Northwest Roofers & Employers Health & Security Trust Fund

Physical: 7525 SE 24th Street, Suite 200, Mercer Island, WA 98040 • Mailing: PO Box 34203, Seattle, WA 98124
Phone: (206) 441-7574 or (800) 732-1121 • Fax: (206) 505-9727 • Website: www.nwrooferstrust.com

Administered by
Welfare & Pension Administration Service, Inc.

February 16, 2018

TO: All Participants of the Northwest Roofers & Employers Health & Security Trust Fund (the "Plan")

RE: Plan Benefit Changes

This is a summary of material modification describing benefit changes adopted by the Board of Trustees.
Please be sure that you and your family read it carefully and keep this document with your Summary Plan Description Booklet.

The Trustees took recent action to make the following changes to the Plan:

Coverage of Transgender Healthcare Services

Effective **January 1, 2018**, the Plan will cover medically necessary transgender healthcare services for Gender Dysphoria (also called Gender Identity Disorder), as generally described below. ***For more information on coverage requirements for transgender healthcare services, please contact the Administration Office at (800) 732-1121, option 1. You and/or your service provider(s) should submit information to the Plan for a coverage determination prior to beginning treatment. Certain inpatient services are subject to the Health Management Program provisions of the Plan.***

Services covered by the Plan include:

- Counseling
- Hormone Therapy
- Gender reassignment surgery
- Services typically associated with one sex, which may continue to be required after transition
- Prescription drugs (as covered under the Prescription Drug Program of this Plan)

To be eligible for coverage you must:

- Be 18 years of age or older,
- Have a well-documented diagnosis of Gender Dysphoria or Gender Identity Disorder meeting the diagnostic criteria of the current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) made by a qualified mental health professional,
- Agree to coordination of care through the Trust's designated Behavioral Health Case Management Program, and
- In the event of gender reassignment surgery or hormone therapy, have no medical contraindications and complete specific evaluation and recommendation requirements.

The Plan does not cover services that are considered cosmetic, not medically necessary and/or are otherwise excluded under the Plan. This includes, but is not limited to:

- Rhinoplasty or nose implants
- Face-lifts
- Lip enhancement or reduction
- Facial bone reduction or enhancement
- Blepharoplasty (eyelid surgery)
- Breast Augmentation
- Liposuction

- Reduction thyroid chondroplasty (Adam 's Apple reduction)
- Hair removal
- Voice modification surgery or training
- Skin resurfacing
- Travel expenses

Prosthetic Devices

Effective January 1, 2018, the requirement for a prosthetic device to replace natural limbs and eyes lost while covered under the Plan is modified and Plan language is modified as follows:

Other Covered Services and Supplies
Other covered services and supplies are:

- Prosthetic devices.

Please keep this important notice with your Plan Document/Summary Plan Description for easy reference to all Plan provisions. If you have any questions about these changes, please contact the Administration Office at (800) 732-1121, option 1. For additional Plan information and forms visit the trust's website at www.nwrooferstrust.com.

This Plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted.

Being a grandfathered health plan means that this Plan does not include certain consumer protections of the Affordable Care Act that may apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, this Plan must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits. Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the Administration Office at 206-441-7574, option 0 or toll free at 800-33-6158, option 0. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

Board of Trustees
Northwest Roofers & Employers Health & Security Trust Fund

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Phone (206) 441-7574 or (800) 732-1121 • Fax (206) 505-9727 • Website www.nwrooferstrust.com

Administered by
Welfare & Pension Administration Service, Inc.

June 1, 2017

TO: All Plan Participants of Local 200 Employers
Northwest Roofers & Employers Health & Security Trust Fund

RE: Summary of Material Modifications – Rate Revisions

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

The purpose of this notice is to inform you of changes to the monthly dollar bank deduction and maximum dollar bank of your benefit plan. These changes are effective with June 2017 employment hours, August 2017 eligibility. The rates will change again in June 2018 as outlined below.

Contribution Rate	
Current	$8.40
Effective June 2017 Hours	$8.90
Effective June 2018 Hours	$9.40
Dollar Bank Deduction	
Current	$1,029.00
Effective June 2017 Hours	$1,091.00
Effective June 2018 Hours	$1,152.00
Dollar Bank Maximum	
Current	$6,174.00
Effective June 2017 Hours	$6,546.00
Effective June 2018 Hours	$6,912.00
Dollar Bank Maximum Eligibility (no change)	
Current	6 months
Effective June 2017 Hours	6 months
Effective June 2018 Hours	6 months
Initial Eligibility	
Current:	$4,200.00
Effective June 2017 Hours	$4,450.00
Effective June 2018 Hours	$4,700.00
Hours Needed to Attain Initial Eligibility (no change)	
Current	500
Effective June 2017 Hours	500
Effective June 2018 Hours	500

If you have any questions regarding these changes please contact the Administration Office at (206) 441-7574 or toll free at (800) 732-1121, option 4.

Board of Trustees
Northwest Roofers & Employers Health & Security Trust Fund

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Northwest Roofers and Employers Health and Security Trust Fund

This booklet contains important information regarding your benefits under the Northwest Roofers and Employers Health and Security Trust. It should be read and retained for future reference.

To All Eligible Participants:

The Trustees of the Northwest Roofers and Employers Health and Security Trust Fund are pleased to provide you with this updated Plan booklet and Summary Plan Description, which contains the general rules for the Northwest Roofers and Employers Health and Security Trust Fund.

This booklet also describes the specific benefits of your Plan covering Medical, Prescription Drug, Vision, Dental, Weekly Disability, Death, Life Insurance and Accidental Death and Dismemberment Benefits as negotiated between Roofers Local Unions and participating employers, and the procedures that should be followed when making a claim. We encourage you to read this document carefully so that you are aware of all the provisions of the Plan.

The Plan has special arrangements with the Premera Blue Cross (Preferred Provider Organization). Under this PPO, certain hospitals, physicians, and other health care professionals agree to reduce their fees. If you use a preferred provider, your reimbursement level in most instances will be higher. When you use a PPO provider, benefits are automatically assigned. A list of preferred providers is available from the Administration Office or Premera.

Individuals eligible for Medicare should be covered under Medicare Parts A and B (hospital and medical services) to receive maximum coverage.

It is our hope that this booklet will help you in making use of your Benefit Plan. Please write or call the Administration Office if you have questions about your status or benefits available to you under your specific Plan. We have authorized the Administration Office to be your contact for information.

Ultimately it is the Board of Trustees that has the full and exclusive authority, in its discretion, to interpret and apply the Plan, including its rules for eligibility. Only the full Board of Trustees is authorized to interpret the Plan. No employer or local union, no representative of any employer or local union, and no individual Trustee is authorized to interpret the Plan - nor can any such person act as an agent of the Board of Trustees to guarantee benefit payments. No agreement between an

employer and a union may change, override or otherwise affect the Plan in any way, except as the Board of Trustees may permit by resolution.

The Northwest Roofers and Employers Health and Security Trust Fund provides benefits to the extent money is available to pay for the benefits. The Plan is not guaranteed to continue indefinitely. The Board of Trustees may make amendments to the Plan, including amendments that affect the eligibility rules and the amount and nature of benefits. Amendments may be made on a prospective or retroactive basis. The Board of Trustees also has the authority to terminate the Plan at any time.

Please refer your questions concerning your Plan or your status to the Trust's Administration Office. Please remember that telephone contact with the Administration Office does not guarantee eligibility for benefits or benefit payments and eligibility for benefits and benefit payments are determined only when a written claim is submitted to the Trust.

In order to keep your eligibility records accurate, we encourage you to keep the Administration Office informed of any change in address, dependent status and designated beneficiary. All changes can be submitted to the Administration Office by completing a new enrollment form. If you have any questions, please contact the Administration Office at (800) 331-6158 or at the number listed at the back of this document.

Sincerely, Board of Trustees
Northwest Roofers and Employers Health and Security Trust Fund

Employer Trustees	**Union Trustees**
Donald Bosnick, Chairman	Steve Hurley
Robert Starkey	Bret Purkett
Monty Moore	Leo Marsura
	Richard Geyer

INTRODUCTION

While some of the following topics and sections are written in technical terms, they reflect the legal requirements that regulate the Northwest Roofers and Employers Health and Security Trust Fund. As always, you may write or call the Administration Office if you have a question about the Benefit Plan or your status.

The Table of Contents will be helpful to you in locating the section that may pertain to your question or circumstances.

In reading this booklet there are several general terms that are used frequently. For example, the "Plan Administrator" is the Board of Trustees of the Northwest Roofers and Employers Health and Security Trust Fund and the "Plan" is the written plan of benefits adopted by the Board of Trustees. The terms "Claims Payor" and "Claims Administrator" generally refer to the specific Claims Administrator that pays claims under your Benefit Plan. For example, Welfare & Pension Administration Service, Inc. is the Claims Payor (Claims Administrator) for health claims. When you submit a claim for benefits you are described in the following sections as "the Claimant."

Full Discretion Reserved. The Plan Administrator (The Board of Trustees) is legally obligated to administer this Plan in accordance with its written terms and established policies, interpretations, practices, and procedures. The Plan Administrator reserves the maximum legal discretionary authority to construe and interpret the terms and provisions of the Plan, to make determinations regarding issues which relate to eligibility for benefits (including the determination of what services, supplies, care and treatments are Experimental), to decide disputes which may arise relative to a Participant's rights, and to decide questions of Plan interpretation and those of fact relating to the Plan. The decisions of the Plan Administrator as to the facts related to any claim for benefits and the meaning and intent of any provision of the Plan, or its application to any claim, shall receive the maximum deference provided by law and will be final and binding on all interested parties.

The general duties of the Plan Administrator include establishing all written documents under which the Plan is administered, determining questions of eligibility, interpreting the Plan documents, to resolve Participant issues covering status, benefits and rights, supervising all Plan professionals, and complying with all government agency reporting.

Amending and Terminating the Plan. The Board of Trustees expects to maintain this Plan indefinitely, however, the Board of Trustees may, in its

sole discretion, at any time, amend, suspend or terminate the Plan in whole or in part. This includes amending the benefits under the Plan or the governing Trust Agreement. If the Plan is terminated, the rights of the Participants are limited to benefits incurred before termination. All amendments to this Plan shall become effective as of a date established by the Board of Trustees.

Grandfathered Status. This is a "grandfathered health plan" under the Patient Protection and Affordable Care act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when the law was enacted.

Being a grandfathered health plan means that this Plan does not include certain consumer protections of the Affordable Care Act that may apply to other plans, for example, the requirement for the provision of preventive health services without cost sharing. However, this Plan must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits. Questions regarding which protections apply and which protections do not apply to a grandfathered health plan what might cause a plan to change from grandfathered health plan status can be directed to the Administration Office at 206-441-7574, option 0 or toll free at 800-331-6158, option 0. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

CONTENTS

WEBSITE AVAILABLE

The Northwest Roofers and Employers Health and Security Trust Fund established a website to provide you with immediate access to your Plan information. The website, located at www.nwrooferstrust.com, includes the following Trust-related material:

- Forms – Medical, Legal Documents, and Notices
- Links to Health Plan Preferred Provider Networks
- HIPAA Privacy Notice and Information
- Plan Booklets

The website will also provide a link to Member Login which may be viewed through a secure location requiring the entry of a personal identification number (PIN) and your social security number, or your WPAS ID number as shown on your ID card. A PIN will be assigned and mailed to you upon your written request to the Administration Office. For security purposes, you may not choose your own PIN. "My Trust Login" information includes the following data:

- Personal Information – Name, address, gender, birth date, marital status, etc.
- Health Eligibility – Eligibility in the current form and past three months
- Hours/Contributions – Statement showing last three employers reporting hours and contributions to the Trust on your behalf
- Dependent Enrollment Information
- Medical and dental claims summary information
- Paid claims detail

If you have any questions about the content on the website or access to "My Trust Login" information, please contact the Administration Office at (800) 331-6158, option 0.

FEDERAL LAWS AND REGULATIONS

The Plan Administrator administers the Plan pursuant to numerous Federal laws and regulations. The primary governing law is the Employee Retirement Income Security Act of 1974 (referred to as "ERISA"). This law governs the general day-to-day administration of the Plan and requires annual reports to Federal agencies. As described in more detail later in this booklet, the Plan is also obligated to comply with (1) the Health Insurance Portability and Accountability Act of 1996 (known as "HIPAA") which governs the use of Participant personal protected health information, (2) the Consolidated Omnibus Budget Reconciliation Act (known as "COBRA") which governs continuation of coverage self-pay opportunities, (3) the Uniform Services Employment and Reemployment Rights Act (known as "USERRA") which governs participation of Participants going into and returning from military service; and (4) the Family Medical Leave Act of 1993 (known as "FMLA") which governs potential participation for Participants during certain types of employment leave.

These and other Federal laws and regulations control how your health care coverage and benefits are made available to you. While sometimes detailed, this general booklet summarizes the most important of these rules and procedures covering your benefits. You are encouraged to use this booklet as a resource for understanding the procedures for obtaining health care benefits under the Northwest Roofers and Employers Health and Security Trust Fund. You may always write to the Administration Office for information about your status under the Plan and the processing of pending benefit applications.

SUMMARY OF BENEFITS

Medical

Deductible ▪ **Individual** ▪ **Family**	\$350 \$700	
Annual Out-of-Pocket Maximum	\$2,000 per person for PPO providers or \$4,000 per person for non-PPO providers.	
Birthing Center	100%	
Hospital ▪ **Within PPO Service Area** ▪ **Outside PPO Service Area**	80%* at PPO hospitals; 50%* at non-PPO hospitals 80%*	
Physician (Charges made by your physician)	**PPO Provider**	**Non-PPO Provider**
▪ **Home and Office Visits**	100% less \$25 copay	80%*
▪ **X-ray and Lab**	100% less \$25 copay	80%*
▪ **Surgery**	100% less \$25 copay	80%*
▪ **Hospital visits**	100% less \$25 copay	80%*
Preventive Care ▪ **Routine physical exam** ▪ **Routine immunizations, pap smears, and mammograms** ▪ **Prostate Specific Antigen (PSA test)** ▪ **Fecal occult blood test**	100% for PPO providers up to \$200 every calendar year; no dollar limit for children under age 12. Non-PPO providers are subject to UCR. 80% according to schedule beginning on pg. 36. Non-PPO facilities: 50%. 80%* every 5 years for Participants age 50 and over only. 80%*	
Maternity	Same as any other condition.	
Substance Abuse ▪ **Inpatient** ▪ **Outpatient**	80% for PPO providers; 50% for non-PPO facilities. 80% for PPO providers; 50% for non-PPO facilities.	

Mental Illness ▪ **Inpatient** ▪ **Outpatient**	80% for PPO providers; 50% for non-PPO facilities. Preauthorization required. 80%
Ambulance	80%
Skilled Nursing Care	50% up to a maximum of 70 days if admitted within 14 days after a covered inpatient hospital stay of at least 3 days.
Rehabilitation Hospital	80%* Preauthorization required for inpatient services. If preauthorization is not obtained, benefits are reduced by 50%, not to exceed $50.
Home Health Care	80%* Treatment plan and letter of necessity required.
Hospice Care	100% up to $7,500 lifetime maximum.

*The Plan pays 100% for the rest of the calendar year after your covered expenses reach the Major Medical Coinsurance out-of-pocket Maximum amount.

Disability and Death

Death Benefit ▪ **Employee** ▪ **Dependents**	 $5,000 Paid according to schedule on pg. 26.
Accidental Death and Dismemberment	Paid according to schedule on pg. 28.
Weekly Disability Benefit	$170 up to a maximum of 26 weeks.

Prescription Drug Plan

EnvisionRxOptions	34-day supply for retail prescriptions; 84 - 90-day supply for mail order prescriptions
Copayment ▪ Generic prescription or refill	$15 copayment for retail; $30 copayment for mail
▪ Brand-name prescription or refill (Formulary Brand)	$25 copayment for retail; $50 copayment for mail

▪ Brand-name prescription or refill (Non-Formulary Brand)	$50 copayment for retail; $100 copayment for mail
▪ Dispense as Written (DAW)	The cost difference between the brand and generic prescription will be applied only if generic is available

Vision — Self Funded

Copayment	$25
VSP Providers	100% of most non-cosmetic expenses for eye examinations, prescription lenses, and their required frames.
Other Providers	Paid according to the schedule on pg. 60.

Dental

Deductible	$50 per individual
Annual Maximum	$2,000 waived for children under age 12.
Benefits	See section beginning on pg. 62.

ELIGIBILITY PROVISIONS

Your Health and Security Trust Fund is financed by contributions from employers who have entered into collective bargaining agreements with various Roofers Locals and have agreed to make required contributions to the Northwest Roofers and Employers Health and Security Trust.

The examples which follow describe the eligibility system whereby your individual dollar bank is charged a certain amount per month to maintain continuing eligibility. The Board of Trustees, however, retain the right to change the amount which is charged each month to maintain eligibility and such amount can either be increased or decreased by action of the Board of Trustees. You should call the Administration Office to verify the amount actually charged to your account per month to maintain eligibility.

Initial Eligibility/Date Coverage Begins

You will be eligible for Plan benefits on the first day of the second calendar month after you have accumulated at least $4,450 in your dollar bank within 9 consecutive months (contributed and reported to the Fund).

- Example 1

Your first day of employment is January 1. Your employer contributes $742 each month beginning in January, so your dollar bank will accumulate at least $4,450 after the contribution for June. You will be eligible for benefits August 1.

						Lag	
Jan	Feb	Mar	April	May	June	July	Aug
If your employer contributes $742 for six (6) months…							You are eligible in this month

- Example 2

Your first date of employment is June 1. If your employer contributes $1,112.50 each month beginning in June, the value of your dollar bank will equal $4,450 in 4 months. You will be eligible for benefits November 1.

				Lag	
June	July	Aug	Sept	Oct	Nov
If your employer contributes $1,112.50 for four (4) months…					You are eligible in this month

The lag month is necessary for the Administrator to process reported dollars.

Continuing Coverage

Once you meet these initial eligibility requirements, you may continue coverage through your dollar bank by continuing to earn contributions through employment covered by a collective bargaining agreement or by self-payment.

Dollar Bank
All dollars contributed and reported are credited to your account. You continue to be eligible as long as you have at least $1,091 in this dollar bank–the amount required to pay 1 month's coverage. Any dollars contributed over $1,091 in any month are credited to your dollar bank, which will provide coverage during months of unemployment.

- Example: (This is an example only. Contact the Administration Office for current eligibility requirements.)

Dollars contributed in a month	$1,112
Subtract coverage dollars	–1,091
	$21

The $21 is added to your dollar bank and applies toward future coverage.

The maximum amount allowed in your dollar bank is $6,546 after deducting the amount required to pay for the current month's coverage. You can accumulate up to 6 additional months of continued eligibility.

If your dollar bank is under $1,091 on the first of any month, you will not be eligible for that month and your eligibility ends unless you elect to continue coverage through self-payment.

If you are receiving weekly disability income benefits from the Plan your dollar bank will be frozen while you continue to receive weekly benefits to a maximum of 3 months. During this period the trust will continue coverage for you and your eligible dependents.

Subsidized Plan

Active employees who satisfy certain eligibility conditions are eligible to make self-payments to continue coverage under an option known as "Subsidized Plan." To qualify for the Subsidized Plan option, you must have had three (3) consecutive months of Trust eligibility (based on employer contributions/dollar bank) immediately prior to February 2013 or later, when you have no coverage.

The Subsidized Plan option is available for up to three (3) months: Only one Subsidized Plan option, for up to three months, will be available per calendar year. The months do not have to be consecutive, but remain limited to three (3) months per calendar year, once the initial qualification requirements are met. The rate for the Subsidized Plan option is approximately one half of the rate for the COBRA full family coverage.

