MARCH 2022

SUMMARY PLAN DESCRIPTION

Vision Plan

WASHINGTON TEAMSTERS WELFARE TRUST

INTRODUCTION

This booklet describes the benefits and provisions of the Washington Teamsters Welfare Trust's Vision Plan EXT for employers who negotiate a collective bargaining agreement requiring Plan contributions on behalf of their employees.

This Plan is designed to assist you and your family in paying the cost of vision care. We encourage you to become familiar with the NBN network of vision care providers, your vision benefits, and the valuable protection they offer. If you have any questions, please contact Northwest Administrators, Inc. (NWA), which administers this plan on behalf of the Washington Teamsters Welfare Trust. This Plan is funded directly by the Trust, using contributions from both employers and participants. This money goes into the Trust and the Trustees, representing the participating employers and local union members, decide the level of funding and plan design. NWA follows the rules set forth by the Trustees, and takes care of the plan's benefit and claims administration.

As you think about how to use your benefits, consider that your use of the Plan directly affects costs. We encourage you to be a wise consumer.

IMPORTANT NOTICE

Payment of benefits as specified in this booklet depends on your employer making contributions for you to the Washington Teamsters Welfare Trust sufficient to maintain these benefits. The amount of necessary employer contributions may increase from time to time. If you are ineligible for Plan coverage, the fact that contributions were made on your behalf will not entitle you to benefits.

Only the Trust Administrative Office, Northwest Administrators, Inc., 2323 Eastlake Avenue East, Seattle, Washington represents the Trustees in administering the Plan and giving information about the amount of benefits, eligibility and other Plan provisions. No union employee, union officer, business agent, employer or employer representative or representative of any other organization except the Trust Administrative Office is authorized to give Plan information, interpret the Plan or commit the Trustees on any matter. In all cases, the terms of the Plan govern.

While no change in the Plan is anticipated, the Trustees reserve the right to terminate, amend or eliminate benefits as deemed necessary. The Trustees have no obligation to furnish benefits beyond those that can be supported by the Trust fund.

Si necesita ayuda para entender este panfleto, comuniquese con la oficina administrativa al 206-726-3278 o 1-800-732-1123.

General Information

General Information

Trust Administrative Office

This Plan is administered by Northwest Administrators, Inc. (NWA). Contact the Trust Administrative Office for questions about:

- Enrollment in the Plan
- Whether you are eligible for coverage
- Filing a vision claim or checking the status of a vision claim or
- Benefits covered under this Plan.

The Trust Administrative Office can be contacted at:

Washington Teamsters Welfare Trust
Northwest Administrators, Inc.
2323 Eastlake Avenue East
Seattle, WA 98102

www.nwadmin.com

206-726-3278 or 800-732-1123

Northwest Benefit Network (NBN)

This Plan uses the NBN network of vision care providers to help control costs. You may choose any licensed vision care provider, but when you use an NBN network provider, you receive the highest level of coverage and reduce your out-of-pocket expenses.

NBN network providers may change from time to time. To verify that your vision care provider is in the network or to check the status of a vision care provider, call the Trust Administrative Office at the number above or check online in the *Resources* section of the Northwest Administrators, Inc. website at www.nwadmin.com.

Enrollment Information

Participant Data Form

To receive benefits under this Plan and avoid delays in claim administration, you must complete and submit a Participant Data Form to the Trust Administrative Office when you first become eligible for coverage. Participant Data Forms can be obtained from the Trust Administrative Office or your local union. When enrolling a new dependent, you must also submit documentation to verify your dependents eligibility. Such documentation may include, but is not limited to:

marriage certificate, birth certificate, proof of adoption or **court-appointed** Guardianship Papers. See Eligible Dependents on page 12 for details.

If you have completed a Participant Data Form for a Trust medical or dental plan, you do not need to complete another form.

Updating Enrollment Data

Accurate and efficient claim processing depends, in part, on the Trust Administrative Office having current data. Changes in address, marital status, number of dependents and information about other insurance are critical. Remember to advise the Trust Administrative Office promptly of these changes by completing a new Participant Data Form or you may update your information online at www.nwadmin.com.

