans COB generally does not occur with respect to the use of panel providers. However, COB may occur if a person receives emergency services that would have been covered by both plans.

Right To Receive And Release Needed Information

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits under this plan and other plans. Aetna and the Trust has the right to release or obtain any information and make or recover any payments it considers necessary in order to administer this provision.

Facility of Payment

Any payment made under another plan may include an amount, which should have been paid under this plan. If so, the Trust may pay that amount to the organization, which made that payment. That amount will then be treated as though it were a benefit paid under this plan. The Trust will not have to pay that amount again. The term “payment made” means reasonable cash value of the benefits provided in the form of services.

Right of Recovery

If the Trust pays more than it should have paid under this COB provision, it may recover the excess from one or more of the persons it has paid or for whom it has paid; or any other person or organization that may be responsible for the benefits or services provided for the covered person. The “amount of the payments made” includes the reasonable cash value of any benefits provided in the form of services.

COORDINATION WITH MEDICARE

When You Have Medicare Coverage

This section explains how the benefits under this Plan interact with benefits available under Medicare.

Medicare, when used in this Booklet, means the health insurance provided by Title XVIII of the Social Security Act, as amended. It includes Health Maintenance Organization (HMO) or similar coverage that is an authorized alternative to Parts A and B of Medicare.

You are eligible for Medicare if you are:

- Covered under it by reason of age, disability, or
- End Stage Renal Disease
- Not covered under it because you:
  1. Refused it;
  2. Dropped it; or
  3. Failed to make a proper request for it.

If you are eligible for Medicare, the plan coordinates the benefits it pays with the benefits that Medicare pays. Sometimes, the plan is the primary payor, which means that the plan pays benefits before Medicare pays benefits. Under other circumstances, the plan is the secondary payor, and pays benefits after Medicare.

Which Plan Pays First

The plan is the primary payor when your coverage for the plan's benefits is based on current employment with your employer. The plan will act as the primary payor for the Medicare beneficiary who is eligible for Medicare:

- Solely due to age if the plan is subject to the Social Security Act requirements for Medicare with respect to working aged (i.e., generally a plan of an employer with 20 or more employees); and
- Due to diagnosis of end stage renal disease, but only during the first 30 months of such eligibility for Medicare benefits. This provision does not apply if, at the start of eligibility, you were already eligible for Medicare benefits, and the plan's benefits were payable on a secondary basis.

The plan is the secondary payor in all other circumstances. For retired employees age 65 age and over and their dependents age 65 and over, or dependents who are otherwise eligible for Medicare, benefits will be coordinated with Medicare as the primary insurer and this plan as the secondary insurer, whether the retired person has enrolled in Medicare B or not.

How Coordination With Medicare Works

When the Plan is Primary - The plan pays benefits first when it is the primary payor. You may then submit your claim to Medicare for consideration.

When Medicare is Primary - Your health care expense must be considered for payment by Medicare first. You may then submit the expense to Aetna or the Trust for consideration.

Aetna will calculate the benefits the plan would pay in the absence of Medicare:

- The amount will be reduced so that when combined with the amount paid by Medicare, the total benefits paid or provided by all plans for the claim do not exceed 100 percent of the total allowable expense.

This review is done on a claim-by-claim basis.

Charges used to satisfy your Part B deductible under Medicare will be applied under the plan in the order received by Aetna. Aetna will apply the largest charge first when two or more charges are received at the same time.

Aetna will apply any rule for coordinating health care benefits after determining the benefits payable.

Right to Receive and Release Required Information

Certain facts about health care coverage and services are required to apply coordination of benefits (COB) rules to determine benefits under This Plan and other plans. Aetna has the right to obtain or release any information, and make or recover any payments it considers necessary, in order to administer this provision.

THIRD-PARTY REIMBURSEMENT AND OVERPAYMENTS

Right to Reimbursement

The provisions of this section apply to all current or former plan participants and also to the parents, guardian, or other representative of a dependent child who incurs claims and is or has been covered by the plan. The plan's right to reimbursement shall apply to the personal representative of your estate, your decedents, minors, and incompetent or disabled persons. "You" or "your" includes anyone on whose behalf the plan pays benefits. No adult covered person hereunder may assign any rights that it may have to recover medical expenses from any tortfeasor or other person or entity to any minor child or children of said adult covered person without the prior express written consent of the plan.

The plan's right of reimbursement, as set forth below, extends to all insurance coverage available to you due to an injury, illness or condition for which the plan has paid medical claims (including, but not limited to, liability coverage, uninsured motorist coverage, underinsured motorist coverage, personal umbrella coverage, medical payments coverage, Workers' Compensation coverage, no-fault automobile coverage or any first party insurance coverage).

Your health plan is always secondary to automobile no-fault coverage, personal injury protection coverage, or medical payments coverage.

1. The plan excludes medical, prescription drug, dental and time loss benefits for any injury or illness caused by the act or omission of another person, (known as the "third party"), where a potential opportunity for recovery exists from the third party, including, but not limited to, an injury or illness potentially covered by any liability policy of a third party or first party coverage available under an automobile insurance policy (including coverage for underinsured or uninsured motorist), homeowners policy or commercial premises policy. If an eligible individual has a potential right of recovery for which a third party or insurer may have legal responsibility, the plan, as a convenience to the eligible individual, may advance benefits pending the resolution of the claim. However, the plan’s payment of benefits is conditioned upon reimbursement from any judgment, settlement, disputed claim settlement, or other recovery, up to the full amount of all benefits provided by the plan, but not to exceed the amount of the recovery.
2. If the plan provides benefits, the plan is entitled to reimbursement of all benefits paid, regardless of whether the eligible individual is made whole by the recovery, and regardless of the characterization of the recovery, except that if the eligible individual complies with the terms of the plan and any agreement to reimburse, the plan will deduct reasonable attorney fees and a pro rata share of the costs from the reimbursement amount, as described below. Costs incurred solely for the benefit of the eligible individual shall be the responsibility of the eligible individual. The plan’s deduction for attorney fees and costs is contingent on compliance with the plan’s reimbursement provisions and/or the agreement to reimburse.
3. Prior to advancing funds on the eligible individual’s behalf, the plan can require that an eligible individual and the eligible individual’s attorney execute an agreement acknowledging this plan’s reimbursement right, and provide the name and address of the party at fault, the name of any insurance company through which coverage may be available, the name of any other lien holders involved, a factual description of the accident and/or injury or illness, and any other information requested by the plan to protect its reimbursement interest.

4. When any recovery is obtained from a third party or insurer, an amount sufficient to satisfy the plan's reimbursement amount must be paid into a trust account or escrow and held there until the plan's claims are resolved by mutual agreement or court order. The eligible individual shall request written permission from the plan prior to distribution of any settlement funds prior to satisfaction of the plan's reimbursement interest. The obligation to place the reimbursement amount in trust is independent of the obligation to reimburse the plan. If the funds necessary to satisfy the plan's reimbursement amount are not placed in trust, the eligible individual, or the individual who receives or distributes the recovery funds shall be liable for any loss the plan suffers as a result.
5. The plan may cease advancing benefits, if there is a reasonable basis to determine that the eligible individual or the eligible individual's attorney will not honor the terms of the plan or the agreement to reimburse, or there is a reasonable basis to determine that the agreement is not enforceable.
6. After recovery by the eligible individual, and pending reimbursement to the plan, the plan may elect to recoup the reimbursement amount from benefit payments, including benefit payments for the eligible individual's family members, by denying such payments until the amount of benefits provided has been recovered. The plan may also seek to recoup the reimbursement amount from the source to which benefits were paid.
7. If the plan is not reimbursed, it may bring an action against the eligible individual to enforce its right to reimbursement and/or the agreement to reimburse, or to seek a constructive trust, or in the alternative may elect to recoup the reimbursement amount by offsetting future benefits. If the plan is forced to bring a legal action, it shall be entitled to its reasonable attorney fees, costs of collection and court costs.