If you select the Subsidized Plan option, your first payment must be postmarked by the 10th of the month immediately following the last month of eligibility. If you elect the Subsidized Plan option, the regular COBRA continuation of coverage option will be available for up to 18 months (possibly longer for certain disabled Participants) immediately following the period of Subsidized Plan coverage.

Self-Payment

If your dollar bank balance contains under $1,091 on the first of any month, you can continue coverage for up to 18 months under the Medical only or Medical, Dental Vision Plans by self-payment under the COBRA provisions. Death benefits and disability benefits cannot be continued by self-payment.

Self-payment forms are available from the Administration Office. See pages 70 through 80 for COBRA and other self-payment provisions.

Reinstatement of Eligibility

If your eligibility ends because your dollar bank is under $1,091, any balance will be carried for 9 months. If you work during that 9 months and add hours to your account, your eligibility will be reinstated on the first of the second month after your dollar bank has $1,091 or more.

If you do not reach reinstatement during this 9-month period, any balance is canceled and you'll have to meet initial eligibility rules again to be covered through the dollar bank.

Armed Forces Full-Time Active Duty
If you join the Armed Forces of the United States, eligibility will end on the last day of the month you enter full-time active duty. Your dependents' eligibility also will end on that date. Any balance in your dollar bank will be preserved until you are discharged. Coverage may be continued by self-payment under these provisions for up to 24 months during your periods of uniformed (military) service.

If coverage was terminated as the result of uniformed (military) service, and you retain reemployment rights, coverage will be reinstated without waiting periods in accordance with applicable federal law. Your employer must notify the Plan in writing of your reemployment. Contact the Administration Office for details. See page 21 for information about the Uniform Services Employment and Reemployment Rights Act (USERRA).

Coverage During a Strike, Lockout, or Labor Dispute
If your compensation is discontinued because of a strike, lockout, or labor dispute, you may continue coverage by self-payment. You can self-pay the required premium during the dispute for up to 6 consecutive months. Your monthly payments must be submitted to the Administration Office by the 15th of the month before the month you would like coverage.

Work for a Non-Participating Employer

Eligibility Frozen

- Notwithstanding any other provision or rule of this Plan, a Participant who is eligible for benefits and who works in non-covered roofing service shall be subject to the following special rules:

  (a) An eligible Participant who works in non-covered roofing service shall have his eligibility and reserve frozen effective on the first day of employment in such non-covered roofing service. Such eligibility and reserve shall remain frozen until the second calendar month after he or she returns to roofing service for a participating employer in service covered by a labor agreement. To reinstate frozen eligibility and reserves, such Participant shall be required to earn at least the amount of employer contributions required by the Plan to maintain continuing eligibility.

  (b) While a Participant's eligibility and reserves are frozen, no benefits or claims are payable with respect to any expenses

incurred by the participant or his or her dependents during the period coverage is frozen.

(c) Unless such a Participant reinstates participation as described in subparagraph (a), such Participant's reserve shall remain frozen for a period of 12 consecutive months at which time such reserve and account shall be closed and the balance of the reserve shall be deemed waived and abandoned.

(d) Application of this rule shall have no effect upon a Participant's or dependent's COBRA rights.

(e) "Non-covered roofing service" is any work as a roofer or waterproofer in the roofing industry within the geographic area covered by the Plan whether an employee, self-employed person or agent for which contributions are not required to be paid to the Plan UNLESS either the person performing the roofing work or the person or entity for whom the roofing work is performed maintains a collective bargaining agreement with a local union of the United Union of Roofers, Waterproofers and Allied Workers which requires contributions for health and welfare covered on behalf of employees covered by such an agreement.

(f) Exceptions to "non-covered roofing service" shall be:

— Work as an employee or agent of the Union of Roofers, Waterproofers and Allied Workers or any affiliated local unions

— Work as an employee or agent of a governmental agency or non-profit organization which has committed itself to compensate roofers at no less than the sum of the wage and fringe benefit rates required under current bargaining agreements maintained by the Plan's participating local unions.

— Any other work previously approved by the Plan.

Associate Employees

Associate employees include full-time managerial employees, office employees, and sales personnel. Dollar banks are not established for associate employees. If you are an associate employee not covered by a collective bargaining agreement and work for an employer that has signed a special agreement covering associate employees, you are eligible under this Plan if:

- That signatory employer contributes on your behalf. The monthly premium charge for an associate employee is the current premium

plus an administration fee, determined periodically by the Board of Trustees.

- Associate coverage contributions must be made on your behalf if you work at least 123 hours per month.
- Two (2) monthly premium payments must have been made for you by the 15th of the month for you to be eligible on the first day of the second month after those payments.
- Your eligibility will continue as long as you are employed, timely payments are made by the employer and the special agreements remain in effect. (Associate employees are not eligible for the Weekly Disability Income Plan.)

Eligibility for your Dependents

You enroll eligible dependents to participate in the plan of benefits at the same time you enroll. Documentation such as marriage and birth certificates may be required. Eligible dependents include:

- Your legal spouse.
- Your children up to age 26. This Plan will be secondary to a plan that covers a dependent as an active employee. This coverage is not automatic; you must enroll your children that are not presently enrolled.
- Stepchildren, foster children, and adopted children may also be considered as eligible dependents.

Benefits continue for children who depend on you for support and are incapable of earning a living due to mental or physical handicap, as long as the incapacity began before the above limiting age. Coverage continues throughout the incapacity if your eligibility continues; however, periodic review of the child's condition may be required.

This coverage is not automatic; you must submit proof to the Administration Office within 90 days after the child reaches the limiting age.

Qualified Medical Child Support Orders (QMCSO)

Participants may be required by court order to provide health care benefits for his or her children. The Plan Administrator shall enroll for immediate coverage under this Plan any Alternate Recipient who is the subject of a Medical Child Support Order that is a "Qualified Medical Child Support Order" ("QMCSO") if such an individual is not already covered by the Plan as an eligible dependent, once the Plan Administrator has determined

that such order meets the standards for qualification set forth below. A Participant should forward a complete copy of the court order to the Plan Administrator to determine if the order is "qualified" as required by law. **"Alternate Recipient"** shall mean any child of a Participant who is recognized under a Medical Child Support Order as having a right to enrollment under this Plan as the Participant's eligible dependent. For purposes of the benefits provided under this Plan, an Alternate Recipient shall be treated as an eligible dependent, but for purposes of the reporting and disclosure requirements, an Alternate Recipient shall have the same status as a Participant.

"Medical Child Support Order" shall mean any judgment, decree or order (including approval of a domestic relations settlement agreement) issued by a court of competent jurisdiction that:

1. Provides for child support with respect to a Participant's child or directs the Participant to provide coverage under a health benefits plan pursuant to a state domestic relations law (including a community property law); or
2. Enforces a law relating to medical child support described in Social Security Act §1908 (as added by Omnibus Budget Reconciliation Act of 1993 §13822) with respect to group health plan.

"National Medical Support Notice" or "NMSN" shall mean a notice that contains the following information:

1. Name of an issuing state agency;
2. Name and mailing address (if any) of an employee who is a Participant under the Plan;
3. Name and mailing address of one or more Alternate Recipients (i.e., the child or children of the Participant or the name and address of a substituted official or an agency that has been substituted for the mailing address of the Alternate Recipients(s)); and
4. Identity of an underlying child support order.

"Qualified Medical Child Support Order" or "QMCSO" is a Medical Child Support Order that creates or recognizes the existence of an Alternate Recipient's right to, or assigns to an Alternate Recipient the right to receive benefits for which a Participant or eligible dependent is entitled under this Plan. In order for such order to be a QMCSO, it must clearly specify the following:

1. The name and last known mailing address (if any) of the Participant and the name and mailing address of each such Alternate Recipient covered by the order;

2. A reasonable description of the type of coverage to be provided by the Plan to each Alternate Recipient, or the manner in which such type of coverage is to be determined;

3. The period of coverage to which the order pertains; and

4. The name of this Plan.

In addition, a National Medical Support Notice shall be deemed a QMCSO if it:

1. Contains the information set forth above in the definition of "National Medical Support Notice"

2. Identifies either the specific type of coverage or all available group health coverage. If the employer receives an NMSN that does not designate either specific type(s) of coverage or all available coverage, the Employer and the Plan Administrator will assume that all are designated

3. Informs the Plan Administrator that, if a group health plan has multiple options and the Participant is not enrolled, the issuing agency will make a selection after the NMSN is qualified, and, if the agency does not respond within 20 days, the child will be enrolled under the Plan's default option (if any), and

4. Specifies that the period of coverage may end for the Alternate Recipient(s) only when similarly situated dependents are no longer eligible for coverage under the terms of the Plan, or upon the occurrence of certain specified events.

However, such an order need not be recognized as "qualified" if it requires the Plan to provide any type or form of benefit, or any option, not otherwise provided to the Participants and Eligible Beneficiaries without regard to this Section 4.05, except to the extent necessary to meet the requirements of a state law relating to medical child support orders, as described in Social Security Act §1908 (as added by Omnibus Budget Reconciliation Act of 1993 §13822).

Upon receiving a Medical Child Support Order, the Plan Administrator shall, as soon as administratively possible:

1. Notify the Participant and each Alternate Recipient covered by the Order (at the address included in the Order) in writing of the receipt of such Order and the Plan's procedures for determining whether the Order qualifies as a QMCSO; and

2. Make an administrative determination if the order is a QMCSO and notify the Participant and each affected Alternate Recipient of such determination.

Upon receiving a National Medical Support Notice, the Plan Administrator shall:

3. Notify the state agency issuing the notice with respect to the child whether coverage of the child is available under the terms of the Plan and, if so:
4. Whether the child is covered under the Plan; and
5. Either the effective date of the coverage or, if necessary, any steps to be taken by the custodial parent or by the official of a state or political subdivision to effectuate the coverage; and
6. Provide to the custodial parent (or any state official serving in a substitute capacity) a description of the coverage available and any forms or documents necessary to effectuate such coverage.

When Dependent Coverage Begins
For eligible dependents, coverage begins the same date as yours. Coverage for your dependents continues as long as you are eligible. New dependents will be covered on the date they are acquired.

When Coverage Ends

Employees
Your coverage ends on the earliest of the date:

- You no longer meet eligibility requirements.
- You enter military service.
- The Plan is discontinued.

Dependents
Dependent coverage ends on the earlier of the date:

- Your coverage ends.
- The last day of the month in which your dependent no longer meets the definition of an eligible dependent as described in this section.

See pages 70 through 80 for information about continuing your medical, dental and vision coverage by self-payment (COBRA).

Uniform Services Employment and Reemployment Rights Act (USERRA)

The Plan desires to assist Participants and their participating Employers in complying with the provisions of the Uniform Services Employment and Reemployment Rights Act of 1994 ("USERRA"). Employees going into or returning from military service may elect to continue Plan coverage as

mandated by USERRA. These rights apply only to eligible employees and eligible dependents covered under the Plan before leaving for military service and may require additional payments from the participating Employer. It is the responsibility of the Participant and the Participating Employer to determine if USERRA is applicable and to coordinate the elections available.

Following your discharge from qualified military service, you may be eligible to apply for re-employment with your former employer in accordance with USERRA. Such re-employment includes your right to elect re-instatement in any then-existing health coverage provided by your employer.

Your employer's leave of absence policy will determine your right to participate in any group life or other insurance.

After re-employment, credit will be given, if applicable, for the period of such service, if required to determine your benefit amounts, eligibility or costs.

Note: If a conflict between this provision and USERRA arises, the provisions of USERRA as interpreted by your employer or former employer will apply.

Definition of Uniformed Service

Uniformed service is the performance of duty on a voluntary or involuntary basis in a uniformed service under competent authority and includes active duty, active duty for training, initial active duty for training, inactive duty training, full time National Guard duty and a period for which a person is absent from a position of employment for the purpose of an examination to determine the fitness of the person to perform any such duty.

Uniformed service includes service in any of the following:

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

Family and Medical Leave Act of 1993

The Plan desires to assist Participants and their participating Employers in complying with the Family Medical Leave Act (FMLA). It is the responsibility of the Participant and the Participating Employer to determine if FMLA is applicable. Such coverage may require monthly payments from the participating Employer. It is the policy of the Plan that Employer payments for employees under FMLA shall be received by the Northwest Roofers and Employers Health and Security Trust Fund even though no actual hours of employment may have been earned. A Participant should contact his or her employer for full information about FMLA. In general, under the FMLA eligible employees of Employers who are covered by the FMLA are entitled to an unpaid leave of absence for up to twelve (12) weeks (spouse of employees who are employees of the Employer are eligible for a maximum combined total of twelve (12) weeks leave under this Act) within a twelve (12) month period.

Retiree Eligibility

You are eligible for retiree benefits if:

- You retire from active employment on or after July 1, 1979, are not eligible as an active employee under any other group policy, and are:
    - At least age 55 and not engaged in any other occupation for wage or profit; or
    - Receiving disability insurance benefits under The Federal Social Security Act; and/or
    - Receiving benefits under the International Roofing Industry Pension Plan; and
- You were insured and monthly premiums were paid for you by this trust for at least 48 of the 60 months immediately before the date you retire.
- You apply for coverage within 30 days of losing your eligibility as an active Plan Participant. Coverage must begin in the month immediately following your loss of active eligibility. Disabled retiree coverage must begin 30 days after receiving Social Security or disability under the International Roofers Pension Plan.

Dependents of eligible retirees are covered under the Plan as long as they meet the eligibility requirements as described on page 18.

When Retiree Eligibility Ends
Your eligibility for retiree benefits will end if you become insured as an employee or dependent under any other group insurance health care or service-type Plan.

If you were covered by the Trust and are rehired, your retiree eligibility will end and the eligibility rules of an active Participant will apply. Your retiree coverage will become effective on the 1st of the month coinciding with or next following the date you retire again.

Coverage for your dependents may continue up to 36 months if coverage would end because of your death, divorce, legal separation, or a child's loss of eligibility. See COBRA on pages 70 through 80.

Contributions
You will be required to make a monthly contribution, determined by the Board of Trustees, as your share of the costs. The Administration Office must receive your payment by the first of each month for which you are eligible. If you fail to make timely payments, coverage will end. You will not be able to reenroll.

Benefits
If you meet the eligibility requirements and pay required contributions:

- Medical coverage will continue for you and your eligible dependents.
- No coverage for Weekly Disability Income, Dental, and Vision Benefits is provided.

The amount of coverage under the Death and Accidental Death and Dismemberment Benefits will continue until retirement. After your retirement date the death and AD&D benefit is reduced by $1,000 on the first of each succeeding calendar year to a minimum of $1,000. (In the first year, you will be eligible for $5,000 for death and AD&D benefits, then $4,000 in the second year, $3,000 in the third year, $2,000 in the fourth year, and $1,000 in the fifth and following years.)

Coverage for dependent death benefits is available for your legal spouse, state registered domestic partner, and/or your dependent children up to age 26. The amount of coverage available for dependent death benefits is $1,500 per eligible dependent.

Application for Coverage
You may apply for retiree benefits by contacting:

Northwest Roofers and Employers
Health and Security Trust Fund

Physical Address:
7525 SE 24th St, Suite 200
Mercer Island, WA 98040

Mailing Address:
P.O. Box 34203
Seattle WA 98124-1203
(206) 441-7574 or (800) 732-1121

Change or Discontinuance Plan

The Board of Trustees will provide retiree health and welfare benefits to the extent that money is available to cover Plan costs. The Board of Trustees has full and exclusive authority to determine whether enough funds are available for the Plan and how money will be used. The Board of Trustees retains the right and authority to change or discontinue at any time any aspect of retiree benefits or eligibility including the benefits available and cost. This Plan does not provide for guaranteed or lifetime benefits and may be withdrawn at any time by the Board of Trustee's Action.

DEATH BENEFITS

Death benefits offer financial protection to your beneficiary if you die. Your death benefit will be paid to your beneficiary in the event of your death—regardless of the cause, time, or place—while you are covered under this Plan.

Benefit

Your death benefit is $5,000. It will be paid to your beneficiary in a lump sum.

Beneficiary
Your beneficiary is the person or persons you name to receive your death benefit. You designate your beneficiary when you first enroll, and may change your beneficiary any time by filing the appropriate form with the Administration Office. The beneficiary who receives your death benefit is the most current beneficiary on file with the Administration Office.

You also may want to name a contingent beneficiary to receive your death benefit if your primary beneficiary does not survive you.

If no beneficiary is named, benefits will be paid to your spouse, if living; otherwise to your children, equally or to the survivor; otherwise to your parents, equally or to the survivor; otherwise to your estate.

Coverage During a Disability
Your death benefits will continue at no cost to you if you cannot work because of a total disability that begins while you're under age 60 and while eligible for death benefits. The coverage will continue until you are no longer disabled. You must give the insurance company satisfactory evidence of your disability within 12 months after it starts. The insurance company also may require you to be examined by the physician of its choice as often as reasonable to verify your disability.

For this Plan, a total disability is one that has existed continuously for nine (9) months and is expected to prevent you from any gainful employment.

Death Benefits for Your Dependents

If your covered dependent dies, the following benefit will be payable:

	Amount of Benefit
Spouse	$1,500
Each of your dependent children based on age at death:	
Birth to 6 months	150

6 months to 2 years	300
2 years to 3 years	600
3 years to 4 years	900
4 years to 5 years	1,200
5 years to 23 years	1,500

You are the beneficiary for the dependent death benefits.

Conversion Rights

Life Insurance

You or your insured dependent may convert this insurance to an individual life insurance policy if any part of you or your dependent's Life Insurance under the Group Policy stops. Proof of good health is not required. You must apply and pay the applicable premium to LifeMap within 31 days after your eligibility ends. Notify LifeMap or the Administration Office, and LifeMap will supply you or your insured dependent with a conversion form to complete and return.

If you or your insured dependent die within the 31-day period allowed for making application to convert, LifeMap will pay a death benefit to you or your insured dependent's beneficiary in the amount you or your insured dependent were entitled to convert, whether or not you applied for an individual policy.

Benefit Amount

Insurance company rules govern the form of policy under these provisions and benefit amounts, which will not necessarily be identical to the group policy. You may request a booklet summarizing these rules from the Administration Office and you may request further information on coverage and premium rates from the insurance company when benefits under the group policy end.

ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D)

AD&D benefits are provided to your beneficiary if you die (or to you in the event of loss of your limbs or sight, or if you become paralyzed) if your death or loss is caused by an accidental injury on or off the job.

Benefit

The following benefits are payable if the injury occurs while you're covered under the Plan and your death or loss occurs within one year after the injury.

For the Loss of:

Life	$5,000
Both Hands	$5,000
Both Feet	$5,000
Both Eyes	$5,000
1 Hand & 1 Foot	$5,000
1 Hand & 1 Eye	$5,000
1 Foot & 1 Eye	$5,000
1 Hand	$2,500
1 Foot	$2,500
1 Eye	$2,500

If more than 1 loss results from a single accident, only the largest amount is payable. Loss of hands or feet means actual severance of the hand or foot at or above the wrist or ankle joint; loss of an eye means the entire, irrevocable loss of sight of that eye.

Exclusions

No benefits will be payable for your death or dismemberment from:

- Disease.
- Voluntary taking of a poison or chemical, voluntary inhalation of gas, or voluntary taking of a drug unless prescribed by a physician and taken according to a physician's direction.
- Bodily injury sustained in the course of any medical, dental, or surgical diagnosis or treatment including the use of nuclear energy.
- Bodily injury sustained while in or on any aircraft except when a fare-paying passenger on a regularly scheduled flight.

WEEKLY DISABILITY INCOME BENEFITS – EMPLOYEE ONLY

Weekly benefits are provided if you are disabled as the result of a non-occupational injury or illness (including a pregnancy-related condition).

Benefit

If you cannot work because of a non-occupational injury or illness, you will be paid a weekly benefit of $170 while disabled, up to 26 weeks.

