
Northwest Laborers-Employers Health & Security Trust Fund Summary Plan Description



APRIL 2010

TRUST FUND CONTACT INFORMATION

TRUST OFFICE

Zenith Administrators, Inc.

201 Queen Anne Avenue North, Suite 100
Seattle, WA 98109-4896

Northwest Laborers Member & Provider Benefits, Eligibility and Claims

Telephone:(206) 282-3600 or (800) 826-2102

Patient Assistant Program: Hospital Pre-Certification; Home Healthcare, Hospice, and BABYTIME – administered for the Trust by CareAllies

Telephone: (800) 422-3038

Mail Order Pharmacy

Telephone: (800) 292-4722

Express Scripts

Network Pharmacy locator: (800) 467-2006
www.express-scripts.com

Premera Blue Cross/BCBS

Network Provider locator: (800) 810-2583
www.premera.com

Vision Service Providers (VSP)

Provider locator: (800) 877-7195
www.vsp.com

TRUST OFFICE WEBSITE

www.zenithadmin.com

This website contains:

- Helpful information about the Plan
- Notices about Plan changes
- Printable versions of claims, change of address and enrollment forms
- Links to Plan providers such as Premera, Mail Order Pharmacy, Express Scripts, Willamette Dental, and VSP
- The Summary Annual Report
- Your personal claims history and eligibility
- The Summary Plan Description (Plan document)

Please contact the Trust office Eligibility Customer Service if you need a password

**PLAN DOCUMENT AND
SUMMARY PLAN DESCRIPTION
FOR
NORTHWEST LABORERS-EMPLOYERS
HEALTH & SECURITY TRUST FUND
REVISED EDITION
APRIL 2010**

NORTHWEST LABORERS-EMPLOYERS HEALTH & SECURITY TRUST FUND INTRODUCTION

This document is a description of the Northwest Laborers-Employers Health & Security Trust Fund (the Plan). No oral interpretations can change this Plan. This Plan is designed to provide Plan Participants with medical, vision, prescription, dental, short term disability, life insurance and accidental death & dismemberment benefits.

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

Dental benefits provided under Dental Plan A are fully insured under a policy that the Trust maintains with Willamette Dental of Washington. Nothing in this booklet will alter the terms or conditions of the Willamette Dental of Washington policy.

Life and accidental death & dismemberment benefits are fully insured under a policy that the Trust maintains with Aetna. Nothing in this booklet will alter the terms or conditions of the Aetna policy.

Coverage under the Plan will take effect for eligible Plan Participants when they satisfy all the eligibility requirements of the Plan. The Plan will pay benefits only for the expenses incurred while this coverage is in force. No benefits are payable for expenses incurred before coverage begins or after coverage terminates, even if the expenses were incurred as a result of an Injury or Sickness that occurred, began, or existed while coverage was in force. An expense for a service or supply is incurred on the date the service or supply is furnished.

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

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

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

We encourage you to read this booklet carefully and keep it with your important documents. If you have questions, contact the Trust Office.

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ELIGIBILITY

A Participant or their medical or dental provider should verify eligibility at the time of service.

ACTIVE ELIGIBILITY AND TERMINATION PROVISIONS

There are four eligibility classifications:

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

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

Certain Retirees and their Dependents are also eligible for coverage under this Plan. Refer to page 18 for Retiree eligibility requirements.

ACTIVE HOUR BANK ELIGIBILITY

Eligibility is determined on the basis of an hour bank system. For purposes of calculating hour bank eligibility, the dollar value of one hour is currently \$5.00. Hours reported and contributions paid at amounts less than or greater than \$5.00 will be prorated. Any contribution rates paid at less than \$5.00 per hour will earn less than one hour in the hour bank, and any contributions paid at an amount greater than \$5.00 per hour will earn more than one hour in the hour bank. The Trustees will periodically adjust the dollar value of one hour. The eligibility requirements under the hour bank system are:

1. Initial Eligibility Requirements
 - a. **A minimum of 300 hours in the hour bank is required for initial eligibility.** You have six months to accumulate the 300 hours. If you do not accumulate 300 hours in your first six months of Covered Employment, the Trust will look to subsequent six month periods until you have met the 300 hour requirement. For example, if you work January through June and do not accumulate 300 hours, the Plan will look to your February through July hours to determine whether you meet the 300 hour requirement. Your January hours will be dropped from your hour bank.
 - b. Coverage will be in effect the first day of the second month following the accrual of 300 hours.
For example:
If you work 180 hours in June and 170 hours in July, and contributions are paid at the rate of \$5.00 per hour, you will become eligible on September 1st. In this example, August is the “lag month.”
 - c. Coverage for Dependents who meet the definition of Dependent, will be in effect on the date the Employee becomes eligible.

2. Employee's Hour Bank

- a. Once the minimum eligibility requirement has been established, 220 hours will be deducted for the first month of eligibility and 120 hours will be deducted from the Employee's hour bank for each subsequent month of coverage. This will provide eligibility beginning the first day of the second month following each month in which hours are deducted. An Employee will continue to be covered as long as there are 120 hours or more in the hour bank. A maximum of six consecutive months of prepaid continuous coverage (720 hours) can be accumulated.
- b. When the hours in the hour bank drop below 120 they remain in the hour bank for 10 months from the last date of eligibility (from hours worked or COBRA self payments) after which period the hour bank is forfeited.

REINSTATEMENT OF ACTIVE HOUR BANK ELIGIBILITY

If you were previously covered you will again become covered if your hour bank shows a total of at least 120 hours within the ten-calendar-month period immediately following the termination of your eligibility. Such reinstatement will become effective on the first day of the second calendar month in which this requirement is met. If your coverage is not reinstated within a ten-calendar-month period, any reserve hours in your hour bank will be forfeited. You will again become eligible for coverage upon completion of the initial eligibility requirement for new Employees.

When you move from one Covered Employer to another your eligibility may continue, even though you are unemployed between jobs, provided you have sufficient accumulated hours credited to your hour bank. You should make sure your new Employer is contributing to the Trust for you.

Hours worked as a Laborer outside the area covered by this Plan usually are not counted in determining eligibility. However, if you move from this Plan area and continue working as a Laborer, you should determine the following:

1. If there is a Laborer's Health and Security Plan in your new area, and
2. If there is a reciprocity agreement in effect between the new area and the old area, as hours in the new area may be used to create eligibility in the event of a claim.

The Trust Office can advise you as to existing reciprocity agreements.

ACTIVE FLAT RATE ELIGIBILITY

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

Coverage becomes effective:

1. For the Employee, on the first day of the second month following the month in which the Employee worked the required number of hours and for which the Employer made the required flat rate contribution to the Trust; and
2. Coverage for Dependents who meet the definition of Dependent will be in effect on the date the Employee becomes eligible.

Coverage terminates:

1. For the Employee, on the first day of the second month following the month in which the Employee did not work the number of hours required by the flat rate agreement; and
2. For the Dependent, on the first day of the month the Employee's eligibility is terminated.

ASSOCIATE/NON-BARGAINING UNIT ELIGIBILITY

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

MONEY-FOLLOWS-THE-MAN RECIPROCITY

The Trust has money-follows-the-man reciprocity agreements with certain other health trusts that allow Employees to request a transfer of hours and contributions to the Employee's home trust when temporarily working in another area. The Employee must contact the Trust Office to determine if an agreement is in force in the area where the Employee is working. Money-follows-the-man reciprocity allows the Employee to accumulate hours in the home trust to help maintain eligibility in that trust. The benefits provided are those provided under the Plan of the home trust.

To request a transfer of hours and contributions, the Employee should contact the Local Union for an authorization form. The authorization form must be completed and returned to the Trust Office as soon as possible and generally no later than 90 days after beginning employment in another area.

ELIGIBLE DEPENDENTS

A Dependent is any one of the following persons:

1. The lawful spouse of an Employee or Retiree. The term "spouse" means the individual legally married to the Employee or Retiree as determined under federal law, and who is treated as a spouse under the Internal Revenue Code. However, a legally separated spouse is not eligible. The Trust Office may require documentation proving a legal marital relationship.
2. An unmarried child of the Employee or Retiree who satisfies each of the following requirements:
 - a. The child is a natural child, stepchild, adopted child, Foster Child, or child "placed for adoption", or any child for which the Employee or Retiree has been awarded Legal Guardianship or Legal Custody; and
 - b. The child has the same principal residence as the Employee or Retiree for more than one-half of the calendar year, or in the case of a stepchild or Foster Child resides in the household of the Employee or Retiree on a full-time basis. If the parents are divorced, legally separated or live apart and the Employee or Retiree is not the custodial parent, then this requirement is

satisfied if the child receives over one-half of his/her support during the year from both parents combined, and the child is in the custody of one or both parents for more than one-half of the year; and

- c. The child is younger than 19 years of age; or is 19 but less than 24 years of age and a full-time student at an accredited educational institution; and
- d. The child has not provided over one half of his/her own support for the year.

When the child reaches age 19, or 24 if a full time student, coverage will end on the last day of the child's birthday month. The Trust requires verification of full-time student status every quarter. Full-time students must carry the minimum credits required to be classified as a full-time student by the accredited school.

An unmarried covered Dependent child who is Totally Disabled, incapable of self-sustaining employment by reason of mental retardation or physical handicap, primarily dependent upon the covered Employee or Retiree for support and maintenance, and covered under the Plan when reaching the limiting age, may continue to be covered provided proof of incapacity is submitted to the Trust Office within 31 days of the date the Dependent would otherwise terminate, and the child continues to satisfy the requirements under paragraph #2 above (other than the limiting age). The Trust Office may require proof of the child's Total Disability and dependency, at reasonable intervals following the child's reaching the limiting age. The Trust Office reserves the right to have such Dependent examined by a Physician of the Trust's choice, at the Plan's expense, to determine the existence of such incapacity.

As required by the Federal Omnibus Budget Reconciliation Act of 1993, any natural or adopted child of the Employee or Retiree, or child placed for adoption with the Employee or Retiree, or who is an alternate recipient under a Qualified Medical Child Support Order shall be considered as having a right to Dependent coverage under this Plan with no pre-existing condition provisions applied.

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

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

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

The following are excluded as Dependents: other individuals living in the covered Employee's or Retiree's home, but who are not eligible as defined; the legally separated or divorced former spouse of the Employee or Retiree; any person who is on active duty in any military service of any country.

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

If both husband and wife are Employees, their children will be covered as Dependents of both husband and wife.

QUALIFIED MEDICAL CHILD SUPPORT ORDER

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

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

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

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

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

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

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

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

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

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

ENROLLMENT

Enrollment Procedures. An Employee must enroll for coverage by filling out and signing an enrollment form. To obtain an enrollment form, contact the Trust Office, or download one at www.zenithadmin.com. In order to keep the eligibility records accurate, you must inform the Trust Office of any change in address, dependent status or change in designated beneficiary, e.g., when adding a Spouse or a Dependent child such as a newborn, an adopted child or a stepchild. All changes must be made by completing a new enrollment form and submitting it to the Trust Office. When adding Dependents, you will be required to provide one or more of the following as proof of Dependent eligibility status, e.g., a marriage or birth certificate or adoption papers. Newborns are enrolled automatically when claims are processed for birth expenses, provided the mother is covered under the Plan; however you must also complete a new enrollment form adding the newborn. Eligibility for other Dependents cannot be determined until enrollment forms and proof of dependent status are received. Please inform the Trust Office promptly in the event of a divorce or legal separation.

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

TERMINATION OF EMPLOYEE COVERAGE

Employee coverage will terminate on the earliest of these dates:

1. On the date the Plan is terminated;
2. As of the first day of the month following the date the Employee ceases to be eligible according to the eligibility rules established by the Board of Trustees.

See the Continuation of Coverage section for information on how to continue your coverage in the event coverage under the Plan is terminated.

TERMINATION OF DEPENDENT COVERAGE

A Dependent's coverage will terminate on the earliest of these dates:

1. The date the Plan or Dependent coverage under the Plan is terminated;
2. The date that the Employee's coverage, under the Plan, terminates for any reason including death;
3. On the first day of the month following the month in which the Dependent no longer qualifies as an eligible Dependent;
4. If the Dependent is your spouse, on the first day of the month following the month in which you are divorced or legally separated from your spouse; or
5. On the day that the Dependent enters active duty with the armed services of any country if the period of active duty exceeds 30 days.

See the Continuation of Coverage section for information on how to continue your coverage in the event coverage under the Plan is terminated.

MEDICALLY NECESSARY LEAVE OF ABSENCE FROM COLLEGE

Effective April 1, 2010, if your Dependent is enrolled in a college, university or other educational institution and must take a Medically Necessary leave of absence due to the Dependent's serious illness or injury, your Dependent's coverage shall not terminate because of the leave of absence. Your Dependent's coverage shall continue until the leave of absence is no longer Medically Necessary, but in no event longer than one year from commencement of the leave of absence. You must notify the Trust Office in order to be granted continued eligibility during a Medically Necessary leave of absence from college. The Trust Office may require written confirmation from your Dependent's treating physician that your Dependent is suffering from a serious illness or injury requiring a Medically Necessary leave of absence.

CERTIFICATE OF FORMER COVERAGE

If your coverage under this Plan ends and you become eligible for a new health plan, the length of time you were covered under this Plan may be used to reduce the length of any pre-existing condition exclusion period in your new plan. A Certificate of Creditable Coverage provides information regarding your period of coverage under this Plan, which your new plan may need to credit coverage.

This Plan will automatically provide a Certificate of Creditable Coverage when Plan coverage ends *or* when you become entitled to elect COBRA continuation coverage, as well as when your COBRA continuation coverage ceases.

You may also request a Certificate of Creditable Coverage before losing coverage under this Plan, or within 24 months after losing coverage, by contacting the Trust Office.

CONTINUATION OF COVERAGE

COBRA CONTINUATION COVERAGE

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

Qualified Beneficiaries. A qualified beneficiary means:

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

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

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

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

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

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

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

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

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

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

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

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

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

In order to qualify for a Social Security disability extension, the qualified beneficiary must notify the Trust Office in writing within 60 days after the date of the Social Security determination, but no later than the date that the initial 18 months of COBRA expires. A copy of the Social Security determination must be included with the written notice. Thereafter, if there is a final determination by Social Security that the individual is no longer disabled, the qualified beneficiary must notify the Trust Office in writing within 30 days of the determination.

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

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

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

Each qualified beneficiary has an independent right to elect COBRA. An Employee or Spouse may elect

COBRA on behalf of other qualified beneficiaries in the family. A parent or Legal Guardian may elect COBRA on behalf of a minor child.

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

1. Medical and Prescription Drug; or
2. Medical, Prescription Drug, Dental and Vision.

Life insurance, accidental death and dismemberment benefits and short-term disability benefits are not available under COBRA.

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

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

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

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

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

Employees and their Dependents, who qualify for both COBRA and Retiree Medical, may elect COBRA in lieu of Retiree Medical. Following termination of COBRA, the Employee and eligible Dependents may apply

for Retiree Medical. However, if COBRA is declined in favor of Retiree Medical, COBRA may not thereafter be elected, unless there is a new qualifying event.

Effect of Not Electing Continuation Coverage. In considering whether to elect COBRA, please be aware that a failure to continue your group health coverage can affect your rights under federal law as follows:

1. Pre-existing condition exclusions under a future group health plan may apply if you have more than a 63-day gap in health coverage, and electing continuation coverage may help you avoid such a gap;
2. You can lose the right to purchase guaranteed individual health coverage that does not impose a pre-existing condition exclusion if you do not obtain continuation coverage for the maximum time available to you; and
3. You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a spouse's plan) within 30 days after your group health coverage from the Trust ends because of your qualifying event. You will also have the same special 30-day enrollment right at the end of the maximum continuation coverage period available to you.

ALTERNATIVE CONTINUATION RIGHTS

There is no individual or group conversion option available for the medical, prescription drug, dental, or vision benefits provided by the Trust. However, your coverage may continue if you qualify for any of the alternative continuation rights set forth below.

FAMILY AND MEDICAL LEAVE

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

If you think you may be eligible for a FMLA leave, contact your employer immediately. Your employer must provide documentation to the Trust to confirm you qualify for FMLA leave, and make arrangements to pay the required contributions to continue coverage.

UNIFORMED SERVICE

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

1. Run-out the hour bank;
2. Freeze the hour bank until a return from military service; or

3. Extend coverage after it would otherwise terminate by making self-payments for USERRA continuation coverage. This option is available regardless of whether the Employee elects to run-out or freeze the hour bank.

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

Notice of Military Service. You are responsible for notifying the Trust Office in writing that you are entering military service. If you want to freeze your hour bank, you must notify the Trust Office within 60 days of beginning military service. If you do not provide timely notice, your hour bank will continue to run.

If you want to elect USERRA continuation coverage, you must notify the Trust Office of your military service within 60 days of termination of your coverage. If you fail to notify the Trust 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 Trust 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 Trust Office, and postmarked or received within 60 days from the later of the date coverage would otherwise end, or 60 days from the date the notification is furnished. 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 you provide timely notice and properly elect to freeze your hour bank, it will be frozen the first of the month following the month in which you begin military service.

If you properly elect to freeze your hour bank and thereafter 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, or you work under a Flat Rate Agreement, USERRA continuation coverage will begin immediately following the date coverage would otherwise end, provided the required self-payments are made.

