WASHINGTON STATE COUNCIL OF COUNTY AND CITY EMPLOYEES AFSCME AFL-CIO

DENTAL PLAN GUIDE

JANUARY 12, 2023

www.council2trust.com

Table of Contents

The key sections of Your booklet appear in the following order.

Trust Website – www.council2trust.com

The Washington State Council of County and City Employees Health and Welfare Trust has established a website to provide You with immediate access to Your Plan information. The site, located at **www.council2trust.com**, includes the following Trust related material:

- Plan Information – Brochures, Forms, and Plan Details
- Links to Health Plan Provider Networks and Other Useful Sites
- HIPAA Information
- Contact Information

This site will also provide a link to "Member Login" information, which is viewed through a secure location requiring the entry of a personal identification number (PIN) and Your social security. An employee PIN has been assigned and enclosed with this notice. For security purposes You *may not* choose Your own PIN. "Member Login" information includes the following data:

- Personal Information – name, address, gender, birth date, marital status, etc.
- Dependent Information
- Dental Claims Summary and Paid Claims Detail

Employees' will only have access to their own personal paid claims history and that of dependents under the age of 13. Spouses and dependent children age 13 and over must request their own PIN. To request dependent PIN, go to the website **www.council2trust.com** and download a Dependent Only PIN form.

The Trustees of the Washington State Council of County and City Employees Health and Welfare Trust are providing this Dental Plan on a self-insured basis. Administrative services for the Plan will be provided through the Plan Administrator, Welfare & Pension Administration Service, Inc (hereafter referred to as WPAS).

DEFINITIONS

When used in the Plan or any Amendment:

Amendment means a provision added to the Plan to expand or limit benefits or coverage.

COBRA means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

Covered Person means You and/or Your dependents that are eligible under the Plan.

Dentist means a person who:

(a) is licensed to practice in the state where the dental procedure is performed;
(b) is operating within the scope of the license; and
(c) performs a service which is payable under the Plan.

Where required to cover by law, Dentist means any other licensed practitioner who:

(a) is acting within the scope of his or her license; and
(b) performs a service which is payable under the Plan when performed by a Dentist.

A Dentist does not include a person who lives with You in Your home or is part of Your family (You; Your spouse; or a child, brother, sister or parent of You or Your spouse).

Expense means the amount incurred for a covered service or supply which has been ordered or prescribed by a Dentist. Expense is considered incurred on the date the service or supply is received. Expense **does not include** any charge:

(a) for a service or supply which is not a Necessary Service or

Supply; or

(b) which is in excess of the Usual, Customary, and Reasonable Charge for a service or supply and exceeds the maximum for that service in the List of Dental Services and provided the service is not listed under the General Exclusions and Limitations.

Experimental or Investigational Treatment means a service or supply is considered experimental or investigational if any of these conditions is present:

(a) The service or supply is described as an alternative to more conventional therapies in written documents by the provider that performs the services;

(b) The service or supply may be given only with approval of an Institutional Review Board as defined by federal law;

(c) There is an absence of authoritative dental, medical, or scientific literature on the subject, or that literature indicates the service or supply is experimental or investigational or that more research is needed;

(d) The Food and Drug Administration (FDA) has not approved marketing of the service or supply or has it under consideration; or

(e) The service or supply is available only through clinical trials sponsored by the FDA, the National Cancer Institute or the National Institutes of Health.

The Board of Trustees has the discretion and authority to determine if a service or supply is or should be considered experimental or investigational. That determination is based on the information and resources available when the service is performed or the supply is provided.

Health Coverage means hospital, surgical, medical, dental, vision or prescription drug coverage provided under the Plan. Health Coverage is subject to change as a result of open enrollments or Plan modifications.

A **Necessary Service** or **Supply** means one which is ordered by a Dentist and which the Administrator, our dental staff, or a qualified party or entity selected by the Plan determines is:

(a) provided for the diagnosis or direct treatment of dental care;

(b) appropriate and consistent with the diagnosis and treatment;

(c) provided in accord with generally accepted dental practice on a national basis; and

(d) the most appropriate supply or level of service which can be provided on a cost effective basis.

The fact that the Dentist prescribes services or supplies does not automatically mean such services or supplies are a Necessary Service or Supply and covered by the Plan.

Placed for Adoption means assumption and retention by the Covered Person of a legal obligation for total or partial support of such child in anticipation of adoption of such child.

Prior Group Plan means the group plan providing similar benefits (whether insured or self-insured including HMOs and other prepayment plans provided by the Plan) in effect immediately prior to the effective date of this Plan.

Serious Health Condition is defined as stated in the FMLA.

Service in the Uniformed Services means 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.

Treatment Plan means the Dentist's report that itemizes the recommended services, shows the charge for each service and is accompanied by supporting X-rays or other diagnostic records where required or requested by the Administration Office.

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

USERRA means the Uniformed Services Employment and Reemployment Rights Act of 1994 (including any amendments to such Act and any interpretive regulations or rulings).

Usual, Customary, and Reasonable Charge (UCR) means the charge for a covered service or supply which is no higher than the 95th percentile of the most currently available prevailing health care charge data. When there is insufficient charge data available for a covered service or supply, the Usual, Customary, and Reasonable Charge will be based on values or amounts established by the Plan.

You, Your means an employee or member who is covered under the Plan.

EMPLOYEE ELIGIBILITY

Eligible Employees
If You are eligible to participate in this Plan under the terms of your collective bargaining agreement, You will become covered on the first day of the second month following the month in which the required contribution is due and paid. For example, contributions for work in January are paid in February and provide coverage in March. (Some employers have special one-month provisions).

When Your Coverage Begins
You will become covered on the day You become eligible.

Amount of Coverage
The amount of coverage for Your classification is shown in the Schedule.

Changes in Your Classification or in the Amount of Your Coverage
Any changes in Your classification or amount of Your coverage will take effect on the day of the change.

Your coverage will end at midnight on the earliest of:

(a) the day the Plan ends;
(b) the day any contribution for Your coverage required from You is due and unpaid; or
(c) the last day of the month following the month in which You are no longer eligible under the Plan.

DEPENDENT ELIGIBILITY

Eligible Dependents
An employee must be eligible for benefits to have their dependents covered. For all new dependents the employee must provide a copy of their marriage certificate for a spouse and birth certificate (parenting plan if divorced) for all dependent children. The coverage for their eligible dependents shall become effective on the latest of the following dates, provided the employee enrolls their dependent within 90 days of becoming eligible for benefits:

(a) On the date the employee's coverage becomes effective, or
(b) On the date the employee acquires an eligible dependent.

If you do not provide the required information within the 90-day period, you will not be allowed to enroll their dependents until the next open enrollment period.

Contact the Administration Office immediately for information on enrolling new dependents.

Only the following are eligible for dependents coverage:

(a) Your lawful spouse;
(b) Your state registered domestic partner (effective July 1, 2014, this will only apply if You or Your partner is age 62 or older);
(c) Your natural-born or legally adopted child up to age 26;
(d) Your stepchild up to age 26;
(e) Children of Your state registered domestic partner (if approved by the Trust);
(f) A foster child; up to age 26
(g) A handicapped child; and
(h) A child who You, Your spouse or domestic partner has legal guardianship or court order.

A **foster child** is:

(a) a child You are raising as Your own;
(b) a child who lives in Your home;
(c) a child who is chiefly dependent on You for support; and
(d) a child for whom You have taken full parental responsibility and control.

A **foster child** is not:

(a) a child temporarily living in Your home;
(b) a child placed with You in Your home by a social service agency which retains control of the child; or
(c) a child whose natural parent is in a position to exercise or share parental responsibility and control.

When Dependent Coverage Begins

Dependents coverage will begin the later of;

(a) the day You are eligible; or
(b) the day You first acquire an eligible dependent.

Once You have a dependent covered, any newly acquired eligible dependent will be covered automatically.

Exceptions

Newborn Children. Your newborn child, born while You are covered under the Plan, will automatically be covered, but coverage beyond 60 days for a newborn child will be continued only if any required contribution is paid.

Adopted Child As Federally Mandated
A minor child, under the age of 26, placed with You for the purpose of legal adoption will be covered from the moment the child is placed in Your custody.