Benefit Schedule
Your benefits begin according to the following schedule:

- If you are unable to work because of an accident or you are hospitalized, benefits begin on the first day you are disabled, or admitted as an inpatient to the hospital.
- If you are unable to work due to an illness or pregnancy, benefits begin on the eighth day you are disabled.

Benefit Payment Periods
To receive benefits, you must be seen and treated regularly by a physician. Your coverage will continue up to the 26-week maximum as long as you are certified by a physician as unable to work at your regular occupation because of the disability.

Reinstatement of Benefits
If you return to active work for at least 2 weeks, you will be eligible for a new period of benefits for either the same or a different disability.

Successive periods of disability separated by less than 2 weeks of continuous, active, full-time work will be considered as one period of disability unless they are due to entirely unrelated causes and begin after you have returned to full-time work.

Exclusions

No weekly disability benefits will be paid for:

- Any period of disability during which you are not under the care of and certified as totally disabled by a legally qualified physician.
- Any disability which arose out of or in the course of employment.
- Any disability for which you are entitled to benefits under any workers' compensation law or similar law.

- Any disability which began prior to your becoming covered under the Plan.
- Any period of disability during which you are receiving unemployment compensation.

Taxation of Benefits

Weekly disability benefits are subject to federal income taxes. Federal regulations require you to report payment of these benefits to the IRS, on an annual W-2 Form prepared by the Administration Office.

You may have federal income tax withheld from weekly disability benefits by filing a W-4S Form with the Administration Office.

Weekly disability benefits also are subject to Social Security (FICA) taxation. The liability for these taxes is divided equally between employee and the Northwest Roofers and Employers Health and Welfare Trust Fund. The Plan is required by federal law to withhold and deposit the employee's share of FICA tax.

MEDICAL BENEFITS

The Plan is designed to protect you and your eligible dependents against the high cost of health care. You may use any licensed hospital, physician, or health care professional covered under the Plan. However, if you use a non-preferred physician or hospital, you'll receive a lower benefit level of benefits for covered services.

The Plan also has a health management program to inform you about health care alternatives and involve you in decisions about your health care and related expenses. The program includes hospital preadmission requirements, concurrent hospital review, and discharge planning review as well as a maternity program.

Preferred Providers

The Plan has special arrangements with Premera Blue Cross (Preferred Provider Organization). Under this PPO, certain preferred hospitals, preferred physicians, and other health care professionals agree to reduce their fees. If you don't use a preferred physician or hospital, your costs may be higher.

Health Management Program

The health management program is an important Plan feature. How the program works and affects benefit payment levels is described below.

Hospital Preadmission Authorization
Most hospital admissions need to be approved as Medically Necessary before the Plan will pay regular benefit levels. During the review, medical professionals will examine information from your doctor against established criteria to decide if the recommended care is Medically Necessary. This review is required for any planned nonemergency hospital confinement due to illness, injury or mental illness and for any confinement in a hospital or treatment center for substance abuse. You initiate this review by calling Innovative Care Management (ICM) at 1-800-862-3338.

The Plan pays medical benefits as follows:

- If the hospitalization is certified as Medically Necessary, the Plan pays at regular benefit levels.
- Regular Plan benefits are reduced by 50%, not to exceed $500, if preauthorization is not obtained.
- No benefits are provided for treatment that is not Medically Necessary.

Innovative Care Management Phone Number Toll Free: (800) 862-3338.

Rules for Preauthorization
Rules for preauthorization vary depending on the type of care you need:

- **Non-emergencies.** You or your physician will need to notify Innovative Care Management at least 10 days before the scheduled admission or care.
- **Maternity Hospital Admissions.** For maternity hospital admissions, you or your physician should call Innovative Care Management for authorization when he or she confirms you or your spouse's pregnancy, and on the first business day after admission for delivery. Preauthorization is not required unless the stay is extended beyond the routine delivery stay timeframe for medical reasons.
- **Emergency Admissions and Surgery.** Emergency hospital admissions and emergency surgery do not require prior authorization; **however, Innovative Care Management must be contacted within 48 hours (or within 72 hours for weekends or holidays) of emergency admission.** The call can be made by you, a family member, your physician, or the hospital.

Concurrent Review
Once you have been admitted to the hospital, skilled nursing facility, or rehabilitative facility, or home health care or hospice care has been authorized, and Innovative Care Management has been notified, concurrent review begins. Innovative Care Management will monitor your progress and assist you in obtaining appropriate care.

If your condition requires more care than originally planned, Innovative Care Management will review additional care as necessary, using information from your physician.

Discharge Planning
If you require continued medical care, but not the intensive services of a hospital, skilled nursing facility or rehabilitative facility, Innovative Care Management professionals will work with you, your physician and the hospital to develop a discharge plan that allows an early and safe release.

Case Management
The Case Management program is designed to help members cope with a variety of complex medical conditions by working closely with them, their families, and their doctors. Each member enrolled in case management is assigned a specific nurse to help coordinate care, help obtain specialized medical equipment, provide information, and listen to their questions and concerns. This support can help you feel more in control and confident

when dealing with the increasingly complicated healthcare system. You may be contacted by an Innovative Care Management (ICM) case manager regarding your condition and treatment.

Deductible

The deductible is the cost of covered medical services you're responsible to pay each year before the Plan begins to pay benefits.

- The deductible does not apply to diabetic education, preferred provider physician visits with copayments, routine physical exams, hospice care, prescription drugs, dental benefits, and the first 3 months of treatment for an accidental injury.
- For all other covered services, the deductible is $350 per calendar year for each person covered under the Plan, up to a $700 family maximum. So that your medical benefits are not subject to a deductible late in the calendar year and soon again in the next, any covered medical expenses used to meet your deductible in October, November, and December will apply to the next year's deductible.

Payment Levels

The Plan pays benefits according to the following guidelines, subject to benefit maximums and other Plan provisions.

Hospital Services
The coinsurance you pay depends on whether you use a preferred hospital as well as where the services are received.

- The Plan payment level depends on the type of hospital you use.
    - Preferred Hospitals 80% payment of the PPO Allowed Amount for covered hospital services and supplies.
    - Other Hospitals 50% of the Usual, Customary and Reasonable Amount for covered hospital services and supplies.
- Outside of the Premera Blue Cross service area, covered hospital services level is 80% of the Usual, Customary and Reasonable Amount.

Other Covered Services
Most other covered services are paid at 80% of Usual, Customary and Reasonable Amount, except:

- Visits to a preferred physician are paid at 100% with a copayment of $25.00.

- Charges for a routine physical exam by a physician are paid at 100% up to a maximum of $200 every calendar year for Participants age 12 and over. Lab and x-ray services in conjunction with the routine physical will be covered at 80% and are not subject to the annual deductible.
- Charges for skilled nursing facility care are paid at 50%, up to a maximum of 70 days, when care is provided 14 days following a covered inpatient hospital stay of at least 3 days.
- Charges for hospice care are paid at 100%, up to a lifetime maximum benefit of $7,500.

Major Medical Out-of-Pocket Maximum
Once the $2,000 per person (PPO) or $4,000 per person (non-PPO) out-of-pocket maximum is reached for covered services and supplies during a calendar year, benefits normally paid at 80% or 50% will then be paid at 100% for the rest of the calendar year. Does not apply to prescription drugs, copays, amounts exceeding UCR, penalties for failure to obtain preauthorization, skilled nursing care, or deductibles.

Maximum Benefit

There is no overall annual or lifetime maximum benefit under the Plan for you or your eligible dependents for medical claims incurred on or after April 1, 2014.

Covered Medical Services and Supplies

The Plan covers Medically Necessary services and supplies when used to diagnose or treat an accidental injury or illness and for certain other covered conditions as described beginning on page 42. This coverage is subject to Plan provisions, including the exclusions beginning on page 44 and the definitions beginning on page 47.

Gender Dysphoria Treatment
Treatment of gender dysphoria will be considered a covered expense, provided that the Trust Policy and other relevant terms of the Plan are met. A copy of the Trust Gender Dysphoria Coverage Policy may be obtained by calling the Trust Office of by visiting the Trust's website. Preauthorization of all treatment services is required. Covered services may include supportive mental health counseling and treatment of any additional co-morbid mental health counseling, appropriate hormonal treatment interventions, orchiectomy, oophorectomy and hysterectomy, as well as genital reconstructive surgery, medically necessary medications and certain surgical procedures where those interventions and treatments

comply with the Plan provisions. For services to be considered a covered expense, patients must coordinate care through the Trust's Behavioral Health Case Management program. Your physician can begin the process by calling the Trust's utilization management vendor, Innovative Care Management at 1-800-862-3338 and selecting Behavioral Health option. Covered services will not include any service considered to be cosmetic or not medically necessary as determined by the Plan.

Hospital Room, Board, and Other Services and Supplies
The Plan covers semiprivate hospital room and board charges and Medically Necessary services and supplies needed to treat an accidental injury, illness, or other covered condition including:

- Operating rooms and equipment.
- Surgical dressings and supplies.
- X-ray and lab services.
- Anesthesia.
- Radiation treatment.
- Drugs.
- Oxygen, blood, and blood derivatives.
- Other covered services include outpatient medical and surgical service as well as emergency room services.

Benefits for hospital admissions are subject to the review requirements of the health management program described on pages 31 to 33. **Benefits will be reduced if the requirements are not met.**

Physician Services
The services of a licensed physician are covered when Medically Necessary to diagnose or treat accidental injuries or illnesses or other covered conditions.

Physician services are also covered for:

- Home, hospital, and office visits.
- Surgical procedures.
- Anesthesia.
- Diagnostic x-ray and lab exams.

Preventive Care
The Plan covers certain procedures necessary to detect or prevent illness and disease. The covered procedures are as follows:

- Routine physical exams: The Plan covers employees and their dependents ages 12 and over with a maximum benefit of $200 per exam every calendar year payable at 100% with no deductible. There is no annual dollar limit for children under age 12.

The following are covered at 80% or 50% for non-PPO facilities:

- Routine immunizations for adults and children.
- Routine pap smears—one each calendar year.
- Mammography screening charges include only:
    - The charges for a mammogram for a covered person age 35 but less than age 40.
    - The charges for a mammogram performed once every two years, or more frequently based on the recommendation of the covered person's physician, for a covered person under age 50.
    - The charges for a mammogram performed once each year for a covered person age 50 or over.
    - The charges for a mammogram performed for a covered person if the covered person is referred by a physician, a physician's assistant, or an advanced registered nurse practitioner.
- Routine fecal occult blood test ages 50 or over once every 5 years. The treatment must be recommended by a physician.
- Prostate Specific Antigen test ages 50 or over once every 5 years.

Other Professional Services
The Plan covers other health care professionals if charges would be covered for the same care by a physician. All health care professionals must be licensed by the state where services are performed and act within the scope of that license. In states with no licensing requirements, appropriate certification is required.

Covered health care professionals examples include:

- Registered nurses, physician or nurse assistants, nurse midwife, nurse anesthetist.
- Psychologists.
- Physical, occupational and speech therapists, if referred by a physician.

- Dentists and denturists.
- Optometrists.
- Podiatrists.
- Chiropractors:

    1. The number of chiropractic service visits will be limited to twenty (20) per calendar year.
    2. After the tenth (10th) visit, the Administration Office will request, and must receive, confirmation of medical necessity before additional benefits will be paid.

Drugs and Medicines
The Plan covers drugs and medicines that can be obtained only with a physician's prescription.

Prescription nicotine patches only are covered up to a lifetime maximum of a three-month supply; no other smoking cessation products are covered.

Foot Orthotic Benefits
Benefits for foot orthotics require a prescription and are available to active Participants only. This benefit is not available to retirees or dependents. Medically Necessary foot orthotic expenses are covered at 80%.

Foot orthotics or other supportive devices of the feet are limited to custom made braces, splints, insoles and supports constructed of acrylic, plastic or metal and prescribed by a physician for the treatment of an illness or injury to the foot. Impression casts required for the fitting of these devices are also covered. The device must be worn at all times that shoes are worn and not just for specific activities. Shoes that accompany orthotics are not covered.

Other Covered Services and Supplies
Other covered services and supplies include:

- X-ray and lab services.
- Surgical dressings, casts, splints, braces, and crutches.
- Prosthetic devices
- Rental (not to exceed purchase price) or purchase of durable medical equipment.
- Anesthesia, blood, blood products, and oxygen.
- Formula necessary for treatment of phenylketonuria (PKU).

Ambulance
The Plan covers charges for local professional ambulance service. If the covered person's condition requires treatment not available in a local hospital, transportation is covered if by a professional ambulance, railroad, or commercial airline (coach rate) on a regularly scheduled flight within the United States or Canada to the nearest hospital equipped to furnish the necessary treatment.

Birthing Centers
The Plan covers charges for birthing centers when utilized as an alternative to hospitalization for maternity.

Neurodevelopmental Therapy
The Plan covers charges for neurodevelopmental therapy up to a lifetime maximum of $2,000 to restore and improve various physical and mental functions or when significant deterioration in the condition would result without the service. Therapy may be from a physician or physical, occupational, or speech therapist.

Skilled Nursing Care Facility
The Plan covers charges for a skilled nursing facility up to a maximum of 70 days if confinement occurs within 14 days of a covered hospital stay of at least 3 days; 2 or more confinements are considered 1 period unless:

- You have returned to full-time work (between periods of confinement) for at least 1 day or have been available for active full-time work.
- Your dependent has completely recovered from the previous confinement.
- The confinements are due to unrelated causes.

Rehabilitation Hospital
The Plan covers the inpatient charges of a rehabilitation hospital for you or your dependents if confinement occurs within 14 days of a covered inpatient stay of at least 3 days in an acute care hospital.

Private Duty Nursing
The Plan covers the Medically Necessary outpatient services of a licensed private duty nurse if services are in place of inpatient care at a hospital, skilled nursing facility, or rehabilitation hospital. A physician must certify these requirements in writing to the Administration Office.

Home Health Care
The charges for home health care that are listed below and that meet all the tests of the covered medical charges definition are covered medical charges. Medical Benefits will be paid for the covered medical charges

incurred for home health care on the same basis as Medical Benefits are paid for treatment of a disease. The Plan will not pay for home health care unless: (1) the treatment plan of home health care is drawn up, or approved, by the covered person's physician or other licensed health care provider; and (2) the Plan validates the physician's certification that:

- The home health care is Medically Necessary;
- In the absence of the home health care, the covered person would be an inpatient at an acute care hospital, rehabilitation hospital, or skilled nursing facility; and
- The covered person has given consent for the home health care based upon the recommendation of the covered person's attending physician or licensed health care provider that such services will adequately meet the covered person's needs.

Home health care charges include:

- The charge for the services of a home health aide on a part-time of intermittent basis.
- The charge for nutrition counseling.
- The charge for psychiatric treatment by a licensed social worker who is practicing within the scope of the license.
- Practitioner Charges and Medical Support Charges.

Home Health Care
"Home health care" is medical care that is furnished by or through a home health agency to a covered person in the covered person's home.

Home Health Agency.
A "home health agency" is an agency that: (1) meets any legal licensing or certification required by the state or other locality in which it is located; or (2) qualifies as a participating home health agency under Medicare.

Hospice Care
The charges for hospice care that are listed below and that meet all the tests of the Covered Medical Charges definition are covered medical charges. Benefits will be paid for hospice care that are incurred only: (1) during a period for which the Plan validates a physician's certification that the covered person is a terminally ill patient; and (2) during the bereavement period. The Plan will not pay: (1) more than the hospice maximum shown in the Schedule of Benefits for all hospice care charges incurred either by the terminally ill patient or the family unit before the

death of the terminally ill patient; or (2) more than $200 for bereavement counseling.

Increased Benefits. The following increased benefits apply to hospice care:

- No deductible applies.
- A percentage payable of 100% will apply.
- The limits specified in the Covered Charges List and in the Areas of Limited Coverage section do not apply.

  Hospice charges include:

- The charge for the confinement of a terminally ill patient as an inpatient. The Plan will not pay for more than five days of respite care for each three-month period of hospice care.
- The charge for home health care furnished to the terminally ill patient in the patient's home. The charges for home health care include:
  - The charge for the services of a home health aide.
  - The charge for the professional services of a nurse.
  - The charge for physical therapy or other therapy furnished by an allied health professional practicing within the scope of his license.
  - The charge for nutrition counseling and special meals.
  - Medical Support Charges.
- The charge for medical social services furnished to the terminally ill patient or to the family unit.
- The charge for bereavement counseling furnished to the family unit during the bereavement period. The Plan will not pay more than $25 for each session of bereavement counseling or for more than eight such sessions.

Bereavement Counseling. "Bereavement counseling" is counseling by a licensed or certified social worker or licensed pastoral counselor to assist the family unit in coping with the death of the terminally ill patient.

Bereavement Period. The "bereavement period" is the 12-month period that begins on the date of the death of the terminally ill patient.

Covered Medical Charges. For hospice care only, the following provisions will apply so that hospice care charges meet the tests of the covered medical charges definition.

- The General Health Limitation that excludes benefits for custodial care does not apply.
- The definition of "Medically Necessary" is:
    - Deemed to include medical social services and bereavement counseling; and
    - Is changed as follows: (i) test 1 is changed to include palliative care as well as treatment or diagnosis; and (ii) test 4 is changed to allow inpatient respite care.

Family Unit. The "family unit" is each member of the terminally ill patient's family who is a covered person.

Hospice Care. "Hospice care" is care that:

- Is furnished or arranged by a hospice that is approved by the Plan.
- Is provided as part of a coordinated plan of home and inpatient care designed to meet the special needs of the terminally ill patient and the family unit due to the terminal illness.
- For the terminally ill patient, may include medical care, palliative care, respite care and medical social services.
- For the family unit, may include medical social services and bereavement counseling.

Hospice. A "hospice" is an agency or facility that is approved by the Plan as meeting established standards, including any legal licensing or certification required by the state or other locality in which it is located.

Medical Social Services. "Medical social services" is counseling furnished to the terminally ill patient or to the family unit to assist each in coping with the dying process of the terminally ill patient. The counseling may be furnished by a social worker or a pastoral counselor but only if such person is licensed and practicing within the scope of the license.

Palliative Care. "Palliative care" is care that is rendered to relieve the symptoms or effects of a disease without curing the disease.

Respite Care. "Respite care" is care that is furnished a terminally ill patient so that the family unit may have relief from the stress of caring for the terminally ill patient.

Terminally Ill Patient. A "terminally ill patient" is a covered person whose physician has certified that the covered person is: (1) terminally ill; and (2) expected to live 6 months or less.

The Plan covers Medically Necessary services and supplies described in the preceding section when they're for treatment of accidental injuries and illnesses. These services and supplies are also covered for the following specific conditions:

Pregnancy-related Conditions
The Plan covers Medically Necessary services and supplies for pregnancy-related conditions for employees and dependent spouses. These conditions include normal delivery, miscarriage, voluntary termination of pregnancy, diagnosis of fetal congenital disorders, and related complications.

The Plan also covers hospital and physician expenses for routine care of a newborn child during the initial confinement. If the newborn is ill, injured, or born prematurely, regular Plan benefits are paid as long as the infant is an eligible dependent enrolled in the Plan.

Substance Abuse
The Plan covers charges for outpatient and inpatient treatment of substance abuse (alcoholism and drug abuse) on the same basis as other medical conditions. This includes an approved treatment facility or hospital, as well as physician services and prescription drugs.

Mental Illness
The Plan covers charges for outpatient and inpatient treatment of mental illness on the same basis as other medical conditions, including physician and hospital services. Treatment by a licensed mental health provider, as defined on page 50, is covered.

Psychiatric Treatment Preauthorization Requirement Waived
The preauthorization requirement will be waived before the covered person receives psychiatric treatment by a state hospital if the covered person is involuntarily committed to a state hospital. Treatment by a licensed mental health provider as defined on page 50 is covered.

Damage to Jaw and Natural Teeth
Dental services to repair the jaw and natural teeth are covered if the damage directly results from an accident (but not from chewing), as long as services are completed within one year after the accident.