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

1. 24 months following the month in which your hour bank was frozen, or your coverage would have otherwise ended because of your entry into military service;
2. 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; or
3. The last day of the month for which a timely self-payment is not received or postmarked.

Available Coverage. You may elect to self-pay for USERRA continuation coverage for yourself, yourself and your dependents, or only your dependents. You may elect the following coverage options:

1. Medical and Prescription Drug; or
2. Medical, Prescription Drug, Dental, Vision

Life insurance, accidental death and dismemberment benefits, and short-term disability benefits are not available under USERRA continuation coverage.

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 Employees. If the Trust changes its benefits, USERRA continuation coverage will also change.

Monthly Self-Payments. If your military leave is less than 31 days, coverage is continued at no cost.

If your military leave is for 31 days or more, a monthly self-payment is required for USERRA continuation coverage. The Trust Office will notify you of the self-payment amount when it sends you the election forms. The rate for USERRA coverage is the same as the COBRA continuation coverage rate.

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

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

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

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

If you properly elected to freeze your hour bank when you entered military service, the balance in your hour bank will be carried over until you are discharged from military service. Your frozen hour bank eligibility will be reinstated the first of the month in which you are discharged. Following reinstatement, hour bank eligibility will terminate the first day of any month your hour bank has less than a month of eligibility at the current hour bank deduction rate, unless you return to employment with a Covered Employer within the time period specified by USERRA, as explained below.

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

If you elected to run out your hour bank, and you return to employment within the time period specified by USERRA, your eligibility will be reinstated the first of the month in which you return to employment. The Plan will provide you with eligibility at no cost to you, for up to six consecutive months, or if earlier, until you reestablish hour bank or flat rate eligibility based upon your hours worked.

For example, if you ran out your hour bank while in military service and, upon discharge, you timely return to employment January 1, the Plan will provide you with eligibility through the earlier of June 30 or the second month following the month you work sufficient hours to reestablish your hour bank or flat rate eligibility.

If you elected to freeze your hour bank and you return to employment within the time period specified by USERRA, you may first run-out your previously frozen hour bank. Once your previously frozen hour bank has less than a month of eligibility at the current hour bank deduction rate, the Plan will provide you with

eligibility at no cost to you for up to six consecutive months, or if earlier, until you reestablish hour bank or flat rate eligibility based upon your hours worked.

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

Relationship of USERRA Continuation Coverage to COBRA. You may have the right to elect COBRA continuation coverage in lieu of USERRA continuation coverage. The length of USERRA continuation coverage may be different from that of COBRA continuation coverage. If you elect the USERRA continuation coverage, you will not have another opportunity to elect COBRA when your USERRA continuation coverage ends.

RETIREE MEDICAL ELIGIBILITY

RETIREE HEALTH AND PRESCRIPTION COVERAGE

The eligibility rules for Retirees who apply for Retiree Medical with a commencement date on or after January 1, 2003, are as follows:

1. The Retiree must have worked at least 15,000 hours in work covered by a collective bargaining agreement that required contributions to the Western Washington Laborers-Employers Pension Trust, the Washington-Idaho Laborers-Employers Pension Trust, a pension plan approved by the Board of Trustees, or the Northwest Laborers-Employers Health & Security Trust.
2. The Retiree must be a covered Employee in the Northwest Laborers-Employers Health & Security Trust at retirement. This provision will be waived if active coverage terminated during the 24-month period preceding the Retiree's retirement effective date, and the Retiree submits medical evidence that the termination of active coverage was the result of a disability. This provision will also be waived if, for the six-month period immediately preceding retirement, the Retiree continuously worked under a collective bargaining agreement with the Washington and Northern Idaho District Council of Laborers or its affiliates which does not require contributions to the Northwest Laborers-Employers Health & Security Trust, provided the Retiree worked at least 15,000 hours in work covered by a collective bargaining agreement that required contributions to the Northwest Laborers-Employers Health & Security Trust.
3. The Retiree must be receiving a pension from the Western Washington Laborers-Employers Pension Trust, the Washington-Idaho Laborers-Employers Pension Trust, or a pension plan approved by the Trustees.
4. If the Retiree has not worked and been covered under the Northwest Laborers-Employers Health & Security Trust for a period of five years or more commencing with the date that he first began participating in the Plan, he must return to Covered Employment for at least 6,000 hours during the five-year period immediately prior to his retirement date. Time worked under a collective bargaining agreement with the Washington and Northern Idaho District Council of Laborers or its affiliates which do not require contributions to the Northwest Laborers-Employers Health & Security Trust will not be counted in determining whether the Retiree had a five year break in coverage.
5. Eligibility will become effective the first of the month following the last month of eligibility from hours worked or the first of the month pension payments commence, whichever is later. In no event will eligibility commence prior to a Retiree's 55th birthday unless eligible for and receiving a disability pension.
6. If a Retiree between the age of 55 and 65, who is eligible for Retiree medical benefits, elects not to self-pay for himself or his Dependents at the time he retires, he and/or his spouse may elect coverage at either age 62 or 65. **You must notify the Trust Office prior to turning age 62 or 65 of your desire to resume your coverage under the medical Plan.** Coverage will commence the first of the month in which you turn age 62 or 65.

The Retiree Medical Plan provides coverage for the Medical and Prescription benefits described in this booklet. No benefits are provided for dental, vision, short term disability, life or accidental death and dismemberment insurance.

COVERAGE COST

The rates for Retirees who commenced Retiree Medical before January 1, 2003 are determined by the Board of Trustees and subject to adjustment at least annually.

Effective for Retirees who commence Retiree Medical on or after January 1, 2003, the retiree rates are based upon the hours worked by the Retiree for which contributions have been paid into the Western Washington Laborers-Employers Pension Trust, the Washington-Idaho Laborers-Employers Pension Trust, a pension plan approved by the Board of Trustees, or the Northwest Laborers-Employers Health & Security Trust and are subject to adjustment at least annually. If you elect to enroll yourself in Retiree Medical you may also enroll your eligible spouse or your eligible Dependents. You, your spouse and your eligible Dependents are required to pay a premium in order to participate in the Retiree Medical Plan. Please contact the Trust Office for information regarding the current retiree rate schedule.

MEDICARE

Medicare includes:

1. Part A (hospital insurance) which helps cover inpatient hospital care, skilled nursing facility care, home health care, and hospice care. Generally, there is no cost for Medicare Part A. You should enroll in Medicare Part A when eligible, because the benefits of this Trust are provided as if you are actually enrolled in Medicare Part A.
2. Part B (medical insurance) which helps cover physician's services and outpatient hospital care. It may also cover some services that Medicare Part A does not cover. You must generally pay a monthly premium for Medicare Part B. You must also pay a deductible before Medicare starts to pay. You should enroll in Medicare Part B when eligible, because the benefits of this Trust are provided as if you are actually enrolled in Medicare Part B.
3. Part D (prescription drug coverage) which helps cover prescription drugs. You must generally pay a monthly premium for Medicare Part D. **If you enroll in Medicare Part D, you will not be eligible for the Trust's prescription drug benefits, including the Mail Order Pharmacy. See the Prescription Drug section for details on enrollment in Part D.**

In order to receive full Plan benefits you MUST enroll in both Medicare parts A and B when you and or your spouse become eligible for them. If you do not sign up for Medicare Part A and Part B, the Trust Office will estimate what Medicare would have paid and coordinate benefits as though you had signed up for Medicare.

You will become eligible to enroll in Medicare when:

1. You turn age 65 or when your Dependent spouse turns age 65; or
2. You are under age 65, and receiving disability benefits from Social Security or the Railroad Retirement Board. (There may be a waiting period before you can commence Medicare); or
3. You have End-Stage Renal Disease.

Enrollment. If you are receiving benefits from Social Security or the Railroad Retirement Board, you should be automatically enrolled in Medicare the first day of the month you turn age 65. If you are under age 65 and disabled, you should be automatically enrolled after you have received disability benefits from Social Security or the Railroad Retirement Board for 24 months (although a shorter waiting period may apply in some instances). If you do not want Medicare Part B, you must follow the instructions that come with your Medicare card. **However, if you are a Retiree or Dependent of a Retiree and you are eligible for Medicare Part B, Plan benefits are provided as if you are enrolled in Medicare Part B, regardless of whether you actually enroll.**

If you are turning age 65 and you are not receiving Social Security or Railroad Retirement benefits, you must apply for Medicare. Even if your Social Security age is older than age 65, you are still eligible to enroll in Medicare at age 65.

There is an initial enrollment period for Medicare Part B, which begins three months before the month you turn age 65, and ends three months after the month you turn age 65. However, your starting date for Medicare Part B will be delayed if you do not sign up before the month you turn age 65.

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

There is a special enrollment period if you waited to enroll in Medicare Part B because you or your spouse were working and had other group health plan coverage based upon your employment. The special enrollment period is anytime you are still covered in the group health plan, or during the eight months following the earlier of the month that group health plan ends or employment ends.

If you are under age 65 and covered by Medicare you must submit proof of your Medicare eligibility.

Please notify the Trust Office in writing within 30 days of receipt of notification of Medicare eligibility. Refer to page 78 for information regarding Coordination of Benefits.

NOTE: The Trustees review these Benefit Plans and Retiree Medical eligibility regularly and they reserve the right to change the eligibility rules and/or cost to participate in the future.

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

RETIREE MEDICAL/DEPENDENT ELIGIBILITY

1. Only the spouse married to the Retiree at the time of the original retirement effective date will be covered, and that marriage must have taken place one year or more prior to the Retiree's original retirement effective date.
2. Only those children of the Retiree at the time of the original retirement effective date are eligible for coverage, provided they meet the definition of Dependent under the Plan.

TERMINATION

1. Medical coverage for Retirees will cease upon the termination of pension benefits, provided that Retirees who return to Covered Employment may continue self-payments for Retiree coverage for up to three months while accumulating hours for coverage in the active Plan. When a Retiree who has returned to active work re-retires, he may elect not to reinstate coverage in the Plan. If the Retiree does reinstate coverage in the Plan he may not make any changes to his original election of coverage. For example, the Retiree may not add Dependents if he did not elect to cover them at the time of his original retirement effective date.
2. Medical coverage terminates the month in which the required self-payments are not made, and may not thereafter be reinstated.

DISABILITY RETIREES

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

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

WIDOWS AND DEPENDENTS OF DECEASED RETIREES

In the event of the Retiree's death, covered Dependents may remain covered until the Spouse remarries or the children no longer qualify as Dependents. The Spouse may delay coverage until the attainment of age 62 or 65. If the original Retiree Medical effective date was prior to January 1, 2003, the self-payment rates are determined by the Board of Trustees. For Retiree Medical that commenced on or after January 1, 2003, the self-payment rate is based on the number of hours the Retiree worked in Covered Employment.

WIDOWS AND DEPENDENTS OF DECEASED ACTIVE PARTICIPANTS

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

Covered Dependents of a deceased active Employee who was vested in the Western Washington Laborers-Employers Trust, Washington-Idaho Laborers-Employers Pension Trust, or a related pension plan approved by the Trustees may continue coverage by making self-payments to the Retiree Medical Plan provided the Employee worked at least 15,000 hours in Covered Employment and was a covered Employee at the time of death. Coverage may continue until the spouse remarries or the children no longer qualify as Dependents. The self-payments will be based on the number of hours worked in Covered Employment by the deceased Employee.

SCHEDULE OF BENEFITS

This Schedule of Benefits is a summary of the benefits provided under this Plan. **Please read the entire booklet for details on specific benefit limitations and maximums, waiting periods and exclusions.**

The Northwest Laborers-Employers Health & Security Trust (The Trust) gives you freedom of choice by allowing you to choose your own doctors and hospitals. You will maximize your coverage by having care provided by Preferred Providers that participate in the Premera Blue Cross/BlueCard PPO Program, these are called network providers. You also have the freedom to select providers who do not participate in the Premera Blue Cross/BlueCard PPO Program. However, if you receive services from out-of-network providers, charges will be subject to Usual, Customary and Reasonable limitations and will be paid at the lower “Out-of-Network” rate described in the Schedule of Benefits. Premera Blue Cross network provider listings are available on line at www.premera.com; or by calling the Provider Locator number at (800) 810-2583. **YOU MUST SHOW YOUR NORTHWEST LABORERS ID CARD EACH TIME YOU VISIT A MEDICAL PROVIDER OR OBTAIN A PRESCRIPTION.**

BENEFIT	IN-NETWORK	OUT-OF-NETWORK
ANNUAL DEDUCTIBLE		
Individual	\$150	\$150
Family	\$375	\$375
ANNUAL OUT-OF-POCKET MAXIMUM		
Individual	\$2,000	Unlimited
Family	\$2,000	Unlimited
LIFETIME MAXIMUM	\$1 million	\$1 million
DOCTOR’S OFFICE VISITS	\$10 co-payment then 85% after deductible	\$10 co-payment then 70% after deductible
<i>The \$10 co-payment will apply to the deductible and out-of-pocket maximums, however it will always be required, even after deductibles and maximums have been met.</i>		
OUTPATIENT LABORATORY/ PATHOLOGY	85% after deductible	70% after deductible
IN-PATIENT HOSPITAL SERVICES <i>Benefits will be reduced by \$150 for failure to pre-authorize non-emergent hospitalizations Refer to page 32</i>	85% after deductible	70% after deductible
EMERGENCY ROOM <i>Co-payment waived if visit is within 24 hours of an accidental injury, or for a life threatening illness</i>	\$150 co-payment then 85% after deductible	\$150 co-payment then 70% after deductible
OUTPATIENT SURGERY	85% after deductible	70% after deductible
OUTPATIENT X-RAY/RADIOLOGY	85% after deductible	70% after deductible
AMBULANCE <i>To nearest hospital only</i>	85% after deductible	85% after deductible
NEURODEVELOPMENTAL DISORDERS <i>(Limited to age six or under)</i>	85% after deductible \$2,000 Lifetime max.	70% after deductible \$2,000 Lifetime max.

BENEFIT	IN-NETWORK	OUT-OF-NETWORK
ROUTINE GYNECOLOGICAL EXAM/PAP <i>1 per calendar year for women of any age. May be paid as part of Routine Physical Benefit if eligibility requirements are met.</i>	\$10 co-payment then 85% after deductible	\$10 co-payment then 70% after deductible
MAMMOGRAM <i>1 per calendar year.</i>	85% after deductible	70% after deductible
PREGNANCY <i>Benefits for Employee or spouse only. Elective abortions are not covered</i>	85% after deductible	70% after deductible
*BABYTIME- HEALTHY PREGNANCY PROGRAM <i>If you enroll in Babytime within the first 16 weeks of pregnancy, the Trust will provide \$500 in benefits for Well Baby Care for the first year of life and will waive the \$150 deductible for the newborn during the year in which the baby is born. You will also receive a copy of "From Here to Maternity". Refer to page 34</i>		
THERAPY SERVICES		
PHYSICAL AND OCCUPATIONAL THERAPY		
– <i>Up to 100 days following accident, stroke or surgery.</i>	85% after deductible	70% after deductible
– <i>All other conditions or following the first 100 days max. 30 visits per calendar year</i>	85% after deductible to \$25 max. benefit	70% after deductible to \$25 max. benefit
CARDIO AND PULMONARY REHABILITATION		
– <i>Pre-authorization recommended. Refer to page 27</i>	85% after deductible	70% after deductible
SPEECH THERAPY		
– <i>Pre-authorization recommended. Only for restoration of lost speech due to injury or illness.</i>	85% after deductible	70% after deductible
SPINAL MANIPULATIONS <i>24 visits per calendar year- Employees 12 visits per calendar year – Dependents</i>		
	85% after deductible to \$25 max. benefit	70% after deductible to \$25 max. benefit
NEUROLOGICAL AND INITIAL PSYCHOLOGICAL TESTS AND EVALUATION		
	85% after deductible	70% after deductible
CHEMO/RADIATION/DIALYSIS		
	85% after deductible	70% after deductible
DURABLE MEDICAL EQUIPMENT & PROSTHETICS <i>contact Trust office prior to purchase</i>		
	85% after deductible	70% after deductible
TEMPOROMANDIBULAR JOINT DISORDER (TMJ)		
	85% to \$1,000 lifetime max.(combined medical and dental coverages)	70% up to \$1,000 lifetime max. (combined medical and dental coverages)

BENEFIT	IN-NETWORK	OUT-OF-NETWORK
HOSPICE AND HOME HEALTH CARE <i>PRE-AUTHORIZATION REQUIRED</i> <i>Refer to page 32</i>	100% No deductible	100% No deductible
SKILLED NURSING FACILITY <i>PRE-AUTHORIZATION REQUIRED</i> <i>Custodial care not covered</i> <i>Lifetime max. \$10,000</i> <i>Refer to page 32</i>	85% after deductible up to \$50 per day	70% after deductible up to \$50 per day
ROUTINE PHYSICAL BENEFIT <i>Eligibility requirement: must have 18 of the past 24 months of eligibility. 1 exam per year for all covered Employees, Retirees and their covered Dependents</i>	100% no deductible	70% after deductible to max. of \$200 each calendar year
MENTAL HEALTH CARE <i>Outpatient – 10 visits per calendar year</i> <i>Inpatient – 5 days per calendar year</i> <i>PRE-CERTIFICATION REQUIRED FOR IN-PATIENT</i> <i>Refer to page 32</i>	50% after deductible	50% after deductible
<i>Note: The above inpatient and outpatient charges for Mental Disorders will not be counted in accumulating covered charges toward the annual maximum out-of-pocket payment for the 100% payment percentage, nor will these charges be subject to the 100% payment.</i>		
SUBSTANCE ABUSE TREATMENT <i>Combined lifetime max of \$10,000 for in and outpatient treatment.</i> <i>Patient MUST complete the prescribed treatment program before benefits will be paid.</i> <i>EXPENSES RELATED TO DETOXIFICATION ARE NOT COVERED UNLESS FOLLOWED BY A COMPLETED TREATMENT PROGRAM.</i>	85% after deductible max. \$5,000 in 24 consecutive months	70% after deductible max. \$5,000 in 24 consecutive months
HEARING AIDS	85% up to \$500 max per ear, each 36 consecutive months	70% up to \$500 max per ear, each 36 consecutive months
ORGAN TRANSPLANTS <i>Preauthorization recommended</i> <i>\$5,000 Donor Lifetime max.</i>	85% up to \$125,000 Lifetime max.	70% up to \$125,000 Lifetime max.