Coverage for such child will not continue beyond 31 days of placement unless any required contribution has been paid to us before that 31st day. If covered, any Preexisting Conditions or Limitations shown in the Plan will not apply.

The child's coverage will continue, subject to any required contribution until the earlier of:

(a) the day the child is removed from Your custody prior to legal adoption; or
(b) the day coverage would otherwise end in accordance with the Plan provisions.

Coverage Under a Qualified Medical Child Support Order
If Your eligible child is not covered because You did not enroll Your child for dependents coverage, such child may be enrolled after the Plan:

(a) receives a final medical child support order which requires enrollment; and
(b) determines that the order is qualified.

"Qualified Medical Child Support Order" means any judgment, decree or order (including approval of a settlement agreement) issued by a court of competent jurisdiction which:

(a) either:
    (1) relates to dental benefits under the Plan and provides for Your child's support or health benefit coverage pursuant to a state domestic relations law (including a community property law); or
    (2) enforces a law relating to medical child support described in Section 1908 of the Social Security Act;
(b) creates or recognizes the existence of Your child's right to be enrolled and receive medical benefits under the Plan;
(c) states the name and last known mailing address (if any) for You and each child covered by the order;
(d) reasonably describes the type of dental coverage to be provided by the Plan to each child, or the manner in which this type of coverage is to be determined;
(e) states the period to which the order applies;
(f) states each Plan to which the order applies; and
(g) does not require the Plan to provide any type or form of benefit or any option not otherwise provided by the Plan, except to the extent necessary to meet the requirements of Section 1908 of the Social Security Act for medical child support orders.

Procedures for Determining if a Medical Child Support Order is Qualified. When the Plan receives a proposed or final medical child support order, the Plan will notify You and each child named in the order, at the addresses shown in the order, that the Plan has received it. The Plan will then review the order to decide if it meets the definition of a "Qualified Medical Child Support Order." Within 30 days after the Plan receives the order (or within a reasonable time thereafter), the Plan will give a written notice of its decision to You and each child named in the order. The Plan will also send notices to each attorney or other representative who may be named in the order or in other correspondence filed with the Plan.

If the Plan decides that the order is not qualified, the Plan notice will provide the specific reasons for its decision and the opportunity to correct the order or appeal our decision by contacting the Plan within 30 days.

If the Plan decides the order is qualified, the Plan's notice will provide instructions for enrolling each child named in the order; and the Plan provisions that apply for other eligible dependents (such as the exceptions for when dependents coverage begins and the rules for determining when dependents coverage ends) will also apply for each child named in the order. The Plan must receive a certified copy for the entire "Qualified Medical Child Support Order" before enrollment can occur. Also, if the cost of each child's coverage is to be deducted from Your pay, then You must receive proper authorization in the order or otherwise.

As part of the Trustees authority to interpret the Plan, the Plan has the discretion and final authority to decide if an order meets or does not meet the definition of a "Qualified Medical Child Support Order" so as to require the enrollment of Your child as an eligible dependent; and the Plan's reasonable decision will be binding and conclusive on all persons. If, as a result of an order, benefits are paid to reimburse dental expenses paid by a child or the child's custodial parent or legal guardian these benefits will be paid to the child, the child's custodial parent, or legal guardian.

Dependents Not Eligible

The following are not eligible for dependents coverage under a Qualified Medical Child Support Order:

(a) Your divorced spouse;
(b) A child who has been legally adopted by another person shall not be considered an eligible dependent (coverage ends on the date custody is assumed by the adoptive parents);

(c) Anyone eligible for coverage under the Plan as an employee or member (unless a Special Husband/Wife Provision is included in the Plan); or
(d) A child who has attained the limiting age (the limiting age is the last day of the month of the child's 26th birthday).

Change in the Amount of Dependents Coverage

Any increase or decrease in the coverage of a dependent will take effect on the day of the change.

Once You have a dependent covered, any newly acquired eligible dependent will be covered automatically.

When Dependents Coverage Ends

A dependent's coverage will end at midnight on the earliest of:
(a) the last day of the month the dependent is no longer eligible;
(b) the day any dependent contribution from You or the dependent is due and unpaid;
(c) the day the Plan ends**;**
(d) the day before a dependent enters the Armed Forces on active duty (except for temporary active duty of two weeks or less); or
(e) the day Your coverage ends.

Handicapped Child

Notwithstanding the above, coverage for a child with a disability, developmental disability, mental illness or mental retardation who is incapable of self-support may be continued after the limiting age and after age 26 without payment of any additional contribution if the child:
(a) is chiefly dependent on You or your spouse or domestic partner for support; and
(b) is not capable of self-sustaining employment.

The coverage will continue only if You give the Plan proof of the child's disability:
(a) no later than 31 days after the child attains the limiting age; and
(b) thereafter as the Plan may require, but not more often than once every year.

Note: Your covered spouse and/or any covered dependent children may also elect to continue Health Coverage when eligibility ends. See COBRA GROUP HEALTH INSURANCE CONTINUATION. In the event more than one continuation provision applies, the periods of continued coverage will run concurrently.

THE DEFINITIONS, GENERAL EXCLUSIONS AND LIMITATIONS ARE VERY IMPORTANT PARTS OF THE PLAN. PLEASE READ THOSE PAGES CAREFULLY.

FAMILY AND MEDICAL LEAVE
As Federally Mandated

Family and Medical Leave

If You become eligible for a family or medical leave of absence in accordance with the Family and Medical Leave Act of 1993 (FMLA) (including any amendments to such Act) Your coverage may be continued on the same basis as if You were actively at work for up to 12 weeks within a 12-month period if Your qualifying leave is for any of the following reasons:

(a) to care for Your child after the birth or placement of a child with You for adoption or foster care; so long as such leave is completed within 12 months after the birth or placement of the child;
(b) to care for Your spouse, child, foster child, adopted child, stepchild, or parent who has a Serious Health Condition; or
(c) for Your own Serious Health Condition.

In the event You or Your spouse are both covered as employees of the Plan, the continued coverage under (a) above may not exceed a combined total of 12 weeks. In addition, if the leave is taken to care for a parent with a Serious Health Condition, the continued coverage may not exceed a combined total of 12 weeks.

Conditions

1. If, on the day Your coverage is to begin, You are already on an FMLA leave of absence You will be considered actively at work. Coverage for You and any eligible dependents will begin in accordance with the terms of the Plan. However, if Your leave of absence is due to Your own or any eligible dependent's Serious Health Condition, benefits for that condition will not be payable to the extent benefits are payable under any Prior Group Plan.
2. You are eligible to continue coverage under FMLA if:
   (a) Your employer employs at least 50 employees within 75 miles from Your worksite;
   (b) You have worked for Your employer for at least one year;
   (c) You have worked at least 1,250 hours over the previous 12 months; and
   (d) You continue to pay any required contributions for Yourself and any eligible dependents in a manner determined by Your employer.
3. In the event You choose not to pay any required contributions during Your leave, Your coverage will not be continued during the leave. You will be able to reinstate Your coverage on the day You return to work, subject to any changes that may have

occurred in the Plan during the time You were not covered. You and any covered dependents will not be subject to any evidence of good health requirement provided under the Plan. Any partially-satisfied waiting periods, including any limitations for a preexisting condition, which are interrupted during the period of time contributions were not paid will continue to be applied once coverage is reinstated.

4. You and Your dependents are subject to all conditions and limitations of the Plan during Your leave, except that anything in conflict with the provisions of the FMLA will be construed in accordance with the FMLA.
5. If requested by the Plan, You or Your employer must submit proof acceptable to the Plan that Your leave is in accordance with FMLA.
6. This FMLA continuation is concurrent with any other continuation option except for COBRA, if applicable. You may be eligible to elect any COBRA continuation available under the Plan following the day Your FMLA continuation ends.
7. FMLA continuation ends on the earliest of:
   (a) the day You return to work;
   (b) the day You notify Your employer that You are not returning to work;
   (c) the day Your coverage would otherwise end under the Plan; or
   (d) the day coverage has been continued for 12 weeks.

Important Notice: Contact Your employer for additional information regarding FMLA.