Motor Vehicle Personal Injury Protection

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

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

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

Repayment of Improperly Paid Benefits

If the plan mistakenly makes a payment for you or your dependents to which they are not entitled, if the plan pays an individual who is not eligible for benefits at all or if an eligible individual fails to observe the plan's Third-Party Reimbursement provisions, the plan has the right to recover the payment from the eligible individual paid or anyone else who benefited from it, including the individual or the provider of services. The plan may also pursue recovery from any individual or entity responsible for providing misinformation to or failing to provide necessary

information to the plan that has resulted in the payment of improper benefits. The plan's right of recovery includes the right to deduct the amount paid by mistake from future benefits payable to the affected eligible individual or any other individual where eligibility is established through the same eligible individual. The plan may also recover benefits from the person responsible for misreporting any person for eligibility purposes. By accepting benefits from the plan, you agree that any court proceeding with respect to this provision may be brought in any court of competent jurisdiction as the plan may elect. By accepting such benefits, you hereby submit to each such jurisdiction, waiving whatever rights may correspond by reason of your present or future domicile. By accepting such benefits, you also agree to pay all attorneys' fees the plan incurs in successful attempts to recover amounts the plan is entitled to under this section.

Recovery of Overpayments

If a benefit payment is made by the Plan, to or on your behalf, which exceeds the benefit amount that you are entitled to receive, the Plan has the right:

- To require the return of the overpayment; or
- To reduce by the amount of the overpayment, any future benefit payment made to or on behalf of that person or another person in his or her family.

Such right does not affect any other right of recovery the Plan may have with respect to such overpayment.

BENEFIT CLAIMS PROCESSING, DENIALS AND APPEALS

Reporting of Claims

A claim for benefits is a request for Plan benefits. A claim must be submitted electronically or in writing. Except for Vision, Weekly Disability Income Benefits, and claims for which Medicare is the primary payer, your medical provider (in-network and out-of-network) will submit your claim to Aetna. .

With respect to vision claims, you must submit a claim electronically or in writing to VSP. Please go to www.vsp.com for claim forms. VSP will submit payment directly to your in-network vision provider or to you for out-of-network providers.

All claims should be reported promptly. The deadline for filing a claim is 90 days after the date of the claim was incurred or loss. If, through no fault of your own, you are not able to meet the deadline for filing claim, your claim will still be accepted if you file as soon as possible. Late claims for health benefits, including late receipt of information that the Administration Office may request to complete your claim will not be covered if they are submitted or completed more than 12 months after the expense(s) was incurred.

Payment of Benefits

All covered health benefits are payable to you. However, Aetna and VSP have the right to pay any health benefits to the in-network service provider. This will be done unless you have told Aetna or VSP otherwise by the time you file the claim.

With respect to your Life Insurance or Accidental Death or Dismemberment benefits, the Plan may pay up to $1,000 of any other benefit to any of your relatives whom it believes fairly entitled to it. This can be done if the benefit is payable to you and you are a minor or not able to give a valid release.

Records of Expenses

Keep complete records of the expenses of each person. They will be required when a claim is made. Very important are:

- Names of physicians, dentists and others who furnish services.
- Dates expenses are incurred.
- Copies of all bills and receipts.

Contacting Aetna

If you have questions, comments or concerns about your benefits or coverage, or if you are required to submit information to Aetna, you may contact Aetna's Home Office at:

Aetna Life Insurance Company
151 Farmington Avenue
Hartford, CT 06156

You may also use Aetna's toll free Member Services phone number on your ID card or visit Aetna's website at www.aetna.com.

If you have questions, comments or concerns about your Vision benefits or coverage, or if you need to submit a claim, contact VSP at:

VSP
PO Box 385018
Birmingham, AL 35238-5018
Telephone: 800-877-7195
www.vsp.com

Assignments

Coverage and your rights under this plan may not be assigned. A direction to pay a provider is not an assignment of any right under this plan or of any legal or equitable right to institute any court proceeding.

All payments for services by PPO providers will be made directly to such providers. In the case of non-PPO providers payments will be made, at the Trust's option, to the participant, to his or her estate, to the provider or as required under federal law, including qualified medical child support orders. No assignment whether made before or after services are provided, of any amount payable according to this Plan shall be recognized or accepted as binding upon the Trust, unless otherwise required by federal law.

Filing Health Claims under the Plan

Under the Plan, you may file claims for Plan benefits and appeal adverse claim determinations. Any reference to "you" in this Claims and Appeals section includes you and your Authorized Representative. An "Authorized Representative" is a person you authorize, in writing, to act on your behalf. The Plan will also recognize a court order giving a person authority to submit claims on your behalf. In the case of an urgent care claim, a health care professional with knowledge of your condition may always act as your Authorized Representative.

Claims and any information requested to complete the claim that is received by the Administration Office more than 12 months after the date services are received are not covered by the Plan and will not be reimbursed. In order for a claim to be considered received, all required information must be received within the 12 months from the date the claim is incurred.

If your claim is denied in whole or in part, you will receive a written notice of the denial from Aetna for dental and prescription drug claims. With respect to vision claims, you will receive written notice of the determination from VSP. For medical and weekly disability income claims, You will receive written notice of the determination of the claim from the Administration Office. The notice will explain the reason for the denial and the appeal procedures available under the Plan.

Weekly Disability Income Claims

You may file claims for weekly income disability benefits and appeal adverse claim determinations. If the claim is denied in whole or in part, you will receive written notice of the denial not later than 45 days after receipt of the claim. The Plan will notify you if a 30 day extension is necessary to issue a decision on your claim (up to a total of 75 days). If the Plan needs additional time to issue a decision on your claim, it will notify you prior to the end of the initial 45 day period. If the Plan determines that an additional extension of time 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.

Urgent Care Claims

An "Urgent Care Claim" is any claim for medical care or treatment for which the application of the time periods for making non-urgent care determinations could seriously jeopardize your life or health or your ability to regain maximum function, or, in the opinion of a physician with knowledge of your medical condition, would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

If the Plan requires advance approval of a service, supply or procedure before a benefit will be payable, and if Aetna or your physician determines that it is an Urgent Care Claim, you will be notified of the decision, whether adverse or not, as soon as possible but not later than 72 hours after the claim is received.

If there is not sufficient information to decide the claim, you will be notified of the information necessary to complete the claim as soon as possible, but not later than 24 hours after receipt of the claim. You will be given a reasonable additional amount of time, but not less than 48 hours, to provide the information, and you will be notified of the decision not later than 48 hours after the end of that additional time period (or after receipt of the information, if earlier).

Other Claims (Pre-Service and Post-Service)

If the Plan requires you to obtain advance approval of a non-urgent service, supply or procedure before a benefit will be payable, a request for advance approval is considered a pre-service claim. You will be notified of the decision not later than 15 days after receipt of the pre-service claim.

For other claims (post-service claims), you will be notified of the decision not later than 30 days after receipt of the claim.

For either a pre-service or a post-service claim, these time periods may be extended up to an additional 15 days due to circumstances outside the Plan's control. In that case, you will be notified of the extension before the end of the initial 15 or 30-day period. For example, they may be extended because you have not submitted sufficient information, in which case you will be notified of the specific information necessary and given an additional period of at least 45 days after receiving the notice to furnish that information. You will be notified of the claim decision no later than 15 days after the end of that additional period (or after receipt of the information, if earlier).

If services that require preauthorization 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.

For pre-service claims which name a specific claimant, medical condition, and service or supply for which approval is requested, and which are submitted to the Plan, but which otherwise fail to follow the Plan's procedures for filing pre-service claims, you will be notified of the failure within 5 days (within 24 hours in the case of an urgent care claim) and of the proper procedures to be followed. The notice may be oral unless you request written notification.