ORGAN TRANSPLANT PROCEDURES:

Organ and tissue transplants are covered except for those that are classified as “Experimental and/or Investigational.” The Covered Participant must have had coverage under the Plan for a period of at least 24 months prior to an organ transplant.

The Plan provides donor expense benefits only when the recipient is a Covered Person.

FOR BENEFITS THAT REQUIRE PRE-AUTHORIZATION, CALL CAREALLIES AT (800) 422-3038. REFER TO PAGE 32 OF THE PLAN BOOKLET FOR FURTHER EXPLANATION.

MEDICAL BENEFITS

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

DEDUCTIBLE

Deductible Amount. This is an amount of covered charges for which no benefits will be paid. Before benefits can be paid in a Calendar Year, a Covered Person must meet the deductible shown in the Schedule of Benefits.

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

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

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

BENEFIT PAYMENT

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

PREFERRED PROVIDERS

When covered services are provided by a Preferred Provider, the Plan generally pays a higher percentage of covered charges than it does when services are provided by a non-Preferred or out-of-network provider. In addition, once a Family Unit reaches the out-of-pocket limit, covered charges by a Preferred Provider for that Family Unit will be payable at 100% for the rest of the Calendar Year.

Charges will be paid at the Preferred Provider level when:

1. The services are provided by a Preferred Provider;
2. The services are provided by a out-of-network anesthesiologist, radiologist, pathologist or assistant surgeon at a Preferred Provider Hospital;
3. An MRI is ordered or performed by Preferred Provider Physician at an out-of-network Hospital;
4. Emergency services that are provided by Preferred Providers or out-of-network providers; or
5. The charges for lab and x-ray services that are ordered by Preferred Provider Physician.

NON-PREFERRED PROVIDERS

When services are provided by a non-Preferred, or out-of-network provider, the Plan generally pays a lesser percentage of covered charges than it does for Preferred Providers, as shown on the Schedule of Benefits. Maximum out-of-pocket limits do not apply to covered charges provided by non-Preferred Providers.

LIFETIME MAXIMUM BENEFIT AMOUNT

The Lifetime Maximum Benefit Amount is shown in the Schedule of Benefits. It is the total amount of benefits that will be paid under the Plan for all covered charges incurred by a Covered Person.

On January 1, of each year, the amount which has been counted against the maximum benefit of any Covered Person and not previously reinstated will be automatically reinstated up to \$10,000.

COVERED CHARGES

Covered charges are the Usual, Customary and Reasonable Charges that are incurred for the following services and supplies. Benefits for these charges are subject to the limitations, exclusions and other provisions of this Plan. A charge is incurred on the date that the service or supply is performed or furnished, unless otherwise stated.

Hospital Care. Inpatient room and board and medical services and supplies furnished by a Hospital or Ambulatory Surgical Center or a Birthing Center. Covered charges will be payable as shown in the Schedule of Benefits. After 23 observation hours, a confinement will be considered an inpatient confinement. **Refer to Hospital Pre-certification requirements on page 32.**

1. **Hospital charges** for days in which the patient leaves the Hospital against medical advice are not covered.
2. **Outpatient treatment** at a Hospital outpatient department is covered for Accidents, Injury or Sickness, subject to the limitations shown in the Schedule of Benefits.

Skilled Nursing Facility Care. The room and board and nursing care furnished by a Skilled Nursing Facility will be payable up to the limitations shown in the Schedule of Benefits if and when:

1. the patient is confined as a bed patient in the facility;
2. the confinement starts immediately following a Hospital confinement of 3 days or more or a period of approved Home Health Care utilization;
3. the attending Physician certifies that the confinement is needed for further care of the condition that caused the Hospital confinement; and
4. the attending Physician completes a treatment plan which includes a diagnosis, the proposed course of treatment and the projected date of discharge from the Skilled Nursing Facility. Covered charges for a Covered Person's care in these facilities are limited to the covered daily charge limit shown in the Schedule of Benefits.

Physician Care. The professional services of a Physician for surgical or medical services.

Home Health Care Services and Supplies. Home care services are an alternative to hospitalization which provides the opportunity to convalesce in the privacy and comfort of your home. Covered services

include visits by a registered or licensed practical nurse, a licensed physical, occupational or speech therapist, and home health aides. The Plan also covers prescribed supplies and prescription medications obtained through the Home Health Care Agency and the rental up to the purchase price, of Durable Medical Equipment prescribed by the Physician. These benefits are not subject to the Plan deductible and charges are considered at 100% of the allowable Usual, Customary and Reasonable Charges when approved in advance by the Plan.

NOTE: Home Health Care benefits must be approved in advance by the Trust. At the time you feel you will be eligible for Home Health Care benefits, your Physician must submit to the Trust Office a written plan of treatment. The Home Health Care Services and Supplies must be in lieu of hospitalization. There will be a professional independent review of the proposed treatment plan and after the review, a letter of certification will be sent to both you and your Physician.

Hospice Care Services and Supplies. This benefit is designed to provide Medically Necessary home care for the terminally ill. Benefits include the Home Health Care benefits above, plus medical social services by a person with a Masters Degree in Social Work. Additionally, the Hospice benefit will cover prescribed supplies, prescription medications obtained through the Hospice Agency and the rental up to the purchase price of Durable Medical Equipment prescribed by a Physician. In addition the Plan will cover 100% of Usual, Customary and Reasonable Charges for short term inpatient hospice services (respite care) up to 12 days during the six month period of care, or 120 hours every three months. The short-term inpatient respite care shall be provided in a Hospital, Skilled Nursing Facility or convalescent home associated with the Hospice Agency. These benefits are not subject to the Plan deductible and charges are considered at 100% of the allowable Usual, Customary and Reasonable Charges when approved in advance by the Trust Office. All Hospice Care will be subject to periodic review for medical necessity and appropriateness. The Hospice Agency must be licensed and approved by the Trust.

Covered charges for Hospice Care Services and Supplies are payable as described in the Schedule of Benefits.

NOTE: Hospice Care benefits must be approved in advance by the Trust.

Hospice Eligibility Requirement. To be eligible for this benefit your Physician must submit for approval a written plan of treatment. Following review of the Physician's plan of treatment, a letter certifying your Hospice Care will be sent to both you and your Physician. Benefits will be limited to six months from the initial date of Hospice Care. At the end of this period the patient may apply for an extension of benefits which will be granted if the Trust determines that continued Hospice Care is medically appropriate.

Other Medical Services and Supplies. These services and supplies not otherwise included in the items above are covered as follows:

1. **Ambulance.** Local Medically Necessary professional land or air ambulance service, provided the service is to the nearest Hospital or Skilled Nursing Facility where treatment can be provided, unless the Trust finds a longer trip was Medically Necessary.
2. **Anesthesia.** Oxygen, blood and blood derivatives that are not donated or replaced, intravenous injections and solutions and administration of these items.
3. **Cardiac Rehabilitation.** Medically Necessary cardiac rehabilitation provided services are rendered (a) under the supervision of a Physician; (b) in connection with a myocardial infarction, coronary occlusion or coronary bypass surgery; (c) initiated within 12 weeks after other treatment for the medical condition ends; and (d) performed in a medical facility.

4. **Chemotherapy/radiation.** The materials and services for technicians providing radiation or chemotherapy and treatment with radioactive substances.
5. **Contact Lenses.** Initial contact lenses or glasses required following cataract surgery.
6. **Durable Medical Equipment.** Rental of Durable Medical Equipment if deemed Medically Necessary. The equipment may be bought rather than rented, with the cost not to exceed the fair market value of the equipment at the time of purchase, but only if agreed to in advance by the Trust. Durable Medical Equipment means equipment which (a) can withstand repeated use, (b) is primarily and customarily used to serve a medical purpose, (c) generally is not useful to a person in the absence of a Sickness or Injury and (d) is appropriate for use in the home.
7. **Medical Supplies.** When ordered by a Physician, may include casts, dressings, splints, braces, colostomy bags and related supplies.
8. **Hearing Aids.** Covered up to the benefit payment maximums shown in the Schedule of Benefits. An examination must take place before obtaining the hearing aid and a written certification must be submitted to the Trust verifying the need for the hearing aid.
9. **Temporomandibular Joint Syndrome (TMJ).** Medically Necessary services for care and treatment of jaw joint conditions, including Temporomandibular Joint syndrome (TMJ), not to exceed the benefit Plan maximums shown in the Schedule of Benefits.
10. **Diagnostic X-ray and Laboratory Studies.** When Medically Necessary for diagnostic studies.
11. **Mental Disorders and Substance Abuse/Chemical Dependency.** Covered charges for care, supplies and treatment of Mental Disorders and Substance Abuse/Chemical Dependency will be limited as follows:
 - a. All treatment is subject to the benefit payment maximums shown in the Schedule of Benefits; and
 - b. Benefits for treatment of Substance Abuse/Chemical Dependency, including detoxification or treatment resulting from ingestion of alcohol or drugs are payable only upon completion of prescribed treatment plan in an approved chemical dependency treatment facility.
12. **Dental Services.** Injury to or care of mouth, teeth, gums, and alveolar processes will be covered charges under Medical Benefits only if that care is for the following oral surgical procedures:
 - a. Excision of tumors and cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth;
 - b. Emergency repair due to Injury to sound natural teeth. This repair must be made within 6 months from the date of an Accident;
 - c. Surgery needed to correct Accidental injuries to the jaws, cheeks, lips, tongue, floor and roof of the mouth;
 - d. Excision of benign bony growths of the jaw and hard palate;
 - e. External incision and drainage of cellulitis. Incision of sensory sinuses, salivary glands or ducts; or
 - f. Reduction of dislocations and excision of temporomandibular joints (TMJs).

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

13. **Neurodevelopmental Disorders.** If a covered Dependent age 6 or under incurs expenses for neurodevelopmental therapy services, the Trust will provide benefits up to the limitations described in the Schedule of Benefits.
14. **Occupational Therapy.** If performed by a licensed occupational therapist. Therapy must be ordered by a Physician, result from an Injury or Sickness and improve a body function. Covered expenses do not include recreational programs, maintenance therapy or supplies used in occupational therapy. Benefit limitations are described in the Schedule of Benefits.
15. **Organ Transplant.** Charges otherwise covered under the Plan that are incurred for the care and treatment related to an organ or tissue transplant are subject to these limitations:
 - a. The recipient must be covered under the Plan for a period of 24 months prior to the transplant;
 - b. The transplant must be performed to replace an organ or tissue;
 - c. The maximum benefit for all transplant procedures performed during a Covered Person's Lifetime is shown in the Schedule of Benefits;
 - d. Charges for obtaining donor organs or tissues are covered charges under the Plan when the recipient is a Covered Person. When the donor has other medical coverage, his or her plan will pay first. The benefits under this Plan will be reduced by those payable under the donor's plan. Donor charges include those for:
 - evaluating the organ or tissue;
 - removing the organ or tissue from the donor; and
 - transportation of the organ or tissue from within the United States and Canada to the place where the transplant is to take place.
 - e. Benefit payments for donor charges are included under the Organ Transplant Maximum Benefit Limit shown in the Schedule of Benefits; and
 - f. Benefit payments for donor charges are subject to the separate donor lifetime benefit limit as shown in the Schedule of Benefits.
16. **Orthotics.** The initial purchase, fitting, repair, and replacement of orthotic appliances such as braces, splints or other appliances required for support for an injured or deformed part of the body as a result of a disabling congenital condition or an Injury or Sickness. Orthotic appliances must be prescribed by a Physician as Medically Necessary, used as prescribed, and made of durable material.
17. **Physical Therapy.** Charges by a licensed physical therapist, provided it is intended to improve a bodily function and is prescribed by a Physician who includes exact orders as to type, frequency and duration. Benefit limitations are described in the Schedule of Benefits.
18. **Pregnancy.** The Usual, Customary, and Reasonable Charges for the care and treatment of Pregnancy are covered the same as any other Sickness for a covered Employee or covered spouse.
 - a. Coverage for a Hospital stay following a normal vaginal delivery may not be limited to less than 48 hours for both the mother (if a Covered Person) and the newborn child. Coverage for a Hospital stay in connection with childbirth following a caesarian section may not be limited to less than 96 hours for both the mother (if a Covered Person) and the newborn child. However, this will not prohibit the mother's or newborn's attending Physician, after consulting with the mother, from discharging the mother or her newborn earlier.

- b. There is no coverage for an elective abortion.
- c. There is no coverage for Pregnancy of a Dependent child.

19. **Routine Preventive Care.** Charges for routine physical exams by a Physician that is not for an Injury or Sickness. Benefit limitations are described in the Schedule of Benefits.

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

- a. Inpatient Nursing Care. Charges are covered only when care is Medically Necessary and not Custodial in nature and either the Hospital's Intensive Care Unit is filled or the Hospital has no Intensive Care Unit.
- b. Outpatient Nursing Care. Charges are covered only when care is Medically Necessary and not Custodial in nature.

The only charges covered for Outpatient nursing care are those shown above and under Home Health Care Services and Supplies. Outpatient private duty nursing care on a 24-hour-shift basis is not covered.

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

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

23. **Speech Therapy.** Charges by a licensed speech therapist, provided it is restorative in nature, ordered by a Physician, and follows either: (a) surgery for correction of a congenital condition of the oral cavity, throat or nasal complex (other than a frenectomy) of a person; (b) an Injury; or (c) a Sickness that is other than a learning or Mental Disorder. Benefit limitations are described in the Schedule of Benefits.

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

25. **Routine Newborn Care.** Charges by a Hospital for Routine Newborn Care which is room, board and other normal care.

- a. This coverage is only provided if a parent is a Covered Person who was covered under the Plan at the time of the birth and the newborn child is an eligible Dependent. This coverage is for routine newborn care only. If the newborn is injured or ill benefits are provided under the Plan's standard medical benefit provisions.
- b. Charges for routine newborn nursery care are limited to Usual, Customary and Reasonable Charges for nursery care for the newborn child while Hospital confined as a result of the child's birth.

- c. Charges for covered routine nursery care will be applied toward the Plan deductible, co-payment and maximums of the newborn child.
- d. Charges for routine newborn Physician care are limited to the Usual, Customary and Reasonable Charges made by a Physician for the first pediatric visit to the newborn child after birth while Hospital confined.
- e. Charges for covered routine Physician care will be applied toward the Plan deductible, co-payment and maximums of the newborn child.
- f. Routine Newborn Care includes coverage for circumcision.

PATIENT ASSISTANCE PROGRAM

Administered for Zenith Administrators by CareAllies

To Enroll in this Program call Toll Free (800) 422-3038

This program requires a Covered Person to take certain steps when a Physician recommends hospitalization or certain other services. A call must be made at least 7 days in advance of services being rendered or the next business day after an emergency. **BENEFITS WILL BE REDUCED BY \$150 FOR FAILING TO PRE-CERTIFY A NON-EMERGENCY HOSPITALIZATION.**

PLEASE NOTE: The attending Physician does not have to obtain pre-certification from the Plan for prescribing a maternity length of stay that is 48 hours or less for a vaginal delivery or 96 hours or less for a caesarian delivery. Also, if you are covered under Retiree Medical **AND** eligible for Medicare, pre-certification is not necessary.

PRE-CERTIFICATION AND UTILIZATION REVIEW

Pre-Certification and Utilization Review is a program designed to help ensure that all Covered Persons receive necessary and appropriate health care while avoiding unnecessary expenses. The purpose of the program is to determine what is payable by the Plan. This program is not designed to be the practice of medicine or to be a substitute for the medical judgment of the attending Physician or other health care provider. In order to maximize Plan reimbursements, please read the following provisions carefully.

If a particular course of treatment or medical service is not certified, it means that the Plan may not consider that course of treatment as appropriate for the maximum reimbursement under the Plan.

The Pre-Certification and Utilization Review consists of:

1. Pre-certification to confirm Medical Necessity of non-emergency services before medical and/or surgical services are provided as follows:
 - a. Hospitalizations;
 - b. Skilled Nursing Facility stays;
 - c. Home Health Care; and
 - d. Hospice Care
2. Concurrent review of the services requested by the attending Physician; and
3. Certification of services, planning for discharge from a medical care facility and completion of medical treatment.

The process for obtaining Pre-Certification and Utilization Review is as follows:

Utilization review is set in motion by the Covered Person calling a Case Manager at (800) 422-3038.