Identification (ID)/Information Card

Your Trust ID/Information card contains important Vision Plan information for you and your vision care providers, such as telephone numbers and where to send claims. When using the services of an NBN network provider, you must identify yourself as a Washington Teamsters Welfare Trust participant by showing your ID card at the time of service.

Quick Guide to Claim Filing

Following these guidelines ensures that the providers and vision claims processors have all the information needed to pay your claims. Using NBN network providers also ensures that you receive the highest level of coverage provided by the Plan.

If you are uncertain about your eligibility, you or your vision provider can call the Trust Administrative Office at 206-726-3278 or 1-800-732-1123 to verify eligibility.

NBN Network Providers

1. Contact the Trust Administrative Office to locate an NBN network provider or to verify that your provider is in the network. A list of network providers can also be found online on the home page of the Northwest Administrators, Inc. website at www.nwadmin.com; just click on *NBN Vision Provider Locator* and enter information for your search.

2. As noted above, when using the services of an NBN network provider you must identify yourself as a Washington Teamsters Welfare Trust participant by showing your ID card at the time of service. If the provider does not identify you as a participant until after services have started, you will be responsible for paying the provider for all services and/or materials provided and you will be reimbursed according to the non-network benefit schedule.

3. You should be charged only for items not covered by the Plan. The provider will bill you for the cost of any non-covered services and/or eyewear,

including the cost of the materials and any additional dispensing fee. You are not required to file a claim. The NBN network provider will submit the claim to NBN for you.

Non-Network Providers

1. Obtain an NBN claim form(s) from the Trust Administrative Office or online at www.nwadmin.com. After you register and login, the form can be located under *Forms and Documents*. A separate claim form must be submitted for each pair of eyewear.

2. You can pay the provider directly or assign your Trust benefit to the provider. Either you or your provider should send a copy of the itemized bill along with the NBN claim form to:

   Washington Teamsters Welfare Trust
   2323 Eastlake Avenue East
   Seattle, Washington 98102-3393

4. If you paid the provider, the Trust's benefit payment will be sent directly to you. If you assigned your benefit to the provider, the Trust's payment will be sent to the provider.

Eligibility and Coverage Effective Dates

Eligibility and Coverage Effective Dates

Who's Eligible

To become eligible for contributions to be made to the Trust on your behalf, you must first meet the requirements in your employer's collective bargaining agreement, consistent with Trust guidelines. Those requirements may include waiting periods and a minimum number of compensable hours or hours worked (usually 80) during a month before employer contributions are due.

Coverage Effective Dates

When Coverage Begins

Coverage and benefits for new hires begin after one month's contribution is made on your behalf under the lag month eligibility system. For example, if you are a new hire who satisfies the requirements of your collective bargaining agreement, you work enough hours in June and your employer makes a contribution in July (the lag month), your coverage begins August 1. *Please note, you need at least two consecutive months of contributions before resigning or retiring to preserve the first month of coverage.* *See Two-Month Rule on page 11 for more information.*

The lag month eligibility system continues while you work enough hours each consecutive month for a contribution to be made on your behalf. For example, if you work enough hours in January and your employer makes a contribution in February (the lag month), coverage is provided in March (rather than February).

Break in Contributions

Coverage and benefits will end, however, any time you have a break in contributions from any one employer for whatever reason. When coverage ends depends on the reason for the break in contributions as explained below.

Resignation, Retirement or Employer Withdrawal from the Trust

When you have a break in contributions from one employer *due to resignation, retirement or as a result of your employer withdrawing from coverage under the Trust*, the lag month system terminates and your coverage will stop at the end of the month following the month in which you last had enough hours to receive a contribution (provided you had at least two consecutive months of contributions; see Two-Month Rule). For example, if you resign in April after working enough hours to receive a contribution, and the final contribution to the Plan is made in May, your coverage will end on May 31.

Layoff, Reduction in Hours, Disability, or Termination of Employment

When you have a break in contributions from one employer due to any reason other than resignation, retirement or as a result of your employer withdrawing from coverage under the Trust – *such as a layoff, a reduction in hours, disability or termination of employment* – the lag month system does not terminate and your coverage will continue until the end of the *second* month following the month in which you last had enough hours to receive a contribution. For example, if you are laid off in April after working enough hours to receive a contribution, and the final contribution to the Plan is made in May, your coverage will end on June 30.