COBRA GROUP HEALTH BENEFITS CONTINUATION
As Federally Mandated

To obtain COBRA continuation coverage a participant must have a qualifying event, make a timely election to continue coverage, and make timely self-payments. These terms are defined below. Employees and dependents that have the right to elect continuation coverage under COBRA may also be called “qualified beneficiaries.”

Health Coverage as used in this provision generally means the dental coverage You had on the day before the qualifying event. Health Coverage is subject to change as a result of open enrollments or Plan modifications.

Continuation of Group Health Benefits

1. **For You and Your Dependents – 18 Month Continuation Coverage**. You and/or any covered dependent may elect to continue Health Coverage for the maximum of 18 months from the day Your coverage ends because of these qualifying events:
   (a) Your employment terminates (other than due to gross misconduct); or
   (b) You no longer satisfy the requirements for hours worked.

If a Covered Person is determined, in accordance with Title II or XVI of the Social Security Act, to have been disabled at any time during the first 60 days of continued coverage, the disabled individual and all qualified beneficiaries may extend COBRA coverage an additional 11 months, to a maximum of 29 months. In order to qualify for this extension, the individual or qualified beneficiary must provide the Administration Office with proof of the Social Security disability determination within 60 days of their receipt of the determination, but no later than the date that the initial 18-month COBRA continuation period ends. Please see Part 3 of this section.

During the period You continue coverage on COBRA:

(a) any new eligible dependents You acquire may be added in accord with the Dependents Eligibility provisions; and
(b) any eligible dependents You declined to cover before Your continued Health Coverage began may be added during any open enrollment period provided by the Plan; provided any additional self-payment is paid. However, after a qualifying event, only qualified beneficiaries, are entitled to continue coverage.

Qualified Beneficiary means, with respect to a covered employee under a group health plan, any other individual who, on the day before the qualifying event for that employee, is a beneficiary under the Plan:

(a) as the spouse/domestic partner of the covered employee;
(b) as the dependent child of the employee; or
(c) a child who is born or is placed for adoption with the covered employee during the period of continued coverage

2. For Your Dependents Only – 36 Month Continuation Coverage. Your covered spouse/domestic partner and/or each of Your covered dependent children may elect to continue Health Coverage for as long as 36 months from the day coverage ends because of these qualifying events:

(a) You die;
(b) You become entitled to Medicare;
(c) You and Your spouse are legally separated;
(d) You and Your spouse are legally separated or divorced;

(e) Your child no longer meets the Plan's definition of an eligible dependent.

If Your dependent is already continuing coverage under Part 1 when an event shown in Part 2 occurs, that second event will not entitle Your dependent to continue coverage beyond 36 months under Parts 1 and 2 combined.

If Your dependent becomes entitled to continue Health Coverage under both Parts 1 and 2 on the same day, the periods of continued coverage will run concurrently and will not exceed 36 months.

3. **Notice Requirements**. Your employer is required by law to notify the Plan Administrator within 30 days after Your termination of employment, reduction in hours, or death. You must notify the Plan Administrator within 60 days after the day You are legally separated or divorced, or Your child ceases to be an eligible dependent. For any initial or second qualifying event, the employee or dependent must notify the Administration Office:
   (a) Within 60 days of a death, divorce, legal separation, or child losing dependent status prior to age 26;
   (b) Upon becoming covered under any other group health plan, including Medicare, after electing COBRA continuation coverage;
   (c) For a Social Security disability extension, within 60 days of Social Security determining an individual is disabled, but not later than the date the initial 18-month COBRA period ends; and
   (d) Within 30 days of Social Security determining an individual is no longer disabled.

4. **Election of COBRA Coverage**.
   Within 14 days after receiving notice of a qualifying event, the Plan Administrator will send You or Your dependent written notice of the continuation right. Upon receiving notification that a qualifying event may have occurred, the Administration Office will notify you, your lawful spouse and each of your covered dependents of their right to elect continuation coverage. The participants must then select continuation coverage by the later of:
   (a) 60 days after the participant's coverage ends; or
   (b) 60 days after the participant receives notification of the continuation rights from the Administration Office.

Failure to elect continuation coverage within this 60-day period will result in the loss of the right to elect COBRA continuation coverage.

5. **Continuous COBRA Coverage Required**.
Your coverage under COBRA must be continuous from the date Trust coverage would have ended if monthly self-payments were not made. You or Your dependent must pay the required self-payment amount, including any retroactive months. The initial self-payment amount must be paid to the Plan Administrator within 45 days after the day continued coverage is elected. The Plan Administrator will inform You or Your dependent of procedures for making monthly self-payments.

6. **Newly Acquired Dependents During COBRA Coverage**.
If You acquire an eligible dependent while eligible for COBRA continuation coverage You may elect to enroll the dependent for continuation coverage in accordance with the plan's normal enrollment rules. However, only child(ren) born to, adopted by or placed for adoption with You during the 18-month period of COBRA Continuation Coverage are qualified beneficiaries entitled to an extension of coverage as a result of a second qualifying event. Spouses and stepchildren acquired after a qualified event are not eligible for 36 months of coverage due to a second qualifying event.

7. **End of Continuation**. A Covered Person's continued Health Coverage will end at midnight on the earliest of:
   (a) 18 months from the date continuation began for individuals whose coverage ended because of a reduction of hours or termination of employment.
   (b) 29 months from the date continuation began if the individual was disabled as of the time their eligibility ended, or within 60 days thereafter, and they provide proof of the Social Security Administration's disability determination within both 60 days of their receipt of it and during the initial 18-month continuation period.
   (c) 36 months from the date continuation began for individuals whose coverage ended because of the death of the employee, divorce or legal separation from the employee, the dependent ceasing to meet the definition of an eligible dependent, or the employee's entitlement to Medicare. If an employee has an 18-month qualifying event after becoming entitled to Medicare, continuation coverage for dependents (lawful spouse or dependent child) will end on the later of 18 months from the date continuation began because of a reduction of hours or termination of employment, or 36 months from the date the employee becomes entitled to Medicare.

(d) End of any month for which the required premium for Your COBRA coverage is not paid within 30 days of the first of the month for which the payment applies. Checks returned for non-sufficient funds will be treated as failing to make a self-payment and if not reissued by the end of the coverage period, coverage will terminate.
(e) The date the individual becomes covered under any other group health plan (except to the extent the other group health plan limits benefits for preexisting conditions that affects the individual's coverage).
(f) The date the individual becomes entitled to Medicare.
(g) The date this plan ends.

8. **Other Continuation Provisions**. In the event Health Coverage is continued under any other continuation provision of the Plan, the periods of continued coverage will run concurrently. If another continuation provision provides a shorter continuation period for which contribution is paid in whole or in part by Your employer, then the self-payment You are required to pay may increase for the remainder of the 18-month, 29- month, or 36-month period provided above.

UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS

As Federally Mandated

If You leave covered employment to perform military service that is covered under the Uniformed Services Employment and Reemployment Rights Act (USERRA), You may elect to continue your dental coverage for You and Your dependents for up to 24 months. If Your military service lasts less than 31 days, coverage will be continued at no cost to you. If Your military service lasts more than 30 days, a monthly self-payment will be required at the rate established by the Trustees.

Under the Uniformed Services Employment and Reemployment Rights Act (USERRA), You must notify Your employer before taking leave unless prevented from doing so by military necessity or other reasonable cause. You should also tell your employer how long You expect to be gone. Upon release from military duty, You must return or apply to return to covered employment within the following time limits:

(a) Less than 31 days of military service – next calendar day following completion of service time plus time required for safe transportation to Your residence plus eight hours.
(b) 31-180 days of military service – within 14 days.

(c) More than 180 days of military service – within 90 days.

If You are hospitalized for or convalescing from an illness or injury that occurred during Your military service, the above deadlines are extended while You recover, but generally not longer than two years.

Note: These rules also apply to uniformed service in the commissioned corps of the Public Health Service.

To continue coverage, You or Your dependent must pay the required self- payment amount (including Your former employer's share and any retroactive contributions), unless Your Service in the Uniformed Service is for fewer than 31 days, in which event You must pay Your share, if any, of the contribution amount. The Plan Administrator will inform You or Your dependent of procedures to make self-payments.