Before a Covered Person enters a Hospital on a non-emergency basis or receives other listed medical services, the Covered Person must contact a Case Manager **at least 7 days before** services are scheduled with the following information:

1. The name of the patient and relationship to the covered Employee or Retiree;
2. The name, Social Security number and address of the covered Employee or Retiree;
3. The name and telephone number of the attending Physician;

4. The name of the Hospital, proposed date of admission, and proposed length of stay; and
5. The diagnosis and/or type of surgery or medical services.

If a Covered Person enters a Hospital on an emergency basis, the Covered Person, Covered Person's family member, Hospital or attending Physician must contact a Case Manager **within the next business day** after the admission.

After the Case Manager is contacted, a Registered Nurse will perform a review to determine if the services are appropriate for Plan reimbursement and the number of days of confinement or use of other listed medical services that are authorized for payment. **Failure to follow this procedure will reduce the reimbursement received from the Plan by \$150.**

The Case Manager will monitor the Covered Person's stay or use of other medical services and coordinate with the attending Physician, Hospital and Covered Person either the scheduled release or an extension of the stay or extension or cessation of the use of other medical services.

If the attending Physician feels that it is Medically Necessary for a Covered Person to receive additional services or to stay in the Hospital for a greater length of time than has been pre-certified, the attending Physician must request the additional services or days.

INDIVIDUAL CASE MANAGEMENT

When a catastrophic condition, such as a spinal cord Injury, cancer, AIDS or a premature birth occurs, a person may require long-term, perhaps lifetime care. After the person's condition is diagnosed, he or she might need extensive services or might be able to be moved into another type of care setting including his or her home.

Individual Case Management is a program whereby a Case Manager monitors the patient and explores, discusses and coordinates alternate types of appropriate Medically Necessary care. The Case Manager consults with the patient, the family and the attending Physician in order to develop a plan of care for approval by the patient's attending Physician and the patient. This plan of care may include some or all of the following:

1. Liaison between patient /family and providers/Physicians;
2. Monitoring Hospital or Skilled Nursing Facility;
3. Determining alternative care options; and
4. Assisting in obtaining necessary equipment and services.

Individual Case Management is available when the Plan determines that it would be beneficial to both the patient and the Plan.

The Case Manager will coordinate and implement the Individual Case Management program by providing guidance and information on available resources and working with the team to achieve the most appropriate covered treatment plan. The Trust, attending Physician, patient and patient's family must all agree to the alternate treatment plan.

Once agreement has been reached, the Trust will reimburse for Medically Necessary expenses as stated in the treatment plan, even if these expenses normally would not be paid by the Plan.

Note: Individual Case Management is a voluntary service. There is no reduction of benefits or penalty if the patient and family choose not to participate.

Each treatment plan is individually tailored to a specific patient and should not be seen as appropriate or recommended for any other patient, even one with the same diagnosis.

BABYTIME - HEALTHY PREGNANCY PROGRAM

Administered for Zenith Administrators by Care Allies, Inc.

This program is an easy to use educational resource to help identify and avoid the difficulties caused by high-risk Pregnancy and to have a healthy Pregnancy.

The Program is available to eligible female Employees and Dependent wives up to the thirty-second (32) week of Pregnancy. However, it is most beneficial when it is started in the first trimester - during the first sixteen (16) weeks of Pregnancy.

IF YOU ENROLL IN THE FIRST SIXTEEN (16) WEEKS OF PREGNANCY, THE TRUST WILL PROVIDE UP TO \$500 IN BENEFITS FOR WELL BABY CARE FOR THE FIRST YEAR OF LIFE AND WILL WAIVE THE \$150 DEDUCTIBLE FOR THE NEWBORN DURING THE YEAR IN WHICH THE BABY IS BORN. BENEFITS WILL BE PAID AT THE CO-INSURANCE LEVEL LISTED IN THE SCHEDULE OF BENEFITS.

The BABYTIME program includes:

1. **Screening** – A registered nurse with a specialty in obstetrics will set up a confidential and personal telephone interview with you to talk about your family and your personal medical history, about your daily schedule and eating habits and about other things in your life that could have a bearing on the outcome of your Pregnancy.

The result of your screening will be sent to you summarizing any areas where you can positively affect your Pregnancy and the health of your baby.

2. **FROM HERE TO MATERNITY** – Following your first interview you will receive a copy of *From Here to Maternity*. *From Here to Maternity* covers many of the topics you are likely to have questions about during your Pregnancy.

To Enroll in the Babytime Program

Call (800) 422-3038

There is no cost to participate in this program!

SHORT TERM DISABILITY BENEFITS

Active Employees only

The Short Term Disability Benefit applies when an active Employee has a Total Disability that meets all of these criteria:

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

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

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

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

BENEFIT PAYMENT

For non-occupational illness and injuries

Weekly benefit limit	\$134 per week
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Benefits are payable:

For Injury	First day of Total Disability
For Sickness	Eighth day of Total Disability

Maximum period payable	13 weeks
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Note: Disability must commence during a month in which the Employee is eligible for active coverage.

PERIOD OF TOTAL DISABILITY

Period of Total Disability is the period of time that an Employee is Totally Disabled. Successive periods due to the same or related causes not separated by return to active work for at least two weeks in a row will be considered as one period of disability. When benefits have been paid for the maximum period, benefits will stop. However, you will again be eligible for benefits as soon as you have returned to or have been available for active work for a period of two weeks, provided that the new period of disability commences while coverage is in force.

INCOME AND FICA TAXES

Short term disability benefits provided by the Trust are subject to federal income tax. Employees may, upon their written request, have income tax withheld by the Trust Office. If you would like income tax withheld, please contact the Trust Office for a withholding application and other details. Please note, however, that federal regulations mandate withholding of at least \$20 from each of your weekly benefit payments, if you request withholding.

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

Short term disability benefits paid by the Trust within the first six months after you cease working are also subject to Social Security (FICA) taxation. The Trust is required by federal law to withhold and deposit with the appropriate depository, your share of the tax from each weekly short term disability benefit payment that is made during the six month period after you cease working.

EXCEPTIONS

Short term disability benefits are not provided for:

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

PRESCRIPTION DRUG BENEFIT

All Covered Participants

The Plan contracts with a Pharmacy Benefit Manager, Express Scripts Inc. (ESI), to provide prescriptions at a discounted rate through Participating Retail Pharmacies. The Plan contracts with a Mail Order Pharmacy to provide services for maintenance prescriptions.

When using a Participating Retail Pharmacy, you must show your Northwest Laborers ID card and pay the applicable co-pays.

PARTICIPATING PHARMACY	GENERIC CO-PAY	BRAND CO-PAY
Up to a 30-day supply or 100 unit dose <i>You do NOT need to submit a claim</i>	\$0	\$10 plus 15% of the balance
NON-PARTICIPATING PHARMACY	GENERIC CO-PAY	BRAND CO-PAY
Up to a 30-day supply or 100 unit dose <i>You MUST pay for the prescription and submit the claim to Express Scripts for reimbursement.</i>	\$10 plus 50% of the balance	\$10 plus 50% of the balance

MAIL ORDER PHARMACY OPTION	GENERIC CO-PAY	BRAND CO-PAY
For maintenance prescriptions up to 100 day supply or 300 unit dose <i>You may need to pay the co-pay when the prescription is ordered.</i>	\$0	\$10 plus 15% of the balance

If the cost of your prescription for a name brand drug is less than \$10, you must pay the full cost of the prescription.

RETAIL PHARMACY BENEFIT OPTION – Express Scripts Inc. (ESI)

To locate retail pharmacies near you that are in the Express Scripts network, visit their website at www.express-scripts.com; visit the Zenith website at www.zenithadmin.com; or call Express Scripts customer service at (800) 467-2006.

NON-PARTICIPATING RETAIL PHARMACY BENEFIT

Covered prescription drugs purchased at non-Participating Pharmacies will be reimbursed at 50% of covered charges following a \$10 co-pay. The co-pay is not a covered expense under the Medical Plan. You must pay for the prescription at the pharmacy and submit a claim form with your prescription receipt to Express Scripts, Inc., for reimbursement. Claim forms can be obtained by calling Express Scripts, Inc. at (800) 467-2006.

MAIL ORDER PHARMACY BENEFIT OPTION

This option is available for maintenance medications (those that are taken for long periods of time, such as drugs sometimes prescribed for heart disease, high blood pressure, asthma, etc.). Prescriptions are filled by mailing or faxing your doctor's prescription form to the Mail Order Pharmacy. You may contact the Pharmacy at (800) 292-4722. You may be required to pay your co-pay amount, at the time the prescription is filled. The co-pay is not a covered expense under the Medical Plan.

CO-PAYS

The co-pays apply to each covered prescription. The co-pays are not covered charges under the Medical Plan. Any one prescription from a retail pharmacy is limited to the greater of a 30-day supply or a 100-unit dose. Any one prescription from a mail order pharmacy is limited to the greater of a 100-day supply or a 300-unit dose.

SMOKING CESSATION.

The Trust will pay 100% of the cost of oral medications, inhalers or nicotine patches purchased while covered, subject to the co-pay listed on page 37 and the following limitations:

1. **The prescription must be purchased through the Mail Order Pharmacy;**
2. The medication must be prescribed by a Physician;
3. The benefit is subject to a Lifetime limitation of two three-month supplies.

COVERED PRESCRIPTION DRUGS

The following prescription drugs are covered subject to the applicable co-pays and Plan exclusions:

1. All drugs prescribed by a Physician that require a prescription either by federal or state law, except injectables (other than insulin) and drugs otherwise excluded in this Plan (see Expenses Not Covered on page 39);
2. All compounded prescriptions containing at least one prescription ingredient in a therapeutic quantity;
3. Insulin when prescribed by a Physician;
4. Newly approved drugs will be covered under this Plan if they fall within the same class or category of drugs already covered under this Plan, unless otherwise specifically excluded; and
5. FDA approved contraceptive drugs, devices and barriers requiring a prescription.

LIMITS TO THIS BENEFIT

Prescription drug benefits are only available when a Covered Person incurs a covered Prescription Drug charge. The covered drug charge for any refills is limited to the number of times specified by a Physician, up to one year from the date of order by a Physician.

SPECIALTY DRUGS

Prescription drugs classified as "specialty drugs" are subject to the Medical Plan's calendar year out-of-pocket maximum. Any co-pays for specialty drug prescriptions which are the responsibility of the patient will be considered as part of the calculation of the out-of-pocket maximum and specialty prescriptions will be paid at 100% when this maximum is met.

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

- Self injected or infused, but some are oral medications and taken by mouth;
- Unique storage or shipment requirements; or
- Usually not stocked at retail pharmacies.

You should check with your physician or pharmacist if you think you have been prescribed a specialty drug and obtain coverage confirmation from the Trust Office.

EXPENSES NOT COVERED

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

1. **Administration.** Any charge for the administration of a covered Prescription Drug.
2. **Consumed on premises.** Any drug or medicine that is consumed or administered at the place where it is dispensed.
3. **Contraceptives.** Contraceptives for Dependent daughters, unless used to treat a covered medical condition.
4. **Devices.** Devices of any type, even though such devices may require a prescription. These include (but are not limited to) therapeutic devices, artificial appliances, braces, support garments, or any similar device.
5. **Dietary supplements or vitamins.** Dietary supplements or vitamins except prenatal (Prenatal vitamins are covered only for the Pregnancy of a female Employee or covered spouse).
6. **Experimental or Investigational.** Experimental or Investigational drugs and medicines, even though a charge is made to the Covered Person.
7. **FDA.** Any drug not approved by the Food and Drug Administration.
8. **Immunization.** Immunization agents or biological sera.
9. **Infertility.** A charge for infertility medication.
10. **Injectables.** A charge for hypodermic syringes and/or needles, injectables or any prescription directing administration by injection (other than insulin).
11. **Medical exclusions.** A charge excluded under Plan Exclusions and Limitations.
12. **No charge.** A charge for Prescription Drugs which may be properly received without charge under local, state or federal programs.
13. **No prescription.** A drug or medicine that can legally be bought without a written prescription. This does not apply to injectable insulin.
14. **Sexual dysfunction.** A charge for Viagra or other medications which enhance sexual function.
15. **Smoking cessation.** Prescription Drugs for smoking cessation except as provided for through the Mail Order Pharmacy, smoking cessation benefit.

Medicare Part D Prescription Drug Plans for Retirees with Medicare

The following section describes your option to elect Medicare Part D for prescription drug coverage.

If you enroll in a Medicare prescription drug plan, it is important to note that you and your Dependents will lose your current prescription drug coverage under the Northwest Laborers Employers Health & Security Trust Fund and you will not be reimbursed for your Part D premiums.

If you and/or your Dependents are entitled to Medicare Part A or enrolled in Medicare Part B, you are also eligible for Medicare Part D Prescription Drug benefits. It has been determined that the prescription drug coverage offered by the Northwest Laborers-Employers Health & Security Trust Fund is “creditable.” This means that the Plan’s prescription drug coverage provided to Medicare eligible Retirees is of equal or greater financial value as the Medicare Part D prescription drug coverage.

Because your existing coverage is “creditable coverage,” you **do NOT need to enroll** in a Medicare prescription drug plan in order to avoid a late penalty under Medicare.

If you go 63 continuous days or longer without prescription drug coverage that is “creditable coverage,” your monthly premium will go up at least 1% per month for every month that you did not have that coverage. For example, if you go nineteen months without coverage, your premium may consistently be at least 19% higher than the base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following November to join.

You may enroll in a Medicare prescription drug plan when you first become eligible for Medicare and each year from November 15th through December 31st. In addition, Employees leaving employer/union sponsored coverage may also be eligible to join a Part D plan at that time using an Employer Group Special Enrollment Period.

More detailed information about Medicare plans that offer prescription drug coverage is in the “Medicare & You” handbook. Medicare eligible individuals will get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans. For more information about Medicare prescription drug coverage:

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

Please contact the Trust Office before you enroll in any Medicare Part D prescription drug plan.

VISION CARE BENEFITS
Active Employees and their
Covered Dependents

The Trust has an agreement with Vision Service Plan (VSP) to provide vision benefits to you and your eligible Dependents. Under this agreement, you can use any provider you wish. However, if you use a VSP network provider, you may receive higher benefits and the provider will automatically file claims for you.

COVERED VISION EXPENSES

The following table summarizes your vision care benefits:

COVERED EXPENSES*	IF YOU SEE A VSP NETWORK PROVIDER THE PLAN REIMBURSES...	IF YOU SEE A NON-VSP PROVIDER THE PLAN REIMBURSES...
Exams (once each calendar year)	100% after \$10 co-pay	Up to \$55, after \$10 co-pay
Lenses (once each calendar year)		
Single vision	100%	up to \$50
Bifocal – lined	100%	up to \$80
Trifocal – lined	100%	up to \$130
Lenticular	100%	up to \$100
Frames (once each two calendar years)	up to \$120	up to \$50
Contacts (once each calendar year in place of eyeglass lenses and frames)		
Elective**	100% up to \$120	up to \$105
Necessary***	100%	up to \$250

*You are responsible for additional non-covered cosmetic expenses, such as progressive lenses and coatings.

**Allowance applies to the cost of the contact lenses and the contact lens evaluation and fitting

***Covered (with prior VSP approval) following cataract surgery, to correct extreme visual acuity problems that cannot be corrected with spectacle lenses, for certain conditions of anisometropia and for keratoconus.

In addition, VSP network providers agree to:

1. 20% discount to provider’s usual and customary fees for additional complete pairs of prescription glasses;
2. Up to 30% discount for lens options, such as scratch-resistant and anti-reflective coatings and progressive lenses; and
3. 15% discount to contact lens fitting and evaluation. This benefit is available in conjunction with the VSP contact lens allowance or can be used to purchase contacts if glasses are already received.

LOW VISION COVERAGE

Low vision benefits are available (with prior VSP approval) for severe visual problems that are not correctable with regular lenses. Please discuss your options with your provider. Low vision coverage includes:

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

Low vision coverage has a benefit maximum of \$1,000 each two calendar years excluding the co-pay.

Low vision care from a non-VSP provider is subject to the same time limits and co-pays as described above for a VSP network provider. You must pay the non-VSP provider's full fee, and then are reimbursed up to what would have been paid to a VSP network provider in similar circumstances.

OBTAINING VISION COVERAGE

To receive eye care services or eyewear from a VSP network provider:

1. Contact VSP by calling (800) 877-7195 or by visiting www.vsp.com to determine if your provider is in the VSP network or to locate a VSP network provider close to your home or work.
2. Make an appointment, provide the VSP network provider with your Social Security number and tell the provider you are a VSP member before your visit. They will verify your eligibility and available benefits.
3. Pay the \$10 co-pay and the cost of any cosmetic options at the time of service. In most cases the Plan then pays 100% for covered services.
4. There is no need to file a claim, the VSP network provider does it for you.

To receive service from a non-VSP provider:

1. Make an appointment with any provider;
2. Pay the non-VSP provider the full amount of the bill and request an itemized copy of the bill. The bill should detail the charges for the eye exam and materials, including lens type; and should include the following information:
 - a. The name, address and phone number of the non-VSP provider;
 - b. The covered Employee's Social Security or other member ID number;
 - c. The covered Employee's name, address and phone number;
 - d. The name of the group (Northwest Laborers Employers Health & Security Trust);
 - e. The patient's name, date of birth, address and phone number; and
 - f. The patient's relationship to the covered Employee (such as self, spouse, child, student, etc.)

Employees can simply write the above information on the bill, obtain a claim form available at the Trust Office or use the printable form available when Employees sign on to the view benefits information at www.vsp.com.