Ongoing Course of Treatment

Concurrent care claims are claims involving an ongoing course of treatment that has received medical necessity approval from the Plan. If you have received pre-authorization for an ongoing course of treatment, you will be notified in advance if the previously authorized course of treatment is intended to be terminated or reduced so that you will have an opportunity to appeal any decision to the Plan and receive a decision on that appeal before the termination or reduction takes effect. If this should occur, the Plan will notify you any denial or decision at least 30 days in advance to allow time to appeal and obtain a determination on the appeal before the decision takes effect.

Any request to extend treatment that involves urgent care is decided as soon as reasonably practical. If the course of treatment involves urgent care, and you request an extension of the course of treatment at least 24 hours before its expiration, you will be notified of the decision within 24 hours after receipt of the request.

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

Notice of Claim Denial

A benefit claim denial contains this information:

1. The reason for the denial.
2. Reference to the plan provision(s) on which the denial is based.
3. Description of any additional material needed for the claim, with an explanation of why it 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 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.
5. If the denial is based on medical necessity or experimental 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 external review and the right to bring a civil action under ERISA § 502(a).

Remedies Available if a Claim is Denied – Appeal Procedures

Notification of Appeal. Any Participant or beneficiary (hereafter "claimant") who applies for benefits and is ruled ineligible by the Trustees (or by the administrator acting for the Trustees), 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 appeal to and request review of the matter by the Board of Trustees, provided that he makes such a request, in writing, within 180 days after the Board's action or within 180 days after receipt of the notification or decision.

An “Adverse Benefit Determination” is defined as a denial, reduction, termination of, or failure to, provide or make payment (in whole or in part) for a service, supply or benefit. Such Adverse Benefit Determination may be based on:

- Your eligibility for coverage, including a retrospective termination of coverage (whether or not there is an adverse effect on any particular benefit);
- Coverage determinations, including plan limitations or exclusions;
- The results of any Utilization Review activities;
- A decision that the service or supply is experimental or investigational; or
- A decision that the service or supply is not medically necessary.

A “Final Internal Adverse Benefit Determination” is defined as an Adverse Benefit Determination that has been upheld by the Plan at the completion of the internal appeals process, or an Adverse Benefit Determination for which the internal appeals process has been exhausted.

Requests for appeal should be sent to the Administration Office at the following address:

Appeals Department
c/o WPAS, Inc.
P.O. Box 34203
Seattle, WA 98124-1203

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

Scheduling of 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. 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 appeal of a pre-service claim within 30 days after receipt of the appeal.

Appeal Procedures. A claimant is generally entitled to present the claimant's position and any evidence in support thereof, at an appeal hearing. Notwithstanding the foregoing, in order to expedite review, the appeal may be held telephonically by the Trustees. The claimant may request postponement of the Trustees' review if the claimant wishes to appear in person at a hearing.

A claimant may be represented by an attorney or by any other authorized representative of his choosing at his own expense.

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 the claim for benefits.

The claimant must introduce sufficient 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.

Decision after Appeal Hearing. The Trustees will issue a written decision on review of a claim (other than a pre-service claim) as soon as possible, but not later than 5 business 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 will be made within 30 days after receipt of the appeal. In the case of an adverse benefit determination, the written denial will indicate:

- The specific reasons for the adverse benefit determination and a specific reference to pertinent Plan provisions on which the denial is based.
- 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.
- A statement of the claimant's right to an external review and the right to bring a civil action under ERISA § 502(a).
- 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.

Review of Trustees' Decision. A claimant who remains dissatisfied after exhausting the appeal procedures may: request external review by an Independent Review Organization (IRO) (provided the claim is a medical claim involving medical judgment or rescission of health coverage); or bring a civil action under ERISA § 502(a). A claimant must exhaust the Internal Appeals Process prior to bringing a civil action or requesting external review by an IRO.

External Review. External review is only available if the claim on appeal involves medical judgment or the retroactive rescission of health coverage. There is no external review for dental,

vision, weekly disability, life insurance, accidental death and dismemberment, or Dependent life insurance.

A request for external review must be filed with Plan within four months from the claimant's receipt of the Trustees' decision on appeal. Requests for external review may be mailed to the following address:

Appeals Department
c/o WPAS, Inc.
P.O. Box 34203
Seattle, WA 98124-1203

Failure to file a request for external review within the four-month period will end the claimant's ability to seek external review.

Expedited External Review. A claimant may request an expedited external review if the claimant received an adverse decision on appeal to the Trustees which involved 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 the facility.

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 request. 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 IRO.

Review by Independent Review Organization (IRO). If a properly filed request for external review is received, the Plan will provide the IRO with the required documentation in the time required by applicable federal regulations. The IRO 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 IRO 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.

If the IRO directs that benefits be paid, benefits will be provided under the Plan in accordance with the decision. If the decision continues to be adverse, the claimant has the right to bring a civil action under ERISA § 502(a).

Judicial Review. If a claimant remains dissatisfied after issuance of the Trustees' decision on appeal, or issuance of the IRO'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 appeal. A failure to file a civil action within the one-year period will operate as a waiver of and bar the right to further review, and the decision of the Trustees will be final and binding.

The question on review of the Trustees' determination will be whether the Trustees' decision was an abuse of their discretion.

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

Weekly Disability Income Claims – Appeals

You may also file an appeal of an Adverse Benefit Determination with respect to Weekly Income Disability claim denials. In addition to the information that is provided with in connection with other claim appeals, the Plan will also:

- Provide you with any new or additional evidence considered, relied upon or generated by the Plan in connection with the claim. This evidence will be provided in advance of the date on which the Appeal of the Adverse Benefit Determination is to be decided, to give you a reasonable opportunity to respond prior to that date.
- Notify you if the Adverse Benefit Determination is based on a new or additional rationale, the basis for the determination in advance of the date of on which the Appeal of the Adverse Benefit Determination is to be decided, to give you a reasonable opportunity to respond prior to that date.

Exhaustion of Internal Appeals Process

Generally, you are required to complete all appeal processes of the Plan before being able to bring an action in litigation. However, if the Plan or its designee, does not strictly adhere to all claim determination and appeal requirements under applicable federal law, you are considered to have exhausted the Plan's appeal requirements ("Deemed Exhaustion") and may pursue any available remedies under §502(a) of ERISA or under state law, as applicable.

Board of Trustees has Exclusive Authority to Determine Eligibility

The Board of Trustees has the exclusive authority to interpret the provisions of the plan, to determine eligibility for an entitlement to plan benefits or to amend the plan. Any interpretation or determination by the Trustees made in good faith, which is not contrary to law, is conclusive on all persons affected.

GLOSSARY

Accident

This means a sudden; unexpected; and unforeseen; identifiable occurrence or event producing, at the time, objective symptoms of a bodily injury. The accident must occur while the person is covered under this Contract. The occurrence or event must be definite as to time and place. It must not be due to, or contributed by, an illness or disease of any kind.

Behavioral Health Provider/Practitioner

A licensed organization or professional providing diagnostic, therapeutic or psychological services for behavioral health conditions.