End of Continuation. Your continued Health Coverage will end at midnight on the earliest of:

(a) the day Your former employer ceases to provide any group health plan to any employee;
(b) the day self-payment is due and unpaid;
(c) the day a Covered Person again becomes covered under the Plan;
(d) 24 months from the date Health Coverage has been continued (or any longer period provided in the Plan); or
(e) the day the Plan terminates.

Any Health Coverage for an eligible dependent will also end as provided in the "When Dependents Coverage Ends" provision of the Plan.

Other Continuation Provisions. In the event Health Coverage is continued under any other continuation provision of the Plan, the periods of continued coverage will run concurrently. If another continuation provision provides a shorter continuation period for which contributions are paid in whole or in part by Your employer, then the self-payment amount You are required to pay may increase for the remainder of the period provided above.

Reemployment (following service in the Uniformed Services)
Following Your discharge from such service, You may be eligible to apply for reemployment with Your former employer in accord with USERRA. Such reemployment includes Your right to elect reinstatement in any then-existing Health Coverage provided by Your employer.

Important Notice
In the event of a conflict between this provision and USERRA, the provisions of USERRA will apply.

DENTAL BENEFITS
For You and Your Dependents

Benefits
If You or Your dependent, while covered under this Plan, incurs Expense for Covered Services, the Plan will pay a percentage of UCR, not to exceed the Expense incurred, after any Deductible(s) are satisfied. The Plan will pay up to the Annual Maximum Benefit for each Covered Person. The **Deductible(s), Percentage(s) Payable** and **Annual Maximum Benefits** for the Class (Classes) of Services for which You or Your dependent are covered are shown in the Schedule. A charge will be considered to be incurred on the date the service is received.

Extension of Benefits
When coverage provided under this provision has ended with respect to a Covered Person, coverage will be extended for completion of services for which a course of treatment was started by a Dentist prior to the date coverage ended. In no event will the Plan be liable for such extended completion of work which takes place more than 30 days after coverage ends. This Extension of Benefits will operate only to the extent that coverage for the services is not otherwise provided for the Covered Person through the Plan.

Predetermination of Benefits
Recognizing that many dental problems can be solved in more than one way, the Plan may pay an amount equal to a generally accepted treatment method which, in its sole judgment, will provide adequate dental care at the lowest cost to the covered participant. In determining its liability the Plan will be guided by nationally established standards of the dental profession. Predetermination is encouraged, particularly if the course of treatment is expected to involve total dental charges of $400 or more. If You have any questions about the proposed treatment or Your share of the cost, have your dentist submit a written predetermination request to the Administration Office **before** the course of treatment is started. An explanation will be returned to You showing what will be paid by the Plan and what You must pay.

If predetermination of benefits is not requested, the Plan retains the right to pay the claim on the basis of the amount of benefits which would have been paid had predetermination been requested.

General Exclusions and Limitations

The Plan will not pay for any Expense or charge:

(a) which is in excess of UCR;

(b) for a service not provided by a Dentist, unless the service is performed by a Dental Hygienist or is an X-ray ordered by a Dentist;

(c) For surgical placement of implants or removal of implants or attachments to implants except as specifically provided.

(d) for a partial or full removable denture or fixed bridgework, or for the addition of teeth thereto, or for a crown or gold restoration, if it involves a replacement or modification of a denture, bridgework, crown or gold restoration which was installed during the immediately preceding five years;

(e) for a partial or full removable denture or fixed bridgework, if it involves replacement of one or more natural teeth which were missing prior to becoming covered under the Plan, unless proof that Your covered dependent had prior dental insurance is submitted and the tooth was extracted in the prior 12 months, or the denture or fixed bridgework includes replacement of a natural tooth which:

(1) is extracted while You or Your dependent is covered under the Plan; and

(2) was not an abutment to a denture or fixed bridge installed within the immediately preceding five years.

(f) for an appliance, or modification of an appliance, for which an impression was taken before You or Your dependent became covered;

(g) for a crown, bridge or gold restoration for which a tooth was prepared before You or Your dependent became covered under the Plan;

(h) for root canal therapy for which the pulp chamber was opened before You or Your dependent became covered under the Plan;

(i) for a dental procedure which is not considered a Medically Necessary Dental Procedure;

(j) for cosmetic or reconstructive purposes, unless necessary because of an accidental Injury sustained while covered under the Plan (facings on crowns or pontics, posterior to the second bicuspid are always considered as cosmetic);

(k) for replacement of lost or stolen appliances, restorations or procedures necessary to alter vertical dimensions or restore occlusion or for the purpose of splinting;

(l) for athletic mouthguards;

(m) for the preparation for, maintenance of, or placement or removal of dental implants;

(n) for hospitalization;

(o) for the treatment of craniomandibular or temporomandibular (TMJ) disorders;
(p) which results, whether the Covered Person is sane or insane, from an intentionally self-inflicted Injury or Sickness, unless the injury was the result of a documented medical condition
(q) resulting from the Covered Person's participation in a riot or in the commission of a felony;
(r) for services or supplies which are provided or paid for by the Federal government or its agencies, except for:
    (1) the Veterans Administration, when services are provided to a veteran for a disability which is not service-connected;
    (2) a military hospital or facility, when services are provided to a retiree (or dependent of a retiree) from the armed services;
    (3) a group plan established by government for its own civilian employees and their dependents; or
    (4) Medicaid, if required by a Medicaid assignment of benefits;
(s) which results from an act of declared or undeclared war or armed aggression; or which:
    (1) is incurred while the Covered Person is on active duty or training in the Armed Forces, National Guard or Reserves of any state or country; and
    (2) any governmental body or its agencies are liable.

LIST OF DENTAL SERVICES

Please refer to the Dental Benefit Summary for your Plan for a list of dental services covered by the Plan and the coverage amounts.

ORTHODONTIA

Definitions

Orthodontic Procedure means movement of teeth by means of active appliances to correct the position of maloccluded or malpositioned teeth.

Orthodontic Treatment Plan means a Dentist's report, on a form satisfactory to the Plan which:
(a) provides a classification of the malocclusion or malposition;
(b) recommends and describes necessary treatment by Orthodontic Procedures;
(c) estimates the duration over which treatment will be completed; and
(d) estimates the total charge for such treatment.

An Orthodontic Treatment Plan must be submitted for review prior to the initiation of services.

Exceptions

Benefits will not be payable for:

(a) any portion of charges for an Orthodontic Procedure that were payable by another Plan or policy in connection with an active appliance installed prior to the first day on which You or Your dependent became covered under this Plan will be deducted from this Plan's benefit maximums;
(b) orthodontia performed exclusively on primary teeth; or
(c) a charge incurred while coverage is not in effect.

COORDINATION OF BENEFITS (COB)

Definitions

Plan means any of the following coverages (including Plan coverage) which provide benefit payments or services to a Covered Person for dental:

(a) Group or blanket coverage (except student accident insurance);
(b) Group Blue Cross and/or Blue Shield and other prepayment coverage on a group basis, including HMOs (Health Maintenance Organizations);
(c) Coverage under a labor-management trusteed plan, a union welfare plan, an employer organization plan or an employee benefits plan; Coverage under government programs, other than Medicaid, and any other coverage required or provided by law;
(d) Group or individual automobile "no fault" coverage; or
(e) Other arrangements of insured or self-insured group coverage.

If any of the above coverages include group and group-type hospital indemnity coverage, Plan also means that amount of indemnity benefits which exceeds $200 a day.

Claimant means the Covered Person for whom the claim is made.

Claim Period means part or all of a calendar year during which the Claimant is covered under the Plan.

A **Covered Expense** means the Usual, Customary, and Reasonable Charge for any Medically Necessary health care service or supply which is covered at least in part by any of the Plans involved during a Claim Period. If a Plan provides benefits in the form of services or supplies rather than cash payments, the reasonable cash value of the service or supply during a Claim Period will also be considered a Covered Expense. The difference in cost of a private hospital room and the cost of a semiprivate room is not considered a covered Expense unless the Claimants stay in a private room is considered Medically Necessary by at least one of the Plans involved.

Coordination of Benefits (COB)

If the Claimant is covered by another Plan or Plans, the benefits under this Plan and the other Plan(s) will be coordinated. This means one Plan pays its full benefits first, and then the other Plan(s) pay(s).