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

VSP
P.O. Box 997105
Sacramento, CA 95899-7105

Please note that claims for reimbursement must be filed within twelve months of the date of service. Members will be reimbursed according to the out-of-network reimbursement schedule. Reimbursement is made directly to you and is not assignable to the provider.

VISION LIMITATIONS AND EXCLUSIONS

VSP includes an additional charge for:

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

VSP does not cover:

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

DENTAL BENEFITS

Active Employees and Their Covered Dependents

A CHOICE OF DENTAL PLANS

Employees with Active coverage under the Northwest Laborers-Employers Health & Security Trust must choose between Dental Plan A and Dental Plan B. You will be given an opportunity to make your selection once you have established eligibility, by completing an enrollment form and indicating your choice. If you do not make a selection within 90 days of your initial eligibility, you will automatically be enrolled in Dental Plan B. You will not be allowed to change dental plans until the next open enrollment period. Each year the Trust will hold an open enrollment period during which time you may select a new dental plan option.

DENTAL PLAN A

Dental Plan A is a managed dental care plan offered by Willamette Dental of Washington in Washington and Willamette Dental Group P.C. in Oregon and Idaho. This plan offers a network of dental clinics in Washington, Oregon and Idaho that provide dental care to eligible enrolled Employees and their eligible Dependents. A list of co-pays, limitations and exclusions can be found on pages 46-50. If you select Dental Plan A for your dental benefits, you must receive your dental care at one of the Willamette Dental network clinics. Co-pays are due at the time of each visit. All dental appointments are scheduled by calling the Willamette Dental Appointment Center. Family members do not have to use the same dental clinic, but all covered family members must use a clinic in the Willamette Dental network. Willamette Dental will verify eligibility when you call for an appointment.

DENTAL PLAN B

Dental Plan B allows enrolled Employees and their covered Dependents to use the dentist of their choice. You must be eligible when you receive treatment and dental benefits for covered services will be paid based on the schedule of benefits and the limitations and exclusions listed on pages 54-58, up to an annual Plan maximum of \$2,000 per covered family member. For those covered under Dental Plan B, some dental providers have agreed to accept the dental schedule of benefits as payment in full, up to the annual Plan maximum. The Trust does not endorse those dental providers and does not have a relationship with them. You may contact your Local Union or the Trust Customer Service to get a list of those dental centers.

NEW EMPLOYEE ENROLLMENT

If you are a new Employee in the Plan or have not been eligible within the last year (12 months), you must enroll in Dental Plan A or Dental Plan B. To do so, fill out the enrollment form which is enclosed in this booklet and submit it to the Trust Office within 90 days of your first month of eligibility. The enrollment form requires you to make a selection between Dental Plan A, Willamette Dental of Washington or Dental Plan B, the scheduled benefit plan. If you do not enroll in Dental Plan A within 90 days, you will automatically be enrolled in Dental Plan B and will not be allowed to change dental plans until the next open enrollment period.

OPEN ENROLLMENT

Each year the Trust will hold an open enrollment period during which time you may select a new dental plan option. If you wish to change your dental plan option, you may do so by filling out a new enrollment form and submitting it to the Trust Office at the address on the enrollment form. **Your next opportunity to change Dental Plans will not be until the next open enrollment period. Please contact the Trust Office for open enrollment dates.**

CHANGING PLANS

Changes to your dental plan option may only be made on an annual basis.

QUESTIONS

For questions regarding **Dental Plan A**, contact Willamette Dental's Patient Relations Department:

Monday – Friday, 8 a.m. to 5 p.m. PST

Toll Free – (800) 360-1909

Email – relations@willamettedental.com

For questions regarding **Dental Plan B** contact the Trust Office at:

Customer Service - (206) 282-3600

Toll Free - (800) 826-2102

**DENTAL PLAN A
WILLAMETTE DENTAL OF WASHINGTON, INC. (WDWI)**

HOW TO OBTAIN TREATMENT

All dental appointments are scheduled by calling the Willamette Dental Appointment Center . Family members do not have to use the same dental office. The list of dental offices can be found on pages 50-52.

The dental office will verify eligibility when you call for an appointment.

Payment of the office visit charge and any co-pays are due the same day treatment is received.

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

EMERGENCY CARE A condition is considered an emergency if it causes acute pain, swelling or bleeding, and is treated within 48 hours of its onset. Willamette Dental provides emergency dental care during regular office hours. If you have a dental emergency, then you should call the Appointment Center toll free at (800) 461-8994. After hours, a dentist is available for emergency consultation over the telephone at no cost. If you are traveling 50 miles or more from a Willamette Dental office, then you may go to any licensed dentist to obtain emergency treatment. Emergency dental treatment may be eligible for reimbursement up to \$100. Upon arriving home, contact our Patient Relations Department for reimbursement. You will need to schedule any follow-up care with your Willamette Dental primary care dentist.

DENTAL PLAN A CO-PAYS

BENEFIT	CO-PAY
ANNUAL MAXIMUM	NO ANNUAL MAX
DEDUCTIBLE	NO DEDUCTIBLE
OFFICE VISIT	\$15.00
DIAGNOSTIC SERVICES AND PREVENTIVE SERVICES	
Routine and emergency exams	Covered at 100%
All X-rays	Covered at 100%
Teeth Cleaning	Covered at 100%
Fluoride Treatment	Covered at 100%
Sealants	Covered at 100%
Head and Neck Cancer Screening	Covered at 100%
Oral Hygiene Instruction	Covered at 100%
Periodontal Charting	Covered at 100%
Periodontal Evaluation	Covered at 100%

BENEFIT	CO-PAY
RESTORATIVE AND PROSTHETICS	
Fillings	Covered at 100%
Permanent Crowns	\$250
Complete Upper or Lower Denture	\$300
Bridge – per tooth	\$250
Dental lab fees	Covered at 100%
ORAL SURGERY	
Routine Extraction – Single tooth	Covered at 100%
Surgical Extraction	\$100
ENDODONTICS AND PERIODONTICS	
Root canal therapy – anterior	\$75
Root canal therapy – bicuspid	\$100
Root canal therapy – molar	\$225
Osseous surgery – per quadrant	\$55
Root planning – per quadrant	\$55
MISCELLANEOUS	
Missed Appointments (w/o 24 Hour notice)	\$ 20.00
Excluded Services	Full Charge
Maximum Benefit	Unlimited
D9230 Nitrous Oxide	\$ 20.00
D9221 General Anesthesia	\$100.00 first 30 minutes \$50.00 each additional 15 minutes
ORTHODONTICS	
Class 1	\$2,800.00
Class 2	\$2,800.00
Class 3	\$2,800.00

PRE-ORTHODONTIC SERVICES: A maximum of \$150.00 will be charged for pre-orthodontic services, but will later be deducted from the orthodontic co-payment specified above if the patient elects to receive orthodontic treatment.

EMERGENCY TREATMENT: If you are over 50 miles from your dental office and you require emergency treatment, Willamette Dental of Washington will reimburse up to \$100.00 toward the cost of the emergency treatment.

DENTAL PLAN A
WILLAMETTE DENTAL OF WASHINGTON, INC. (WDWI)

LIMITATIONS

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

1. Prosthodontics
 - a. A prosthetic appliance solely for the purpose of replacing an existing appliance will not be provided more than once in every five-year period. Said five-year period will be measured from the date on which the existing appliance was last supplied, whether under this Plan or under any prior dental care agreement between or involving as signatories, the Plan and Willamette Dental of Washington. Services which are necessary to make an appliance satisfactory will be provided in accordance with Dental Plan A. The term “existing” as used in this paragraph, is intended to include an appliance which was placed at the inception of the five-year period but which, for whatever reason, is no longer in the possession of the patient.
 - b. Complete Dentures: If a satisfactory result can be achieved through the utilization of standard procedures and materials, but the patient and the dentist select a personalized appliance or one involving specialized techniques, the obligation of the Plan will be any of the benefits appropriate to those procedures necessary to eliminate oral disease and restore missing teeth. The balance of the cost will remain the responsibility of the patient.
2. Restorative
 - a. Metal, baked porcelain restoration, inlays, crowns and jackets. If a tooth can be adequately restored with amalgam, composite or plastic, these will be the materials used to restore the tooth.
 - b. Mouth Rehabilitation. Benefits for mouth rehabilitation are limited to only procedures which are necessary and appropriate to eliminate oral disease and replace the missing teeth. The balance of the costs, including costs to increase vertical dimension or restore the occlusion will remain the responsibility of the patient.
3. Accidental Injury to Natural Teeth (treatment received within 12 months of Injury).

The Trust’s medical plan provides primary coverage for Accidental Injuries to Natural Teeth within 6 months from the date of injury. Dental Plan A provides secondary coverage during that time.

EXCLUSIONS

No benefits will be allowed for any of the following:

1. Services and supplies furnished solely for cosmetic purposes.
2. Replacement, addition of teeth to an existing removable denture or partial or fixed bridge unless:
 - a. Additional natural teeth are being replaced; or
 - b. The existing denture or bridge either was installed more than five years prior to replacement or cannot be made satisfactory.

3. Treatment started before the patient became eligible under Dental Plan A for dental benefits, and services or supplies provided after eligibility has terminated from Dental Plan A except for the following:
 - a. Prosthetic devices which were fitted, ordered and pre-certified by your dental center prior to termination but were delivered to you within sixty (60) days after the date of termination; or
 - b. Treatment in process that is completed within sixty (60) days after the date of termination provided that the first visit and plan of treatment were completed prior to date of termination.
4. Experimental procedures - services or supplies that are, in the judgment of Dental Plan A, experimental or investigational. These include any that are not recognized as accepted dental practice in our service area and any for which the required approval of a government agency has not been granted at the time of service.
5. Services not necessary for the participant's dental health.
6. War related conditions - the treatment of any condition caused by, or arising out of, an act of war, armed invasion or aggression.
7. Gnathologic recordings - recordings of the jaw movement and position.
8. Services otherwise available, including services or supplies for which payment could be obtained in whole or in part by the Employee or Dependent under any city, county, state, or federal law; services or supplies that could have been received in a Hospital or program operated by a governmental agency or authority; services or supplies for which an employer is required by any state or federal workers compensation, liability or other law, to provide benefits even though the person waives such benefits; services and supplies received from a dental or medical department maintained by or on behalf of an employer, a mutual benefit association, labor union, trustees or similar person or group.
9. Charges made for services or supplies furnished while the Employee or eligible Dependent is confined in a Hospital.
10. Dental implants.
11. Splints, nightguards and other appliances used to increase vertical dimension, restore the bite, or correct habits such as tongue thrust and teeth grinding.
12. Temporomandibular disorder or dysfunction, equilibration and x-rays, dental services for surgery involving tumor, cysts or fractures.
13. To ensure the continued success of this program in containing dental costs, the patient must actively participate in his/her dental care by: 1) Keeping scheduled appointments; and 2) Following the prescribed course of treatment. Should a patient fail to follow through with his/her responsibilities as indicated above, the dentist shall have the right to: 1) Refuse treatment; or 2) Charge an additional fee with the approval of Trust.
14. Treatment of cleft palate, anodontia and mandibular prognathicism.
15. Cases in which, in the professional judgment of the attending dentist, a satisfactory result cannot be obtained, such as poor bone structure or short roots.
16. The placement of bone grafts, gingival grafts or extra-oral substances in the treatment of periodontal disorders.
17. Reimbursement for the costs of services secured from other Physicians, dentists or dental surgeons, other than the dental office selected by the Employee, will not be paid for unless expressly authorized in writing by the Trust.

18. The costs of prescribed drugs or medications in conjunction with dental services shall not be a covered benefit.
19. When the Employee or eligible Dependent has at least 12 posterior teeth in occlusion (3/4 of chewing surface) replacement of missing posterior teeth is not a covered benefit.
20. Sealants are not covered if child is over 16 years of age, on teeth other than first or second molars and sealants cannot be placed more than once in a five year period.

If you choose Dental Plan A for your dental benefits, you must receive your care from any of the Willamette Dental offices listed below.

**WILLAMETTE DENTAL OFFICES
WASHINGTON**

(800) 359-6019 - Appointments • (800) 360-1909 - Customer Service

Bellevue (Park 120 Office Complex)

626 120th Ave. NE, Ste. B210
Bellevue, WA 98005

Bellingham (Pacific Meridian Plaza)

4164 Meridian St.
Bellingham, WA 98226

Everett

4310 Colby Ave., Suite 300
Everett, WA 98203

Federal Way

181 S. 333rd St., Ste C-100
Federal Way, WA 98003

Kennewick (Westhaven Professional Park)

602 N. Colorado
Kennewick, WA 99336

Kent

24722 104th Ave. SE
Kent, WA 98031

Lakewood

9307 Bridgeport Way SW
Tacoma, WA 98499

Longview

1461 Broadway St., Ste. A
Longview, WA 98632

Lynnwood (Scriber Lake Office Center)

6101 200th St. SW, Ste, 201
Lynnwood, WA 98036

Olympia (Columbia Commons)

3773-C Martin Way, Ste. 105
Olympia, WA 98506

Pullman (Wheatland Shopping Center)

1646 S. Grand Avenue
Pullman, WA 99163

Puyallup

702 South Hill Park Dr., Ste 201
Puyallup, WA 98373

Renton

1000 Oakesdale Ave. SW
Renton, WA 98055

Richland

104 Columbia Point Drive
Richland, WA 99352

Seattle - Dexter

133 Dexter Ave N.
Seattle, WA 98109

Seattle - Northgate

2111 N. Northgate Way, Ste. 100,
Seattle, WA 98133

Silverdale

3505 NW Anderson Hill Rd.
Silverdale, WA 98383

Spokane - Northpointe

9717 N. Nevada
Spokane, WA 99218

Spokane – South Hill

(Fidelity Associates Building)
501 S. Bernard, Ste 203
Spokane, WA 99204

Tacoma – West

Sixth Avenue Plaza Shopping Center
5401 Sixth Avenue
Tacoma, WA 98406

Tumwater

6120 Capitol Blvd. S.
Tumwater, WA 98501

Vancouver - East

1201 SE Tech Center Dr. Ste. 150,
Vancouver, WA 98683

Vancouver - Hazel Dell

910 NE 82nd Street
Vancouver, WA 98665

Vancouver – Mill

9609 Mill Plain Blvd.,
Vancouver, WA 98664

Wenatchee

Mission Plaza Professional Center
317 N. Mission Street, Suite 200,
Wenatchee, WA 98801

Yakima

1200 Chesterley Dr., Ste 230,
Yakima, WA 98902

WILLAMETTE DENTAL SPECIALTY OFFICES: Northgate Specialty

11011 Meridian Ave. N., Ste 104
Seattle, WA 98133

OREGON

Appointments: Portland area - (503) 952-2100 • Outside Portland: (800) 461-8994

Customer Service : Portland area: (503) 952-2000 • Outside Portland - (800) 460-7644

Albany

2225 Pacific Blvd. SE, Suite 201
Albany, OR 97321

Beaverton

4425 SW Allen
Beaverton, OR 97005

Bend

Apple Tree Office Park, Bldg. D,
62968 O.B. Riley Road
Bend, OR 97701

Corvallis

2420 NW Professional Dr., Suite 150
Corvallis, OR 97330

Eastport

4104 SE 82nd Ave., Suite 450
Portland, OR 97266

Eugene

2703 Delta Oaks Dr.
Eugene, OR 97408

Grants Pass

2166 NW Vine St., Ste H
Grants Pass, OR 97526

Gresham

1107 NE Burnside
Gresham, OR 97030

Hillsboro

5935 SE Alexander St.
Hillsboro, OR 97123

Jefferson

1933 SW Jefferson St.
Portland, OR 97201

Lincoln City

1105 SE Jetty, Ste. B
Lincoln City, OR 97367

Medford

773 Golf View Dr.
Medford, OR 97504

Milwaukie

6902 SE Lake Rd, Ste. 200
Milwaukie, OR 97267

Roseburg

2365 NW Stewart Pkwy.
Roseburg, OR 97471

Salem – Lancaster

3490 Lancaster Dr. NE
Salem, OR 97305

OREGON, CONTINUED

Salem –Liberty

4755 Liberty Rd. S.
Salem, OR 97302

Springfield

2510 Game Farm Road
Springfield, OR 97477

Stark Street

13255 SE Stark St.
Portland, OR 97233

Tigard - Scholls

11415 SW Scholls Ferry Road
Beaverton, OR 97008

Tillamook

800 Main Avenue, Ste B
Tillamook, OR 97141

Tualatin

17130 SW Upper Boones Fy.
Durham, OR 97224

Weidler Street

220 NE Weidler St.
Portland, OR 97232

WILLAMETTE DENTAL SPECIALTY

OFFICES: Beaverton Specialty

14495 SW Allen Blvd.
Beaverton, OR 97005

Gateway Specialty

1320 NE 106th
Portland, OR 97220

Stark Specialty

405 SE 133rd
Portland, OR 97233

IDAHO

(800) 603-1738 - Appointments • (800) 603-1738 - Customer Service

Boise

8950 W. Emerald St., Suite 108
Boise, ID 83704

Coeur d'Alene

943 W. Ironwood Drive
Coeur d'Alene, ID 83814-4925

Idaho Falls

2860 Valencia Dr., Suite 100
Idaho Falls, ID 83404

Meridian (Midvalley Professional Building)

2365 Gala St., Suite 1
Meridian, ID 83642

DENTAL PLAN B SCHEDULED BENEFIT PLAN

HOW TO SUBMIT A CLAIM

If you and your Dependents are covered under Dental Plan B, you will be required to file claims for all covered services with the Trust Office. In order to file a claim, you must:

1. Obtain a dental claim form from your employer, local union, the Trust Office, or on the Zenith Website: www.zenithadmin.com.
2. Fill in the Employee and patient section of the claim form completely. Be sure to include the Employee's Social Security Number on the form.
3. Have your dentist complete their section of the form or attach an itemized statement, and return it to the Trust Office. If there is need for continued treatment, the dentist should forward subsequent bills to the Trust Office.
4. For dental services in connection with crowns or periodontal treatment, a Dental Treatment Plan must be submitted to the Trust Office for predetermination of benefits. Please refer to the paragraph below for further explanation.