Cosmetic Surgery
The Plan covers necessary services and supplies for cosmetic surgery only if required for:

- Repair of an accidental injury provided that the services and supplies are provided within one year of the date of the injury.

- Reconstructive breast surgery following or coinciding with a mastectomy and performed as a result of an illness or injury, including all reduction stages of the non-diseased breast.
- Congenital defects of newborn children covered since birth.
- Repair of defects resulting from surgery for which benefits are paid under this Plan.

Human Organ Transplants
When your physician recommends a transplant, you or your physician needs to contact the Administration Office for preauthorization of benefit coverage.

Generally, the Plan covers the following organ and tissues transplants:

- Heart
- Heart and Lung
- Lung
- Liver
- Kidney
- Pancreas and Kidney
- Cornea
- Bone Marrow

If you or a covered dependent receives a human organ or tissue transplant covered by this Plan, certain donor organ procurement costs may also be covered. Benefits are limited to selection, removal of the organ, storage, transportation of the surgical harvesting team and the organ, and other Medically Necessary procurement costs. Donor expenses that are covered under this Plan are limited to a maximum of $25,000.

The Plan does not cover the following:

- Nonhuman, artificial or mechanical transplants.
- Experimental or investigational services or supplies.
- Services and supplies for the donor when the donor benefits are available through other group coverage.
- Expenses when government funding of any kind is provided.
- Expenses when the recipient is not covered under this Plan.
- Lodging, food or transportation costs.

- Donor and procurement services and costs incurred outside the United States.

Living (non-cadaver) donor transplants of the lung, liver, or other organ (except kidney), including selective islet cell transplants of the pancreas.

General Medical Exclusions

No benefits will be paid for:

- Services that are not Medically Necessary.
- Charges in excess of Usual, Customary and Reasonable (UCR) Amounts.
- Services not prescribed or ordered by the attending physician as necessary to treat a covered condition.
- Routine physical examinations, health checkups, or other preventive care, except as specifically provided.
- Any condition covered by workers compensation or occupational disease law, or injuries occurring in the course of employment or self-employment for wage or profit.
- Injury or illness resulting from war, non-therapeutic release of nuclear energy, or committing a crime.
- Intentionally self-inflicted injuries, and injuries or illnesses sustained in the following circumstances:
    - Suicide or attempted suicide, unless due to a documented mental illness
    - While engaged in any activity that results in a felony conviction
    - While performing any acts of violence of physical force that would not be performed by a reasonably prudent person in similar circumstances.
- Services you or your dependents are not required to pay for or that would be free without this coverage.
- Experimental or investigational medical services or supplies (and related complications).
- Services by any person in your or your dependent's immediate family or by a person who ordinarily lives in your home.
- Charges for bed and board by a school or other institution for training, rest, or the aged.

- Counseling, education, or training services. This includes vocational assistance and outreach, smoking cessation programs; and family, marital, social, sexual, nutritional, fitness counseling, or relaxation therapy except as specifically provided for diabetic education.
- Custodial care.
- Extra charges made for a laboratory test or x-ray examination because it is performed by a laboratory, including a laboratory that is part of a hospital, outside of its normal operating hours or automated lab tests.
- Reversal of sterilization, removal of contraceptive devices.
- In-vitro fertilization, artificial insemination, or embryo transfer.
- Charges in connection with the pregnancy of a dependent child.
- Acute or chronic alcoholism, drug addiction, or drug abuse, except as described under "Substance Abuse" on page 42.
- Hearing aids, including implantable bone conduction hearing devices.
- Cochlear implants.
- Hospitalization for conditions for which patients are not usually hospitalized; services, supplies and settings to the extent that they are not Medically Necessary for treatment of an injury, illness or physical disability (even if court-ordered), are not recommended and approved by the attending physician, are not reasonably priced or are not provided by a covered provider.
- Charges for missed appointments, telephone, internet or other consultations where a patient is not physically seen by a physician or other covered provider of service.
- Care in any hospital or facility owned or operated by the federal, state or local government, except as required by law.
- Charges for Home Health and Hospice Care services, except as specifically provided, on pages 38 to 42.
- Medical, surgical or hospital services or supplies incident to the placement of nonhuman or manufactured organs; donor charges when the organ or tissue is received by someone other than you or your eligible dependents; other organ transplants, except as specifically described under "Human Organ Transplants" on page 43.
- Vitamins or vitamin injections, supplements or herbal remedies.
- Arch supports, corrective shoes and elastic stockings; nail trimming and paring of corns or calluses; foot orthotics, except as specifically provided.

- Wigs or hairpieces.
- Treatment by a naturopathic physician.
- Habilitative, educational or conduct disorders, adolescent behavior problems, learning disabilities and for disorders or delays in the development of a child's language, cognitive, motor or social skills, including evaluations, except as described under neurodevelopmental therapy.
- Chelation therapy, biofeedback and other forms of self-care or self-help training and any related diagnostic testing.
- Any condition for which the Veterans' Administration, federal, state, county or municipal government or any of the armed services is responsible or provides treatment for, except as required by law.
- Genetic testing except when there are symptoms or signs presented indicating a possible disease presence and testing is needed to identify the disease in order for the physician to prescribe covered appropriate treatment, provided such testing is not experimental or investigational.
- Routine eye exams, eyeglasses, or contact lenses. See Vision Benefits for coverage information.
- Charges for a surgical procedure to correct refraction errors of the eye.
- Dental services, except as specifically described on page 62. See Dental Benefits for coverage information.
- Cosmetic surgery, except as specifically described on page 42.
- Obesity, weight loss programs, surgical treatment of obesity, reversal of surgical treatment for obesity, and complications arising from surgery or treatment of obesity. Exception: Medically Necessary treatment for morbid obesity is covered.
- Travel expenses, including lodging, car rentals, and meals, and travel, except as specifically provided for ambulance service as described on page 38.
- Expenses incurred for surgery for dental implantology.
- Treatment or service for temporomandibular joint dysfunction (TMJ) or myofascial pain dysfunction (MPD) except as determined to be Medically Necessary.
- Services for medical, surgical or hospital care for any illness, injury or physical disability received prior to the date coverage begins under this Plan.

- Services and supplies related to sexual reassignment surgery not covered under the Trust Gender Dysphoria Coverage Policy. See page 34 for a summary of the covered benefit and see the Trust website for the Policy.

Definitions

Birthing Center
A birthing center is a facility that meets professionally recognized standards and all the tests that follow:

- It mainly provides an outpatient setting for childbirth following a normal, uncomplicated pregnancy.
- It has: (a) at least two birthing rooms; (b) all the medical equipment needed to support the services furnished by the facility; (c) laboratory diagnostic facilities; and (d) emergency equipment trays, and supplies for use in life threatening events.
- It has a medical staff that: (a) is supervised full time by a physician; and (b) includes a registered nurse at all times when patients are in the facility.
- It has written agreements with the local acute care hospital and a local ambulance company for the immediate transfer of the patients who require greater care than can be furnished at the facility.
- It admits only patients who: (a) have undergone an educational program to prepare them for the birth; and (b) have records of adequate parental care.
- It schedules stays of not more than 24 hours for a birth.
- It maintains medical records for each patient.
- It complies with all licensing and other legal requirements that apply.
- It is not: (a) the office or clinic of one or more physicians; (b) an acute care hospital; or (c) a specialized facility other than a birthing center.

Calendar Year
Calendar Year is a period beginning January 1 and ending on December 31 of each year.

Copay
The specified dollar amount you are required to pay for physician visits to a preferred provider or for prescriptions.

Custodial Care
Custodial care is care that does not require the continuing services of skilled medical or allied health professionals and is primarily to assist the patient in activities of daily living. This includes institutional care to support self-care and provide room and board. Types of custodial care include help in walking, getting into and out of bed, bathing, dressing, feeding and preparing of special diets, and supervising medications that are ordinarily self-administered.

Deductible
The deductible is the cost of covered medical services you're responsible to pay before the Plan begins to pay benefits.

Dentist
A dentist is a legally qualified dentist practicing within the scope of his or her license. (For coverage of a dentist's services, see page 62.)

Durable Medical Equipment
Durable Medical Equipment means equipment that meets all of the following requirements:

- Is designed for repeated use
- Is mainly and customarily used for medical purposes
- Is not generally of use to a person in the absence of a disease or injury.
- Is usable only by the patient.

Durable Medical Equipment includes, but is not limited to, such items as: hospital bed; wheelchair; traction apparatus; intermittent positive pressure breathing machine; brace; crutch.

The items in the list that follows are examples of some, but not all, of the types of equipment that are not considered to be durable medical equipment: air conditioner; air purifier; heat lamp; heating pad; bed board; orthopedic shoes; corrective device for use in shoes; gravity traction device; exercise bicycle; weight lifting equipment; specially equipped van or items needed only for separate activities such as exercise. Deluxe items are not covered.

Experimental or Investigational Treatment
In determining whether treatment is experimental, the Administration Office will consider whether the treatment:

- Is in general use by the medical community
- Is Medically Necessary for the condition being treated
- Is under continued scientific testing and research

- Results in greater benefits for a particular illness or disease than other generally available services
- Is proven to be safe and effective

A treatment will be considered experimental if:

- Required approval by a U.S. government agency, such as the FDA, has not been granted;
- It is the subject of ongoing phase I or phase II clinical trials or the research, study or investigational portion of ongoing phase III clinical trials, or is otherwise under study to determine its maximum tolerated dose, toxicity, safety, efficacy or its efficacy as compared with a standard means of treatment; or
- The prevailing opinion among experts in the pertinent field, as reflected in the medical or scientific literature or in written treatment protocols, is that further studies or clinical trials are necessary to determine its maximum tolerated dose, toxicity, safety, efficacy or efficacy as compared with a standard means of treatment or diagnosis.

If your claim or request for prior authorization of services is denied due to experimental treatment, the Administration Office will notify you in writing within 20 working days of receipt of a written request or proof of loss. The Administration Office may extend the review period beyond 20 working days with the informed written consent of the covered person.

An explanation of the reason for denial will be provided in writing and will include the specific reason for the denial, reference to the plan provision upon which the denial was based, a description of any additional information you might be required to provide, and an explanation of the Plan's claim review procedure.

You or your authorized representative may appeal the denial by filing a written request for a review to the Administration Office within 60 days after receipt of the written notice of denial. In addition, you may request a copy of any documents relative to your claim.

A decision on your appeal will be rendered within 20 working days, or longer with the informed written consent of the covered person, after receipt of the request for review. If there are any special circumstances, the decision will be rendered as soon as possible. This decision will be in writing and will include specific reasons for the decision.

Hospital
A hospital is an institution which has all these characteristics:

- Primarily provides medical treatment to registered inpatients

- Maintains facilities for diagnosis
- Provides 24-hour care by registered nurses
- Maintains permanent facilities for surgery
- Keeps a daily record for each patient
- Complies with all licensing and other legal requirements
- Is not, except incidentally, a place of rest, for custodial care, for the aged, for drug addicts, for alcoholics, for the care of persons with mental, nervous, or emotional disorders or conditions, for the care of senile or mentally deficient persons, a nursing home, a hotel, or similar institution.

Licensed Mental Health Provider
A Licensed Mental Health Provider, inpatient or outpatient, is a Physician, Licensed Clinical Psychologist, Licensed Marriage and Family Counselor (LMFT), Certified Mental Health Counselor (CMHC), Masters in Social Work (MSW), or a state licensed mental health agency.

Medically Necessary
Medically Necessary means that the service or supply meets all of the tests listed below:

- It is rendered for the treatment or diagnosis of a covered injury or disease, including premature birth, congenital defects, and birth defects.
- It is appropriate for the symptoms, consistent with the diagnosis, and is otherwise in accordance with generally accepted medical practice and professionally recognized standards.
- It is not mainly for the convenience of the covered person or of the covered persons' physician or other provider.
- It is the most appropriate supply or level of service needed to provide safe and adequate care. When applied to confinement in an acute care hospital or other facility, this test means that the covered person needs to be confined as an inpatient due to the nature of the service rendered or due to the covered person's condition and that the covered person cannot receive safe and adequate care through outpatient treatment.

Nurse
A registered nurse (RN) is a person licensed in the area where his or her services are performed and practicing within the scope of that license.

Occupational Therapist
An occupational therapist is a person licensed in the area where his or her services are performed and practicing within the scope of that license. In a location without licensing requirements, the therapist must be certified by the American Occupational Therapy Association.

Outpatient
Outpatient refers to services a patient receives in a physician's office, at home, or in a hospital outpatient department.

Physical Therapist
A physical therapist is a person licensed in the area where his or her services are performed and practicing within the scope of that license. In a location without licensing requirements, the therapist must be certified as a registered physical therapist by the American Physical Therapy Association.

Physician
A Physician is a person practicing within the scope of his or her license or certification as a Doctor of Medicine or Doctor of Osteopathy, or to the extent benefits are provided, as a Doctor of Dentistry, Doctor of Podiatry, Doctor of Optometry, Doctor of Chiropractic, Licensed Optician, or Psychologist.

Preferred Hospital
A Preferred Hospital is one that has agreed to participate in the Preferred Provider Organization (PPO) established by Premera Blue Cross.

Preferred Provider Organization (PPO)
In a PPO, certain hospitals and physicians agree to reduce their fees. In exchange, the Plan offers financial incentives for Participants to use those facilities.

Rehabilitative Hospital
A Rehabilitative Hospital is an institution which has each of these characteristics – it must:

- Be licensed.
- Have facilities for the diagnosis and inpatient rehabilitative treatment of disease or injury with the objective of restoring physical function to the fullest extent possible. (Examples of conditions treated in a rehabilitative hospital are amputations, spinal cord injuries, head injuries, paraplegia and quadriplegia, CVA, severe arthritis, and paralysis.)

- Have facilities or a contract with another hospital in the area for emergency treatment, surgery, and any other diagnostic or therapeutic services that might be required during a confinement.
- Provide all normal infirmary-level medical services required to treat any disease or injury occurring during confinement.
- Have a staff of physicians specializing in physical medicine and rehabilitation directly involved in the treatment program, with one present at all times during the treatment day.
- Be accredited as a medical inpatient rehabilitation hospital by the Joint Commission on Accreditation of The American Hospital Association and/or the Commission on Accreditation of Rehabilitation Facilities.
- Not be a place for rest, the aged, drug addicts or alcoholics or a chronic disease facility, nursing home, or sheltered workshop.
- Not be primarily for custodial care, treatment of mental disorders, special education, vocational counseling, job training, or social adjustment services.

Skilled Nursing Facility
A Skilled Nursing Facility is an institution which meets all these characteristics:

- Primarily provides skilled nursing care to registered inpatients under 24-hour supervision of a physician or registered nurse.
- Has available at all times a physician who is a hospital staff member.
- Has on 24-hour duty an RN, licensed vocational nurse, or skilled practical nurse and an RN on duty at least 8 hours a day.
- Maintains a daily medical record for each patient.
- Complies with all licensing and other legal requirements.
- Is not, except incidentally, a place of rest, for alcoholics, for the care of persons with mental, nervous, or emotional disorders or conditions, for the care of senile or mentally deficient persons, a hotel, or a similar institution.

Substance Abuse Treatment Facility
A Substance Abuse Treatment Facility is a facility approved under the laws of the State of Washington or other state as a primary care facility for treating of alcohol, drug, or chemical abuse.

Usual, Customary, and Reasonable (UCR) Amounts:
In determining the UCR amounts made by a provider, the Plan takes into consideration all of the following:

- The usual fee which the provider of service most frequently charges to the majority of their patients for a similar service or medical procedure.
- The fees which fall within the customary range of fees charged in a locality by most providers of a similar training and experience for the performance of a similar service or medical procedure. Unusual circumstances or medical complications requiring additional time, skill and experience in connection with a particular service or medical procedure. The Plan makes the final determination as to whether or not the fee is "Usual, Customary and Reasonable."

PRESCRIPTION DRUG PLAN

The prescription drug plan is specifically designed to help protect you and your family's good health. The program saves money and encourages you to ask your physician to prescribe generic drugs whenever possible.

Benefits

Prescription drug coverage is available in two convenient ways:

Prescription Drug Card Program
The prescription drug card program is administered by EnvisionRxOptions. The drug card program provides a maximum of a 34-day supply of medication per prescription from any EnvisionRx network pharmacy.

EnvisionRx Pharmacies:

- Generic drug prescriptions: $15 copay per prescription required.
- Preferred brand name drug prescriptions: $25 copay per prescription required. You will also need to pay the difference between its cost and the cost of the generic drug if a generic is available. (If no generic drug is available, then you will only be responsible for the $25 copay.)
- Non-preferred brand name drug prescriptions: $50 copay per prescription required.

Non-Network Pharmacies:

If you do not use an EnvisionRx participating pharmacy, you will have to pay the full cost of the prescription and be required to file a claim for reimbursement with EnvisionRx as explained on page 55.

Mail-Order Prescription Drugs Provided by EnvisionMail
The mail-order prescription drug program is administered through EnvisionMail. Prescriptions for an 84 - 90-day supply – whichever is greater – may be filled through this program. The EnvisionMail Program is a convenient way to have your prescriptions filled.

- Generic drug prescriptions: $30 copay per prescription required.
- Preferred brand name drug prescriptions: $50 copay per prescription required. You will also need to pay the difference between its cost and the cost of the generic drug if a generic is available. (If no generic drug is available, then you will only be responsible for the $50 copay.)
- Non-preferred brand name drug prescriptions: $100 copay per prescription required.

Rx90 Program
The Rx90 program through EnvisionRx offers Participants the convenience of filling a 90-day supply of a maintenance prescription at a retail Rx90 pharmacy for the same price as mail order.

TheRx90 maintenance medication network consists of Walgreens, Rite Aid and Costco. The Plan allows two 30-day supply grace fills at an EnvisionRx participating retail pharmacy. If by the third fill the maintenance prescription is not switched to a Walgreens, Rite Aid or Costco, you will pay 100% of the cost of the medication.

Non-Essential Drug Program
Medications in the Non-Essential Drug program are not covered. These medications consist of high-cost prescription drugs for which there are lower cost alternatives available that are proven to be safe and effective in treating the same condition.

For a list of medications currently on this program, visit www.envisionrx.com and login under your member account.

How to Use Your Prescription Drug Card
To use your prescription drug card, simply present it along with the physician's prescription to any participating pharmacy. Participating pharmacists will fill your prescription and charge you the appropriate copay amount.

For a complete list of retail pharmacies, go to www.EnvisionRx.com, or call the EnvisionRx customer service line at (800) 361-4542

Other Pharmacies
If you use a nonparticipating pharmacy, you are responsible for paying the pharmacist for the prescription drug. You must then file a claim form with EnvisionRx to receive reimbursement for covered expenses as described below.

Filing a Prescription Drug Claim
If you purchase your prescription drugs at a participating pharmacy using your prescription benefit, you do not have to file a claim.

You must file a claim by sending a completed claim form with the itemized bills when any of the following situations apply:

- You did not present your prescription drug card to the participating pharmacy at the time a prescription is filled.
- The pharmacy does not agree to accept the prescription drug card.
- A prescription is filled by a pharmacy that is not part of the EnvisionRx network.

Claims must be submitted to EnvisionRx within 12 months from the date prescriptions were received. Claims submitted after twelve months are not eligible for benefits. Be sure to attach itemized pharmacy receipts showing the date of purchase, name of the individual for whom the drugs were prescribed, the prescription number, name of the drug prescribed, and charge for each drug as well as the name of the doctor prescribing the drug.

Mail prescription claims to:
EnvisionRxOptions
Attn: DMR Department
2181 E Aurora Rd, Suite 201
Twinsburg, OH 44087

If you have questions about your prescription claim, contact the EnvisionRx Help Desk at (800) 361-4542.

How to Use the Mail-Order Prescription Drug Programs
To use the mail-order prescription drug program, complete a mail-order prescription order form. These forms are available at the Administration Office. You will need to complete the form as directed and send it to the address indicated on the form.