Birthing Center

A freestanding facility that meets all of the following requirements:

- Meets licensing standards.
- Is set up, equipped and run to provide prenatal care, delivery and immediate postpartum care.
- Charges for its services.
- Is directed by at least one physician who is a specialist in obstetrics and gynecology.
- Has a physician or certified nurse midwife present at all births and during the immediate postpartum period.
- Extends staff privileges to physicians who practice obstetrics and gynecology in an area hospital.
- Has at least 2 beds or 2 birthing rooms for use by patients while in labor and during delivery.
- Provides, during labor, delivery and the immediate postpartum period, full-time skilled nursing services directed by an R.N. or certified nurse midwife.
- Provides, or arranges with a facility in the area for, diagnostic X-ray and lab services for the mother and child.
- Has the capacity to administer a local anesthetic and to perform minor surgery. This includes episiotomy and repair of perineal tear.
- Is equipped and has trained staff to handle emergency medical conditions and provide immediate support measures to sustain life if:
  - Complications arise during labor; or
  - A child is born with an abnormality which impairs function or threatens life.
- Accepts only patients with low-risk pregnancies.
- Has a written agreement with a hospital in the area for emergency transfer of a patient or a child. Written procedures for such a transfer must be displayed and the staff must be aware of them.
- Provides an ongoing quality assurance program. This includes reviews by physicians who do not own or direct the facility.

- Keeps a medical record on each patient and child.

Cosmetic Services

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

Covered Expense

Medical, dental, vision or hearing services and supplies shown as covered under this Plan Booklet/SPD.

Covered Provider

A person licensed and practicing within the scope of their license to treat an illness or injury in the State in which the treatment is rendered.

Custodial Care

Services and supplies that are primarily intended to help you meet personal needs. Custodial care can be prescribed by a physician or given by trained medical personnel. It may involve artificial methods such as feeding tubes, ventilators or catheters. Examples of custodial care include:

- Routine patient care such as changing dressings, periodic turning and positioning in bed, administering medications;
- Care of a stable tracheostomy (including intermittent suctioning);
- Care of a stable colostomy/ileostomy;
- Care of stable gastrostomy/jejunostomy/nasogastric tube (intermittent or continuous) feedings;
- Care of a stable indwelling bladder catheter (including emptying/changing containers and clamping tubing);
- Watching or protecting you;
- Respite care, adult (or child) day care, or convalescent care;
- Institutional care, including room and board for rest cures, adult day care and convalescent care;
- Help with the daily living activities, such as walking, grooming, bathing, dressing, getting in or out of bed, toileting, eating or preparing foods;
- Any services that a person without medical or paramedical training could be trained to perform; and
- Any service that can be performed by a person without any medical or paramedical training.

Dentist

A legally qualified dentist, or a physician licensed to do the dental work he or she performs.

Durable Medical and Surgical Equipment (DME)

Equipment, and the accessories needed to operate it, that is:

- Made to withstand prolonged use;

- Made for and mainly used in the treatment of an illness or injury;
- Suited for use in the home;
- Not normally of use to people who do not have an illness or injury;
- Not for use in altering air quality or temperature; and
- Not for sports, exercise or training.

Durable medical and surgical equipment does not include equipment such as whirlpools, portable whirlpool pumps, sauna baths, massage devices, over bed tables, elevators, communication aids, vision aids and telephone alert systems.

Emergency Care

This means the treatment given in a hospital's emergency room to evaluate and treat an emergency medical condition.

Emergency Medical Condition

A recent and severe medical condition, including (but not limited to) severe pain, which would lead a prudent layperson possessing an average knowledge of medicine and health, to believe that his or her condition, illness, or injury is of such a nature that failure to get immediate medical care could result in:

- Placing your health in serious jeopardy; or
- Serious impairment to bodily function; or
- Serious dysfunction of a body part or organ; or
- In the case of a pregnant woman, serious jeopardy to the health of the fetus.

Experimental or Investigational Medical Care

Is a service or supply if any of the following apply:

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

used by the treating facility or the protocol(s) of another facility studying substantially the same drug, device, medical treatment or procedure; or the written informed consent used by the treating facility or by another facility studying substantially the same drug, device, medical treatment or procedure (except as provided below).

Exceptions: A service or supply will not be considered experimental or investigational if it is part of an approved clinical trial. An approved clinical trial is one that meets the criteria in either Category 1 or 2 below:

Category 1

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

Category 2

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

The plan's administrator shall investigate each claim for benefits that might include experimental or investigational treatment. The administrator may consult with medical professionals, including its own staff, to determine whether the treatment is excluded as experimental or investigational, or whether it is covered as one of the exceptions stated above.

Generally Accepted Professional Standards and/or Medical Practice

Generally Accepted Professional Standards and/or Medical Practice shall mean profession standards and practice set forth in published guidance published by nationally recognized peer-review organizations, such as the American Medical Association, American Board of Medical Specialties, American Board of Internal Medicine, American Academy of Professional Coders, as well as federal institutions, such as the Centers for Medicare & Medicare Services and the U.S. Department of Health and Human Services. Examples of published guidance include, but are not limited, to the most current versions of the Current Procedural Terminology (CPT), Healthcare Common Procedural Coding System (HCPCS), International Classification of Diseases, National Drug Codes (NDC), Code on Dental Procedures and Nomenclature, Diagnostic and Statistical Manual of Mental Disorders (DSM) and Medicare Provider Reimbursement Manual, and related interpretive materials published by the same or similar organization.

Homebound

This means that you are confined to your place of residence:

- Due to an illness or injury which makes leaving the home medically contraindicated; or
- Because the act of transport would be a serious risk to your life or health.

- Situations where you would not be considered homebound include (but are not limited to) the following:
- You do not often travel from home because of feebleness or insecurity brought on by advanced age (or otherwise); or
- You are wheelchair bound but could safely be transported via wheelchair accessible transportation.

Home Health Aide

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

Hospice Care Agency

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

Hospice Care Program

This is a written plan of hospice care, which:

- Is established by and reviewed from time to time by a physician attending the person, and appropriate personnel of a hospice care agency;
- Is designed to provide palliative and supportive care to terminally ill persons, and supportive care to their families; and
- Includes an assessment of the person's medical and social needs; and a description of the care to be given to meet those needs.

Hospice Facility

A facility, or distinct part of one, that meets all of the following requirements:

- Mainly provides inpatient hospice care to terminally ill persons.
- Charges patients for its services.
- Meets any licensing or certification standards established by the jurisdiction where it is located.
- Keeps a medical record on each patient.
- Provides an ongoing quality assurance program including reviews by physicians other than those who own or direct the facility.
- Is run by a staff of physicians. At least one staff physician must be on call at all times.
- Provides 24-hour-a-day nursing services under the direction of an R.N.
- Has a full-time administrator.

Hospital

An institution that:

- Is primarily engaged in providing, on its premises, inpatient medical, surgical and diagnostic services;
- Is supervised by a staff of physicians;
- Provides twenty-four (24) hour-a-day R.N. service,
- Charges patients for its services;
- Is operating in accordance with the laws of the jurisdiction in which it is located; and
- Does not meet all of the requirements above, but does meet the requirements of the jurisdiction in which it operates for licensing as a hospital and is accredited as a hospital by the Joint Commission on the Accreditation of Healthcare Organizations.

In no event, does hospital include a convalescent nursing home or any institution or part of one which is used principally as a convalescent facility, rest facility, nursing facility, facility for the aged, extended care facility, intermediate care facility, skilled nursing facility, hospice, rehabilitative hospital or facility primarily for rehabilitative or custodial services.

Institute of Excellence (IOE)

A hospital or other facility that has contracted with Aetna to give services or supplies to an IOE patient in connection with specific transplants, procedures at a negotiated charge. A facility is an IOE facility only for those types of transplants, procedures for which it has signed a contract.

Jaw Joint Disorder

This is:

- A Temporomandibular Joint (TMJ) dysfunction or any alike disorder of the jaw joint; or
- A Myofascial Pain Dysfunction (MPD); or
- Any alike disorder in the relationship of the jaw joint and the related muscles and nerves.

Maintenance Care

Care made up of services and supplies that:

- Are given mainly to maintain, rather than to improve, a level of physical, or mental function; and
- Give a surrounding free from exposures that can worsen the person's physical or mental condition.