For claims assistance, contact the Trust Office.

NOTE: Incomplete forms and bills that are not itemized may delay payment of your claim. **No claim will be accepted unless filed within twelve months from the date dental treatment was performed.**

DENTAL PRE-DETERMINATION OF BENEFITS

Pre-determination of benefits helps you determine your out-of-pocket expense prior to authorizing your dentist to complete a recommended treatment plan. If treatment begins prior to pre-determination of benefits, you may experience unanticipated out-of-pocket expenses.

For all dental services in connection with crowns and periodontal treatment, a Dental Treatment Plan must be submitted to the Trust Office for pre-determination of benefits. If the Trust determines that alternate procedures, services, or courses of treatment may be performed to correct a dental condition, the maximum amount that Dental Plan B will cover is an allowance up to the least expensive procedure which will produce a professionally satisfactory result as determined by the Trust.

If the procedures shown on the Dental Treatment Plan are not completed within 12 months, you must submit a new Dental Treatment Plan to the Trust Office. **You must be eligible for benefits on the date the service is incurred, even if benefits were pre-determined.**

**DENTAL PLAN B
SCHEDULE OF BENEFITS
EFFECTIVE FEBRUARY 1, 2010**

You may go to any dentist and you will be reimbursed according to the schedule listed below (**up to a maximum benefit of \$2,000 per calendar year**). You must pay the difference between the dental charge and this payment schedule. A complete schedule is on file with the Trust Office.

PROCEDURE	MAXIMUM ALLOWANCE
Examinations (two per year)	
initial oral exam	\$ 64.00
periodic oral exam	49.00
emergency oral exam	58.00
Radiographs (x-rays), complete mouth	
x-rays (once each calendar year) and intraoral (including bitewings)	114.00
panoramic	113.00
Intraoral periapical	
single, first film	23.00
each additional film	18.00
Bitewings	
single film	24.00
two films	36.00
four films	59.00
PREVENTIVE	
Prophylaxis (cleaning and scaling) (two per calendar year)	
age 14 and over	103.00
to age 14.	67.00
Fluoride Treatment, topical application of fluoride (limited to two each calendar year) to age 19	38.00
Sealant, each tooth to age 19	44.00
MINOR RESTORATIONS	
Amalgam Restorations	
primary - one surface	121.00
primary - two surfaces	151.00
primary - three surfaces	185.00
permanent - one surface	121.00
permanent - two surfaces	151.00
permanent - three surfaces	185.00
permanent - four or more surfaces	140.00
pin retention	48.00
Other Minor Restorations	
composite resin - one surface	149.00
composite resin - two surfaces	176.00
composite resin - three surfaces	216.00

PROCEDURE**MAXIMUM ALLOWANCE****MAJOR RESTORATIONS**

Inlays and Onlays

gold inlay- one surface	738.00
gold inlay- two surfaces	826.00
gold inlay- three surfaces	910.00

Crowns

plastic (acrylic)	166.00
plastic with metal (gold)	896.00
porcelain	944.00
porcelain with metal (gold)	516.00
gold (full cast)	842.00
gold (3/4 cast)	509.00
stainless steel (primary)	104.00
crown buildup (pin retained)	118.00
re-cement crown	166.00

ENDODONTICS

Pulp Treatment

pulp cap	42.00
vital pulpotomy	94.00

Root Canal Therapy (includes Treatment Plan, clinical procedures and follow-up care; excludes final restoration)

single rooted	377.00
bi-rooted	452.00
tri-rooted	572.00
four or more roots	572.00
apicoectomy (performed as a separate surgical procedure)	579.00

Retrograde filling	192.00
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PERIODONTICS

Nonsurgical Services

periodontal prophylaxis (limited to one every 3 months)	101.00
occlusal adjustment (limited)	121.00
occlusal adjustment (complete)	634.00
periodontal scaling and root planing (per quadrant)	122.00

Surgical Services

gingivectomy (per quadrant)	567.00
osseous surgery	811.00
free soft tissue grafts	845.00

*not payable if performed in conjunction with osseous surgery or gingivectomy

PROCEDURE**MAXIMUM ALLOWANCE****ORAL SURGERY**

Extractions (includes local anesthesia and routine post-operative care)	
single tooth (uncomplicated)	82.00
erupted tooth (surgically removed)	226.00
impacted tooth - soft tissue	277.00
impacted tooth- partially bony	380.00
impacted tooth - completely bony	296.00
impacted tooth - completely bony - complicated	533.00
root recovery (per tooth)	256.00

RELATED ORAL SURGICAL PROCEDURES

alveoloplasty (per quadrant)	228.00
incision and drainage of abscess (intraoral)	165.00
frenectomy (separate procedure)	401.00
biopsy of oral tissue (soft)	274.00
tuberosity reduction/removal of exostosis	476.00

PROSTHODONTICS

Dentures

complete upper	609.00
complete lower	604.00
partial upper or lower (no clasps, acrylic base)	701.00
partial upper or lower (two gold or chrome clasps, acrylic base)	711.00

Related Denture Services

denture adjustment	80.00
repair broken denture (no teeth involved)	69.00
replace missing or broken tooth	113.00
reline denture	167.00

Bridgework

cast gold pontic	449.00
porcelain fused to gold pontic	476.00
re-cement bridge	132.00

BENEFITS WILL BE CONSIDERED BASED ON THE DATE THE PROSTHETIC IS SEATED**ORTHODONTICS - Not Covered****OTHER DENTAL PROCEDURES**

general anesthesia, first 30 minutes	338.00
each additional 15 minutes	123.00
space maintainers	
fixed space maintainer (band type)	224.00
nightguard	564.00

If the procedure performed is not shown in the above Schedule and is not expressly excluded by any of the terms of this Plan, a procedure of equivalent gravity and severity may be used as a basis for determining the Maximum Amount payable. The final determination of allowances, if any, is within the sole discretion of the Trust.

DENTAL PLAN B

LIMITATIONS AND EXCLUSIONS

No benefits are available for the following services and supplies, unless otherwise noted:

1. Oral examination and cleaning of teeth more than twice a year.
2. Periodontal prophylaxis more than once every three months.
3. Full mouth x-rays more than once each Calendar Year for each Employee or Dependent.
4. Oral hygiene instruction.
5. Services and supplies furnished solely for cosmetic purposes.
6. Nitrous oxide.
7. Replacement to any existing removable denture or partial denture or fixed bridge unless:
 - a. Additional natural teeth are being replaced; or
 - b. The existing denture or bridge either was installed more than five years prior to replacement or cannot be made satisfactory.
8. Gold restorations when other materials can be used satisfactorily, i.e., amalgams, composite, resin.
9. Crowns, except for abutments for a fixed bridge or when there is no other way to restore the tooth. For other crowns, the Plan will pay no more than would be paid for amalgam restoration.
10. Expenses incurred after termination of eligibility from Plan B except for the following:
 - a. Prosthetic devices which were fitted, ordered and pre-certified by the Trust Office prior to termination but were delivered to the Covered Person within sixty (60) days after the date of termination; or
 - b. Treatment in process that is completed within sixty (60) days after the date of termination provided that the first visit and plan of treatment were completed prior to date of termination.
11. Charges for treatment when an optional plan of treatment is available at a lesser fee.
12. Experimental procedures - services and supplies that are, in the Trust's judgment, experimental or investigational. These include any that are not recognized as accepted dental practice in our service area and any for which the required approval of a government agency has not been granted at the time of service.
13. Services that are not necessary dental care.
14. War related conditions - the treatment of any condition caused by, or arising out of, an act of war, armed invasion or aggression.
15. Gnathologic recordings - recording of the jaw movement and position.
16. Care, treatment or supplies furnished by a program or agency funded by any government.
17. Charges made for services or supplies furnished while the Employee or Dependent is confined in a Hospital unless such confinement is deemed to be Medically Necessary and dental treatment in a dental office will cause significant risk to the patient's health.
18. Dental implants and all related services.

19. Expenses for orthodontic treatment or correction of malocclusion.
20. Should the patient fail to follow through on a prescribed course of treatment, and subsequently develops a more extensive necessary course of treatment, Dental Plan B shall only be responsible for the initially prescribed course of treatment.
21. A prosthetic device will not be provided more than once in every 5-year period. Said 5-year period will be measured from the date on which the existing appliance was last supplied, whether under the current dental agreement or under any prior dental agreement. Services which are necessary to make an appliance satisfactory will be provided in accordance with the agreement. The term "existing" as used in this paragraph is intended to include an appliance that was placed at the inception of the aforementioned 5-year period, but, for whatever reason, is no longer in the possession of the patient.
22. The Trust's medical plan provides primary coverage for Accidental Injuries to natural teeth for the first six months from the date of the injury. Dental Plan B provides secondary coverage.
23. Services related to the treatment of Temporomandibular Joint Syndrome (TMJ) are limited to a combined medical/dental plan Lifetime maximum of \$1,000.00.
24. Expenses in excess of the Calendar Year maximum of \$2,000.00.
25. Sealants and fluoride treatments limited to age 19.
26. Care and treatment for which there would not have been a charge if no coverage had been in force.

LIFE INSURANCE BENEFITS

Active Employees and eligible Dependents

Life insurance is provided through a group policy between the Plan and Aetna, a life insurance carrier. It insures your life, the life of your Spouse and unmarried Dependents who are not otherwise eligible as Employees or in the Armed Forces. The following is a summary of Life and Accidental Death and Dismemberment (AD&D) features of this policy. This summary is intended for general purposes only and in no way changes or affects the policy as it is actually issued. In the event of any discrepancy between this booklet and the policy, the terms of the policy shall apply. **To obtain a certificate of insurance booklet, please contact the Trust office.**

SUMMARY OF LIFE INSURANCE BENEFITS

Life Insurance Amount – Active Employee	\$5,000 – coverage for the Employee
Life Insurance Amount – Dependents	\$2,000 for a Dependent spouse and/or unmarried child from live birth to age 19 or to age 23 if attending school.

SUMMARY OF ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS – ACTIVE EMPLOYEES ONLY

AD&D Death Benefit Amount –	\$5,000 – if the covered Employee suffers the loss due to an accident. Benefit does not apply to Dependents.
Added Features – Active Employee only	The following features are available only if the covered Employee suffers the loss due to an accident. These features do not apply to Dependents.
Loss of: Hearing, Speech or Eyesight	If an accident results in the Employee’s inability to speak or hear or see, the benefit pays 100% of the AD&D benefit for complete loss of both hearing and speech or of both eyes; 50% for loss of hearing or speech, or loss of one eye.
Dismemberment	Pays a benefit if an accident results in loss of a hand, arm, foot, leg, or fingers. The benefit percentage varies depending on the extent of the injury.
Third-Degree Burns	Pays a benefit if the Employee suffers burns as the result of exposure to heat, chemicals or water. The benefit percentage varies depending on the extent of the burns.
Paralysis	Pays a benefit if the accident results in partial or total paralysis. The benefit percentage varies depending on the extent of the paralysis.
Exposure or Disappearance	Pays 100% of your AD&D amount for death due to accidental exposure or in the event of a disappearance.
Coma Benefit	If the Employee suffers an accident and as a direct result become comatose, there is a monthly benefit of 5% of the principle sum if you remain in a coma for more than 30 days. Benefit is payable for up to 12 months.

SUMMARY OF ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS – ACTIVE EMPLOYEES ONLY

Repatriation of Remains	If a covered loss of life of the Employee occurs as a direct result of an accident while he/she is at least 200 miles from home, a benefit will be payable for the preparation and transportation of the body to a hometown mortuary. The benefit provides for \$5,000 to prepare and transport the body.
Passenger Restraint and Airbag	If a covered loss of life of the Employee occurs as a direct result of a motor vehicle accident and the Employee is properly using a passenger restraint and (if the driver) is properly licensed, a benefit will be payable. If an airbag is activated as a result of the same accident, an additional benefit will be payable. Passenger restraint and airbag usage will require verification. The benefit provides for \$10,000 for use of a passenger restraint and an additional \$5,000 if an airbag is activated.
Education Benefit	If a loss of life of the Employee occurs as a direct result of an accident, an education benefit will be payable on behalf of each Dependent child and/or a surviving spouse for a maximum of 4 years from the date of death, with verification of continued enrollment. The benefit provides for 5% of Employee's principal sum not to exceed \$5,000 per year.
Child Care	If a loss of life of the Employee occurs as a direct result of an accident, a benefit will be payable to the guardian of the estate of the Dependent child, or to the custodian, or adult caretaker, to cover expenses associated with the Dependent child's enrollment in a legally licensed child care center as of the date of the accident or subsequently enrolled within 90 days of the accident. The benefit is payable for a maximum of 4 years from the date of death, with verification of continued enrollment. The benefit provides for 3% of the Employee's principal sum to a maximum of \$2,000 per child per year.
Medical Coverage Funding Benefit	If the Employee loses his or her life as a direct result of an accident, this benefit will offset out-of-pocket expenses that surviving Dependents may incur as a result of having to continue medical expenses coverage in accordance COBRA. The benefit payable is \$300 per month / \$3,600 per year for a maximum of 36-months.
Monthly Hospital Benefit	If the Employee is injured in an accident and that accident results in the person being confined to a hospital and/or convalescent facility for at least 30-successive days, a monthly hospital benefit will be payable. Thereafter, additional monthly benefits will be payable for each period of confinement lasting 30-days. The benefit payable is \$2,500 per month for a maximum of 12-months. Maximum \$30,000.
Adaptive Home and Vehicle	If the Employee suffers a loss of limb by actual severance or becomes stricken with a covered form of paralysis as a direct result of an accident, a benefit will be payable for the out-of-pocket expenses that are incurred by the person to alter their principal place of residence and/or the personal motor vehicle to render them accessible and useable. This is a one-time, expense incurred benefit of up to \$10,000.

SUMMARY OF ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS – ACTIVE EMPLOYEES ONLY

Rehabilitation Training Benefit

Pays for out-of-pocket expenses that are incurred by the Employee as a result of entering a rehabilitation training program that has been designed to help the person return to work with their employer. The benefit pays a maximum of \$2,500 dollars for expenses that are incurred within 2-years from the date of the loss.

AD&D Limitations

This coverage is only for losses caused by accidents. No benefits are payable for a loss caused or contributed to by:

- A bodily or mental infirmity.
- A disease, ptomaine, or bacterial infection. *
- Medical or surgical treatment.*
- Suicide or attempted suicide (while sane or insane).
- An intentionally self-inflicted injury.
- A war or any act of war (declared or not declared).
- Voluntary inhalation of poisonous gases.
- Commission of or attempt to commit a criminal act.
- Use of alcohol, intoxicants, or drugs, except as prescribed by a physician.
- Intended or accidental contact with nuclear or atomic energy by explosion and/or release.
- Air or space travel. This does not apply if a person is a passenger, with no duties at all, on an aircraft being used only to carry passengers (with or without cargo).

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

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

DESIGNATION OF BENEFICIARY

Payment will be made to the beneficiary or beneficiaries named in writing by you. You have the right to change your beneficiary. However, if you are married and the beneficiary you choose is not your Spouse, your Spouse must consent to such designation. An enrollment form with designation of beneficiary is available at the Trust Office for this purpose. Any change will be binding only upon receipt of written request by the Trust Office.

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

If a named beneficiary dies before you, his or her share will be payable in equal shares to any other named beneficiaries who survive you.

If no named beneficiary survives you or if no beneficiary has been named, payment will be made as follows to those who survive you:

- Your spouse, if any;
- If there is no spouse, in equal shares to your children;
- If there is no spouse or child, to your parents, equally or to the survivor;
- If there is no spouse, child, or parent, in equal shares to your brothers and sisters; or
- If none of the above survives, to your executors or administrators.

A beneficiary designation of a spouse will be automatically revoked at the time a marriage is dissolved or invalidated. You must complete a new beneficiary designation following a dissolution or invalidation of marriage, even if you intend to re-designate your former spouse.

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, 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.

CONVERSION PRIVILEGE

If your life insurance ceases because of termination of eligibility or of membership in the class or classes eligible for insurance under the policy, the amount of insurance which ceases (or a lesser amount if desired) may be converted to an individual life insurance policy. Your converted policy may be any kind of individual policy then customarily being issued by Aetna for the amount being converted and for your age (nearest birthday) on the date it will be issued, except a term policy or one with disability or other supplementary benefits. You may convert your group life insurance without evidence of insurability, provided you make application and pay the required premium within 31 days after such termination of eligibility or of membership.

The premium for the converted policy will be at Aetna's then customary rates for the same policy issued to any other person of the same class of risk and age at the time the converted policy is to become effective.