1. The Primary Plan (which is the Plan that pays benefits first) pays the benefits that would be payable under its terms in the absence of this provision.
2. The Secondary Plan (which is the Plan that pays benefits after the Primary Plan) will limit the benefits it pays so that the sum of its benefit and all other benefits paid by the Primary Plan will not exceed 100% of the total Covered Expense exclusive of copayments, deductibles and other cost-sharing arrangements.

The Order of Benefit Determination paragraph below explains the order in which Plans must pay.

This COB provision will not apply to a claim when the Covered Expense for a Claim Period is $50 or less; but if:

(a) additional Expense is incurred during the Claim Period; and
(b) the total Covered Expense exceeds $50; then this COB provision will apply to the total amount of the claim.

Order of Benefit Determination

When another Plan **does not** have a COB provision, that Plan must determine benefits first.

When another Plan **does** have a COB provision, the first of the following rules which applies governs:

(a) If a Plan covers the Claimant as an employee, member or nondependent, then that Plan will pay its benefits first.
(b) If the Claimant is a dependent child whose parents are not divorced or separated, then the Plan of the parent whose birthday anniversary is earlier in the calendar year will pay first; except:
    (1) If both parents' birthdays are on the same day, rule (d) below will apply.
    (2) If another Plan does not include this COB rule based on the parents' birthdays, but instead has a rule based on the gender of the parent, then that Plan's COB rule will determine the order of benefits.
(c) If the Claimant is a dependent child whose parents are divorced or separated, then the following rules apply:
    (1) A Plan which covers a child as a dependent of a parent who by court decree must provide Health Coverage will pay first.
    (2) When there is no court decree which requires a parent to provide Health Coverage to a dependent child, the following rules will apply:

a. When the parent who has custody of the child has not remarried, that parent's Plan will pay first.
b. When the parent who has custody of the child has remarried, then benefits will be determined by that parent's Plan first, by the stepparent's Plan second, and by the Plan of the parent without custody third.

(d) If none of the above rules apply, the Plan which has covered the Claimant for the longer period of time will pay its benefits first; except when:
(1) one Plan covers the Claimant as a laid-off or retired employee (or a dependent of such an employee); and
(2) the other Plan includes this COB rule for laid-off or retired employees (or is issued in a state which requires this COB rule by law); then the Plan which covers the Claimant as other than a laid-off or retired employee (or a dependent of such an employee) will pay first. If part of a Plan coordinates benefits and a part does not, each part will be treated like a separate Plan.

Credit Savings
If the Plan does not have to pay its full benefits because of COB, the savings will be credited to the Claimant for the Claim Period. These savings would be applied to any unpaid Covered Expense during the Claim Period.

How COB Affects Plan Benefit Limits
If COB reduces the benefits payable under more than one Plan provision, each benefit will be reduced proportionately. Only the reduced amount will be charged against any benefit limit in those Plan provisions.

Right to Collect and Release Needed Information
To receive benefits, the Claimant must give the Plan any information which is needed to coordinate benefits. With the Claimant's consent, the Plan may release to, or collect from, any person or organization any needed information about the Claimant.

Facility of Payment
If benefits which this Plan should have paid are instead paid by another Plan, this Plan may reimburse the other Plan. Amounts reimbursed are Plan benefits and are treated like other Plan benefits in satisfying Plan liability.

Right of Recovery
If this Plan pays more for a Covered Expense than is required by this provision, the excess payment may be recovered from:

(a) the Claimant;
(b) any person to whom the payment was made; or
(c) any insurance company, service plan or any other organization which should have made payment.

Right to Reimbursement (Third Party Liability)

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

- By accepting or claiming benefits the Covered Person agrees that the Plan is entitled to reimbursement from any judgment, settlement, disputed claim settlement, or other recovery, up to the full amount of all benefits provided by the Plan (including the first $5,000 of such benefits), but not to exceed the amount of the recovery. The Plan is entitled to reimbursement, regardless of whether the Covered Person is made whole by the recovery, and regardless of the characterization of the recovery, except that the Plan will deduct reasonable attorney fees and a pro rata share of the costs from the reimbursement amount, if the Covered Person complies with the terms of the Plan and the agreement to reimburse.
- The Plan can require a Covered Person to execute and deliver instruments and papers, disclose the circumstances resulting from the injury or illness, and do whatever else is necessary to secure the Plan's right to reimbursement (including an assignment of rights). The Plan may require the Covered Person and the Covered Person's representative to sign an agreement to reimburse the Plan from the proceeds of any recovery before the Plan will advance any benefits.
- A Covered Person must do nothing after payment of benefits to prejudice the Plan's right of reimbursement.
- When any recovery is obtained from a third party or insurer, whether by direct payment, settlement, judgment, or any other way, an amount sufficient to satisfy the Plan's reimbursement amount must be paid by the Covered Person into an escrow or trust account and held there until the Plan's claim is resolved by mutual agreement, arbitration or court order. If the funds necessary to satisfy the Plan's reimbursement amount are not placed in an escrow or trust account, the Covered Person will be personally liable for any loss the Fund suffers as a result.
- The Plan may cease advancing benefits if there is a reasonable

basis to determine that the Covered Person will not honor the terms of the Plan or the agreement to reimburse, or the Board of Trustees modifies the Plan provisions related to the advancement of benefits.

- If the Plan is not reimbursed upon recovery on a third party claim, the Plan may bring an action against the Covered Person to enforce its right to reimbursement and/or the agreement to reimburse, or in the alternative may elect to recoup the reimbursement amount by offsetting future benefit payments of the Covered Person and the Covered Person's family members, or by recovery from the source to which benefits were paid.

After recovery on a third party claim, the Plan is relieved from any obligation to pay further benefits for the illness or injury up to the amount of the balance of the recovery.

Repayment of Improperly Paid Benefits

If the Plan mistakenly makes a payment for You or Your dependents to which they are not entitled, if the Plan pays an individual who is not eligible for benefits at all or if an eligible individual fails to observe the Plan's Third- Party Reimbursement provisions, the Plan has the right to recover the payment from the eligible individual paid or anyone else who benefited from it, including the individual or the provider of services. The Plan may also pursue recovery from any individual or entity responsible for providing misinformation to or failing to provide necessary information to the Plan that has resulted in the payment of improper benefits. The Plan's right of recovery includes the right to deduct the amount paid by mistake from future benefits payable to the affected eligible individual or any other individual where eligibility is established through the same eligible individual. The Plan may also recover benefits from the person responsible for misreporting any person for eligibility purposes.

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 if 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 claim, no further benefits will be provided related to the injury or illness.

NOTE: If a Claimant is covered under more than one Plan, it is recommended that the claim be submitted to all Plans at the same time. In that way, the proper coordinated benefits may be determined and paid most quickly.

PAYMENT OF CLAIMS

Predetermination of Benefits

The Dental Plan contains an optional Predetermination of Benefits procedure in order to remove any misunderstanding between You and Your Dentist on the benefits payable. Under this procedure, Your Dentist's proposed Treatment Plan should be submitted to the Administration Office PRIOR to the start of treatment. The Administration Office will review the Treatment Plan and return it to the Dentist showing estimated benefits. It is recommended that a Treatment Plan be submitted when the total charges exceed $400.00, other than for emergency care. Predetermination of Benefits is not a guarantee of payment. Benefits are subject to all Plan provisions and limitations.

Predetermination of Benefits permits the review of the proposed Treatment Plan in advance and allows for resolution of any questions before, rather than after, the work has been done. Additionally, both You and Your Dentist will know in advance what is covered and what the estimated benefits are. You must be eligible at the time services are actually incurred in order to receive benefits.

A regular claim form may be used for predetermination. Your Dentist should check the pretreatment estimate box and leave the "date service performed" area blank. Universal billing forms are also accepted.

If predetermination is used:

1. Your Dentist will determine what treatment should be given, will show the proposed course of treatment on the claim form and send the form to the Administration Office.

2. The Administration Office will return the form to the Dentist showing a predetermination of the covered benefit and Your portion of the fee.
3. At this point You will have the opportunity to review the Predetermination of Benefits with the Dentist and to decide whether any changes should be made in the Treatment Plan.
4. Your Dentist will proceed with the agreed-upon treatment and will submit the claim to the Administration Office when the work is completed.