If following a break in employer contributions from any one employer, you return to work for sufficient hours in a month and contributions are again made on your behalf, your coverage will resume the same as for a new hire.

Note: Some collective bargaining agreements may have a waiting period before contributions become payable to the Trust. An agreement may also require a minimum number of hours be worked in order for contributions to be made. Refer to your collective bargaining agreement or contact your local union or employer about any waiting periods or hour requirements. In no event, however, will a waiting period exceed a cumulative hours of service requirement of 1,200 hours, followed by a 90 day waiting period.

Two-Month Rule: If you are a new hire or an employee reestablishing eligibility, you must have at least two consecutive months of employer contributions in order to preserve lag month coverage for the first contribution if you subsequently lose coverage due to *resignation, retirement, or if your employer ceases to participate in the Plan.* For example, if you have only one contribution on your behalf and you resign or retire, you will not qualify for coverage. However, if you have only one contribution on your behalf and your employment is terminated, you are laid off, disabled, or do not work enough hours, you will receive one month of coverage.

When Coverage Ends

Your coverage will end if this Plan terminates or if your employer ceases to make required contributions or stops participating in the Plan.

When you have a break in contributions, coverage stops at the end of the first or second month following the month in which you last have the minimum number of hours stated in the collective bargaining agreement for contributions from any one contributing employer, depending on the reason for your break in contributions. See Break in Contributions on page 10 for more information.

Any employee or dependent in full-time military service will not be covered except as described in Military Service Under USERRA on page 18 and COBRA Self-Pay Option on page 20.

Dependent Coverage

Eligible Dependents

Eligible dependents are:

- Your spouse
- Your domestic partner ***if*** your local union and your employer negotiated domestic partner benefits for your group (see "Domestic Partner Benefits" below).
- Your children under age 26 who are your:
  - Natural children
  - Adopted children
  - Step children
  - Children placed with you for adoption

  These children do not have to depend on you for support, do not have to attend school full time, can be married, and can have access to other health coverage through their own employment.

- Your unmarried children up to age 19 who live with you, are dependent on you for support, and are:
  - Children for whom you are the **court-appointed** guardian (custody agreements are not acceptable)
  - Grandchildren
  - Children of your domestic partner ***if*** your local union and employer negotiated domestic partner benefits (see Domestic Partner Benefits below).

  These dependent children who would otherwise qualify as eligible dependents but are 19 years or older will be eligible until age 26 (through 25th year) if they are unmarried, depend on you for support/maintenance, and are full-time students in an accredited educational institution. School vacation and total disability periods that interrupt but do not terminate what would have been a continuous course of study are considered part of full-time attendance. A dependent who (i) takes a physician certified medically necessary leave of absence from a postsecondary school (college, university, or trade school) due to a serious illness or injury, which causes the dependent to lose student status and (ii) was an eligible dependent immediately before the first day of the medical leave, will continue to have coverage through the Applicable Period. Applicable Period means the earlier of one year from the first day of the medical leave of absence or the date on which dependent coverage under the Plan would otherwise terminate. Proof of a medically necessary leave of absence must be certified in writing to the Plan by the student's treating physician. If the student recovers from the serious illness or injury, he or she must notify the Plan immediately and begin classes

again at (or enroll again in) a postsecondary school if within the Applicable Period in order to resume dependent student status under the Plan. If the medical leave of absence exceeds the Applicable Period, a dependent cannot resume student status but may be eligible for COBRA coverage. COBRA coverage will run consecutive with any student disability coverage.

An unmarried eligible dependent child who is physically or mentally incapable of self-support is eligible under the Plan while incapacitated, if your own coverage is in effect. To cover a child under this provision, file a Proof of Incapacity Form with the Trust Administrative Office within 31 days after coverage would otherwise end or within 31 days of the date you become covered by the Plan if a child is 19 or older at that time. Additional proof will be required from time to time; unless you provide additional proof as requested, the child's coverage will end.