You can order refills by mail, by phone (available 24 hours a day) at 1-844-293-4761, or online at www.EnvisionPharmacies.com. Additional information on how to use the mail-order program is available at the Administration Office.

Covered Drugs (Prescription Drug Card and Mail-Order Prescription Drugs)
The Plan covers prescription drugs and medications when prescribed by a physician or other lawful prescriber. This includes:

- Generic drugs
- Betaseron.*
- Brand name drugs.
- Compounded medication when at least one ingredient is a prescription brand name when filled at Envision Compounding Pharmacy.
- Insulin, needles and syringes dispensed in combination with insulin.
- Diabetic supplies (including chem strips and lancets).
- Tretinoin (all dosage forms including Retin-A) for individuals through age 25.
- Viagra, limited to six in thirty days.

* Not available through the Mail Order Prescription Drug Envision Mail Pharmacy.

Expenses Not Covered

- Attention-deficit Disorder (ADD) medications for individuals 26 years of age or older.
- Anorectics, antiobesity drugs or any drug used for the purpose of weight loss.
- Any prescription refilled in excess of the number specified by the physician, or any refill dispensed after one year from the physician's original order.
- Blood Monitoring Units
- Charges for the administration or injection of any drug.
- Contraceptives, oral or other, whether medication or device, regardless of intended use.
- Dexedrine for individuals 20 years of age and over.
- Drugs labeled "Caution – limited by federal law to investigational use," or experimental drugs, even though a charge is made to the individual.
- Fluoride preparations.
- Immunization agents, biological sera, blood or blood plasma.
- Infertility medications.
- Medication which is to be taken by or administered to an individual, in whole or in part, while he or she is a patient in a licensed hospital, rest home, extended care facility, convalescent hospital, nursing home or similar institution which operates on its premises, a facility for dispensing pharmaceutical.
- Medications in the Non-Essential Drug Program. For a list of medications currently on this program, visit www.envisionrx.com and login under your member account.
- Nicorette (or any drug containing nicotine or other smoking deterrent medications).
- Non-legend drugs other than insulin.
- Over the Counter (OTC) Products
- Prescriptions which an eligible person is entitled to receive without charge from Worker's Compensation Laws.

- Therapeutic devices or appliances, support garments and other non-medical substances, regardless of intended use, except disposable insulin needles/syringes dispensed in combination with insulin.
- Tretinoin (all dosage forms including Retin A) for individuals 26 years of age or older.
- Vitamins, singly or in combination.

VISION CARE BENEFITS

Self-funded vision benefits for you and your dependents are provided through Vision Service Plan (VSP). If you use services of a VSP member doctor, the Plan covers the vision care described in the following paragraphs at no cost to you except for a $25 copayment. You may choose to use a different doctor, but you will need to pay for the services and submit a claim to VSP. You will be reimbursed according to the schedule beginning on page 60.

Benefits

The Plan covers the following vision care services and supplies:

- Eye examinations when performed by a legally qualified ophthalmologist or optometrist.
- Prescription lenses and their required frames.
- Contact lenses instead of the above examination, lenses, and frames.
    - Necessary contact lenses are covered by VSP when the VSP member doctor secures prior approval for these conditions: following cataract surgery; to correct extreme visual acuity problems that cannot be corrected with other lenses; certain conditions of anisometropia; keratoconus.
    - If you choose contacts for other reasons, VSP will pay in lieu of lenses and frames:
        - — $105 for materials when obtained from a VSP member doctor.
        - — $105 when obtained from a nonmember doctor.

Benefit Schedule

- Vision examination: Once every 12 months.
- Lenses: Once every 12 months only if needed.
- Frames: Once every 24 months only if needed.

In addition to the benefits listed above, VSP providers have also agreed to provide the following:

- 20% discount applied to provider's usual and customary fees for additional pairs of prescription glasses and spectacle lens options.
- 15% discount applied to contact lens professional services.
    - Discounts are only available through the VSP participating doctor who last provided a covered eye examination.

How to Obtain Vision Benefits

- Choose a VSP provider from the Provider Directory. If you do not know if your provider is in the VSP network or wish to obtain a VSP directory, contact VSP at 1-800-877-7195 or visit the website at www.vsp.com.
- Once you have selected your doctor, identify yourself as a VSP member and make an appointment for an examination.
- When services have been received, pay the $25 copayment. VSP will pay the member doctor directly.
- Selecting a doctor from the VSP list assures direct payment to the doctor.

Non-VSP Doctors

If you decide to go to a doctor who is not a VSP member, pay the full fee for the doctor's services and send a Member Reimbursement Form with a copy of your itemized receipt(s) to the following address:

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

Write the member's name, address, patient name, date of birth, and the last four digits of the Social Security Number on the statement.

To obtain a Member Reimbursement Form, contact VSP at 1-800-877-7195 or complete the reimbursement process online at www.vsp.com.

You will be reimbursed in accordance with the following schedule:

Reimbursement Schedule

Examination	Up to $45
Single Vision Lenses	Up to $45 (Pair)
Bifocal Lenses	Up to $65 (Pair)
Trifocal Lenses	Up to $85 (Pair)
Lenticular Lenses	Up to $125 (Pair)
Frames	Up to $47
Contact Lenses	
Elective	Up to $105 (Pair)
Necessary	Up to $210 (Pair)

For more information on vision care benefits, contact VSP at 1-800 877-7195.

Limitations

This Plan is designed to cover *visual needs* rather than cosmetic materials. When you or an eligible dependent select any of the following extras, the Plan will pay the basic cost of the allowed lenses, and you are responsible to pay the additional costs for the options.

- Blended lenses.
- Contact lenses (except as noted).
- Oversize lenses.
- Photochromic lenses; tinted lenses except Pink #1 and Pink #2.
- Progressive multifocal lenses.
- The coating of the lens or lenses.
- A frame that costs more than the Plan allowance.
- Certain limitations on low vision care.
- Cosmetic lenses.
- Optional cosmetic processes.
- UV (ultraviolet) protected lenses.

Exclusions

There is no benefit for professional services or material connected with:

- Orthoptics or vision training and any associated testing; plano lenses (less than a ±.38 diopter power) or two pair of glasses in lieu of bifocals;
- Replacement of lenses and frames furnished under this Plan which are lost or broken, except at the normal intervals when services are otherwise available.
- Medical or surgical treatment of the eyes;
- Any eye examination, or any corrective eyewear required by an employer as a condition of employment.

VSP may, at its discretion, waive any of the Plan limitations if, in the opinion of VSP's optometric consultants, it is necessary for the visual welfare of the patient.

DENTAL BENEFITS

Smile Dental Network

The Trust has contracted with dental providers in Washington and Oregon to provide quality service at discounted rates through the Smile Dental Network program.

Participation in this program is voluntary. By electing a dentist in the Smile Dental Network, you have access to discounts and avoid balance billing for covered amounts above the contracted rates. The deductible is waived for services classified as preventive care.

Additional information regarding the Smile Dental Network is available by contacting the Administration Office or by visiting the Trust website at www.nwrooferstrust.com.

If you choose to not participate in the Smile Dental Network, benefits for dental services will be paid up to the allowed Usual, Customary and Reasonable Amount (UCR), as detailed below.

Benefit Periods

Your program is designed to provide regular dental care. Each calendar year the Plan pays a share of covered and allowable Class I, Class II and Class III benefits. Your dollar maximum benefits renew January 1 of each year.

Deductible
$50 per person will be applied to most dental services. The deductible will be waived for services classified as preventive care. The deductible renews January 1 of each year.

Payment for Class I and Class II Benefits
The benefit level for covered Class I and Class II charges is 80% of the Usual, Customary and Reasonable Amount for each procedure.

Payment for Class III Benefits
The benefit level for covered Class III charges is 50% of the Usual, Customary and Reasonable Amount for each procedure.

Usual, Customary and Reasonable (UCR) Amounts
In determining the UCR amounts made by a provider, the Plan takes into consideration all of the following:

- The usual fee which the provider of service most frequently charges to the majority of their patients for a similar service or procedure.
- The fees which fall within the customary range of fees charged in a locality by most providers of a similar training and experience for the performance of a similar service or procedure. Unusual circumstances or complications requiring additional time, skill and experience in connection with a particular service or procedure.

The Plan makes the final determination as to whether or not the fee is "Usual, Customary, and Reasonable."

Description of Benefits

The following are Class I, Class II and Class III covered dental benefits under this Dental Plan which are subject to the limitations and exclusions contained in this booklet. The maximum dental benefit per calendar year for Participants age 12 and over is $2,000. There is no annual dollar maximum for children under age 12.

Class I: Diagnostic and Preventive
Covered Dental Benefits: Exams, X-rays, prophylaxis (cleaning), topical application of fluoride, sealants, and space maintainers.

Class II: Basic
Covered Dental Benefits: Fillings, root canals, periodontics, denture repair on relines, and extractions.

Class III: Major
Covered Dental Benefits: Crowns, bridges, and dentures.

Certain procedures not listed above may be covered under the Dental Plan. The Administration Office will determine the benefit for these procedures which will be consistent with those listed above.

If you receive treatment while covered under the Plan and then your coverage ends, benefits will be paid only if treatment is completed within 30 days after coverage ends. This extension applies only to crowns, dentures and root canals.

Treatment for the repair of accidental injuries to sound, natural teeth, which is provided within one year following the accidental injury to such teeth, is covered under the medical plan.

General Dental Exclusions

No benefits will be paid for:

- Charges in excess of Usual, Customary, and Reasonable (UCR) Amounts.
- Services not prescribed or ordered by the attending dentist as necessary to treat a covered condition.
- Any condition covered by workers compensation or occupational disease law or injuries occurring in the course of employment or self-employment for wage or profit.
- Injury or illness from war, nontherapeutic release of nuclear energy, or committing a crime.
- Injury or illness while in military service.
- Injury or illness that is intentionally self-inflicted, while sane or insane.
- Services you or your dependents are not required to pay or that would be free without coverage.
- Experimental services or supplies, which are those whose use and acceptance as a course of dental treatment for a specific condition is still under investigation/observation. In determining whether services are experimental, the Plan, in conjunction with the American Dental Association, will consider if: (1) the services are in general use in the dental community, (2) the services are under continued scientific testing and research; (3) the services show a demonstrable benefit for a particular dental condition; and (4) they are proven to be safe and effective. Any individual whose claim is denied due to this experimental exclusion clause will be notified of the denial within 20 working days of receipt of a fully documented request.
- Services by any person in your or your dependent's immediate family or by a person who ordinarily lives in your home.
- Any expense for dental treatment by anyone other than a dentist or denturist, except that scaling and cleaning may be performed by a licensed dental hygienist if under dentist's supervision and direction.
- Prosthetic devices (including bridges and crowns) and their fitting if ordered before you or your dependent became covered under the Plan.
- Replacement of prosthetics less than 5 years after a preceding placement.

- Treatment on or to the teeth or gums for cosmetic purposes, including congenital malformations (other than for a newborn child) and personalization or characterization of dentures or laminates or bleaching of teeth.
- Expenses incurred for orthodontic services including guidance procedures.
- Replacement of lost or stolen prosthetics.
- More than 2 oral examinations and/or prophylaxis in any one calendar year.
- More than 1 set of full mouth X-rays in any 1 calendar year.
- Prescription drugs.
- Expense incurred for anesthesia while hospital confined.
- Any condition for which the Veterans' Administration, federal, state, county or municipal government or any of the armed services is responsible or provides treatment for, except as required by law.
- Restorations or appliances necessary to correct vertical dimension or to restore the occlusion. Such procedures include restoration of tooth structure lost from attrition and restorations for malalignment of teeth.
- Application of desensitizing medicaments.
- Expenses charged for broken appointments, for completing insurance forms, telephone, internet or other consultations where a patient is not physically seen by a covered provider.
- Analgesics such as nitrous oxide or any other euphoric drugs, injections or prescription drugs.
- Patient management problems.
- Treatment or service for temporomandibular joint dysfunction (TMJ) or myofascial pain dysfunction (MPD) except as determined to be Medically Necessary and covered under Medical Benefits.
- Hospitalization charges except as specifically provided for dentist charges which are otherwise covered expenses.
- Surgical placement or removal of implants or attachments to implants.

OTHER LIMITATIONS AND EXCLUSIONS (MEDICAL, DENTAL, AND VISION PLANS)

When an Injury Is Caused by Another's Negligence (Subrogation)

If a third party is legally liable or there is a recovery from any source for an injury to a person covered under one of these plans, regular Plan benefits are paid if the injured person agrees to cooperate with the Plan in administering the Plan's subrogation rights. This means supplying all necessary requested information and submitting bills for the injury. Injured Participants also must agree to reimburse the Plan if they recover payment from the liable party or any other source. See "Third Party Recovery Subrogation and Reimbursement" beginning on page 102.

Coordination of Benefits

If you or your dependents have group medical, dental, vision, or other health care coverage in addition to the Medical, Dental and Vision Plans, the other benefits are considered before you're paid under these Plans. Other group coverage includes another employer's group benefit plan or other group coverage arrangement, whether insured or uninsured. The term plan shall not include an individual or family insurance policy, a hospital indemnity plan except as allowed by law, or an accidental injury policy provided through a school for students unless such policy contains a clause which would coordinate benefit with this Plan.

The group plan that pays benefits first is considered the primary plan and will pay without regard to benefits that may be payable under other plans. When another group plan is primary for medical, dental or vision coverage, this Plan will pay an amount that, when added to benefits under the other plan, does not exceed 100% of allowable expenses. The difference between the cost of a private hospital room and the cost of a semi-private room is not considered an allowable expense under the above definition, unless the covered person's stay in a private hospital room is considered medically necessary under at least one plan.

Allowable expenses are any necessary, Usual, Customary and Reasonable charges, partially or completely covered under any other plan, during a calendar year while that person is covered under the Medical, Prescription Drug, Dental or Vision Plan.

If, because of the coordination provision, this Plan does not pay its regular benefit, a record is kept of the reduction. This amount will be used to increase your later claim payments under the Plan in the same calendar year, to the extent there are allowable expenses that otherwise would not

be fully paid by this Plan and the other plans. Therefore, on a later claim you may receive a greater benefit under our Plan than would normally be allowed.

The following rules determine which group plan will be considered primary:

- A plan that does not contain coordination of benefits provisions will pay benefits before a plan that does have these provisions.
- A plan that covers a person other than as a dependent will pay before a plan that covers the person as a dependent.
- If a dependent child is covered under both parents' group plans, primary coverage is through the parent whole birthday comes first; secondary coverage is through the parent whose birthday comes later. If the other group plan does not rely on this birthday rule but on gender to determine benefit coordination, the gender rule used by the other plan will decide what order the plans pay benefits.
- If a dependent child's parents are divorced or separated and a court decree establishes financial responsibility for the child's coverage, the plan of the parent with that financial responsibility will be primary. If the divorce decree is silent, these guidelines apply:
    - The plan of the natural parent with custody.
    - The plan of the new spouse of the natural parent with custody.
    - The plan of the natural parent without custody.
    - The plan of the new spouse of the natural parent without custody.

    — Unmarried parents who live together (i.e., parents who are not separated) like married parents apply the "birthday rule." Under the "birthday rule" the primary plan is the plan of the parent whose birthday is earlier in the year.

    — If the parents are never married and are separated, use the same rule used for divorced parents.

    — If the court decree establishes provisions for joint custody but does not establish financial responsibility for the child's health care, the "birthday rule" will apply.
- The plan covering the individual (or a dependent) as a non-COBRA self-payer is primary over a plan covering the individual (or a dependent) as a COBRA self-payer.
- In the case of retired or laid-off employees and their dependents, Plan benefits will pay only after the benefits of any other plan covering the

person as an active employee or dependent, however, if the other plan does not have a provision regarding retired or laid-off employees, resulting in each plan determining its benefits after the other, this Plan's provision for retired or laid-off employees will not apply.

- If none of the above rules establishes which group plan should pay first, the plan that has covered the person for the longest period will be primary.

  The Trust has the right to obtain the release of any information or recover any payment it considers necessary to administer these provisions.

How Medicare Affects Your Medical Benefits

- Active Employees

If you reach age 65 and become eligible for Medicare while actively working for a contributing employer, Medicare normally becomes your secondary coverage — paying benefits after the Medical Plan benefits are paid. Or, if you elect Medicare as your primary coverage, your Medical Plan benefits stop and Medicare becomes your only source of medical benefits. If you choose to keep the Medical Plan as your primary coverage, the Plan pays for covered medical expenses and you can submit unreimbursed amounts to Medicare for possible payment. Since Medicare supplements your Medical Plan benefits, you may want to enroll in Medicare Part A (hospital) and Part B (physician services) even if you keep primary coverage under the Medical Plan.

- Retired Employees

If you are eligible for coverage under the Medical Plan as a retired employee, Medicare normally becomes your primary coverage. You or your physician will submit most of your claims to Medicare first. Once Medicare has paid its benefits and you receive your Explanation of Medicare Benefits form (EOMB), send a copy of the EOMB with your claim to the Administrator. The Medical Plan, as your secondary coverage, will then pay benefits according to the Coordination of Benefits provision beginning on page 66.

When benefits are determined under the Medical Plan for retirees eligible for Medicare, it is assumed the covered person enrolled in Medicare and that benefits are payable from Part A and Part B. Claims payments will be reduced by benefits provided under both parts A and B even if you have not signed up for both parts. This makes it important for you and your dependents to enroll in Medicare promptly.

If an item is not covered by Medicare you may send the claim, along with an itemized bill, directly to the Administration Office.

SELF PAYMENTS FOR CONTINUATION COVERAGE FOR MEDICAL, VISION AND DENTAL COVERAGE UNDER COBRA
(CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT)

The following information about your COBRA rights sets out in detail your rights and responsibilities under the Trust's COBRA continuation provisions, as well as other health coverage alternatives that may be available to you through the Health Insurance Marketplace. It provides additional information about the effect of your legal rights of not electing COBRA coverage, what alternative coverage (if any) is available from the Trust and your notification obligations. This includes how to obtain an 11-month extension of COBRA continuation coverage if you or an eligible family member is found to be disabled by the Social Security Administration; notifying the Administration Office within 60 days of the later of your qualifying event; the date you receive your disability determination; or your responsibility to notify the Administration Office within 60 days if a second qualifying event occurs while you are on COBRA.

Other Coverage Options Besides COBRA Continuation Coverage

Instead of enrolling in COBRA continuation coverage, there may be other more affordable coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage.

You should compare your other coverage options with COBRA continuation coverage and choose the coverage that is best for you. For example, if you move to other coverage you may pay more out of pocket than you would under COBRA because the new coverage may impose a new deductible.

When you lose job-based health coverage, it's important that you choose carefully between COBRA continuation coverage and other coverage options, because once you've made your choice, it can be difficult or impossible to switch to another coverage option.

If you have questions after reading the notice, you may contact the Administration Office or you may contact the nearest office of the Department of Labor Employee Benefits Security Administration.

Addresses and phone numbers are available through EBSA's website at www.dol.gov/ebsa.

Continuation Coverage (COBRA)

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

Notices to Trust Concerning COBRA
The Administration Office for the Northwest Roofers and Employers Health and Security Trust Fund is responsible for administering COBRA continuation rights for the Trust. All communications must be made in writing; and identify the Participant and the individual requesting COBRA; if different; the Trust's name (Northwest Roofers and Employers Health & Security Trust Fund) and the qualifying event. Communications must be sent to the Administration Office at the following address:

Northwest Roofers and Employers Health and Security Trust Fund
P.O. Box 34203
Seattle, WA 98124

Qualifying Events
COBRA coverage is available if you or your dependents lose coverage because of specific qualifying events. You (as the Participant) have the right to elect continuation of coverage if you would otherwise lose eligibility because of a reduction in hours of employment or termination of employment.