NOTE: You must be eligible at the time services are incurred in order to receive benefits.

If predetermination is not used:

1. The Dentist will proceed with the treatment without first sending the claim form to the Administration Office.
2. When the work is completed, the Dentist will send the claim form to the Administration Office.

How to File Claims

The claim procedure is designed so that if the estimated charge is more than
$400 and predetermination is used, You and the Dentist will clearly understand what is covered, and what the estimated benefits are before the dental work is started. Another aspect of the procedure is that You may authorize direct payment to the Dentist. Please see the Predetermination of Benefits section above.

Before benefits are paid, the Plan must be given a written proof of claim/service, as described below. In the event of Your death or incapacity, Your beneficiary or someone else may give the Plan the proof.

Proof of Service Requirements

1. Before a visit to the Dentist, request a Dental Plan claim form from the Union Office or Plan Administrator. The Plan Administrator, WPAS, Inc. can be contacted at (206) 441-7574 or (800) 331-6158, option 0.
2. If emergency treatment is required and You cannot get a claim form in advance, obtain the form and give it to the Dentist as soon as You can.
3. Complete the upper part of the claim form (Part 1) and sign where shown.
4. Take the form to the Dentist on the first visit. The Dentist will perform the initial exam. This exam may include necessary X-rays. The Dentist will list on the form all procedures needed to complete

treatment, including the fee.

5. Before the treatment begins -- unless it is of an emergency nature or the cost of the treatment is less than $400.00 -- the Dentist must send the form to the Plan Administrator. The Plan Administrator will verify eligibility and determine the benefits for the procedure so You will know in advance what payment will be made under the Plan.
6. After the form is returned, the Dentist will contact You to arrange appointments for treatment.
7. Finally, return the claim form (with any bills) to the Plan Administrator at PO Box 34687 Seattle, WA 98124-1687. The claim form is due:
   (a) within 90 days after You receive the dental services; or
   (b) as soon as reasonably possible, but not later than one year after above, unless the Claimant is not legally capable. Claims, including receipt of requested information to decide the claim, must be submitted within one year from the service being incurred in order to be considered timely filed.

Direct Payments

Any benefits for dental services that have been assigned will be paid to the provider of the services. If benefits have not been assigned, the Plan, at its option, will pay You or the provider of the services. Any benefits not paid to the provider shall be paid to You, except that benefits unpaid at Your death may be paid, at the Plan's option, to:

(a) any relative who is determined to be entitled to the benefits; or
(b) Your estate.

If Your beneficiary is unable to give a valid release, or if benefits unpaid at Your death are not more than $1,000, the Plan may pay up to $1,000 to any relative of Yours who the Plan finds is entitled to the benefit.

Any payment made in good faith will fully discharge the Plan to the extent of the payment.

Dental Examinations

It is sometimes required that a Claimant be examined by a Dentist of the Plan's choice. The Plan will pay for these examinations. The Plan will not require more than a reasonable number of examinations.

CLAIM REVIEW AND APPEAL PROCEDURES

Claim Review Procedures

Claimants will have 180 days from the date of denial to appeal an adverse benefit determination. An appeal shall be submitted by the participant or an authorized representative in writing. It shall be submitted to the proper address for either the Administration Office or the claims administrative agent that made the denial. An appeal shall

identify the benefit determination involved, set forth the reasons for the appeal and provide any information the participant believes is pertinent. Appeals will be accepted from an authorized representative only if accompanied by a written statement signed by the claimant (or parent or legal guardian where appropriate), which identifies the representative and authorizes him or her to seek benefits for the claimant. An assignment of benefits is not sufficient to make a provider an authorized representative.

A failure to file a claim appeal within 180 days of the denial will serve as a bar to any claim for benefits or for other relief from the Trust.

Once the Plan receives information necessary to evaluate the claim, the Plan will make a decision within the time periods set forth below.

In the event an extension is necessary due to matters beyond the Plan's control, the Plan will notify You of the extension and the circumstances requiring the extension. Except where You voluntarily agree to provide the Plan with additional time, extensions are limited as set forth below.

If an extension is necessary due to Your failure to submit complete information, the Plan will notify You of the additional information required. Such notice of incomplete information will be sent within the time periods set forth below.

For the Plan to continue processing Your claim, the missing information must be provided to the Plan within the time periods set forth below.

You may contact the Plan at any time for additional details about the processing of the claim.

Claims or Requests for Benefits

(a) Initial review: 30 days, unless additional information is requested as set forth below;
(b) Extension period: 15 days; and
(c) Maximum number of extensions: one.

If additional information is needed, the Plan will notify You within five days of its receipt of the request. Once You receive the Plan's request for additional information, You will be given no less than 45 days to submit the additional information to the Plan. The Plan will make their determination within 15 days of its receipt of the additional information. If the Plan does not receive the additional information within the specified time period, the Plan will make their determination based upon

the available information.

Claim Denials

If a request for a claim is denied or partly denied, You will receive a written or electronic notice of the denial, which will include:

(a) the specific reason(s) for the denial;
(b) reference to the specific Plan provisions on which the denial is based;
(c) if applicable, a description of any additional material or information necessary to complete the claim and the reason the Plan needs the material or information;
(d) a description of the appeal procedures; the applicable time frames, including Your right to request an appeal within 180 days and Your right to bring a civil action following the appeal process; and
(e) any other information which may be required under state or Federal laws and regulations.

Information To Be Provided Upon Request

You and/or Your authorized representative, may upon request and free of charge have reasonable access to all documents relevant to the claim for benefits. Relevant documents shall include information relied upon, submitted, considered or generated in making the benefit determination. It will also include internal guidelines, procedures or protocols concerning the denied treatment option without regard to whether such document or advice was relied on in making the benefit determination. Absent a specific determination by the Board of Trustees that disclosure is appropriate, relevant documents do not include any other individual's medical or claim records or information specific to the resolution of other individuals' claims. If a denial is based upon a medical determination, an explanation of that determination and its application to the claimant's medical circumstances is also available upon request.

Appeal Procedures

If Your claim has been denied or partially denied, the Board of Trustees has adopted the following procedures to appeal benefit claim denials.

1. **Plan Review.** In the event a claim for benefits is denied or any employee or beneficiary feels he or she is adversely affected by the operation of the Plan, that person or his or her representative is entitled to a review of the decision. The request for review should include:
   (a) the name of the patient;
   (b) the name of the person filing the appeal if different from the patient;

(c) the member's identification number;
(d) the nature of the appeal; and
(e) the names of all individuals, facilities and/or services involved with the appeal.

It is suggested that You contact the Administration Office, WPAS, before invoking the hearing procedures outlined below. They may be able to solve any problems and thereby save You considerable time and trouble.

2. **Hearing Before Board of Trustees.** Any participating employee or beneficiary of a participating employee who applies for benefits and is ruled ineligible by the Trustees (or by a committee of Trustees, an administrative agent, or other organization acting for the Trustees) or who believes he or she did not receive the full amount of benefits to which he or she is entitled, or who is otherwise adversely affected by any action of the Trustees, shall have the right to request the Trustees to conduct a hearing in the matter, provided he or she makes such a request in writing within 60 days after being apprised of, or learning of, the action. The Trustees shall then conduct a hearing at which the participating employee or beneficiary shall be entitled to present his or her position and any evidence in support thereof. The participating employee or beneficiary may be represented at any such hearing by an attorney or by any other representative of his or her choosing. Thereafter, the Trustees shall issue a written decision affirming, modifying, or setting aside the former action. The written decision of the Trustees shall include the specific reasons for the decision as well as specific reference to the pertinent Plan provision(s) on which the decision is based and shall be written in a manner calculated to be understood by the Claimant. If the Claimant's position is denied, the written decision shall also include a notice of opportunity to arbitrate.

3. **Appeal to Arbitration**. If the participating employee or beneficiary is dissatisfied with the written decision of the Trustees, he or she shall have the right to appeal the matter to arbitration in accordance with the labor arbitration rules of the American Arbitration Association, provided he or she submits a request for arbitration to the Trustees, in writing, within 60 days of receipt of the written decision. If an appeal to arbitration is requested, the Trustees shall submit to the arbitrator a certified copy of the record upon which the Trustees' decision was made.