Medically Necessary or Medical Necessity

Is a procedure, service or supply that meets all of the following criteria and limitations:

- It is appropriate to the diagnosis and/or treatment of the patient’s illness or injury.
- It is known to be effective in improving health outcomes for the patient’s medical condition in accordance with generally accepted standards of medical practice.
- It represents the most economically efficient use of medical services and supplies that may be provided safely and effectively to the patient, as determined by the Plan.
- It is not primarily for the convenience of the patient or provider.
- When applied to an inpatient, it cannot safely be provided to the patient as an outpatient.

A service or supply may be medically necessary in part only. The fact a procedure, service, or supply may be furnished, prescribed, recommended or approved by a physician or other covered provider does not, of itself, make it medically necessary under the terms of the plan.

For these purposes "generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer-reviewed literature. They must be generally recognized by the relevant medical community. Otherwise, the standards are consistent with physician specialty society recommendations. They must be consistent with the views of physicians practicing in relevant clinical areas and any other relevant factors.

Partial Confinement Treatment

A plan of medical, psychiatric, nursing, counseling, or therapeutic services to treat substance abuse or mental disorders. The plan must meet these tests:

- It is carried out in a hospital; psychiatric hospital or residential treatment facility; on less than a full-time inpatient basis.
- It is in accord with accepted medical practice for the condition of the person.
- It does not require full-time confinement.
- It is supervised by a psychiatric physician who weekly reviews and evaluates its effect.
- Day care treatment and night care treatment are considered partial confinement treatment.

Pharmacy

An establishment where prescription drugs are legally dispensed. Pharmacy includes a retail pharmacy, mail order pharmacy and specialty pharmacy network pharmacy.

Physician

A duly licensed member of a medical profession who:

- Has an M.D. or D.O. degree;
- Is properly licensed or certified to provide medical care under the laws of the jurisdiction where the individual practices; and
- Provides medical services which are within the scope of his or her license or certificate. This also includes a health professional who:
- Is properly licensed or certified to provide medical care under the laws of the jurisdiction where he or she practices;
- Provides medical services which are within the scope of his or her license or certificate;
- Under applicable insurance law is considered a "physician" for purposes of this coverage;
- Has the medical training and clinical expertise suitable to treat your condition;
- Specializes in psychiatry, if your illness or injury is caused, to any extent, by alcohol abuse, substance abuse or mental disorder; and
- A physician is not you or related to you.

Prescription Drug

A drug, biological, or compounded prescription which, by State and Federal Law, may be dispensed only by prescription and which is required to be labeled "Caution: Federal Law

prohibits dispensing without prescription." This includes an injectable drug prescribed to be self-administered or administered by any other person except one who is acting within his or her capacity as a paid healthcare professional. Covered injectable drugs include injectable insulin.

Psychiatric Hospital

This is an institution that meets all of the following requirements.

- Mainly provides a program for the diagnosis, evaluation, and treatment of alcoholism, substance abuse or mental disorders.
- Is not mainly a school or a custodial, recreational or training institution.
- Provides infirmary-level medical services. Also, it provides, or arranges with a hospital in the area for, any other medical service that may be required.
- Is supervised full-time by a psychiatric physician who is responsible for patient care and is there regularly.
- Is staffed by psychiatric physicians involved in care and treatment.
- Has a psychiatric physician present during the whole treatment day.
- Provides, at all times, psychiatric social work and nursing services.
- Provides, at all times, skilled nursing services by licensed nurses who are supervised by a full-time R.N.
- Prepares and maintains a written plan of treatment for each patient based on medical, psychological and social needs. The plan must be supervised by a psychiatric physician.
- Makes charges.
- Meets licensing standards.

Psychiatric Physician

This is a physician who:

- Specializes in psychiatry; or
- Has the training or experience to do the required evaluation and treatment of alcoholism, substance abuse or mental disorders.

Recognized Charge

The Recognized Charge is the provider's discounted charge which it has contractually agreed to in its contract with the Plan's PPO network: If there is no direct contract, the Recognized Charge is the provider's discounted charge agreed to in a contract with any third party that is not an affiliate of Aetna who Aetna has contracted through. For these providers, the Recognized Charge is the amount the preferred provider has agreed to accept as full payment for covered health care services or supplies.

The Recognized Charge for out-of-network providers is the Usual, Customary and Reasonable (UCR) charge determined by the Plan.

You may be responsible for all amounts above the Recognized Charge. The Recognized Charge may be less than the provider's full charge. In all cases, the Recognized Charge is determined based on the Geographic Area where you receive the service or supply.

Except as otherwise specified below, the Recognized Charge for each service or supply is the lesser of what the provider bills and:

- For professional services and for other services or supplies not mentioned below - the reasonable amount rate;
- For services of hospitals and other facilities - the reasonable amount rate;
  For prescription drugs - 110% of the Average wholesale price (AWP).

Residential Treatment Facility

This is an institution that meets all of the following requirements:

- On-site licensed Behavioral Health Provider 24 hours per day/7 days a week.
- Provides a comprehensive patient assessment (preferably before admission, but at least upon admission).
- Admissions are approved by a Physician.
- Has access to necessary medical services 24 hours per day/7 days a week and 24-hours per day/7 days a week supervision by a physician with evidence of close and frequent observation.
- Provides living arrangements that foster community living and peer interaction that are consistent with developmental needs.
- Offers group therapy sessions with at least an RN or Masters-Level Health Professional.
- Has the ability to involve family/support systems in therapy (required for children and adolescents; encouraged for adults).
- Provides access to at least weekly sessions with a Psychiatrist or psychologist for individual psychotherapy.
- Has peer oriented activities.
- Services are managed by a licensed Behavioral Health Provider who, while not needing to be individually contracted, needs to (1) meet the Aetna credentialing criteria as an individual practitioner, and (2) function under the direction/supervision of a licensed psychiatrist (Medical Director).
- Has individualized active treatment plan directed toward the alleviation of the impairment that caused the admission.
- Provides a level of skilled intervention consistent with patient risk.
- Meets any and all applicable licensing standards established by the jurisdiction in which it is located.
- Is not a Wilderness Treatment Program or any such related or similar program, school and/or education service.
- For substance abuse admissions, if the member requires detoxification services, must have the availability of on-site medical treatment 24 hours per day/7days a week, which must be actively supervised by an attending Physician.
- For substance abuse admissions, ability to assess and recognize withdrawal complications that threaten life or bodily functions and to obtain needed services either on site or externally.

Semi-Private Room Rate

The room and board charge that an institution applies to the most beds in its semi-private rooms with 2 or more beds. If there are no such rooms, Aetna will figure the rate based on the rate most commonly charged by similar institutions in the same geographic area.

Skilled Nursing Facility

An institution that meets all of the following requirements:

- It is licensed to provide, and does provide, the following on an inpatient basis for persons convalescing from illness or injury:
- Professional nursing care by an R.N., or by a L.P.N. directed by a full-time R.N.; and
- Physical restoration services to help patients to meet a goal of self-care in daily living activities.
- Provides 24 hour a day nursing care by licensed nurses directed by a full-time R.N.
- Is supervised full-time by a physician or an R.N.
- Keeps a complete medical record on each patient.
- Has a utilization review plan.
- Is not mainly a place for rest, for the aged, for drug addicts, for alcoholics, for mental retardates, for custodial or educational care, or for care of mental disorders.
- Charges patients for its services.
- An institution or a distinct part of an institution that meets all of the following requirements:
- It is licensed or approved under state or local law.
- Is primarily engaged in providing skilled nursing care and related services for residents who require medical or nursing care, or rehabilitation services for the rehabilitation of injured, disabled, or sick persons.
- Qualifies as a skilled nursing facility under Medicare or as an institution accredited by:
- The Joint Commission on Accreditation of Health Care Organizations;
- The Bureau of Hospitals of the American Osteopathic Association; or
- The Commission on the Accreditation of Rehabilitative Facilities

Skilled nursing facilities also include rehabilitation hospitals (all levels of care, e.g. acute) and portions of a hospital designated for skilled or rehabilitation services.