In accordance with federal law, the Plan also provides medical coverage (including dental and vision coverage if these coverages are being provided through a Trust plan) to certain dependent children (called alternate recipients) if directed to do so by a Qualified Medical Child Support Order (QMCSO) issued by a court or state agency of competent jurisdiction and your own health care coverage is in effect. Contact the Trust Administrative Office for details.

Any employee or dependent in full-time military service will not be covered except as described in Military Service Under USERRA on page 18 and COBRA Self-Pay Option on page 20.

Documentation Requirements

You are required to submit a copy of the following documents to enroll and cover your eligible dependents:

- Spouse - Marriage certificate
- Child - Birth certificate
- Grandchild - Birth certificates of your child and your grandchild and a copy of the first page of your most recent IRS Form 1040 listing your grandchild as a dependent (you may black out Social Security numbers and income information)
- Children for whom you are the **court-appointed** guardian - Court document showing your appointment as legal guardian (custody agreements are not acceptable)

Dependent Consent to Disenroll

Participants may elect to not cover their spouse if they are legally separated and provide documentation of this fact to the Trust Administrative Office. Participants may otherwise elect to not cover their spouse only if their spouse consents to not being covered. Participants may elect to later reenroll their spouse or their spouse may revoke consent and again be enrolled.

Participants may elect to not cover a child age 18 or older, however, under federal law such child has a right to be enrolled in coverage under the participants' plan through the age of 25, therefore, in order to not cover a child age 18 or older participants must first provide the Trust Administrative Office with the child's address in order for the child to be notified coverage is being terminated. The child will be given the right to re-enroll. Participants may elect to later re-enroll a child provided the child is under age 26 at the time.

Termination of coverage or coverage upon re-enrollment of a spouse or child will be effective the first of the month following receipt of written notification by the Trust.

Domestic Partner Benefits

If your group has negotiated to add domestic partner benefits, you may enroll your same or opposite sex domestic partner for benefits if:

- You (the covered member) and your domestic partner have registered as domestic partners or entered into a civil union in the state or municipality where registered; or
- You and your domestic partner meet all of the following requirements:
  - You are both at least age 18
  - Neither of you is legally married or in a domestic partnership with another person
  - You are not related by blood to a degree of closeness that would prohibit marriage
  - You are in an exclusive, committed relationship that is intended to be permanent
  - You share a mutual obligation of support and responsibility for each other's welfare
  - You currently share a principal residence and have done so for at least 6 months, and intend to do so permanently

    or

  - You are married adults of the same sex and your marriage is recognized by the state where you live.

Documentation Required

If your group negotiates domestic partner benefits and you want to enroll your domestic partner, you and your partner will be required to complete a notarized Affidavit of Domestic Partnership and submit a birth certificate or driver's license as proof of your domestic partner's age, plus additional documentation to verify your domestic partner's eligibility including that you have shared a principal residence for at least six months. This additional documentation must include any three of the following:

- Declaration, Affidavit, or Certification of Civil Union from a state or municipality that issues such
- Marriage certificate from a state or municipality that recognizes same sex marriages
- Legal documents indicating that, as domestic partners, they are responsible for each other's welfare
- Home title or other documents showing joint ownership of significant property
- Rental agreement documenting joint tenancy
- Canceled checks showing rent or utility payments from both partners at the same address, or bills proving same
- Evidence of joint banking accounts (savings, checking, etc.)
- Power of Attorney (durable property or health care)
- Wills, life insurance policies, or retirement annuities naming each other as primary beneficiary
- Co-parenting or adoption agreement.

Children of Domestic Partners

If your group negotiates domestic partner benefits and you want to enroll children of your domestic partner, the child(ren) may be enrolled subject to the plan's preceding dependent children eligibility requirements including that the child(ren) are:

- Dependent upon you for support and maintenance, and
- Unmarried, and
- Under 19 years old and residing with you and your domestic partner ***or*** at least 19 but under 26 and enrolled full-time in an accredited educational institution ***or*** disabled and physically or mentally incapable of self-support.

Other Important Information about Domestic Partner Benefits

It's important to note that domestic partner benefits are subject to different federal and state tax rules. Income taxes may be payable as a result of the Trust providing benefits to your domestic partner and his or her children. If your bargaining unit has bargained domestic partner benefits and you are covering a domestic partner, you may wish to consult a tax professional for advice on your personal situation. Domestic partners and their dependent children are not eligible for COBRA self-pay benefits when coverage ends.