   The question for the arbitrator shall be:
   (a) whether the Trustees were in error upon an issue of law;
   (b) whether they acted arbitrarily or capriciously in the exercise of their discretion; or

(c) whether their findings of fact were supported by substantial evidence.

The decision of the arbitrator shall be final and binding upon the Trustees, upon the appealing party and upon all other parties whose interests are affected thereby.

Any further review, judicial or otherwise, will be based on the record considered by the arbitrator and is limited to whether the arbitrator acted arbitrarily or capriciously in the exercise of his or her discretion. The expense of arbitration shall be borne equally by the appealing party and by the Trust Fund, unless otherwise ordered by the arbitrator.

By requesting an appeal, You have authorized the Plan, or anyone designated by the Plan, to review any and all records (including, but not limited to, Your medical records) which the Plan determines may be relevant to Your appeal.

STANDARD PROVISIONS

Changes in the Plan

The Plan may be changed (including reducing or terminating benefits or increasing contribution costs) any time the Trustees agree to a change. No one else has the authority to change the Plan. A change in the Plan:

(a) does not require Your or Your beneficiary's consent; and
(b) must be:
    (1) in writing;
    (2) made a part of the Plan; and
    (3) signed by an officer of the Plan.

A change may affect any class of Covered Persons.

Applications

The Plan may use misstatements or omissions in Your application to contest the validity of coverage, reduce coverage, or deny a claim; but the Plan must first furnish You or Your beneficiary with a copy of that application. The Plan will not use a person's application to contest or reduce coverage which has been in force for two years or more during Your lifetime. However, if You are not eligible for coverage, there is no time limit on the right to contest coverage or deny a claim.

Statements in application are treated as representations, not as warranties.

Legal Actions
No legal action can be brought until at least 60 days after the Plan has been given written proof of a claim. No legal action can be brought more than three years after the date written proof of a claim is required.

SUMMARY PLAN DESCRIPTION
For
Washington State Council of County and City Employees

Plan Name
The Plan is known as the Washington State Council of County and City Employees Health and Welfare Trust.

Board of Trustees -- Plan Administrator
This Plan is sponsored and administered by a Board of Trustees; the name, address and telephone number of which is:

Washington State Council of County and City Employees
c/o WPAS, Inc.
P.O. Box 34203
Seattle, Washington 98124-1203
Telephone: (800) 732-1121

Participants and beneficiaries can receive, upon written request, information as to whether a particular employer or employee organization is a sponsor of the Plan, and, if so, the appropriate address. The Trustees may impose a reasonable charge to cover the cost of providing this information.

Plan Identification Number
The employer identification number assigned to the Trust Fund by the Internal Revenue Service is EIN 91-0985132. The Plan number is 501.

Type of Plan
This Plan is a health and welfare plan, providing dental benefits.

The benefits under the Plan are self-insured by the Washington State Council of County and City Employees Health and Welfare Trust. Benefits under the Plan are guaranteed to the extent all Plan provisions are met and subject to all terms and conditions of the Plan (including, but not limited to, all exclusions, limitations and exceptions in the Plan).

Type of Administration
This Plan is administered by the Board of Trustees with the assistance of WPAS, Inc., a third party administrator.

Agent for Service of Legal Process
The administrative agent at the Administration Office is designated as agent for purposes of accepting service of legal process on behalf of the Plan. The name, address and telephone number of the administrative manager is as follows:

Washington State Council of County and City Employees
Attn: Adam Keck
c/o WPAS, Inc.
7525 SE 24th St, Suite 200
Mercer Island, Washington 98040
Telephone: (800) 732-1121

Each member of the joint Board of Trustees is also authorized to accept service of legal process on behalf of the Plan. The names and addresses of the individuals currently serving on the joint Board of Trustees are as follows:

TRUSTEES
Michael Rainey (Chairman)
Ron Fredin
Kathleen McConnell

Washington State Council of County and City Employees
3305 Oakes Ave.
P.O. Box 750 Everett, WA 98206-0750
PHONE: (425) 303-8818 and FAX: (425) 303-8906

Description of Collective Bargaining Agreement
This Plan is maintained in accordance to the collective bargaining agreements. Copies of these agreements may be obtained by participants and beneficiaries upon written request to the Administration Office. As there may be a reasonable charge for this document, You may wish to determine what the charge will be before making such a request. This agreement is also available for examination by participants and beneficiaries at the local union office.

Name and Address of Employers
You may obtain a complete list of employers by sending a written request to the Plan Administrator. You may examine the list of employers at any reasonable time at the address of the Plan Administrator.

Eligibility and Benefits
Employees are entitled to participate in the Plan if they work under the collective bargaining agreement described above, and if their employer makes contributions to the Trust Fund on their behalf.

The eligibility rules that determine which employees and beneficiaries are entitled to benefits are set forth in this booklet.

The benefits to which eligible employees and beneficiaries are entitled are set forth in this booklet.

Circumstances Which May Result in Ineligibility or Denial of Benefits
An employee or beneficiary who is eligible for benefits may become ineligible as a result of one or more of the following circumstances:

(a) the employee's failure to work the required hours to maintain his or her eligibility;
(b) the failure of the employee's employer to report the hours and remit contributions on his or her behalf to the Trust Fund; and/or
(c) in the case of beneficiaries who are dependents of an eligible employee, they may become ineligible if:
    (1) they are no longer dependents; or
    (2) they have attained the limiting age. See the Eligibility provision of this booklet. An employee 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 employee or beneficiary to file a complete claim for benefits;
        (b) the failure of the employee or beneficiary to file a complete and truthful benefit application; and/or
        (c) where the employee or beneficiary has other group insurance coverage, it is possible that benefits payable under this Plan may be reduced or denied due to coordination of benefits between the two Plans. See the Coordination of Benefits provision.

The Board of Trustees has the authority to terminate the Trust Fund and Plan. The Trust Fund will also terminate upon the expiration of all collective bargaining agreements requiring the payment of contributions to the Trust Fund. In the event of the termination of the Trust Fund, any and all monies and assets remaining in the Trust Fund, after payment of Expenses, will be used for the continuance of the benefits provided by the then-existing benefit plans, until such monies and assets have been exhausted.

Source of Contributions
Contributions to the Plan are made by participating employers who are parties to the collective bargaining agreements. This agreement provides that the participating employers will make monthly contributions to the Trust Fund in amounts specified in the agreement. Contributions are also received from eligible employees and dependents who continue their coverage under the self-payment rules of the Plan.

The contributions are received and held in trust by the Board of Trustees pending the payment of claims and administrative expenses. Funds remaining after the payment of claims and other operating expenses of the Plan are also held in Trust.

Plan Year
The end of the Plan's fiscal year is April 30th.

Change or Discontinuance of Plan
It is hoped this Plan will be continued indefinitely but, as with any group benefits Plan, the right of change or discontinuance by the Trustees at any time must be reserved.

AUTHORITY TO INTERPRET THE PLAN

The Trustees of the Washington State Council of County and City Employees Health and Welfare Trust have the exclusive and final authority to construe and interpret this Plan. This means that the Trustees have the authority to decide all questions of eligibility and all questions regarding the amount and payment of any Plan benefits within the terms of the Plan. In making any decision, the Trustees may rely on the accuracy and completeness of any information furnished by the Plan or a Covered Person. The Trustees' interpretation of the Plan as to the amount of benefits and eligibility shall be binding and conclusive on all persons.

PLAN CHANGES

The persons with authority to change, including the authority to terminate, the Plan on behalf of the Plan are the Trustees of the Washington State Council of County and City Employees Health and Welfare Trust, or any person or persons authorized by the Trustees to take such action.

WASHINGTON STATE COUNCIL OF COUNTY AND CITY EMPLOYEES HEALTH AND WELFARE TRUST
NOTICE OF PRIVACY PRACTICES

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

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

PROTECTED HEALTH INFORMATION

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 HEALTH INFORMATION

Your health information may be used and disclosed without an authorization in the following situations:

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

coverage or health care treatment with other health plans to coordinate payment of benefits. The Trust may also share your protected health information with another entity to assist in the adjudication of reimbursement of your health claims.