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

- The Participant's termination of employment or reduction in hours of employment.
- Death of the Participant, or
- Divorce or legal separation from the Participant.
- A dependent child has the right to elect continuation of coverage if eligibility would otherwise be lost for any of the following reasons:
- The Participant's termination of employment or reduction in hours of employment.

- Death of the Participant.
- Divorce or legal separation of a lawful spouse from the Participant, or
- The child no longer qualifying as an eligible dependent under the Plan.

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

COBRA Notification Responsibilities
The Trust offers continuation coverage only after it has been notified of a qualifying event. You or your eligible dependents have the responsibility to inform the Administration Office of a loss of coverage resulting from a divorce, legal separation or a child losing dependent status. If you or your eligible dependents have a loss of coverage because of these events, you must notify the Administration Office in writing at the address listed one page one within 60 days of the date of the later of: the date of the qualifying event; the date coverage would be terminated as the result of the qualifying event; or the date you are first provided this notice, or another notice (e.g., the plan booklet) describing the procedure for electing continuation coverage. The notice must identify the individual who has experienced the qualifying event; the eligible Participant's name, if different; the qualifying event that occurred and the Trust. Even after you have made a written election with the Administration Office you may later revoke, change or modify your election notice with a follow-up written election notice made and forwarded to the Administration Office any time before the 60 days has expired. Elections, changes or revocations must be sent to the Administration Office in writing at the address listed on page one within the 60-day period.

Failure to provide timely notice will result in your coverage ending as it normally would under the terms of the Plan, and you and your dependents will lose the right to elect continuation coverage.

Your employer is responsible for informing the Trust of any other qualifying event. The Board of Trustees reserves the right to determine whether coverage has in fact been lost due to a qualifying event.

Election of COBRA
Once the Administration Office has received proper notice that a qualifying event has occurred, it will notify you, your lawful spouse and each of your eligible dependents of your right to elect continuation coverage. A written election must be sent to the Administration Office at the address listed on page one, and post marked 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 by the Trust.

Failure to elect continuation coverage within this 60-day period will cause eligibility to end as it normally would under the terms of the Plan, and you and your dependents will lose the right to elect continuation coverage.

Available Coverage
The continuation coverage offered is the same as provided to current Participants of your former employer.

You and/or your eligibility dependents may elect the following coverages:

- Medical and prescription drug coverage.
- Medical, prescription drug, dental and vision coverage.

Continuation coverage is not available for time loss or life and accidental death and dismemberment benefits. If you elect to continue medical and prescription drug coverage, you cannot subsequently add dental and vision coverage nor can you switch to medical and prescription drug coverage only if you have selected to continue medical, prescription drug, dental, and vision coverage.

Adding New Dependents
COBRA is only available to individuals who were covered under the Plan at the time of the qualifying event. However, if you elect COBRA and acquire a new dependent through marriage, birth, adoption or placement for adoption you may add the new dependent to your COBRA coverage by providing written notice to the Administration Office at the address indicated on page one, within 31 days of acquiring the new dependent. The written notice must identify the Participant, the new dependent, and the date the new dependent was acquired. A copy of the marriage certificate, birth certificate or adoption papers must be included with the written notice.

Children acquired through birth, adoption or placement for adoption are entitled to extend their continuation coverage if a second qualifying event occurs, as discussed below.

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

Cost
There is a cost for continuation coverage. The cost for the coverage available through the Trust is set annually. If you have a qualifying event, you will be notified of the applicable monthly self-payment premium for the coverage options available to you. If you or your dependents are eligible for an extension of coverage as a result of you or a dependent being disabled, the cost of the coverage may be 150% of the COBRA self-payment rate for the additional 11 months of coverage provided as a result of your or your dependents disability.

Other coverage options may cost less. If you choose to elect continuation coverage, you don't have to send any payment with the Election Form. Additional information about payment will be provided to you after the election form is received by the Plan. Important information about paying your premium can be found at the end of this notice.

You may be able to get coverage through the Health Insurance Marketplace that costs less than COBRA continuation coverage. You can learn more about the Marketplace below.

What is the Health Insurance Marketplace?

The Marketplace offers "one-stop shopping" to find and compare private health insurance options. In the Marketplace, you could be eligible for a new kind of tax credit that lowers your monthly premiums and cost-sharing reductions (amounts that lower your out-of-pocket costs for deductibles, coinsurance, and copayments) right away, and you can see what your premium, deductibles, and out-of-pocket costs will be before you make a decision to enroll. Through the Marketplace you'll also learn if you qualify for free or low-cost coverage from Medicaid or the Children's Health Insurance Program (CHIP). You can access the Marketplace for your state at www.HealthCare.gov.

Coverage through the Health Insurance Marketplace may cost less than COBRA continuation coverage. Being offered COBRA continuation coverage won't limit your eligibility for coverage or for a tax credit through the Marketplace.

When Can I Enroll In Marketplace Coverage?
You always have 60 days from the time you lose your job-based coverage to enroll in the Marketplace. That is because losing your job-based health coverage is a "special enrollment" event. **After 60 days your special enrollment period will end and you may not be able to enroll, so you should take action right away.** In addition, during what is called an "open enrollment" period, anyone can enroll in Marketplace coverage.

To find out more about enrolling in the Marketplace, such as when the next open enrollment period will be and what you need to know about qualifying events and special enrollment periods, visit www.HealthCare.gov.

If I Sign Up For COBRA Continuation Coverage, Can I Switch To Coverage In The Marketplace? What About If I Choose Marketplace Coverage And Want To Switch Back To COBRA Continuation Coverage?

If you sign up for COBRA continuation coverage, you can switch to a Marketplace plan during a Marketplace open enrollment period. You can also end your COBRA continuation coverage early and switch to a Marketplace plan if you have another qualifying event such as marriage or birth of a child through something called a "special enrollment period." But be careful—if you terminate your COBRA continuation coverage early without another qualifying event, you'll have to wait to enroll in Marketplace coverage until the next open enrollment period, and could end up without any health coverage in the interim.

Once you've exhausted your COBRA continuation coverage and the coverage expires, you'll be eligible to enroll in Marketplace coverage through a special enrollment period, even if Marketplace open enrollment has ended.

If you sign up for Marketplace coverage instead of COBRA continuation coverage, you cannot switch to COBRA continuation coverage under any circumstances.

Can I Enroll In Another Group Health Plan?

You may be eligible to enroll in coverage under another group health plan (like a spouse's plan), if you request enrollment within 30 days of the loss of coverage.

If you or your dependent chooses to elect COBRA continuation coverage instead of enrolling in another group health plan for which you're eligible, you'll have another opportunity to enroll in the other group health plan within 30 days of losing your COBRA continuation coverage.

What Factors Should I Consider When Choosing Coverage Options?

When considering your options for health coverage, you may want to think about:

- Premiums: Your previous plan can charge up to 102% of total plan premiums for COBRA coverage. Other options, like coverage on a spouse's plan or through the Marketplace, may be less expensive.
- Provider Networks: If you're currently getting care or treatment for a condition, a change in your health coverage may affect your access to a particular health care provider. You may want to check to see if your current health care providers participate in a network as you consider options for health coverage.
- Drug Formularies: If you're currently taking medication, a change in your health coverage may affect your costs for medication–and in some cases, your medication may not be covered by another plan. You may want to check to see if your current medications are listed in drug formularies for other health coverage.
- Severance payments: If you lost your job and got a severance package from your former employer, your former employer may have offered to pay some or all of your COBRA payments for a period of time. In this scenario, you may want to contact the Department of Labor at 1-866-444-3272 to discuss your options.
- Service Areas: Some plans limit their benefits to specific service or coverage areas–so if you move to another area of the country, you may not be able to use your benefits. You may want to see if your plan has a service or coverage area, or other similar limitations.
- Other Cost-Sharing: In addition to premiums or contributions for health coverage, you probably pay copayments, deductibles, coinsurance, or other amounts as you use your benefits. You may want to check to see what the cost-sharing requirements are for other health coverage options. For example, one option may have much lower monthly premiums, but a much higher deductible and higher copayments.

Monthly Self-Payments Required

You or your eligible dependents are responsible for the full cost of continuation coverage. All payments for continuation of coverage are due on the first of each month for that month's coverage and must be sent to the Administration Office at the address printed on the payment coupons.

The first payment is due 45 days from the date the election form is sent to the Administration Office. The first payment must cover all months since the date coverage would have otherwise terminated. Eligibility for continuation coverage will not commence, nor will claims be processed until the initial payment has been made. You or your dependents will lose the right to continuation coverage if the initial payment is not postmarked or received by the Administration Office by the due date.

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

Length of Continuation Coverage

Continuation of coverage may last for up to 18 months following loss of coverage as a result of a termination of employment or reduction in hours. The 18-month period may be extended as provided below for "Disabled Individuals," "Second Qualifying Event," and "Medicare Entitlement."

For all other qualifying events (death of employee, divorce or legal separation from the employee, employee becoming Medicare eligible or a child no longer qualifying as a dependent under the Plan) continuation coverage may last for up to 36 months.

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

- A required self-payment is not postmarked or received by the Administration Office on a timely basis for the next monthly coverage period.
- You or your eligible dependent becomes covered under any other group health plan after the date of your COBRA election (unless the other group health plan limits or excludes coverage for a pre-existing condition of the individual seeking continuation coverage). You are required to notify the Administration Office when you become eligible under another group health plan (note: there are limitations on plans imposing a pre-existing condition exclusion and such exclusions will become prohibited beginning in 2014 under the Affordable Care Act).
- You or your eligible dependent provide written notice that you wish to terminate your coverage.
- You or your eligible dependent become entitled to Medicare benefits after the date of your COBRA election, or

- The Trust discontinues the Plan, or
- Your employer no longer participates in the Plan, unless the employer or its successor does not offer another health plan for any classification of its employees that formerly participated in the Trust.

Length of Continuation Coverage – Disabled Individuals
If you, your spouse or any dependent covered by the Trust is determined by the Social Security Administration to be disabled within the first 60 days of continuation coverage, the entire family of the disabled individual can receive an additional 11 months of continuation coverage for up to a maximum of 29 months. To obtain the additional months of coverage, you must notify the Administration Office in writing within 60 days of the later of your qualifying event or your receipt of your Social Security Disability Determination and prior to the end of your initial 18-month period of continuation coverage. If the disabled individual is subsequently found to not be disabled, you must notify the Administration Office within 30 days of this determination.

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

Length of Continuation Coverage – Second Qualifying Event
Eligible dependents that are entitled to continuation coverage as the result of a Participant's termination of employment or reduction of hours can extend their coverage up to a total of 36 months if a second qualifying event (e.g., an event which would have caused coverage to end if it occurred first) occurs during the initial 18 months of continuation coverage. Possible second qualifying events are the Participant's death, a divorce or legal separation from the Participant, or a child losing dependent status.

If an eligible dependent wants extended coverage as a result of a second qualifying event, he or she must notify the Administration Office in writing within 60 days of the second qualifying event. Failure to give such timely written notice of a second qualifying event will cause the individual's coverage to end as it normally would under the terms of the Plan. In no event will continuation of coverage extend beyond a total of 36 months.

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

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

Relationship Between COBRA and Medicare or Other Health Coverage

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

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

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

Effect of Not Electing Continuation Coverage

In considering whether to elect continuation coverage, please be aware that federal law gives you special enrollment rights. 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 Coverage
There is no conversion option available for medical, prescription drug, dental, vision or AD&D benefits provided by the Trust. However, the Trust offers certain other alternatives that may be elected in lieu of COBRA continuation coverage.

There is a conversion option for Life benefits, provided you complete the application form and send it to the Trust's Life insurance provider with the first premium payment within 31 days of the termination of the Trust's Life insurance benefits. See the Plan booklet for details.

If you leave employment with a contributing employer for military service, you may elect to continue coverage for up to 24 months in accordance with the Uniform Services Employment and Reemployment Rights Act ("USERRA"). If leave is less than 32 days, coverage is continued at no cost to you. If leave exceeds 31 days, a monthly self-payment is required at the rate established by the Trustees. The maximum length of coverage is the lesser of 24 months, or the period ending the day after you fail to return to employment within the time allowed by USERRA.

If you qualify for both COBRA continuation coverage and retiree medical, you and your eligible dependents may elect COBRA in lieu of retiree medical. Following termination of COBRA, you and your dependents may apply for retiree medical. However, if COBRA continuation coverage is declined in favor of retiree medical, COBRA may not thereafter be elected, unless there is a new qualifying event.

Additional Information

For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, visit the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) website at www.dol.gov/ebsa or call their toll-free number at 1-866-444-3272. For more information about health insurance options available through the Health Insurance Marketplace, and to locate an assister in your area who you can talk to about the different options, visit www.HealthCare.gov.

Keep Your Plan Informed of Address Changes
To help ensure you receive necessary notices, you should notify the Administration Office if your address or that of any family member changes. You should retain this notice and also keep a copy of any written notices you send the Trust.

Plan Contact Information
If you have any questions regarding your eligibility/COBRA, please contact the Administration Office at (800) 732-1121 or (206) 441-7574, option 4.

Keep the Administration Office Informed of Address Changes
In order to protect you and your family's rights to elect self-payment coverage, you should keep the Administration Office informed of any changes in the addresses of family members. It is your responsibility to keep the Plan up-to-date and to ensure that your (and your dependents') addresses on file with the Administration Office are current.

HOW TO FILE A CLAIM

To be considered a claim, you or your dependent must request that the Trust provide benefits for a specific service or supply. Claims, supporting documentation and additional information that is requested to process the claims, must be submitted within one year from the date the expense was incurred. Incomplete claims will not be considered until all the required information has been provided. Failure to submit a completed claim within this one-year period will cause the claim to be denied unless you or your dependent can establish to the Trustees' satisfaction that it was not possible to file the completed claim within the one-year period. Subject to the special provisions dealing with urgent care claims, claims must be submitted in writing and to the proper address.

For any claim the Trust may require additional information to process claims or to meet Plan requirements. This may include inquiries related to eligibility, the nature of the services or supplies provided, coordination of benefits, third party reimbursement requirements or other Plan provisions. Failure to provide this required information may result in the denial of a claim. The Trustees have established the following requirements for filing claims:

Medical Benefits

Preferred Providers: Identify yourself as a Premera Blue Cross member by presenting your identification card when you receive care from a preferred provider. (You will not have to file a claim; your Premera provider will submit the bill directly to the Administration Office.) Benefit payment will be made directly to the Premera provider as per agreement between Premera and the Trust. (Do not pay the preferred provider bill until you receive the Explanation of Benefit payment form from the Administration Office. It will show you the exact amount you owe the provider.)

Non-Preferred Providers: Obtain a claim form from the Administration Office or your local union office. Complete the Insured's Statement portion of the claim form in full and attach the itemized bill(s) to the form and send to:

Northwest Roofers
P.O. Box 34498
Seattle, WA 98124-1498
(206) 441-7574 (800) 331-6158

1. You need to file one claim form for yourself and one for each of your dependents.

2. Complete the form including all information requested. Be sure to complete the accident portion if the claim is accident related. Also provide all information regarding any other group insurance coverage. You must sign and date the form.

3. Attach all itemized physician, hospital, and other bills pertaining to the claim to the completed claim form.

4. An itemized bill is the actual bill from the provider showing the date of the service, a diagnosis code, the procedure(s) performed and the cost of each procedure. A "balance due" notice from the provider or an Explanation of Payment from other coverage or Medicare will not provide adequate information for determining benefits and payments. Non-itemized bills are not acceptable and if submitted will cause significant delay of payment.

5. You need to submit claim forms and attached itemized bills to this office within 90 days after the service was received. (Completed claims received more than twelve months after the expenses have been incurred will be denied.)

Except for Premera providers, benefit payments will be sent to you unless you have assigned payment of benefits to the provider. In that instance, benefit payment will be made directly to the provider and you will be sent an explanation of benefits payment form showing the amount the provider has been paid and the balance you owe the provider.

Premera is available to help you with any preferred provider network questions you may have. Contact information for Premera:

Toll Free	(800) 810-BLUE (2583)
Website	www.Premera.com

Prescription Drug Plan

See pages 54 through 58.

Vision

See pages 59 through 61.

Dental

- Obtain a dental claim form from the Administration Office or your local union office.
- Complete the member's statement portion of the form, sign and date it, and attach a complete itemized billing of charges from your dentist or have them complete their portion of the form.

- The dentist may send the claim form with their itemized charges directly to the Administration Office for processing.
- You must submit claim forms and bills to the Administration Office within 90 days after the services were incurred for the charges to be covered. (Completed claims received more than twelve months after the expenses have been incurred will be denied.)

Death and AD&D Benefits

- Obtain a claim form from the Administration Office or your local union office.
- Complete the form according to the instructions.
- Return the form to the Administration Office with a certified copy of the death certificate.

Weekly Disability

- Obtain a claim form from the Administration Office or your local union office.
- Complete your portion of the form completely and sign it.
- The physician who is treating you for the disabling condition must fully complete the doctor portion of the form.
- Then return the form to the Administration Office for processing.

CLAIMS PROCEDURES

The following described procedures must be followed to obtain payment of health benefits under this Plan.

Types Of Health Claims Described

All claims and questions regarding health claims should be directed to the Claims Administrator which is Welfare & Pension Administration Service, Inc. (referred to frequently as "WPAS, Inc.") for medical claims. The Board of Trustees of the Northwest Roofers and Employers Health and Security Trust Fund is ultimately responsible for adjudicating (that is, approving or denying) such claims and for providing full and fair review of the decision on such claims in accordance with the following provisions and with the Employee Retirement Income Security Act of 1974, as amended ("ERISA"). Benefits under the Plan will be paid only if the Claims Administrator decides that the claim is payable as described by the written Benefit Plan. The Board of Trustees reserves the right to interpret all terms and rules of the Plan as it decides in its discretion. The responsibility to process claims in accordance with the Plan Document and Summary Plan Description may be delegated to the Claims Administrator; provided, however, that the Claims Administrator is not a fiduciary of the Plan and does not have the authority to make decisions involving the use of discretion.

Each claimant claiming benefits under the Plan shall be responsible for supplying, at such times and in such manner as the Claims Administrator in its sole discretion may require, written proof that the claim expenses were incurred or that the benefit is covered under the Plan. If the Claims Administrator in its sole discretion shall determine that the claimant has not incurred a covered expense or that the benefit is not covered under the Plan, or if the claimant shall fail to furnish such proof as is requested, no benefits shall be payable under the Plan.

Under the Plan, there are two types of claims: Pre-service (Urgent and Non-urgent), and post-service. These terms are defined below and are important to understanding the claim processing rules.

A "Pre-service Claim" is a claim for benefits under the Plan where payment of the benefit, in whole or in part, is based upon on approval of the benefit in advance of obtaining medical care.

In some circumstances, claim review is urgent. A **"Pre-service Urgent Care Claim"** is any claim for benefits with respect to which the application of the time periods for making non-urgent care determinations could seriously jeopardize the life or health of the claimant or the claimant's ability to regain maximum function, or, in the opinion of a

physician with knowledge of the claimant's medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

A "Post-service Claim" is a claim for a benefit under the Plan which is submitted after the services have been provided.

When Health Claims Must Be Filed: Health claims must be filed with the Claims Administrator within 12 months of the date charges for the services were incurred. Benefits are based upon the Plan's provisions at the time the charges were incurred. Charges are considered incurred when treatment or care is given or supplies are provided. **Completed claims filed later than that date shall be denied.** (However, if the Plan is terminated the final claims must be received within ninety (90) days of termination).

A "Pre-service Claim" is considered to be filed when the request for approval of treatment or services is made and received by the Utilization Review Manager in accordance with the Plan's procedures.

A "Post-service Claim" is considered to be filed when the following information is received by the Claims Administrator, (together with a Form HCFA or Form UB92):

1. The date of service;
2. The name, address, telephone number and tax identification number of the provider of the services or supplies;
3. The place where the services were rendered;
4. The diagnosis and procedure codes;
5. The amount of charges;
6. The name of the Plan or group number;
7. The name and Social Security Number of the covered Participant; and
8. The name of the patient.