Continuation of Coverage

Continuation of Coverage

This section describes various options for continuing vision coverage under specific circumstances.

Quick Guide to Continuing Your Coverage

The Trust offers a number of options for continuing your vision coverage after it would normally end, depending on your situation. The chart below provides an overview of these options, which are described in more detail in the following pages.

Continuing Your Vision Coverage Overview

Continuation option	How long coverage can be continued	Who can be covered	For details
Continues coverage lost due to delinquency of employer contributions	Up to three months	You and your eligible dependents	See page 18
Continues coverage lost due to a strike, lockout or labor dispute	Up to six months	You and your eligible dependents	See page 18
Continues coverage during a military leave	During your military leave (maximum of 24 months)	You and your eligible dependents	See page 18
Continues coverage during a Family or Medical Leave (FMLA)	During your FMLA leave (maximum of 12 weeks)	You and your eligible dependents	See page 19
Total Disability Waiver of Contributions	Up to three months	You and your eligible dependents	See page 20
COBRA (self-pay option)	Normally up to 18 months Up to 29 months if disabled Up to 36 months for dependents in certain circumstances	You and/or your eligible dependents	See page 20

Please note, this chart is only a brief summary and does not describe many details of the continuation options. Please refer to the pages shown in the chart for more detailed descriptions, or call the Trust Administrative Office.

Continuing Coverage Lost Due to Delinquency of Employer Contributions

Vision coverage for you and your eligible dependents may be continued without self-payment for up to three months if your employer is delinquent in Plan contributions and the employer account has been referred for collection. To be eligible for continued coverage, you must provide proof of employment that would have created eligibility had the required employer contribution been made. This continued coverage is for a maximum of three months after employer contributions stop and is available only once for an employer or successor. (This provision does not relieve an employer of any obligation to contribute to the Plan.)

Continuation of Vision Coverage in the Event of a Strike, Lockout or Other Labor Dispute

If your coverage terminates because active work ends as a result of strike, lockout or other labor dispute, your vision coverage may continue during the dispute while the Plan is in effect if you self-pay the required contributions. See pages 20 to 23 for information on COBRA self-pay coverage.

In no event may you continue your benefits beyond *the earliest* of these dates:

- Six months after you stop active work
- Your request that coverage be terminated
- Your failure to make the required self-payment on time
- Your eligibility for similar coverage under another group plan
- Termination of the Plan.

Military Service Under USERRA

If you leave covered employment to perform certain United States military service, you and your covered dependents may have the right to continue vision coverage. If your military service lasts less than 31 days (for example, active duty for training), the Plan will continue to cover you and your dependents. If your military service lasts 31 days or more, you and your dependents will be eligible to continue coverage through self-payment for up to 24 months. When you return to covered employment, your regular coverage will begin immediately, if you meet the requirements summarized on the following page.

Under the Uniformed Services Employment and Reemployment Rights Act (USERRA), you must notify your employer before taking leave (unless

precluded 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 apply for reemployment as follows:

- Less than 31 days military service — apply immediately, taking into account safe transportation plus an eight-hour rest period
- 31-180 days military service — apply within 14 days
- More than 180 days military service — apply within 90 days.

If you are hospitalized or convalescing, these reemployment deadlines are extended while you recover (but not longer than two years).

The rules above also apply to uniformed service in the commissioned corps of the Public Health Service.

To ensure proper crediting of service under USERRA, have your employer notify the Trust Administrative Office when you go on leave and again when you are reemployed following your return from leave.

If You Take a Family or Medical Leave

To be eligible under the federal Family and Medical Leave Act (FMLA), you must have worked for your current employer for at least 12 months and for at least 1,250 hours in the 12 months before your leave. If you meet these requirements and work for an employer with 50 or more employees within a 75-mile radius, the law requires your employer to continue contributions for your (and your dependents') vision coverage (if covered under the Trust) for up to 12 weeks during a 12-month period if you're on leave due to:

- Birth of a child, or placement for adoption or foster care
- Serious health condition of a child, spouse or parent
- Your own serious health condition.