Skilled nursing facility does not include institutions which provide only:

- Minimal care;
- Custodial care services;
- Ambulatory;
- Part-time care services; or
- Institutions which primarily provide for the care and treatment of alcoholism, substance abuse or mental disorders.

Skilled Nursing Services

Services that meet all of the following requirements:

- The services require medical or paramedical training.
- The services are rendered by an R.N. or L.P.N. within the scope of his or her license.
- The services are not custodial.

Specialty Care Drugs

Prescription drugs include injectable, infusion and oral drugs prescribed to address complex, chronic diseases with associated co-morbidities such as cancer, rheumatoid arthritis, hemophilia, multiple sclerosis which are listed in the specialty care drug list.

Specialty Pharmacy Network

A network of pharmacies designated to fill specialty care drugs.

Substance Abuse

This is a physical or psychological dependency, or both, on a controlled substance or alcohol agent (These are defined on Axis I in the Diagnostic and Statistical Manual of Mental Disorders (DSM) published by the American Psychiatric Association which is current as of the date services are rendered to you or your covered dependents.) This term does not include conditions not attributable to a mental disorder that are a focus of attention or treatment (the V codes on Axis I of DSM); an addiction to nicotine products, food or caffeine intoxication.

Surgery Center

A freestanding ambulatory surgical facility that meets all of the following requirements:

- Meets licensing standards.
- Is set up, equipped and run to provide general surgery.
- Charges for its services.
- Is directed by a staff of physicians. At least one of them must be on the premises when surgery is performed and during the recovery period.
- Has at least one certified anesthesiologist at the site when surgery requiring general or spinal anesthesia is performed and during the recovery period.
- Extends surgical staff privileges to:
  - Physicians who practice surgery in an area hospital; and
  - Dentists who perform oral surgery.
- Has at least 2 operating rooms and one recovery room.
- Provides, or arranges with a medical facility in the area for, diagnostic x-ray and lab services needed in connection with surgery.
- Does not have a place for patients to stay overnight.
- Provides, in the operating and recovery rooms, full-time skilled nursing services directed by an R.N.
- Is equipped and has trained staff to handle emergency medical conditions.

- Provides an ongoing quality assurance program. The program must include reviews by physicians who do not own or direct the facility.
- Keeps a medical record on each patient.

Must have all of the following:

- A physician trained in cardiopulmonary resuscitation; and
- A defibrillator; and
- A tracheotomy set; and
- A blood volume expander.
- Has a written agreement with a hospital in the area for immediate emergency transfer of patients.
- Written procedures for such a transfer must be displayed and the staff must be aware of them.

Urgent Admission

A hospital admission by a physician due to the onset of or change in an illness, the diagnosis of an illness or an injury, which, while not needing an emergency admission, is severe enough to require confinement as an inpatient in a hospital within 2 weeks from the date the need for the confinement becomes apparent.

Urgent Care Provider

This is a freestanding medical facility that meets all of the following requirements:

- Provides unscheduled medical services to treat an urgent condition if the person's physician is not reasonably available.
- Routinely provides ongoing unscheduled medical services for more than 8 consecutive hours.
- Makes charges.
- Is licensed and certified as required by any state or federal law or regulation.
- Keeps a medical record on each patient.
- Provides an ongoing quality assurance program. This includes reviews by physicians other than those who own or direct the facility.
- Is run by a staff of physicians. At least one physician must be on call at all times.
- Is not the emergency room or outpatient department of a hospital.
- Has a full-time administrator who is a licensed physician.

Urgent care provider, maybe a physician's office, but only one that:

- Has contracted with Aetna to provide urgent care; and
- Is, with Aetna's consent, included in the directory as a network urgent care provider.

Urgent Condition

This means a sudden illness; injury; or condition; that:

- Is severe enough to require prompt medical attention to avoid serious deterioration of your health;

- Includes a condition which would subject you to severe pain that could not be adequately managed without urgent care or treatment;
- Does not require the level of care provided in the emergency room of a hospital; and
- Requires immediate outpatient medical care that cannot be postponed until your physician becomes reasonably available.

Usual and Customary Charges (U&C)

For professional service providers, this means a charge for a covered service which is no higher than the 90th percentile identified by a commercially available database selected by the Plan.

For facility charges, this means the Facility Charge Review (FCR) Rate. The FCR rate is an amount that the Trust or Aetna determines is enough to cover the provider's estimated costs for the service and leave the provider with a reasonable profit. For hospitals and other facilities which report costs (or cost-to-charge ratios) to CMS, the FCR Rate is based on what the facilities report to CMS, the FCR Rate is based on statewide averages of the facilities that do report to CMS. The Trust or Aetna may adjust the formulas as needed to maintain the reasonableness of the recognized charge. For example, an adjustment may be made if it is determined that in a particular state the charges of ambulatory surgery centers (or another class of facility) are much higher than charges of facilities that report costs (or cost-to -charge ratios) to CMS.

When there is, in the Plan's determination, minimal data available from the database for a covered service, the Plan will determine the U&C charge by calculating the unit cost for the applicable service category using the database, and multiplying that by the relative value of the covered service assigned by the Medicare resource based relative value scale (supplemented with a commercially available relative value scale selected by the Plan where one is not available from Medicare).

In the event of an unusually complex covered service, a covered service that is a new procedure or a covered service that otherwise does not have a relative value that is in the Plan's determination applicable, the Plan will assign one.

In no event will the U&C charge exceed the amount billed by the professional service provider or the amount for which the covered person is responsible. The term "usual and customary charge" may not reflect the actual charges of the professional service provider, and does not take into account the professional service provider's training, experience or category of licensure.

INFORMATION REQUIRED BY THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974

Name of Plan

This Plan is known as the Northwest Insulation Workers Welfare Trust.

Board of Trustees-Plan Administrator

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

c/o Welfare & Pension Administration Service, Inc.
Physical Address:
7525 SE 25th St, Suite 200
Mercer Island, WA 98040
Mailing address:
P.O. Box 34203
Seattle, WA 98124
Administration and Claims Office: (206) 441-7574 or (844) 811-6789

A list of participating employers and labor organizations can be examined at this office.

Identification Number

The Employer Identification Number assigned to the Plan by the Internal Revenue Service is:

EIN 91-6035786. The Plan Number is: PN 501.

Type of Plan

This Plan can be described as an employee welfare benefit plan which provides Medical, Prescription Drug, Life, Accidental Death and Dismemberment, Time Loss, Dental, Hearing and Vision Benefits.

Type of Administration

This Plan is administered by the Board of Trustees, with the assistance of Welfare & Pension Administration Service, Inc., a contract administration organization.

Description of Collective Bargaining Agreements

This Plan is maintained by a number of collective bargaining agreements requiring contributions by the employers into the Trust Fund for the purpose of providing and maintaining benefits. A copy of the relevant agreement may be obtained by participants and beneficiaries upon written request to the Trustees. Further, such agreement is available for examination by participants and beneficiaries at the Trust Office, and at local union office, upon 10 days advanced written request. The Trustees may impose a reasonable charge to cover the cost of furnishing the agreement. Participants and beneficiaries may wish to inquire as to the amount of the charges before requesting copies.

Participation and Eligibility

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

The eligibility rules that determine which employees and beneficiaries are entitled to benefits are set forth beginning on page 8.

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

Termination of Eligibility

Circumstances that may result in termination of eligibility are set forth beginning on page 9.

The Board of Trustees has the authority to terminate the Trust Fund and Plan. They will also terminate upon the expiration of all collective bargaining agreements requiring the payment of contributions to the Trust Fund.