Upon receipt of this information, the claim will be deemed to be filed with the Plan. The Claims Administrator will determine if enough information has been submitted to enable proper consideration of the claim. If not, more information may be requested as described later in this booklet. This additional information must be received by the Claims Administrator within 45 days (or within 48 hours in the case of Pre-service Urgent Care Claims) from receipt by the claimant of the request for additional information. **Failure to do so may result in claims being declined or reduced.**

Time Limitations For Claim Decisions

The Claims Administrator shall notify the claimant, in accordance with the provisions set forth below, of any adverse benefit determination (and, in the case of Pre-service Claims, of decisions that a claim is allowable based on all Plan provisions) within the following timeframes:

Pre-service Urgent Care Claims:

- If the claimant has provided all of the necessary information, as soon as possible, taking into account the medical necessities, but not later than 72 hours after receipt of the claim.
- If the claimant has not provided all of the information needed to process the claim, then the claimant will be notified as to what specific information is needed as soon as possible, but not later than 24 hours after receipt of the claim. The claimant will be notified of a determination of benefits as soon as possible, but not later than 48 hours, taking into account the medical necessities, after the earliest of (a) the Plan's receipt of the specified information, or (b) the end of the period afforded the claimant to provide the information.

Pre-service Non-urgent Care Claims:

- If the claimant has provided all of the information needed to process the claim, in a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after receipt of the claim, unless an extension has been requested, then prior to the end of the 15-day extension period.
- If the claimant has not provided all of the information needed to process the claim, then the claimant will be notified as to what specific information is needed as soon as possible, but not later than 5 days after receipt of the claim. The claimant will be notified of a determination of benefits in a reasonable period of time appropriate to the medical circumstances, either prior to the end of the extension period (if additional information was requested during the initial processing period) or by the date agreed to by the Claims Administrator (and extension period), or by the date agreed to by the Claims Administrator and the claimant (if additional information was requested during the extension period).

Post-service Claims:

- If the claimant has provided all of the information needed to process the claim, in a reasonable period of time, but not more than 30 days after receipt of the claim, unless an extension has been requested, then prior to the end of the 15-day extension period.

- If the claimant has not provided all of the information needed to process the claim and additional information is requested during the initial processing period, then the claimant will be notified of a determination of benefits prior to the end of the extension period, unless additional information is requested during the extension period, then the claimant will be notified of the determination by a date agreed to by the Claims Administrator and the claimant.

Extensions - Pre-service Urgent Care Claims. No extensions are available in connection with Pre-service Urgent Care Claims.

Extensions - Pre-service Non-urgent Care Claims. This period may be extended by the Plan for up to 15 days, provided that the Claims Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the claimant, prior to the expiration of the initial 15-day processing period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision.

Extensions - Post-service Claims. This period may be extended by the Plan for up to 15 days, provided that the Claims Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the claimant, prior to the expiration of the initial 30-day processing period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision.

Calculating Time Periods. The period of time within which a benefit determination is required to be made shall begin at the time a claim is deemed to be filed in accordance with the procedures of the Plan.

Notification Of An Adverse Benefit Determination

An "adverse benefit determination" is any decision by the Claims Administrator which denies in whole or in part the requested benefits. The Claims Administrator shall provide a claimant with a notice, either in writing or electronically (or, in the case of Pre-service Urgent Care Claims, by telephone, facsimile or similar method, with written or electronic notice following within 3 days), containing the following information:

1. A reference to the specific portion(s) of the Plan Document and Summary Plan Description upon which a denial is based;
2. Specific reason(s) for a denial;
3. A description of any additional information necessary for the claimant to perfect the claim and an explanation of why such information is necessary;

4. A description of the Plan's review procedures and the time limits applicable to the procedures, including a statement of the claimant's right to bring a civil action under Section 502(a) of ERISA following an adverse benefit determination on final review;
5. 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;
6. The identity of any medical or vocational experts consulted in connection with a claim, even if the Plan did not rely upon their advice (or a statement that the identity of the expert will be provided, upon request);
7. Any rule, guideline, protocol or similar criterion that was relied upon in making the determination (or a statement that it was relied upon and that a copy will be provided to the claimant, free of charge, upon request);
8. In the case of denials based upon a medical judgment (such as whether the treatment is Medically Necessary or Experimental), 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 explanation will be provided to the claimant, free of charge, upon request; and
9. In a claim involving Urgent Care, a description of the Plan's expedited review process.

NOTICE OF PRIVACY PRACTICES

Pursuant to Federal regulations, the Trust is providing you this Notice about the possible uses and disclosures of your protected health information ("PHI") under 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 PHI. This Notice describes the circumstances under which and the purposes for which your PHI may be used and disclosed and your rights in regard to such information.

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

Use And Disclosure Of Protected Health Information
Your PHI may be used and disclosed without an authorization in the following situations:

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

Treatment: The Trust may disclose information to facilitate medical treatment or services by providers. For example, the Trust may disclose the name of your treating Physician to another Physician so that the Physician may ask for your x-rays.

Health Care Operations: The Trust may use or disclose PHI for its own operations. These uses and disclosures are necessary to administer the Trust health plan. For example, the Trust may use PHI in connection with

conducting quality assessment and improvement activities; underwriting premium rating, and other activities relating to health plan coverage; submitting claims for stop-loss (or excess-loss) coverage; conducting or arranging for medical review, legal services, audit services, and fraud and abuse detection programs; business planning and development such as cost management; and business management and general plan administrative activities. However, the Trust will not use your genetic information for underwriting purposes.

Disclosure to the Trustees: The Trust may disclose your PHI to the Board of Trustees (which is the health plan sponsor) in performing health plan administration functions, such as handling claim appeals.

The Trust also may disclose summary health information to the Board of Trustees for the purpose of obtaining premium bids from insurers for providing health insurance coverage under the plan, or modifying, amending, or terminating the health plan. "Summary health information" is information that summarizes claims information but from which names and other identifying information have been removed.

Disclosure to You: When you request, the Trust is required to disclose to you your PHI that contains medical records, billing records, and any other records used to make decisions regarding your health care benefits. If your request for access directs the Trust to transmit the copy of PHI directly to another person designated by you, the Trust will provide the copy to the person you designate. Your request must be in writing, signed by you, and clearly identify the designated person and where to send the copy of PHI.

Also, absent special circumstances, the Trust will send all mail from the Trust to the individual's address on file with the Trust Administration Office. You are responsible for ensuring that your address with the Trust Administration Office is current. Although mail is normally addressed to the individual to whom the mail pertains, the Trust cannot guarantee that other individuals with the same address will not intercept the mail. You have the right to request restrictions on where your mail is sent as set forth in the request restrictions section below.

Disclosure to your Personal Representative: The Trust will disclose PHI to your personal representative (or to another person designated by your personal representative) the same as the Trust will disclose PHI to you or to another person designated by you (see *Disclosure to You*, above). Your personal representative is a person who has authority under law to act on your behalf on matters related to health care. The Trust does not,

however, have to make disclosures to a personal representative if, in the exercise of professional judgment, the Trust believes doing so would not be in the best interest of you because of a reasonable belief that you have been or may be subject to domestic violence, abuse or neglect by the personal representative, or that doing so would otherwise endanger you.

Disclosure to Employer: The Trust may disclose to your employer information about whether you are participating in the Trust or one of its available options.

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

1. *In Connection With Judicial and Administrative Proceedings.* The Trust may disclose your PHI to a health oversight agency for authorized activities (including audits; civil; administrative or criminal investigations; inspections; licensure or disciplinary action); government benefit programs for which PHI is relevant; or to government agencies authorized by law to receive reports of abuse, neglect or domestic violence as required by law. The Trust, however, may not disclose your PHI 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.

2. *When Legally Required and For Law Enforcement Purposes.* The Trust will disclose your PHI when it is required to do so by any federal, state or local law. Additionally, as permitted or required by state law, the Trust may disclose your PHI to a law enforcement official for certain law enforcement purposes, such as identifying a suspect or to provide evidence of criminal conduct.

3. *To Conduct Public Health and Health Oversight Activities.* The Trust may disclose your PHI to a health oversight agency for authorized activities (including audits, civil administrative or criminal investigations, inspections, licensure or disciplinary action), government benefit programs for which PHI is relevant, or to government agencies authorized by law to receive reports of abuse, neglect or domestic violence as required by law.

   The Trust, however, may not disclose your PHI if you are the subject of an investigation and the investigation does not arise out

of or is not directly related to your receipt of health care or public benefits.

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

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

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

Authorization To Use Or Disclose Protected Health Information
Other than as stated above, the Trust will not disclose your PHI without your written authorization, or the written authorization of your personal representative. (A "personal representative" is described in *Disclosure to your Personal Representative*, above.)

Generally, you will need to submit an authorization if you wish the Trust to disclose your PHI to someone other than yourself. Authorization forms are available from the Privacy Contact Person listed below.

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

Special rules apply about disclosure of psychotherapy notes. Your written authorization generally will be required before the Trust will use or disclose psychotherapy notes. Psychotherapy notes are a mental health professional's separately filed notes which document or analyze the contents of a counseling session. Psychotherapy notes do not include

summary information about your mental health treatment or information about medications, session stop and start times, the diagnosis and other basic information. The Trust may use and disclose psychotherapy notes when needed to defend against litigation filed by you or as necessary to conduct Treatment, Payment and Health Care Operations.

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

If your personal representative signs an authorization, a description of the representative's authority to act for you must also be provided.

Your Rights With Respect To Your Protected Health Information
You have the following rights regarding your PHI that the Trust maintains:

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

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

Right to Receive Confidential Communications: You have the right to request that the Trust communicate with you in a certain way if you feel the disclosure of your PHI through regular procedures could endanger you. For example, you may ask that the Trust only communicate with you at a certain telephone number or by e-mail. If you wish to receive confidential communications, please make your request in writing to the Privacy

Contact Person listed below. The Trust will attempt to honor reasonable requests for confidential communications.

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

Right to an Accounting: You have the right to request a list of disclosures of your PHI made by the Trust. The request must be made in writing to the Privacy Contact Person. The request should specify the time period for which you are requesting the information. No accounting will be given of disclosures made: to you or any one authorized by you; for Treatment, Payment or Health Care Operations; disclosures made before April 14, 2003; disclosures for periods of time going back more than six years; 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 Be Notified of a Breach. You have the right to be notified in the event that we (or a Business Associate) discover a breach of unsecured protected health information.

Right to a Paper Copy of this Notice: You have a right to request and receive a paper copy of this Notice at any time, even if you have received this Notice previously or agreed to receive the Notice electronically. To obtain a paper copy, please contact the Privacy Contact Person listed below. If this Notice is modified, you will be mailed a new copy. You will also be able to obtain a copy of the current version of the Trust's Notice at its web site, www.nwrooferstrust.com.

Right to Complain. You have the right to complain to the Trust and to the Office for Civil Rights of the Department of Health and Human

Services if you believe that your privacy rights have been violated. Any complaint to the Trust should be made in writing to the Privacy Contact Person identified below. You will not be retaliated against in any way for filing a complaint with the Office of Civil Rights or the Trust.

Privacy Contact Person/Privacy Official: To exercise any of these rights related to your PHI you should contact the Privacy Contact Person listed below. The Trust has also designated a Privacy Official to oversee its compliance with the Privacy Rules who is also listed below.

Privacy Contact Person
Assistant Claims Manager
c/o Welfare & Pension Administration Service, Inc.
P.O. Box 34203
Seattle, WA 98124-1203
Phone No: 206-441-7574
Toll Free: 800-331-6158
Fax No: 206-441-9110

Privacy Official
Claims Manager
c/o Welfare & Pension Administration Service, Inc.
P.O. Box 34203
Seattle, WA 98124
Phone No: 206-441-7574
Toll Free: 800-331-6158
Fax No: 206-441-9110

Duties Of The Trust
The Trust is required by law to maintain the privacy of your PHI as set forth in this Notice, 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 PHI that it maintains. If the Trust changes its policies and procedures, the Trust will revise the Notice and will provide a copy of the revised Notice to you by mail to their last-known address on file with the Trust Administration Office.

APPEALS OF ADVERSE BENEFIT DETERMINATIONS

An "adverse benefit determination" is any decision by the Claims Administrator that denies in whole or in part a claim submitted for payment. A claimant is entitled to submit a written request of appeal for review of such adverse benefit determination. The following described rules govern the submission of all appeals and requests for review.

It shall be the responsibility of the claimant to submit proof that the claim for benefits is covered and payable under the provisions of the Plan. Any appeal must include:

1. The name of the Participant;
2. The Participant's Identification Number or Social Security Number;
3. The group name or identification number;
4. All facts and theories supporting the claim for benefits. Failure to include any theories or facts in the appeal will result in their being deemed waived. In other words, the claimant will lose the right to raise factual arguments and theories which support this claim if the claimant fails to include them in the appeal;
5. A statement in clear and concise terms of the reason or reasons for disagreement with the handling of the claim; and
6. Any material or information that the claimant has which indicates that the claimant is entitled to benefits under the Plan.
7. A written release authorizing the Claims Administrator access to private information.

Timing of Notification of Benefit Determination on First Appeal: The Claims Administrator shall notify the claimant of the Plan's benefit determination on review within the following timeframes:

- Pre-service Urgent Care Claims: As soon as possible, taking into account the medical exigencies, but not later than 36 hours after receipt of the appeal.
- Pre-service Non-urgent Care Claims: Within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after receipt of the appeal;
- Post-service Claims: Within a reasonable period of time, but not later than 30 days after receipt of the appeal.
- Calculating Time Periods: The period of time within which the Plan's determination is required to be made shall begin at the time an appeal is filed in accordance with the procedures of this Plan, without regard

to whether all information necessary to make the determination accompanies the filing.

Manner and Content of Notification of Adverse Benefit Determination on First Appeal: The Claims Administrator shall provide a claimant with notification, with respect to Pre-service Urgent Care Claims, by telephone, facsimile or similar method, and with respect to all other types of claims, in writing or electronically, of a Plan's adverse benefit determination on review, setting forth:

1. The specific reason or reasons for the denial;
2. Reference to the specific portion(s) of the Benefit Plan Document upon which the claim is based and Summary Plan Description on which the denial is based;
3. The identity of any medical or vocational experts consulted in connection with the claim, even if the Plan did not rely upon their advice;
4. 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;
5. If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge to the claimant upon request;
6. If the adverse benefit determination is based upon a medical judgment, a statement that an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances, will be provided free of charge upon request;
7. A description of any additional information necessary for the claimant to perfect the claim and an explanation of why such information is necessary;
8. A description of the Plan's review procedures and the time limits applicable to the procedures;
9. For Pre-service Urgent Care Claims, a description of the expedited review process applicable to such claims;
10. A statement of the claimant's right to bring an action under section 502(a) of ERISA, following an adverse benefit determination on final review; and

11. The following statement: "You and your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your state insurance regulatory agency."

Furnishing Documents in the Event of an Adverse Determination: In the case of an adverse benefit determination on review, the Claims Administrator shall provide such access to, and copies of, documents, records, and other information described in items 3 through 7 of the section relating to "Manner and Content of Notification of Adverse Benefit Determination on First Appeal" as appropriate.

Timing of Notification of Benefit Determination on Second Appeal: The Plan Administrator shall notify the claimant of the Plan's benefit determination on review within the following timeframes:

- Pre-service Urgent Care Claims: As soon as possible, taking into account the medical exigencies, but not later than 36 hours after receipt of the second appeal.
- Pre-service Non-urgent care Claims: Within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after receipt of the second appeal.
- Post-service Claims: Within a reasonable period but not later than 30 days after receipt of the second appeal.
- Calculating Time Periods. The period of time within which the Plan's determination is required to be made shall begin at the time the second appeal is filed in accordance with the procedures of this Plan, without regard to whether all information necessary to make the determination accompanies the filing.

Manner and Content of Notification of Adverse Benefit Determination on Second Appeal: The same information must be included in the Plan's response to a second appeal, except for (i) a description of any additional information necessary for the claimant to perfect the claim and an explanation of why such information is needed; (ii) a description of the Plan's review procedures and the time limitations applicable to the procedures; and (iii) for Pre-service Urgent Care Claims, a description of the expedited review process applicable to such claim. See the section entitled "Manner and Content of Notification of Adverse Benefit Determination on First Appeal."

Furnishing Documents in the Event of an Adverse Determination: In the case of an adverse benefit determination on the second appeal, the Plan Administrator shall provide such access to, and copies of, documents,

records, and other information described in items 3 through 7 of the section relating to "Manner and Content of Notification of Adverse Benefit Determination on First Appeal" as is appropriate.

Decision on Second Appeal to be Final: If, for any reason, the claimant does not receive a written response to the appeal within the appropriate time period set forth above, the claimant may assume that the appeal has been denied. The decision by the Plan Administrator or other appropriate Named Fiduciary of the Plan on review will be final, binding and conclusive and will be afforded the maximum deference permitted by law.

Note: **All claim review procedures provided for in the Plan must be exhausted before any legal action is brought. Any legal action for the recovery of any benefits must be commenced within one year after the Plan's claim review procedures have been exhausted.**

Appointment of Authorized Representative: A claimant is permitted to appoint an authorized representative to act on his or her behalf with respect to a benefit claim or appeal of a denial. An assignment of benefits by a claimant to a provider will not constitute appointment of that provider as an authorized representative. To appoint such a representative, the claimant must complete a form which can be obtained from the Plan Administrator or the Claims Administrator. However, in connection with a claim involving Urgent Care, the Plan will permit a health care professional with knowledge of the claimant's medical condition to act as the claimant's authorized representative without completion of this form. In the event a claimant designates an authorized representative, all future communications from the Plan will be with the representative, rather than the claimant, unless the claimant directs the Plan Administrator, in writing, to the contrary.

GENERAL BENEFIT PLAN PROCEDURES AND DEFINITIONS

This Section describes general Benefit Plan rules, procedures and definitions that might apply to the processing of your claim for benefits. Contact the Administration Office if you have a question about whether any of these provisions apply to your claims.

Alternate Benefits
Alternate benefits means payment for those services or supplies which are not otherwise Covered Expenses of the Plan, but that the Claims Administrator believes to be Medically Necessary and cost-effective. If payment for alternate benefits is approved by the Claims Administrator, the Claimant will be notified of such approval and the duration of such approval.

The fact that alternate benefits are paid by the Plan shall not obligate the Plan to pay such benefits for other Claimants, nor shall it obligate the Plan to pay continued or additional alternate benefits for the same Claimants. Payments for alternate benefits are Covered Expenses for all purposes under the Plan.

Examination
If necessary to assist in making a benefit determination, the Plan may request that the Claimant be examined by a doctor selected and paid for by the Plan. If the Claimant chooses not to comply with this request, benefits will be denied.

Rights of Recovery
Whenever payments have been made by the Trust with respect to Covered Expenses in excess of the maximum amount of payment necessary to satisfy the intent of this Plan, the Plan Administrator shall have the right, exercisable alone and in its sole discretion, to recover such excess payments.

Time Limitation
If any time limitation of the Plan with respect to giving notice of claim or furnishing proof of loss, or the bringing of an action at law or in equity, is less than that permitted by the law of the State of Washington or ERISA, such limitation is hereby extended to agree with the minimum period permitted by such law.

Free Choice of Provider
The Covered Person shall have free choice of any legally qualified Physician or surgeon and the Physician-patient relationship shall be maintained.

Worker's Compensation Not Affected
This Plan does not affect any requirements for and is not in lieu of coverage provided by Worker's Compensation Insurance.