Contact your employer as soon as you think you are eligible for a family or medical leave since the law requires you to give 30 days notice, or tell your employer immediately if your leave is caused by a sudden, unexpected event. Your employer can tell you of your other rights under FMLA.

If you have not returned to work when your coverage under FMLA ends, you and your dependents will be able to elect COBRA self-pay coverage, as described on pages 20 to 23.

If you qualify for a Disability Waiver of Contributions, as described in the following section, and your leave falls under FMLA because of your own serious health condition employer contributions are not required by the Trust while you remain qualified for the Disability Waiver of Contributions.

Waiver of Contributions for Total Disability

If you fail to work the specified minimum monthly hours for eligibility because you are totally disabled, and you have submitted proof of the disability from your physician and employer, you may receive a waiver of contributions for up to *three* months if you remain totally disabled. The waiver period will begin on the first of the month following the month your employer's paid coverage ends. This waiver allows continuation of:

- Vision
- Dental — if covered by this Trust
- Medical/prescription — if covered by this Trust
- Life AD&D — if covered by this Trust.

At the conclusion of the waiver period you may elect COBRA and begin making COBRA self-payments, but your combined continuation coverage under the waiver period and COBRA may not exceed 18 months (29 months if disabled, or 36 months for your dependents under certain circumstances).

To determine eligibility for waiver of contributions, you must become disabled in a month for which you have eligibility based on an employer contribution or, if you have returned to covered work, for which you have eligibility based on a disability waiver of contributions due to a prior disability. You must also be:

- Totally disabled due to a covered accident or illness (including pregnancy and its complications), and
- Unable to perform the normal duties of your occupation, and
- Not engaged in any occupation for wage or profit (except light-duty work that may be allowed under your collective bargaining agreement), and
- Under a physician's regular care for that injury or sickness.

A subsequent disability separated by less than two weeks of full-time work is considered the same disability unless it is due to a different cause and begins after you return to full-time work.

Self-Pay for Continuing Vision Coverage

COBRA Self-Pay Option

You may be eligible to continue vision coverage after it would otherwise terminate based on a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). If you are an employee covered by the Plan, you and your covered dependents may choose COBRA self-pay coverage for up to 18 months if your coverage terminates for one of these qualifying events:

- A reduction in your hours of employment
- Termination of your employment for reasons other than gross misconduct.

A dependent spouse covered by the Plan may choose COBRA self-pay coverage for up to 36 months if coverage terminates for one of these qualifying events:

- Death of the participating employee
- Divorce from the participating employee
- Participating employee's entitlement to Medicare benefits.

A dependent child covered by the Plan may choose COBRA self-pay coverage for up to 36 months if coverage terminates for one of these qualifying events:

- Death of the participating employee
- Divorce of the participating employee and spouse
- Participating employee's entitlement to Medicare benefits (Part A, Part B or both)
- Participating employee's dependent child no longer meets the eligibility requirement under the Plan.

A spouse or dependent child who elects COBRA self-pay coverage for 18 months due to the employee's termination for reasons other than gross misconduct, or reduction in hours, may be eligible to continue coverage for up to 36 months for a second qualifying event:

- Death of the participating employee
- Participating employee divorces
- Participating employee's entitlement to Medicare benefits (Part A, Part B or both)
- Participating employee's dependent child no longer meets the eligibility requirements under the Plan.

It is your or your dependent's responsibility to inform the Trust Administrative Office of a divorce or loss of dependent status within 60 days from the latest of the following:

- Date of the divorce or loss of dependent status
- Date coverage is lost because of the event
- Date on which you were informed of the responsibility to provide the notice and of the Plan's procedures for notifying the Trust Administrative Office**.**

The employer is responsible for notifying the Trust Administrative Office when the employee's coverage ceases.

You or your dependent could receive a Social Security determination confirming disability at the time of the COBRA qualifying event (or within the first 60 days of continuation coverage due to the event). If this happens, the disabled person and all COBRA-eligible family members may be eligible for up to 29 months of continuation coverage. The Trust Administrative

Office must receive a copy of the disability determination within *60 days* of the determination date and *within the original 18-month coverage period.*

If the disabled individual is later determined no longer to be disabled by the Social Security Administration, *you must notify the Trust Administrative Office within 30 days of the determination.* In this case, the 11-month COBRA extension will end as of the effective date the individual is no longer entitled to Social Security disability benefits.