If you have been insured under the policy for at least five years in a row and your insurance terminates due to termination of the policy or of the insurance of the class in which you are insured, you will be entitled to the conversion privilege (subject to the same conditions outlined in the above paragraph) but the amount of individual insurance to which you may convert shall not exceed \$5,000.

In order to convert, written application must be made for an individual policy and the first premium must be paid within 31 days after cessation of insurance for any of the above reasons. No evidence of insurability will be required.

Should you die within the 31 day period and before such individual policy becomes effective, the amount of insurance you are entitled to convert will be paid.

DEFINED TERMS

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

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

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

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

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

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

Covered Employment is work covered by a collective bargaining agreement or associate agreement that requires contributions to Western Washington Laborers-Employers Pension Trust, Washington-Idaho Laborers-Employers Pension Trust, or the Northwest Laborers-Employers Health & Security Trust.

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

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

Dependent is defined under the **Eligible Dependents** section on pages 6 and 7.

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

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

ERISA is the Employee Retirement Income Security Act of 1974, as amended.

Experimental and/or Investigational means a prescription drug or medical service, supply, care or treatment which does not constitute accepted medical practice properly within the range of appropriate medical practice under the standards of the case and by the standards of a reasonably substantial, qualified, responsible, relevant segment of the medical community or government oversight agencies at the time services were rendered.

The Board of Trustees will independently evaluate whether a specific prescription drug or medical service, supply, care or treatment is Experimental or Investigational guided by a reasonable interpretation of Plan provisions. The evaluation shall be made in good faith following a detailed factual background investigation of the claim and the proposed treatment. The Board of Trustees will be guided by the following principles:

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

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

Fiduciary/Named Fiduciary means the Board of Trustees.

Foster Child means an unmarried child under the limiting age shown in the Eligible Dependents section of this Plan for whom a covered Employee has assumed a legal obligation. All of the following conditions must be met: the child is being raised as the covered Employee's child; the child depends on the covered Employee for primary support; the child lives in the home of the covered Employee; and the covered Employee may legally claim the child as a federal income tax deduction.

A covered Foster Child is not a child temporarily living in the covered Employee's home; one placed in the covered Employee's home by a social service agency which retains control of the child; or whose natural parent(s) may exercise or share parental responsibility and control.

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

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

Home Health Care Plan must meet these tests: it must be a formal written plan made by the patient's attending Physician which is reviewed at least every 30 days; it must state the diagnosis; it must certify that the Home Health Care is in place of Hospital confinement; and it must specify the type and extent of Home Health Care required for the treatment of the patient.

Home Health Care Services and Supplies include: part-time or intermittent nursing care by or under the supervision of a registered nurse (R.N.); part-time or intermittent home health aide services provided through a Home Health Care Agency (this does not include general housekeeping services); physical, occupational and speech therapy; medical supplies; and laboratory services by or on behalf of the Hospital.

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

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

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

Hospice Unit is a facility or separate Hospital unit that provides treatment under a Hospice Care Plan and admits at least two unrelated persons who are expected to die within six months.

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

The definition of "Hospital" also includes the following:

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

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

Intensive Care Unit is defined as a separate, clearly designated service area which is maintained within a Hospital solely for the care and treatment of patients who are critically ill. This also includes what is referred to as a “coronary care unit” or an “acute care unit.” It has: facilities for special nursing care not available in regular rooms and wards of the Hospital; special life saving equipment which is immediately available at all times; at least two beds for the accommodation of the critically ill; and at least one registered nurse (R.N.) in continuous and constant attendance 24 hours a day.

Legal Guardian or Legal Custody means any judgment, decree or order issued by a court of competent jurisdiction by which the court declares, establishes or finds that the Employee or Retiree is the guardian or custodian of the child and is legally responsible for the care, maintenance and support of the child.

Lifetime is a word that appears in this Plan in reference to benefit maximums and limitations. Lifetime is understood to mean while covered under this Plan. Under no circumstances does Lifetime mean during the lifetime of the Covered Person.

Medical Emergency means a sudden onset of a condition with acute symptoms requiring immediate medical care and includes such conditions as heart attacks, cardiovascular accidents, poisonings, loss of consciousness or respiration, convulsions or other such acute medical conditions.

Medically Necessary care and treatment is recommended or approved by a Physician; is consistent with the patient’s condition or accepted standards of good medical practice; is medically proven to be effective treatment of the condition; is not performed mainly for the convenience of the patient or provider of medical services; is not conducted for research purposes; and is the most appropriate level of services which can be safely provided to the patient.

All of these criteria must be met. Merely because a Physician recommends or approves certain care does not mean that it is Medically Necessary.

The Trust has the discretionary authority to decide whether care or treatment is Medically Necessary.

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

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

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

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

Physician means a Doctor of Medicine (M.D.), Doctor of Osteopathy (D.O.), Doctor of Dental Surgery (D.D.S., D.M.D.), Doctor of Podiatry (D.P.M.), Doctor of Chiropractic (D.C.), Audiologist, Certified Nurse Anesthetist, Licensed Professional Physical Therapist, Midwife, Optician, Physician Assistant (P.A.), Occupational Therapist, Optometrist (O.D.), Physiotherapist, Psychiatrist, Psychologist (Ph.D.), Speech

Language Pathologist. All providers must be licensed and regulated by a state or federal agency and acting within the scope of his or her license.

For the purpose of Mental Health and Substance Abuse, a Physician also means a Certified Clinical Social Worker (CCSW), Certified Mental Health Counselor (CMHC), Licensed Mental Health Counselor (LMHC), Certified Masters Social Worker (CMSW), Masters in Social Work (M.S.W.), Education Doctorate (EdD), Masters in Psychology (M.A.) and Master of Education (MED) who is certified and/or licensed by the State to provide counseling and who is practicing within the scope of his or her license.

Plan means Northwest Laborers-Employers Health & Security Trust Fund.

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

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

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

Preferred Provider (Dental) means a provider that participates in the Willamette Dental of Washington, Inc. (WDWI) in Washington, Oregon and Idaho.

Preferred Provider (Medical) means a provider that participates in the Premera Blue Cross Network in Washington and Alaska and Blue Cross/Blue Shield in all other locations in the United States.

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

Retiree is one who meets the eligibility requirements for Retiree Medical as set forth on page 18, and pays the required Retiree Medical premium.

Sickness is:

1. For all persons but a covered Dependent daughter: illness, disease or Pregnancy.
2. For a covered Dependent daughter: illness or disease, not including Pregnancy or its complications.

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

1. It is licensed to provide professional nursing services on an inpatient basis to persons convalescing from Injury or Sickness. The service must be rendered by a registered nurse (R.N.) or by a licensed practical nurse (L.P.N.) under the direction of a registered nurse. Services to help restore patients to self-care in essential daily living activities must be provided;
2. Its services are provided for compensation and under the full-time supervision of a Physician;
3. It provides 24 hour per day nursing services by licensed nurses, under the direction of a full-time registered nurse;
4. It maintains a complete medical record on each patient. It has an effective utilization review plan;

5. It is not, other than incidentally, a place for rest, the aged, drug addicts, alcoholics, mentally handicapped, Custodial or educational care or care of Mental Disorders; and
6. It is approved and licensed by Medicare.

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

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

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

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

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

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

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

Usual, Customary and Reasonable Charge is a charge which is not higher than the usual charge made by the provider of the care or supply and does not exceed the usual charge made by most providers of like service in the same area. This test will consider the nature and severity of the condition being treated. It will also consider medical complications or unusual circumstances that require more time, skill or experience.

The Trust has the discretionary authority to decide whether a charge is Usual, Customary and Reasonable.

PLAN EXCLUSIONS AND LIMITATIONS

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

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

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

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

Custodial care. Services or supplies provided mainly as a rest cure, maintenance or Custodial Care.

Dental care. Dental care services are not provided in the Medical Plan, except for tumors and injuries to natural teeth as provided for in the Plan. Please refer to the Dental Plans for limitations and exclusions for dental care.

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

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

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

Experimental or not Medically Necessary. Care and treatment that is deemed either Experimental, Investigational or not Medically Necessary.

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

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

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

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

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

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

Illegal drugs or medications. Services, supplies, care or treatment to a Covered Person for Sickness or Injury which results from or was contributed to by that Covered Person's voluntary taking of or being under the influence of any controlled substance, drug, hallucinogen or narcotic not administered on the advice of a Physician; except as provided for under the Substance Abuse/Chemical Dependency provisions.

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

Marriage and/or family counseling.

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

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

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

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

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

Obesity. Care and treatment of obesity, weight loss or dietary control whether or not it is, in any case, a part of the treatment plan for an Injury or another Sickness.

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

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

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

Pregnancy of daughter. Care and treatment of Pregnancy and complications of pregnancy for a Dependent daughter.

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

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

Routine care. Charges for routine or periodic examinations, screening examinations, evaluation procedures, preventive medical care, or treatment or services not directly related to the diagnosis or treatment of a specific Injury, Sickness or Pregnancy-related condition which is known or reasonably suspected, unless such care is specifically covered in the Schedule of Benefits.

Self-Inflicted. Any loss due to an intentionally self-inflicted Injury or Sickness, unless the Injury or Sickness results from a medical condition. An Injury or Sickness will be considered intentional, if it is a natural or probable consequence of an intentional act.

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

Sexual dysfunctions. Care, services or treatment for sexual dysfunctions including non-congenital transsexualism, gender dysphoria or sexual reassignment or change. This exclusion includes medications, implants, hormone therapy, surgery, medical or psychiatric treatment.

Sleep disorders. Care and treatment for sleep disorders unless deemed Medically Necessary.

Smoking cessation. Care and treatment for smoking cessation programs except as provided for under the Mail Order Prescription Drug Benefit.

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

Third Party Claims. Services and supplies for an Injury or Sickness caused by the act or omission of another person (known as a “third party”), and where an opportunity for recovery exists from the third party and/or under an automobile (including uninsured and underinsured motorist policies), homeowners, commercial premises, renter’s, medical malpractice, or other insurance coverage or liability policy of the third party.

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

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

CLAIMS PROCEDURES

HOW TO SUBMIT A CLAIM

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

You MUST show your Northwest Laborers ID card to your provider each time you receive services.

MEDICAL CLAIMS

When you receive medical care, both Preferred and non-Preferred Providers will submit your claims for you directly to Premera Blue Cross. Premera Blue Cross will then apply the appropriate discounts then forward the claim to the Trust office for processing. Benefit payments will be paid directly to the Provider.

DENTAL PLAN B, SHORT TERM DISABILITY, LIFE INSURANCE AND ACCIDENTAL DEATH AND DISMEMBERMENT

Claim forms are required for Dental Plan B, Short Term Disability and Life Insurance and Accidental Death and Dismemberment Benefits. You may obtain a claim form by contacting the Trust Office or by accessing the website at www.zenithadmin.com. When submitting a claim to the Trust Office, be sure to complete all applicable areas of the claim form and for dental services, attached a fully itemized bill. This will expedite processing of your claim.

DENTAL PLAN A CLAIMS

Dental Plan A claims are handled by Willamette Dental of Washington Inc., claim forms are not required.

VISION CLAIMS

Vision claims are handled by VSP. If you receive care from a VSP provider, your provider will submit your claim directly to VSP and claim forms are not required. If you see a non-VSP provider, you will receive a lesser benefit. Before seeing a non-VSP provider, call (800) 877-7195 for more details, VSP will provide the necessary claim form when using a non-VSP provider.

PRESCRIPTION DRUG CLAIMS

Prescription Drugs purchased at an Express Scripts participating pharmacy or the mail order pharmacy do not require a claim form to be submitted. If you purchase prescriptions at a non- Express Scripts Pharmacy, you must pay the full retail price for the prescription, obtain a prescription claim form and submit the claim form with the itemized prescription receipt to Express Scripts to receive your benefit payment. Claim forms can be obtained by calling Express Scripts at (800) 467-2006.

MEDICARE CLAIMS

If you are a Retiree and covered by Medicare you may need to submit a copy of the Explanation of Medicare Benefits (EOMB) to the Trust if the provider does not include the Medicare payment information at the time the claim is submitted. Please keep a copy of the EOMB so that you have it available in the event the Trust Office requests it.

NO WAIVER OF CLAIM PAID IN ERROR – RECOVERY BY TRUST

If a claim is paid erroneously, or if payment is made because of incomplete or inaccurate information furnished to the Plan, or if payment is made in an incorrect account due to a clerical error, payment of the claim will not constitute a waiver of applicable Plan eligibility requirements, or any Plan limitation or exclusion. The Plan may recoup the erroneous payment from the provider, Employee, Retiree, spouse, or Dependent, or the Plan may offset future benefit payments of the Employee, Retiree or other family members by the amount of the claim paid in error. The Plan may also take appropriate legal action to recover the amount of an overpayment.

MISREPRESENTATION

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

ASSIGNMENT

The Trust and benefits payable in accordance with the Plan, shall not be subject in any manner to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance or charge by any person, provided that the Trustees may recognize assignments of benefits from a Covered Person to a Physician, Hospital, or other person or institution that has treated or cared for, or provided services or goods to, the Covered Person; and shall recognize a Qualified Medical Child Support Order (QMSCO) as provided on page 8.

TIME PERIOD FOR FILING CLAIMS

Claims must be filed with the Trust Office within 12 months of the date charges for the services were incurred, or in the case of short-term disability benefits, within 12 months of the date the disability commences. Claims filed later than that date may be declined or reduced, unless: it is not reasonably possible to submit the claims in that time; and the claimant is not legally capable of submitting the claims.

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

Processing of Claims. Claims that are properly filed will be processed in accordance with the following guidelines:

Pre-Service Health Claims. A pre-service health claim is a properly filed claim for medical or dental benefits that must be preauthorized to receive full benefits from the Plan. **Failing to obtain preauthorization for a pre-service claim will result in reduced benefits.** Pre-service claims include non-emergency admission to a Hospital, or a Skilled Nursing Facility, Home Health Care or Hospice Care. A pre-service claim will generally be processed within 15 days of receipt. This period may be extended for up to 15 days if the Plan determines an extension is necessary due to matters beyond the control of the Plan, and notifies the claimant within the initial 15-day period of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision.

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

If services that require 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.

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

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

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

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

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

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

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

expects to render a decision. If the Plan determines that an additional extension of time for making the benefit determination is necessary due to matters beyond the control of the Plan, and notifies the claimant prior to the expiration of the first 30-day extension period of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision, then the period for making a benefit determination may be extended by the Plan for an additional 30 days (to a total of 105).

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

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

NOTIFICATION OF A CLAIM DENIAL

If a claim is denied or partly denied, the claimant will be notified in writing and given an opportunity for review. The written denial will give:

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

REMEDIES AVAILABLE SHOULD A CLAIM BE DENIED

APPEAL TO BOARD OF TRUSTEES

Notification of Appeal. Any Employee or beneficiary (hereafter “claimant”) who applies for benefits and is ruled ineligible by the Trust Office, 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. Notwithstanding the foregoing, the appeal of a claim involving the reduction or termination of a previously approved concurrent care claim must be made within the time prescribed by the Plan in the notice of denial. The appeal of a claim for urgent care may be made orally or in writing.

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

Appeal Procedures. The claimant is generally entitled to present his position and any evidence in support thereof, at an appeal hearing. Notwithstanding the foregoing, in order to expedite review, the appeal of a pre-service, concurrent care, or urgent care claim may be held telephonically by the Trustees, and unless the participation of the claimant or his representative is necessary to develop an adequate record, may be based upon the written record. The claimant may request postponement of the Trustees’ review if the claimant wishes to appear in person at a hearing.

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

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

The claimant must introduce 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 or urgent care claim) as soon as possible, but not later than 5 days following the conclusion of the Appeals Committee meeting. Where necessary, the Trustees may issue a more detailed explanation of the reasons for an adverse decision within 30 days of the conclusion of the Appeals Committee meeting. Notwithstanding the foregoing, a decision on review of a pre-service claim or concurrent care claim will be made within 30 days after receipt of the appeal, and a decision on review of an urgent care claim will be made within 72 hours after receipt of the appeal. In the case of an adverse benefit determination, the written denial will indicate:

1. The specific reasons for the adverse benefit determination and a specific reference to pertinent Plan provisions on which the denial is based;
2. A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of all documents, records, and other information relevant to the claimant's claim for benefits;
3. A statement of the claimant's right to bring a civil action under ERISA §502(a); and
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.

REVIEW OF TRUSTEES' DECISION

The Plan does not provide for any voluntary alternative dispute resolution procedures. If a claimant remains dissatisfied with the Plan's determination after exhausting the claim appeal procedures, the claimant may bring a civil action under ERISA §502(a). Any action must be brought no later than 180 days after the date the Trustees' decision was issued. If suit is brought the questions for consideration on review will be whether, in the particular instance, the Trustees: (1) were in error upon an issue of law; (2) acted arbitrarily or capriciously in the exercise of their discretion; or (3) whether their findings of fact were supported by substantial evidence.

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

COORDINATION OF BENEFITS

Coordination of the benefit plans. Coordination of benefits sets forth rules for the order of payment of Covered Charges when two or more plans, including Medicare, are paying. When a Covered Person is covered by this Plan and another plan, or the Covered Person's spouse is covered by this Plan and by another plan or the couple's covered children are covered under two or more plans, the plans will coordinate benefits when a claim is received.