To Facilitate Treatment: The Trust may disclose information to facilitate treatment which involves providing, coordinating or managing health care or related services. For example, the Trust may disclose the name of your treating Physician to another Physician so that the Physician may ask for your x-rays.

To Conduct Health Care Operations: The Trust may use or disclose health information for its own operations, to facilitate the administration of the Trust and as necessary to provide coverage and services to all of the Trust's Participants.

Health care operations include: making eligibility determinations; contacting health care providers; providing Participants with information about health- related issues or treatment alternatives; developing clinical guidelines and protocols; conducting case management; medical review and care coordination; handling claim appeals; reviewing health information to improve health or reduce health care costs; participating in drug or disease management activities; conducting underwriting; premium rating or related functions to create, renew or replace health insurance or health benefits; and performing the general administrative activities of the Trust (such as providing customer service, conducting compliance reviews and auditing, responding to legal matters and compliance inquiries, handling quality assessment and improvement activities, business planning and development including cost management and planning-related analyses and formulary development, and accreditation, certification, licensing or credentialing activities). For example, the Trust may use your health information to conduct case management of ongoing care or to resolve a claim appeal you file.

For Disclosure to the Plan Trustees: The Trust may disclose your health information to the Board of Trustees (which is the Plan sponsor) and to necessary advisors which assist the Board of Trustees in performing Plan administration functions, such as handling claim appeals. The Trust also may provide Summary Health Information to the Board of Trustees so that it may solicit bids for services or evaluate its benefit plans. Summary Health Information is information which summarizes Participants' claims information but from which names and other identifying information have been removed. The Trust may also disclose information about whether you

are participating in the Trust or one of its available options.

For Disclosure to You or Your Personal Representative: When you request, the Trust is required to disclose to you or your personal representative your protected health information that contains medical records, billing records, and any other records used to make decisions regarding your health care benefits. Your personal representative is an individual designated by you in writing as your personal representative, attorney-in-fact. The Trust may request proof of this designation prior to the disclosure. Also, absent special circumstances, the Trust will send all mail from the Trust to the individual's address on file with the Administration Office. You are responsible for ensuring that your address with the Administration Office is current. Although mail is normally addressed to the individual to whom the mail pertains, the Trust cannot guarantee that other individuals with the same address will not intercept the mail. You have the right to request restrictions on where your mail is sent as set forth in the request restrictions section below.

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

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

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

3. *To Conduct Public Health and Health Oversight Activities.* The Trust may disclose your protected health information to a health oversight agency for authorized activities (including audits, civil administrative or criminal investigations, inspections, licensure or

disciplinary action), government benefit programs for which health information is relevant, or to government agencies authorized by law to receive reports of abuse, neglect or domestic violence as required by law. The Trust, however, may not disclose your health information if you are the subject of an investigation and the investigation does not arise out of or is not directly related to your receipt of health care or public benefits.

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

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

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

AUTHORIZATION TO USE OR DISCLOSE HEALTH INFORMATION

Other than as stated above, the Trust will not disclose your health information without your written authorization.

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

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

Special rules apply about disclosure of psychotherapy notes. Your written Authorization generally will be required before the Trust will use or disclose psychotherapy notes. Psychotherapy notes are a mental health professionals 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 health information that involves marketing, the sale of your health information, or any disclosure involving direct or indirect remuneration to the Trust.

YOUR RIGHTS WITH RESPECT TO YOUR HEALTH INFORMATION

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

Right to Request Restrictions: You may request restrictions on certain uses and disclosures of your health information. You have the right to request a limit on the Trust's disclosure of your health information to someone involved in payment for your care. 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 Health Information: You have the right to inspect and copy your health information. This right, however, does not extend to psychotherapy notes or information compiled for civil, criminal or administrative proceeding. The Trust may deny your request in certain situations subject to your right to request review of the denial. A request to inspect and copy records containing your health information must be made in writing to the Privacy Contact Person listed below. If you request a copy of your health information, the Trust may charge a reasonable fee for copying, assembling costs and postage, if applicable, associated with your request. Notwithstanding the foregoing, the fee for a copy of your health information in electronic 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 health information through regular procedures could endanger you. For example, you may ask that the Trust only communicate with you at a certain telephone number or by e-mail. If you wish to receive confidential communications, please make your request in writing to the Privacy Contact Person listed below. The Trust will attempt to honor reasonable requests for confidential communications.

Right to Amend the Your Health Information: If you believe that your health information records are inaccurate or incomplete, you may request that the Trust amend the records. That request may be made as long as the information is maintained by the Trust. A request for an amendment of records must be made in writing to the Trust's Privacy Contact Person listed below. The Trust may deny the request if it does not include a reasonable reason to support the amendment.

The request also may be denied if your health information records were not created by the Trust, if the health information you are requesting to amend is not part of the Trust's records, if the health information you wish to amend falls within an exception to the health information you are permitted to inspect and copy, or if the Trust determines the records containing your health information are accurate and complete.

Right to an Accounting: You have the right to request a list of disclosures of your health information made by the Trust. The request must be made in writing to the Privacy Contact Person. The request should specify the time period for which you are requesting the information. No accounting will be given of disclosures made: to you 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 Opt Out of Fundraising Communications. If the Trust participates in fundraising, you have the right to opt-out of all fundraising communications.

Right to a Paper Copy of this Notice: You have a right to request and receive a paper copy of this Notice at any time, even if you have received this Notice previously or agreed to receive the Notice electronically. To obtain a paper copy, please contact the Privacy Contact Person listed below. You will be able to obtain a copy of the current version of the Trust's Notice at its website, www.council2trust.com. If this Notice is modified, you will be mailed a new copy.

Privacy Contact Person/Privacy Official: To exercise any of these rights related to your health information you should contact 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
Claims Manager
c/o Welfare & Pension Administration Service, Inc.
P.O. Box 34203 Seattle, WA 98124-1203
Toll Free: (800) 331-6158
Fax: (206) 441-9110

Privacy Official
Sean Minner
c/o Welfare & Pension Administration Service, Inc.
P.O. Box 34203
Seattle, WA 98124-1203
Toll Free: (800) 331-6158
Fax No: (206) 505-9727

DUTIES OF THE TRUST

The Trust is required by law to maintain the privacy of your health information as set forth in this Notice, to provide to you this Notice of its duties and privacy practices, and to notify you following a breach of unsecured protected health information. The Trust is required to abide by the terms of this Notice, which may be amended from time to time. The Trust reserves the right to change the terms of this Notice and to make the new Notice provisions effective for all health information that it maintains. If the Trust changes its policies and procedures, the Trust will revise the Notice and will provide a copy of the revised Notice to you within 60 days of the change. You have the right to express complaints to the Trust and to the Secretary of the Department of Health and Human Services if you believe that your privacy rights have been violated.

Any complaints to the Trust should be made in writing to the Privacy Contact Person identified above. The Trust encourages you to express any concerns you may have regarding the privacy of your health information. You will not be retaliated against in any way for filing a complaint.

The Trust is prohibited by law from using or disclosing genetic health information for underwriting purposes.

EFFECTIVE DATE

This Notice was originally effective **April 14, 2003**, as amended September 19, 2013**.**

YOUR RIGHTS

The Trustees of the Plan have agreed that certain information should be furnished to You as a participant of this Plan. The Trustees have determined that all Plan participants will be entitled to:

Receive Information About Your Plan and Benefits

- Examine, without charge, at the Fund Office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements.
- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and updated Summary Plan Description. The Plan Administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

- Continue health care coverage for Yourself, spouse or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or Your dependents may have to pay for such coverage. Review this Summary Plan Description and the documents governing the Plan on the rules governing Your COBRA continuation coverage rights.
- Reduction or elimination of exclusionary periods of coverage for preexisting conditions under the Plan, if You have creditable coverage from another Plan. You should be provided a certificate of creditable coverage, free of charge,

from Your group health 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 preexisting condition exclusion for 12 months (18 months for late enrollees) after Your enrollment date in Your coverage.

Amendment and Termination

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

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

The Trust may be terminated by the employers and union by an instrument in writing executed by mutual consent at any time. Upon voluntary termination of the Trust, all assets remaining in the Trust after payment of all expenses shall be used for the continuance of benefits provided in the Plan until such assets have been depleted.

Benefits Not Guaranteed

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