Disputed Workers' Compensation Claims
The Plan does not provide benefits for expenses incurred in connection with accidental bodily injury or illness arising out of or in the course of employment, or which are compensable under any workers' compensation or occupational disease act or law. If a dispute arises concerning whether an injury or illness is work-related, and the covered person appeals the denial of the claim by a state or federal workers' compensation agency or insurer, the Plan may advance payment of benefits pending resolution of the appeal, provided the covered person submits documentation indicating the basis for denial of the claim and signs and returns an agreement to reimburse the Plan 100% of the amount of such benefits, or the amount recovered is less, upon recovery on the workers' compensation claim. Reimbursement is required regardless of whether recovery is through acceptance of the claim, award, settlement, or disputed claim settlement, or any other method of recovery, and regardless of whether the covered person is made whole by the recovery. The amount to be reimbursed to the Plan shall not be reduced for attorney fees or costs incurred by the covered person. The covered person shall do nothing to prejudice the Plan's right to reimbursement and the Plan may offset future benefit payments, including those of family members, by denying such payments until the benefits provided under this provision have been repaid. Following recovery on the workers compensation claims, no further benefits will be provided related to the injury or illness.

Conformity With Law
If any provision of this Plan is contrary to any law to which it is subject, such provision is hereby deemed amended to conform to the minimum requirements thereto.

Statements
In the absence of fraud, all statements made by a Claimant will be deemed representations and not warranties. No such representations will void the Plan benefits or be used in defense to a claim hereunder unless a copy of

the instrument containing such representation is or has been furnished to such Covered Person.

Pre-Adoption Health Coverage
A child under the age of eighteen (18) is eligible for coverage from the time the child is placed for adoption in the home of a Participant, and shall be treated in the same manner as a natural child of a Participant, even if the adoption has not become final.

The Plan will provide a certificate of Creditable Coverage to Participants and dependents covered under the Plan as required by HIPAA.

Miscellaneous
Section titles in this booklet and all other Plan booklets are for convenience of reference only, and are not to be considered in interpreting this Plan. The Board of Trustees retains the right and authority to interpret and apply all rules and terms of the Plan documents.

No failure to enforce any provision of this Plan shall affect the right thereafter to enforce such provision, nor shall such failure affect its right to enforce any other provision of the Plan.

Third Party Recovery, Subrogation And Reimbursement

Benefits Subject to This Provision
This provision shall apply to all benefits provided under any section of this Plan.

When This Provision Applies
A Claimant may incur medical or other charges related to Injuries or Illness caused by the act or omission of another person; or Another Party may be liable or legally responsible for payment of charges incurred in connection with the Injuries or Illness. If so, the Claimant may have a claim against that other person or Another Party for payment of the medical or other charges. In that event, the Plan will be secondary, not primary, and the Plan will be Subrogated to all rights the Claimant may have against that other person or Another Party and will be entitled to Reimbursement. In addition, the Plan shall have the first lien against any Recovery to the extent of benefits paid or to be paid and expenses incurred by the Plan in enforcing this provision. The Plan's first lien supersedes any right that the Claimant may have to be "made whole." The Plan expressly rejects the "make-whole" doctrine, also known as the "double-recovery" rule, as well as any similar Washington law or doctrine, such as *Thiringer v. American Motors Insurance Co.*, that purports to compel the Plan to proportionally or otherwise reduce its claim for Reimbursement based on the allocation of the Recovery to cover the Claimant's various general and

specific damages, including medical expenses. **In other words, the Plan is entitled to Reimbursement out of any Recovery the Claimant obtains or may be entitled to obtain prior to and regardless of whether the Claimant has received compensation for any of his or her damages or expenses, including any of his or her attorneys' fees or costs.** Additionally, the Plan's right of first Reimbursement will not be reduced for any reason, including attorneys' fees, costs, comparative negligence, limits of collectability or responsibility, or otherwise. The Plan expressly rejects the "common-fund" doctrine as well as any similar Washington law or doctrine, such as *Mahler v. Szucs*, that purports to compel the Plan to pay some or all of Claimant's attorneys' fees and costs or otherwise reduce its claim for Reimbursement. As a condition to receiving benefits under the Plan, the Claimant agrees that acceptance of benefits is constructive notice of this provision. Unless previously authorized in writing, the Plan and/or the Trust Fund does not retain the participant's attorney or otherwise authorize legal representation by any attorney not specifically retained by the Plan and/or Trust Fund.

In order to proceed with payment of benefits the Claimant must:

1. Execute and deliver a Subrogation and Reimbursement Agreement;
2. Authorize the Plan to sue, compromise and settle in the Claimant's name to the extent of the amount of medical or other benefits paid for the Injuries or Illness under the Plan and the expenses incurred by the Plan in collecting this amount, and assign to the Plan the Claimant's rights to Recovery when this provision applies;
3. Immediately Reimburse the Plan, out of any Recovery made from Another Party, 100% of the amount of medical or other benefits paid for the Injuries or Illness under the Plan and expenses (including attorneys' fees and costs of suit, regardless of an action's outcome) incurred by the Plan in collecting this amount (without reduction for attorneys' fees, costs, comparative negligence, limits of collectability or responsibility, or otherwise);
4. Notify the Plan in writing of any proposed settlement and obtain the Plan's written consent before signing any release or agreeing to any settlement; and
5. Cooperate fully with the Plan in its exercise of its rights under this provision, do nothing that would interfere with or diminish those rights and furnish any information required by the Plan.

When a right of recovery exists, and as a condition to any payment by the Plan (including payment of future benefits for other Illnesses or Injuries), the Claimant will execute and deliver all required instruments and papers, including a Subrogation and Reimbursement

Agreement provided by the Plan, as well as doing and providing whatever else is needed, to secure the Plan's rights of Subrogation and Reimbursement, before any medical or other benefits will be paid by the Plan for the Injuries or Illness. If the Plan pays any medical or other benefits for the injuries or illness before these papers are signed, the Plan still will be entitled to Subrogation and Reimbursement. In addition, the Claimant will do nothing to prejudice the Plan's right to Subrogation and Reimbursement and acknowledges that the Plan precludes operation of the made-whole and common-fund doctrines.

The Claims Administrator has maximum discretion to interpret the terms of this provision and to make changes as it deems necessary.

Amount Subject to Subrogation or Reimbursement

Any amounts recovered from any source will be subject to Subrogation or Reimbursement. In no case will the amount subject to Subrogation or Reimbursement exceed the amount of medical or other benefits paid for the Injuries or Illness under the Plan and the expenses incurred by the Plan in collecting this amount. The Plan has a right to recover in full, without reduction for attorneys' fees, costs, comparative negligence, limits of collectability or responsibility, or otherwise, even if the Claimant does not receive full compensation for all of his charges and expenses.

The following Definitions apply to benefits under this section: "Another Party" shall mean any individual or organization, other than the Plan, who is liable or legally responsible to pay expenses, compensation or damages in connection with a Claimant's Injuries or Illness. "Another Party" shall include the party or parties who caused the Injuries or Illness; the insurer, guarantor or other indemnifier of the party or parties who caused the Injuries or Illness; a Claimant's own insurer, such as uninsured, underinsured, medical payments, no-fault, homeowner's, renter's or any other liability insurer; a workers' compensation insurer and any other individual or organization that is liable or legally responsible for payment in connection with the Injuries or Illness.

"Recovery" shall mean any and all monies paid to the Claimant by way of judgment, settlement or otherwise (no matter how those monies may be characterized, designated or allocated) to compensate for any losses caused by, or in connection with, the Injuries or Illness. Any Recovery shall be deemed to apply, first, for Reimbursement.

"Subrogation" shall mean the Plan's right to pursue the Claimant's claims for medical or other charges paid by the Plan against Another Party.

"Reimbursement" shall mean repayment to the Plan for medical or other benefits that it has paid toward care and treatment of the Injury or Illness and for the expenses incurred by the Plan in collecting this benefit amount.

When a Claimant Retains an Attorney
If the Claimant retains an attorney, that attorney must sign the Subrogation and Reimbursement Agreement as a condition to any payment of benefits and as a condition to any payment of future benefits for other Illnesses or Injuries. Additionally, the Claimant's attorney must recognize and consent to the legal conclusion that the Plan precludes the operation of the "made-whole" and "common fund" doctrines. The attorney must further agree not to assert either doctrine in his pursuit of Recovery. The Plan will neither pay the Claimant's attorneys' fees and costs associated with the recovery of funds, nor reduce its reimbursement pro rata for the payment of the Claimant's attorneys' fees and costs. Attorneys' fees will be payable from the Recovery only after the Plan has received full Reimbursement.

A Claimant or his attorney who receives any Recovery (whether by judgment, settlement, compromise, or otherwise) has an absolute obligation to immediately tender the Recovery to the Plan under the terms of this provision. A Claimant or his attorney who receives any such Recovery and does not immediately tender the Recovery to the Plan will be deemed to hold the Recovery in constructive trust for the Plan, because the Claimant or his attorney is not the rightful owner of the Recovery and should not be in possession of the Recovery until the Plan has been fully reimbursed.

When the Claimant is a Minor or is Deceased
These provisions apply to the parents, trustee, guardian or other representative of a minor Claimant and to the heir or personal representative of the estate of a deceased Claimant, regardless of applicable law and whether or not the minor's representative has access or control of the Recovery.

When a Claimant Does Not Comply
When a Claimant does not comply with the provisions of this section, the Plan Administrator shall have the authority, in its sole discretion, to deny payment of any claims for benefits by the Claimant and to deny or reduce future benefits payable (including payment of future benefits for other Injuries or Illnesses) under the Plan by the amount due as Reimbursement to the Plan. The Plan Administrator may also, in its sole discretion, deny or reduce future benefits (including future benefits for other Injuries or Illnesses) under any other group benefits plan maintained by the Plan Sponsor. The reductions will equal the amount of the required Reimbursement. If the Plan must bring an action against a Claimant to enforce this provision, then that Claimant agrees to pay the Plan's attorneys' fees and costs, regardless of the action's outcome.

Right To Receive And Release Necessary Information

For the purposes of determining the applicability of and implementing the terms of this provision of this Plan or any provision of similar purpose of any other plan, the Plan may, without the consent of or notice to any person, release to or obtain from any insurance company or other organization or person any information, with respect to any person, which the Plan deems to be necessary for such purposes. Any person claiming benefits under this Plan shall furnish to the Plan such information as may be necessary to implement this provision

SUMMARY PLAN DESCRIPTION

ERISA requires that the following Summary Plan Description and information be furnished to each eligible Participant in an employee benefit plan.

1. **Name of Plan:** Northwest Roofers and Employers Health and Security Trust Fund.

2. **Employer Identification Number (EIN) Assigned by the Internal Revenue Service:** 91-6030802

3. **Plan Number:** 501

4. **Type of Plan:** Welfare benefit plan which provides medical benefits, vision benefits, accidental death and dismemberment, short term disability and life insurance and dependent life insurance and dental benefits.

5. **Type of Administration:** This Plan is administered by the Board of Trustees, with the assistance of Welfare & Pension Administration Service, Inc., a contract administration organization. The funding for the benefits is derived from the funds of the Trust and contributions from Employers and contributions made by covered employees, if any. The Plan is fully insured.

6. **Name, Business Address and Telephone Number of the Plan Sponsor:**
   Board of Trustees
   Northwest Roofers and Employers
   Health and Security Trust Fund
   Physical Address:
   7525 SE 24th St, Suite 200
   Mercer Island, WA 98040

   Mailing Address:
   P.O. Box 34203
   Seattle, WA 98124-1203
   (206) 441-7574
   (800) 331-6158

7. **Name, Business Address And Telephone Number Of The Plan Administrator (Named Fiduciary):**
   Board of Trustees
   Northwest Roofers and Employers Health and Security Trust Fund
   c/o Welfare & Pension Administration Service, Inc.

Physical Address:
7525 SE 24th St, Suite 200
Mercer Island, WA 98040

Mailing Address:
P.O. Box 34203
Seattle, WA 98124-1203
(206) 441-7574
(800) 331-6158

8. **Name and Address for Service of Legal Process:** Each member of the Board of Trustees and Welfare & Pension Administration Service, Inc. is an agent for purposes of accepting service of legal process on behalf of the Trust. The names and addresses of the Trustees are set forth in item #10 below. The address of Welfare & Pension Administration Service, Inc., is set forth in item #7 above.

9. **Name, Business Address and Telephone Number of the Claims Administrator:**
Board of Trustees
Northwest Roofers and Employers Health and Security Trust Fund
c/o Welfare & Pension Administration Service, Inc.

Physical Address:
7525 SE 24th St, Suite 200
Mercer Island, WA 98040

Mailing Address:
P.O. Box 34498
Seattle, WA 98124-1498
(206) 441-7574
(800) 331-6158

10. **Name, Address and Telephone Number of Trustees:**

Employer Trustees
Donald Bosnick
2915 68th Ave. W.
Tacoma, WA 98466

Robert Starkey
Krueger Sheet Metal Company
731 N. Superior St.
Spokane, WA 99202

Union Trustees
Steve Hurley
Roofers Local Union No. 54
2800 1st Ave., Room 105
Seattle, WA 98121

Bret Purkett
Roofers Local Union No. 200
915 Berryman Road
Pocatello, ID 83201

Employer Trustees
Monty Moore
Pacific Rainier Roofing
18012 Bothell Everett Hwy,
Ste. 6
Bothell, WA 98012

Union Trustees
Leo Marsura
Roofers Local Union No. 189
315 W. Mission Ave., Ste. 24
Spokane, WA 99201

Richard Geyer
Roofers Local Union No. 153
3049 S. 36th St., Room 223B
Tacoma, WA 98409-5701

11. Description of Collective Bargaining Agreement:

This Plan is maintained pursuant to various collective bargaining agreements. Copies 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 Administration Office and at local union offices, upon ten days advance written request. The Trustees may impose a reasonable charge to cover the cost of furnishing the agreement. Participants and beneficiaries may wish to inquire as to the amount of the charge before requesting copies.

12. Participation, Eligibility, and Benefits:

Employees are entitled to participate in this Plan if they work under the collective bargaining agreement described in item #11 above and if their Employer contributes to the Trust on their behalf. Also, certain non-bargaining unit Participants are entitled to participate pursuant to special agreements between their Employers and the Board of Trustees. There is no age or years of service requirement for this participation.

13. Circumstances Which May Result in Ineligibility or Denial of Benefits:

A Participant or beneficiary who is eligible for benefits may become ineligible as a result of one or more of the following circumstances:

a. The Participant's failure to work the required hours to maintain eligibility (or failure to make a self-payment where authorized).

b. The failure of the Participant's Employer to report the hours and remit contributions on his or her behalf to the Trust.

c. Beneficiaries who are dependents of an eligible Participant may become ineligible if (a) they are no longer dependents or (b) they have attained the disqualifying age.

A Participant or beneficiary who is eligible may nonetheless be denied benefits as a result of one or more of the following circumstances:

a. The failure of the Participant or beneficiary to file a claim for benefits within 12 months of the date the expenses were incurred.

b. The failure of the Participant or beneficiary to file a complete and truthful benefit application.

c. The failure of the Participant or beneficiary to incur the deductible amount or copayment amount. Expenses may not be paid if they fall under Plan limitations and exclusions.

d. Where the Participant or beneficiary has other insurance coverage, it is possible that benefits payable under this Plan may be reduced or denied due to coordination of benefits with other group plans.

e. If a Participant or beneficiary is injured and another party is at fault, the other party or the other party's insurance company should pay the doctor and hospital bills.

14. Source of Contributions:

This Plan is funded through Employer contributions and contributions made by covered Participants, if any, the amount of which is specified in the underlying collective bargaining agreements. Self-payment of contributions is permitted is certain circumstances.

15. Entities Used for Accumulation of Assets and Payment of Benefits:

The Employer contributions and the Participant contributions are received and held in trust by the Board of Trustees pending the payment of benefit claims, insurance premiums and administrative expenses.

16. Date Fiscal Year Ends:

The fiscal year for this plan ends, each year, on March 31.

17. Procedures to be Followed in Presenting Claims for Benefits and Remedies Available for Redress of Claims Which are Denied:

Full and Fair Review of All Claims: In cases where a claim for benefits is denied, in whole or in part, and the claimant believes the claim has been denied wrongly, the claimant may appeal the denial and review pertinent documents. The claims procedures of this Plan provide a claimant with a reasonable opportunity for a full and fair review of a claim and adverse benefit determination. More specifically, the Plan provides:

(a) Claimants at least 180 days following receipt of a notification of an initial adverse benefit determination within which to appeal the

determination and 60 days to appeal a second adverse benefit determination;

(b) Claimants the opportunity to submit written comments, documents, records, and other information relating to the claim for benefits;

(c) For a review that does not afford deference to the previous adverse benefit determination and that is conducted by an appropriate Named Fiduciary of the Plan, who shall be neither the individual who made the adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual;

(d) For a review that takes into account all comments, documents, records, and other information submitted by the claimant relating to the claim, without regard to whether such information was submitted or considered in any prior benefit determination;

(e) That, in deciding an appeal of any adverse benefit determination that is based in whole or in part upon a medical judgment, the Plan fiduciary shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment, who is neither an individual who was consulted in connection with the adverse benefit determination that is the subject of the appeal, nor the subordinate of any such individual;

(f) For the identification of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a claim, even if the Plan did not rely upon their advice;

(g) That a claimant will be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits in possession of the Plan Administrator or the Claims Administrator, information regarding any voluntary appeals procedures offered by the Plan; any internal rule, guideline, protocol or other similar criterion relied upon in making the adverse determination; and an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances; and

(h) In an Urgent Care Claim, for an expedited review process pursuant to which:

- A request for an expedited appeal of an adverse benefit determination may be submitted orally or in writing by the claimant; and

- All necessary information, including the Plan's benefit determination on review, shall be transmitted between the Plan and the claimant by telephone, facsimile, or other available similarly expeditious method.

First Appeal Level

Requirements for First Appeal
The claimant must file the first appeal in writing (although oral appeals are permitted for Pre-service Urgent Care Claims) within 180 days following receipt of the notice of an adverse benefit determination. For Pre-service Urgent Care Claims, if the claimant chooses to orally appeal, the claimant may telephone the Claims Administrator as identified in #9 above.

Second Appeal Level

Adverse Decision on First Appeal; Requirements for Second Appeal
Upon receipt of notice of the Plan's adverse decision regarding the first appeal, the claimant has 60 days to file a second appeal of the denial of benefits. The claimant again is entitled to a "full and fair review" of any denial made at the first appeal, which means the claimant has the same rights during the second appeal as he or she had during the first appeal. As with the first appeal, the claimant's second appeal must be in writing (although oral appeals are permitted for Pre-service Urgent Care Claims) and must include all of the items set forth in the section entitled "Requirements for First Appeal."

Statement Of ERISA Rights

As a Participant in the Plan, you are entitled to certain rights and protections Under ERISA. ERISA provides that all Plan Participants are entitled to:

Receive Information About Your Plan and Benefits
Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls (if any), all documents governing the Plan, including insurance contracts, collective bargaining agreements (if any), and copies of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Pension and Welfare Benefit Administration.

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements (if any), 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 Plan Document 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 your group health plan, if you have Creditable Coverage from another plan. You should be provided a Certificate of Coverage, free of charge, from your group health plan 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 (if any), or any other person may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

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

Under ERISA, there are steps you can take to 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 Plan Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a Medical Child Support Order, you may file suit in Federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who would 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 Administration, you should contact the nearest Office of the Pension and Welfare Benefits Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C., 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Pension and Welfare Benefits Administration.

All questions with respect to Plan participation, eligibility for benefits, or with respect to any matter of Trust or Plan administration, should be referred to the Plan's Administration Office:

Welfare & Pension Administration Service, Inc.
P.O. Box 34203
Seattle, WA 98124-1203

The only party authorized by the Board of Trustees to answer questions concerning the Trust and Plan is the Administration Office. No participating Employer, employer association, or labor organization, nor any individual employed thereby, has any authority in this regard. Notwithstanding any other provision in this Plan, the Trustees reserve the right to change the Plan to improve or reduce benefits as conditions may require.