In the event of termination of the Trust Fund any and all monies and assets remaining in the Trust Fund, after payment of expenses, shall be used for the continuance of the benefits provided by the then existing benefit plans until such monies and assets have been exhausted.

Funding Medium

The Trust is funded through employer contributions, the amount of which is determined through collective bargaining agreements and contribution agreements. Self-payments are also permitted as outlined in this Summary Plan Description. Medical, Prescription Drug, Dental, and Vision Benefits are provided directly from Trust assets. Life Insurance and Accidental Death and Dismemberment and Time Loss coverage is fully insured and is provided under contract with Aetna. Aetna's address and telephone number is outlined on the ***Quick Reference Chart***.

Entities Used for Accumulation of Assets and Payment of Benefits

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

The Life Insurance and Accidental Death and Dismemberment Benefits provided by the plan are fully insured by Aetna. Companion Life Insurance Company provides a policy of stop loss insurance to the plan, under which they have assumed the financial responsibility for medical claims exceeding $250,000 per covered individual per policy year, up to the applicable lifetime maximum specified in the plan, and for aggregate claims exceeding 200% of the expected claims for the policy year.

Fiscal Year/Plan Year

The end of the Plan's fiscal year and official plan year is June 30.

Members of the Board of Trustees

The names, addresses and titles of the individual Trustees as of the date of this Booklet are as follows:

EMPLOYER TRUSTEES	UNION TRUSTEES
Kenneth Gritter, Chairman Hudson Bay Insulation P.O. Box 80424 Seattle, WA 98108-0424	**Todd Mitchell, Secretary** Heat & Frost Insulators & Asbestos Workers Local 7 14675 Interurban Ave. S., Ste. 103 Tukwila, WA 98168-4614
Matthew Loya PCI 4050 Irongate Rd. Bellingham, WA 98226-8026	**Nolan Olson** Heat and Frost Insulators Local 97 PO Box 203212 Anchorage, AK 99520-3212
Britt Freel Holaday Parks 1820 Marika Rd. Fairbanks, AK 99709-5520	**Michael Loberg** Heat & Frost Insulators & Asbestos Workers Local 82 3919 E. Main Ave. Spokane, WA 99202
Terry Philley (Alt Trustee) Alaskan Insulation Specialties 261 E. 56th Ave., Bldg. B Anchorage, AK 99518-1241	**Gary Phillips (Alt. Trustee)** P.O. Box 7247 Spokane, WA 99207-0247

Each member of the Board of Trustees is an agent for the purpose of accepting service of legal process on behalf of this Plan.

Availability of Information

Plan documents and all other pertinent documents required to be made available under ERISA are available for inspection at the Administration Office during regular business hours. Upon written request, copies of these documents will be provided. However, the Trustees may make a reasonable charge for the copies; the Plan Administrator will state the charge for specific documents on request, so you can find out the cost before ordering.

Future of the Plan and Trust

The Board of Trustees is providing this program of benefits, including the Retiree benefits, to the extent that monies are currently available to pay the cost of such programs. The Board of Trustees retains full and exclusive authority, at its discretion, to determine the extent to which monies are available for this program and to determine the expenditures of such monies for the program. The program is not guaranteed to continue indefinitely. The program may be terminated or modified at any time by the Board of Trustees.

The Board of Trustees has the exclusive authority to interpret the provisions of the plan, to determine eligibility for an entitlement to plan benefits or to amend the plan. Any interpretation or determination by the Trustees made in good faith which is not contrary to law is conclusive on

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

The Trust Fund will terminate upon the expiration of all collective bargaining agreements requiring the payment of contribution to the Trust Fund. In the event of the termination of the Trust Fund, any and all monies and assets remaining in the Trust Fund, after payment of expenses, shall be used for the continuance of the benefits provided by the then existing benefit plans, until such monies and assets have been exhausted.

Protection of Trust Fund, Contributions, and Benefits. No part of the Trust Fund (including the contributions) or the benefits payable under the Plan shall be subject in any manner by an Employee, Retiree or Dependent or other beneficiary to anticipation, alienation, sale, transfer, assignment, encumbrance, or charge, and any such attempt shall be null and void, provided that the Trustees may recognize assignment of benefits from an Employee, Retiree or Dependent or other beneficiary to a doctor, hospital, or other person or institution that has treated or cared for, or provided services or goods to the Employee, Dependent or other beneficiary, and provided further that the Trustees shall recognize the assignment of benefits under a State Medicaid Plan, or an alternate payee's right to receive benefits, under a Qualified Medical Child Support Order. No part of the Trust Fund (including contributions, or the benefits payable under the Plan) shall be liable for the debts of an Employee, Dependent or beneficiary, nor be subject in any manner to garnishment, attachment, lien, charge or any other legal process brought by any person against an Employee, Dependent or other beneficiary and any attempt shall be null and void.

In the event the Trust determines that an individual is incompetent or incapable of executing a valid receipt and no guardian has been appointed, or in the event an individual has not provided the Trust with an address at which he can be located for payment, the Trust may during the lifetime of the individual, pay any amount otherwise payable to the individual to the husband or wife or relative by blood or to any other person or institution determined by the Trust to be equitably entitled thereto; or in the case of the death of the individual before all amounts payable under the Plan have been paid, the Trust may pay any such amount to any person or institution determined by the Trust to be equitably entitled thereto. The remainder of such amount shall be paid to one or more of the following surviving relatives of the individual: lawful spouse, child or children, mother, father, brothers or sisters, or to the estate, as the Board in its sole discretion may designate. Any payment in accordance with this provision shall discharge the obligation of the Trust hereunder.

Availability of Fund Resources

Benefits provided by the Plan can be paid only to the extent that the Trust has available adequate resources for such payments. No contributing employer has any liability, directly or indirectly, to provide benefits beyond the obligation to make contributions as stipulated in the Collective Bargaining Agreement. In the event that at any time the Trust does not have sufficient

assets to permit continued payments, nothing in the Plan shall be construed as obligating any contributing employer to make payments in order to provide Plan benefits.

A portion of the benefits available to you are paid directly from the assets of the Trust. There is no liability on the Trustees, individually or collectively, or upon any employer, the Union, signatory association or other person or entity to provide benefits if the Trust does not have sufficient assets to pay premiums due or to make benefit payments.

Authority to Make Changes

In order that the Board of Trustees may carry out its obligation to maintain, within the limits of its resources, a program dedicated to providing the maximum possible benefits for Employees, the Board expressly reserves the right, in its sole discretion at any time and from time to time:

- To terminate or amend either the amount or conditions with respect to any benefit even though such termination or amendment affects claims which have already accrued; and
- To alter or postpone the method or payment of any benefit; and
- To amend or rescind any other provisions of the Plan.

The benefits of this Plan are provided on a month-to-month basis to the extent that employer contributions and self-payments continue to be sufficient for such purpose. There is no long-range funding or reserve program. The Trustees reserve the right to change the eligibility rules, reduce the benefits, increase the required self-payments, amend or eliminate Retiree coverages or eliminate the Plan entirely, as may be required by future circumstances.

Right to Recover Excess Payments

In the event that through mistake or inadvertence or any other circumstance, an Eligible Individual or other individual has been paid or credited with more than he is entitled to under the Plan or under the law, the payment or credit will not constitute a waiver of applicable Plan provisions, including any limitation or exclusion. The Trust may set off, recoup or recover the amount of overpayment or excess credit accrued or thereafter accruing from the Eligible Individual or other individual, or from the service provider, or it may offset future benefit payments due to the Eligible Individual or the Eligible Individual's family members by the amount paid in error. The Trust may also take such further action as the Board shall determine.

Misrepresentation

An individual who knowingly presents a false or fraudulent claim for payment or knowingly misrepresents facts relating to 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.