The plan that pays first according to the rules will pay as if there were no other plan involved. The secondary and subsequent plans will pay the balance due up to 100% of the total allowable expenses in a Calendar Year. If the other insurance is primary, you must submit your claim to the other insurance first, then submit a copy of their explanation of benefits along with your itemized bill to the Trust Office.

Annual verification of family coverage. Many families have more than one family member working and are covered by more than one health care plan. **The Trust requires that family coverage information be updated at least annually.**

Benefit plan. This provision will coordinate the benefits of a benefit plan. The term benefit plan means this Plan or any one of the following plans:

1. Group or group-type plans, including franchise or blanket benefits plans;
2. Blue Cross and Blue Shield group plans;
3. Group practice and other group prepayment plans;
4. Any group coverage under labor-management trustee plans, union welfare plans, employer organization plans, employee benefit organizations;
5. Federal government plans or programs, including Medicare;
6. Other plans required or provided by law. This does not include Medicaid or any benefit plans like it that, by its terms, does not allow coordination; and
7. No Fault Auto Insurance, by whatever name it is called, when not prohibited by law.

Allowable charge. For a charge to be allowable it must be a Usual and Reasonable Charge and at least part of it must be covered under this Plan.

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

In the case of service type plans where services are provided as benefits, the reasonable cash value of each service will be the allowable charge.

Third party automobile limitations. When medical payments are available under a third party's vehicle insurance, the Plan shall pay excess benefits only. A third party is defined as someone other than the Employee, Retiree or their covered Dependent.

Benefit Plan payment order. When two or more plans provide benefits for the same allowable charge, the primary plan is determined using the first of the following rules that apply.

1. Plans that do not have a coordination provision, or one like it, will pay first. Plans with such a provision will be considered after those without one.
2. Plans without a coordination provision will pay their benefits by these rules up to the allowable charge.
3. Plans with a coordination provision will pay their benefits by the following rules up to the allowable charge:
 - a. **Plans Covering Non-Dependents.** A plan, including this Plan, that covers a person other than as a Dependent, for example as an Employee, member, policyholder, subscriber or Retiree is primary over plans that cover a person as a Dependent. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the plan covering the person as a Dependent, and primary to the plan covering the person as other than a Dependent (i.e. a retired employee), then the order of benefits between the two plans is reversed so that the plan covering the person as an Employee, member, policyholder, subscriber or Retiree is secondary and the plan covering the person as a Dependent is primary.
 - b. **Plans Covering a Dependent Child.** Unless there is a court decree stating otherwise, when a Dependent child is covered by more than one plan, the order of benefits is determined as follows:
 - (i) For a Dependent child whose parents are married or are living together, whether or not they have ever been married:
 - (A) The plan of the parent whose birthday falls earlier in the Calendar Year is the primary plan; or
 - (B) If both parents have the same birthday, the plan that has covered the parent the longest is the primary plan.
 - (ii) For a Dependent child whose parents are divorced or separated or not living together, whether or not they have ever been married:
 - (A) If a court decree states that one of the parents is responsible for the Dependent child's health care expenses or health care coverage and the plan of that parent has actual knowledge of those terms, that plan is primary. This rule applies to claim determination periods commencing after the plan is given notice of the court decree;
 - (B) If a court decree states one parent is to assume primary financial responsibility for the Dependent child but does not mention responsibility for health care expenses, the plan of the parent assuming financial responsibility is primary;
 - (C) If a court decree states that both parents are responsible for the Dependent child's health care expenses or health care coverage, the provisions of subparagraph (3)(b)(i) above determine the order of benefits;

(D) If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the Dependent child, the provisions of subsection 3(b)(i) above determine the order of benefits; or

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

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

(iii) For a Dependent child covered under more than one plan of individuals who are not the parents of the child, the provisions of subsections 3(b)(i) and (ii) above determine the order of benefits as if those individuals were the parents of the child.

- c. Active Employee. The plan that covers a person as an active Employee is primary over a plan that covers a person as a Retiree regardless of which plan has covered the person longest.
- d. If a person is under a disability extension from a previous benefit plan, that benefit plan will pay first and this Plan will pay second.
- e. COBRA or state continuation coverage. If a person whose coverage is provided under COBRA or under a right of continuation provided by state or other federal law is covered under another plan, the plan covering the person as an Employee, member, subscriber or Retiree or covering the person as a Dependent of an Employee, member, subscriber or Retiree is the primary plan and the COBRA or state or other federal continuation coverage is the secondary plan. If the other plan does not have this rule, and as a result, the plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule under paragraph (3)(a) can determine the order of benefits.
- f. Longer or shorter length of coverage. The plan that covered the person as an active Employee, member, policyholder or subscriber longer is the primary plan and the plan that covered the person the shorter period of time is the secondary plan.
- g. If the preceding rules do not determine the order of benefits, the allowable expenses must be shared equally between the plans meeting the definition of plan. In addition, this Plan will not pay more than it would have paid had it been the primary plan.

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

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

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

Right of recovery. This Plan may pay benefits that should be paid by another benefit plan. In this case this Plan may recover the amount paid from the other benefit plan or the Covered Person. That repayment will count as a valid payment under the other benefit plan.

Further, this Plan may pay benefits that are later found to be greater than the allowable charge. In this case, this Plan may recover the amount of the overpayment from the source to which it was paid.

THIRD PARTY RECOVERY PROVISION

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

1. By accepting or claiming benefits, the Covered Person agrees that the Plan is entitled to reimbursement from any judgment, settlement, disputed claim settlement, or other recovery, up to the full amount of all benefits provided by the Plan, but not to exceed the amount of the recovery. The Plan is entitled to reimbursement, regardless of whether the Covered Person is made whole by the recovery, and regardless of the characterization of the recovery, except that the Plan will deduct reasonable attorney fees and a pro rata share of the costs from the reimbursement amount, if the Covered Person complies with the terms of the Plan and the agreement to reimburse.
2. Prior to advancing benefits the Plan can require a Covered Person and the Covered Person’s attorney or legal representative to execute and deliver instruments and papers, disclose the circumstances resulting from the Injury or Sickness, and do whatever else is necessary to secure the Plan’s right to reimbursement (including an assignment of rights).
3. A Covered Person must do nothing after payment of benefits to prejudice the Plan’s right of reimbursement.
4. When any recovery is obtained from a third party or insurer, whether by direct payment, settlement, judgment, or any other way, an amount sufficient to satisfy the Plan’s reimbursement amount must be paid by the Covered Person or the Covered Person’s attorney or legal representative into an escrow or trust account and held there until the Plan’s claim is resolved by mutual agreement, arbitration or court order. If the funds necessary to satisfy the Plan’s reimbursement amount are not placed in an escrow or trust account, the Covered Person or the person named to hold the funds will be personally liable for any loss the Trust suffers as a result.
5. If the Plan is forced to bring a legal action against the Covered Person to enforce the terms of the Plan’s provisions, it shall be entitled to its reasonable attorney fees, costs of collection and court costs.
6. The Plan may deny coverage or seek reimbursement from providers if there is a reasonable basis to determine this provision or any agreement to reimburse the Plan is not enforceable, or if there is a reasonable basis for believing that the parties involved will not honor the terms of this provision or any agreement to reimburse the Plan or the Board of Trustees modify this provision related to advancing benefits when a third party recovery is anticipated. Pursuant to this exclusion, the Plan may continue to exclude expenses incurred after judgment or settlement of the claim, if such expenses are related to the third party recovery. In addition, the Plan may offset future benefits, including those of family members, by denying such payments until it is reimbursed for the benefits provided that are related to the third party recovery.
7. The Covered Person expressly affirms the Plan’s right to bring a breach of contract action in state court to enforce the Plan’s right to reimbursement under this Plan provision and affirms the Plan’s right to seek a constructive trust in federal court under ERISA 502(a)(3) to recover the funds received by the Covered Person from a third party according to this Plan provision.

8. Venue for any enforcement action of this Plan provision will be in King County Superior Court in the State of Washington or the U.S. District Court for the Western District of Washington. The Plan may bring an action in an appropriate court to enforce the agreement to reimburse, enforce the requirement that funds be placed in trust or seek other appropriate relief.

SUMMARY PLAN DESCRIPTION

TYPE OF PLAN

The Plan is a self-funded welfare plan providing medical, dental, vision, prescription drug and short term disability benefits. Dental Plan A benefits are insured by Willamette Dental of Washington Inc. Life insurance and accidental death and dismemberment benefits are insured benefits provided by Aetna. The administration is provided through a contract administrative agent, Zenith Administrators, Inc.

PLAN NAME

Northwest Laborers-Employers Health & Security Trust Fund

TAX ID NUMBER

91-1283260

PLAN NUMBER

501

PLAN YEAR ENDS

March 31st

CONTRACT ADMINISTRATIVE AGENT

This Plan is administered by the Board of Trustees, with the assistance of a contract administrative organization, Zenith Administrators, Inc., 201 Queen Anne Ave. North, Seattle, WA 98109-4896. Telephone number is (206) 282-4100 or toll free (800) 426-5980.

AGENT FOR SERVICE OF LEGAL PROCESS

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

NAMES AND ADDRESS OF THE BOARD OF TRUSTEES

Employer Trustees

John Frodesen, Chairman
Farwest Construction Co.
P.O. Box 70612
Ballard Station
Seattle, WA 98127-0612

Monte Geiger
2808 S. Needham Drive
Veradale, WA 99037

Butch Henry
H & S Enterprises
700 Lincoln Street, Suite 200
Kelso, WA 98626

Mark Perry
Northwest Cascade
P.O. Box 73399
Puyallup, WA 98373

Doug Peterson
Associated General Contractors
1200 Westlake Ave. North, Suite 301
Seattle, WA 98109-3528

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

Labor Organization Trustees

David J. Letinich, Secretary
Washington and Northern Idaho
District Council of Laborers
P.O. Box 12917
Mill Creek, WA 98082

Dale Cannon
Laborers Local #242
2800 First Avenue, Room 50
Seattle, WA 98121-1114

Don McLeod, Jr.
Laborers Local #252
4803 South M Street
Tacoma, WA 98408

Bob Abbott
Washington and Northern Idaho
District Council of Laborers
P.O. Box 12917
Mill Creek, WA 98082

Kim Williams
Laborers Local #440
565 13th Avenue
Seattle, WA 98122

Mark Reavis
Laborers Local # 348
P.O. Box 1530
Pasco, WA 99301

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

DESCRIPTION OF COLLECTIVE BARGAINING AGREEMENT

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

PARTICIPATION, ELIGIBILITY AND BENEFITS

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

SOURCE OF CONTRIBUTIONS

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

ENTITIES USED FOR ACCUMULATIONS OF ASSETS AND PAYMENTS OF BENEFITS

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

The following are the names and addresses of issuers under contract with the Plan:

Aetna 1385 E. Shaw Ave. Fresno, CA. 93710	A life insurance company that provides and administers fully insured life insurance and accidental death and dismemberment benefits.
Willamette Dental of Washington, Inc. 15025 SW Farmington Beaverton, Oregon 97005	Provides dental services to Dental Plan A participants through a network of dental clinics.
Express Scripts Inc. (ESI) 711 Ridgedale Ave. East Hanover, New Jersey 07936	A prescription benefit manager that provides pharmacy network management.

Ellingson's Pharmacy
P.O. Box 57328
Portland, Oregon 97238

A mail order pharmacy providing pharmacy mail order services.

Vision Service Plan, Inc. (VSP)
121 S.W. Morrison Street, Ste. 1050
Portland, OR 97204

Provides vision care services

Premera Blue Cross
7001 220th St. S.W.
Building 3, M.S. 323
Mountlake Terrace, WA. 98053-2124

Provides a network of medical providers that provide discounts for medical services

STATEMENT OF ERISA RIGHTS

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

RECEIVE INFORMATION ABOUT YOUR PLAN AND BENEFITS

- Examine, without charge, at the Trust Office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain, upon written request to 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 Plan administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report. The Plan administrator is required by law to furnish each participant with a copy of this summary annual report.

CONTINUE GROUP HEALTH PLAN COVERAGE

- Continue health care coverage for yourself, spouse or Dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your Dependents may have to pay for such coverage. Review this Summary Plan Description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.
- Reduction or elimination of exclusionary periods of coverage for pre-existing conditions under the Plan, if you have creditable coverage from another Plan. You should be provided a certificate of creditable coverage, free of charge, from your group health or health insurance issuer when you lose coverage under the Plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a pre-existing condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

PRUDENT ACTIONS BY PLAN FIDUCIARIES

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

ENFORCE YOUR RIGHTS

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

Under ERISA, there are steps you can take to enforce the above rights. For instance:

- If you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator.
- If you have a claim for benefits which is denied or ignored, in whole or in part, you may request a hearing before the Board of Trustees. If you are dissatisfied with the determination of the Trustees, you may file suit in a state or federal court. In addition, if you disagree with the Plan decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in federal court.
- If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

ASSISTANCE WITH YOUR QUESTIONS

If you have any questions about your Plan, you should contact the Plan administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan administrator, contact the Department of Labor at one of the following addresses:

Employee Benefits Security Administration
U.S. Department of Labor
Seattle District Office
1111 Third Avenue, Suite 860
MIDCOM Tower
Seattle, WA 98101-3212
Phone (206) 553-4244

Division of Technical Assistance and Inquiries
Employee Benefits Security Administration
U.S. Department of Labor
200 Constitution Ave. NW
Washington, DC 20210

You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

AMENDMENT AND TERMINATION

In order that the Plan may carry out its obligation to maintain, within the limits of its resources, a program dedicated to providing the maximum possible benefits for all participants, the Board of Trustees expressly reserves the right, in its sole discretion at any time and from time to time, upon a non-discriminatory basis, to:

- Terminate or amend the Plan;
- Alter or postpone the method of payment of any benefit;
- Construe the provisions of the Plan and determine any and all questions pertaining to administration, eligibility, and benefit entitlement, including the right to remedy possible ambiguities and inconsistencies or omissions. Any construction or determination by the Trustees made in good faith shall be conclusive on all persons affected thereby;
- Reduce or eliminate any Plan subsidy; and
- Amend or rescind any other provision of this Plan.

The Trust may be terminated by the Employers and union by an instrument in writing executed by mutual consent at any time, subject, however, to all the requirements and procedures for Plan termination under ERISA and all regulations issued there under. Upon voluntary termination of the Trust, all assets remaining in the Trust after payment of all expenses shall be used for the continuance of benefits provided in the Plan until such assets have been depleted. Any such voluntary termination shall be performed in accordance with ERISA and applicable governmental regulations.

BENEFITS NOT GUARANTEED

None of the benefits provided by this Plan are insured by any contract of insurance, except the dental benefits provided by Willamette Dental of Washington, Inc., and the life insurance and accidental death and dismemberment benefits provided by Aetna. There is no liability on the Board of Trustees or any other individual or entity to provide payments over and beyond the amount in the Trust collected and available for such purpose. No Employee or Dependent shall have any accrued or vested rights to benefits under this Plan.

HIPAA PRIVACY DISCLOSURES AND CERTIFICATION

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

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

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

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

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

1. The Trustees will not use or disclose any PHI received from the Plan, except as permitted in this amendment or required by law;
2. The Trustees will ensure that any of their subcontractors or agents to whom they may provide PHI that was received from the Plan, agree to written contractual provisions that impose at least the same obligations to protect PHI as are imposed on the Trustees;

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

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

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

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

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

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

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

PROTECTED HEALTH INFORMATION

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

USE AND DISCLOSURE OF HEALTH INFORMATION

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

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

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

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

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

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

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

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

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

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

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

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

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

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

AUTHORIZATION TO USE OR DISCLOSE HEALTH INFORMATION

Other than as stated previously, the Trust will not disclose your health information other than with your written authorization. Authorization forms are available from the Privacy Office, listed below. If you have authorized the Trust to use or disclose your health information, you may revoke that authorization in writing at any time. The revocation should be in writing, include a copy of or reference your authorization and be sent to the Privacy Office, listed below.

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

YOUR RIGHTS WITH RESPECT TO YOUR HEALTH INFORMATION

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

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

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

Right to Inspect and Copy Your Health Information. You have the right to inspect and copy your health information in paper or electronic format, if available. You also have the right to have the Trust transmit a copy of your health information to an entity or person of your choice. These rights, however, do not extend to psychotherapy notes or information compiled for civil, criminal or administrative proceedings. The Trust may deny your request in certain situations subject to your right to request review of the denial. A request to inspect, copy, or transmit records containing your health information must be made in writing to the Privacy Office, listed below. Notwithstanding the foregoing, the fee for a copy of your health information in electronic format shall not be greater than the Trust's labor costs in responding to the request.

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

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

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

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

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

PRIVACY OFFICE/PRIVACY CONTACT

Zenith Administrators, Inc.
201 Queen Anne Avenue North, Suite 100
Seattle, WA 98109-4896
Phone: (206) 352-9730
Fax: (206) 285-1701
Email: contactperson@zenithadmin.com

DUTIES OF THE TRUST

The Trust is required by law to maintain the privacy of your health information as set forth in this Notice and to provide to you this Notice of its duties and privacy practices. 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 review the Notice and will provide a copy of the revised Notice to you within 60 days of the change. You have the right to express complaints to the Trust and to the Secretary of the Department of Health and Human Services if you believe that your privacy rights have been violated. Any complaints to the Trust should be made in writing to the Privacy Office identified above. The Trust encourages you to express any concerns you may have regarding the privacy of your health information. You will not be retaliated against in any way for filing a complaint.