Administration and Operation of Plan

The Board of Trustees shall administer the Plan and serve as named fiduciaries pursuant to the Employee Retirement Income Security Act of 1974, as amended. The Trustees may establish rules for the transaction of their business and the administration of the Plan. The Trustees have the exclusive right to determine eligibility under the Plan, to construe the provisions of the Plan, and to determine any and all questions arising under the Plan or in connection with its administration, including the right to remedy possible ambiguities, inconsistencies, or omissions and any construction or determination by the Trustees made in good faith shall be binding upon the Union, Employees, Retired Employees, employers, and any association signatory to the Trust Agreement.

The Trust recognizes that new technologies may develop which are not specifically addressed in the Plan. The Trust reserves the right to determine whether or not a service or supply is covered, and if covered, to determine Covered Expense. If an Employee, Retiree, or Dependent selects a more expensive service or supply than is customarily provided, or specialized techniques rather than standard procedures, the Trust reserves the right to consider alternate professionally acceptable services and supplies as the basis for benefit consideration under the Plan.

The Board of Trustees may engage employees, accountants, actuaries, consultants, investment managers, attorneys and other professionals or persons to render advice and/or perform services with regard to any of its responsibilities under the Plan, as determined to be necessary and appropriate.

STATEMENT OF RIGHTS UNDER EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974

As a participant in the Northwest Insulation Workers Welfare Trust you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA) and subsequent amendments. ERISA provides that all Plan Participants are entitled to:

Receive Information About Your Plan and Benefits

- Examine, without charge, at the Plan Administrator's 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 Pension and Welfare Benefit Administration.
- Obtain, upon written request of the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

- Continue health care coverage for yourself and Dependent(s) if there is a loss of coverage under the Plan as a result of a Qualifying Event. You or your Dependent(s) may have to pay for such coverage. Refer to the COBRA Continuation Coverage section of this Booklet.

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 employee benefit plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in your interest and the interest of 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 welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you have the right to a hearing before the Trustees at which you may present your position and any supporting evidence. You also have the right to be represented by an attorney or any other representative of your choosing. If

you are dissatisfied with the Trustees' determination, you may also file suit in state or federal court.

In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in federal court.

If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the 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 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 Avenue N.W.
Washington, D.C. 20210

You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration at (866) 444-3272.

HIPAA PRIVACY DISCLOSURES AND CERTIFICATION

Protected Health Information. For purposes of this Article, the term "Protected Health Information" ("PHI") shall have the same meaning as in 45 CFR § 164.501. This Article shall be administered by the Trustees in accordance with regulations adopted by the Department of Health and Human Services at 45 CFR Part 164.

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 Administration functions:

- To make or obtain payment for care received by Eligible Individuals.
- To facilitate treatment which involves the provision, coordination or management of health care or related services.
- To conduct health care operations to facilitate the administration of the Plan and as necessary to provide coverage and services to Eligible Individuals.
- In connection with judicial or Administration proceedings in response to an order of a court or Administration tribunal as expressly authorized by such order or in response to a subpoena, discovery request or other lawful process.
- If legally required to do so by any federal, state or local law, or as permitted or required by law for law enforcement purposes.
- To review enrollment and eligibility information or claim appeals, solicit bids for services, modify, amend or terminate the Plan, or perform other plan Administration 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.
- For authorized activities by health oversight agencies, including audits, civil, Administration or criminal investigations, licensure or disciplinary action.
- To prevent or lessen a serious and imminent threat to an Eligible Individual'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.
- For specified government functions under 45 CFR Part 164.
- 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 these procedures have been adopted and the Trustees, as Plan sponsor, agree to the following:

- The Trustees will not use or disclose any PHI received from the Plan, except as permitted in these procedures or as required by law.
- 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.
- 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.

- The Trustees will report to the Plan any known impermissible or improper use or disclosure of PHI not authorized by these procedures of which they become aware.
- 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.
- 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.

Adequate Separation

The Trustees represent that adequate separation exists between the Plan and the Trustees so that PHI will be used only for Plan administration. Each Trustee will certify that he has no employees, or other persons under his control that will have access to PHI.

Effective Mechanism for Resolving Issues of Noncompliance

Anyone who suspects an improper use or disclosure of PHI may report that occurrence to the Plan Privacy Official.

HIPAA Security

In compliance with HIPAA Security regulations, the Plan Sponsor will:

- Implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of electronic PHI that it creates, receives, maintains or transmits on behalf of the group health plan,
- Ensure that the adequate separation discussed above, specific to electronic PHI, is supported by reasonable and appropriate security measures,
- Ensure that any agent, including a subcontractor, to whom it provides electronic PHI agrees to implement reasonable and appropriate security measures to protect the electronic PHI, and
- Report to the Plan any security incident of which it becomes aware concerning electronic PHI.

NORTHWEST INSULATION WORKERS WELFARE 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 issued by the Department of Health and Human Services pursuant to the Health Insurance Portability and Accountability Act of 1996 ("HIPAA").

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

This Notice describes the circumstances under which and the purposes for which your health information may be used and disclosed and your rights with regard to such information. This Notice is also available at the Trust's website: www.nwinsulationtrust.com.

USE AND DISCLOSURE OF HEALTH INFORMATION

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

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

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

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

development, and accreditation, certification, licensing or credentialing activities). For example, the Trust may use your health information to conduct case management of ongoing care or to resolve a claim appeal you file.

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

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

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

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

(1) In Connection With Judicial and Administrative Proceedings

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

(2) When Legally Required and For Law Enforcement Purposes

The Trust will disclose your protected health information when it is required to do so for law enforcement purposes. This may include compliance with laws which require reporting certain types of injuries, pursuant to court issued legal process; or a grand jury subpoena or other administrative requests if satisfactory documentation is provided that the request is relevant to a legitimate law enforcement purpose, the request is reasonably tailored to meet this legitimate

law enforcement purpose and de-identified individual cannot be reasonably provided as an alternative. Additionally, limited disclosure may be made for purposes of identifying or locating a suspect, fugitive, material witness or missing person, identifying a victim of a crime or in connection with a criminal investigation that occurred on Trust premises. For example, the Trust could upon request of a law enforcement agency provide information concerning the address of a fugitive.

(3) To Conduct Public Health and Health Oversight Activities

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

(4) In the Event of a Serious Threat to Health or Safety

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

(5) 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.

(6) For Workers Compensation

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

AUTHORIZATION TO USE OR DISCLOSE HEALTH INFORMATION

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

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

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

YOUR RIGHTS WITH RESPECT TO YOUR HEALTH INFORMATION

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

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

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

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

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

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

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

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

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

Privacy Contact Person

Assistant Claims Manager
Welfare & Pension Administration Service, Inc.
P.O. Box 34203
Seattle, WA 98124
Phone No: 206-441-7574 or Toll Free: 800-331-6158
Fax No: 206-441-9110

Privacy Official

Claims Manager
Welfare & Pension Administration Service, Inc.
P.O. Box 34203
Seattle, WA 98124
Phone No: 206-441-7574 or Toll Free: 800-331-6158
Fax No: 206-441-9110

DUTIES OF THE TRUST

The Trust is required by law to maintain the privacy of your health information as set forth in this Notice, to provide to you this Notice summarizing its privacy practices and duties, and to notify you following a breach of unsecured protected health information. The Trust is required to abide by the terms of this Notice, which may be amended from time to time. The Trust reserves the right to change the terms of this Notice and to make the new Notice provisions effective for all health information that it maintains. If the Trust changes its policies and procedures, the Trust will revise the Notice and will provide you a copy of the revised Notice within 60 days of the change. You have the right to request a written copy of the Notice at any time.

You have the right to express complaints to the Trust and to the Secretary of the Department of Health and Human Services if you believe that your privacy rights have been violated. Any complaints to the Trust should be made in writing to the Privacy Official 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 inquiring about or filing a complaint about privacy matters.

551J 05/2019