When the Trust Administrative Office is notified that a qualifying event has occurred, it will supply details including:

- Application for COBRA self-pay coverage
- Cost information and payment procedures
- Requirements for continuation of coverage.

Special Tax Credit For TAA Individuals

The Trade Act of 2002 created a second COBRA election for workers displaced by the impact of foreign trade and who are determined to be trade adjustment assistance (TAA) eligible individuals. TAA eligible individuals who declined COBRA when they were first eligible can elect COBRA within the 60-days of the first day of the month in which they become TAA eligible individuals. Nonetheless, this election may not be made more than six months after the date the TAA individual's group health plan coverage ended.

TAA eligible individuals are also eligible for a health insurance tax credit for a percentage of qualified health insurance premiums, including COBRA coverage. Beginning May 1, 2009, the American Recovery and Reinvestment Act of 2009 (ARRA) provided for an extension of the COBRA coverage period under certain circumstances. The Omnibus Trade Act of 2010 and the Trade Adjustment Assistance Extension Act of 2011 generally extended the tax credit (at 72.5% of premiums for the months beginning after February 12, 2011) and the COBRA coverage period through January 1, 2014. Under the Trade Preferences Extension Act of 2015, the tax credit for eligible individuals was reinstated for months beginning January 1, 2014 through December 2019. If you have questions about your extended ability to elect COBRA coverage or this new tax credit you may call the IRS at (800) 829-1040. More information about the TAA Program and the extension of the tax credit described above is available at www.irs.gov/hctc.

Timing Is Important

Your application and self-payments must be timely. You will be eligible for COBRA self-pay coverage only within the following time frames:

- You have *60 days* to elect COBRA from the later of the date you are notified or the loss of coverage date. You will not be eligible for COBRA self-pay coverage after this 60-day election period ends.
- The first self-payment is due within *45 days* of the date your first payment notice is mailed. Subsequent self-payments will be due no later than the last day of the month for which payment is being made. Your COBRA coverage will terminate automatically unless you make timely payments.

Employees who qualify for a total disability extension and waiver of contributions, described on page 20, may not have to make COBRA payments during the three-month waiver period. However, the combined period under COBRA self-pay coverage and the waiver may not exceed 18 months (29 months if disabled). To qualify for the additional 11-month COBRA disability period, you must qualify for and be receiving Social Security disability benefits. Contact the Trust Administrative Office for details.

COBRA self-pay coverage will be identical to that provided under the Plan to similarly situated active employees or dependents.

If you have other benefits under the Trust, such as medical and dental plan benefits, you may also be required to self-pay for those benefits in order to self-pay for vision plan benefits. Contact the Trust Administrative Office for details.

COBRA self-pay coverage will terminate before the COBRA eligibility period ends for any of the following reasons:

- Payment for continuation of coverage is not received by the last day of the month for which payment is being made.
- You, your spouse and/or eligible dependents obtain coverage under any other group health plan after the last date to elect COBRA self-pay coverage (unless the other plan excludes or limits your benefits because of a preexisting condition).
- You became entitled to Medicare benefits (Part A or Part B) after the last date to elect COBRA self-pay coverage; however, your dependents may be entitled to further continuation of coverage. (If your spouse or dependent becomes eligible for Medicare for any reason, coverage for that individual will end.)
- The Plan terminates.
- Social Security determines you are no longer disabled during an 11-month disability extension period.

If you have any questions about COBRA coverage or the application of the law, contact the Trust Administrative Office. You may also contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA). Addresses and phone numbers of regional and district EBSA offices are available through EBSA's website at www.dol.gov/ebsa.

VISION PLAN PROVISIONS

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Schedule of Vision Plan Benefits

	NBN Network Provider	Non-Network Provider
Examination	Paid in full	$ 35
Lenses (per pair)		
• Single Vision	Paid in full*	$ 30
• Bifocal	Paid in full*	$ 40
• Trifocal	Paid in full*	$ 45
• Lenticular	Paid in full*	$ 90
Frames	Paid in full**	$ 30
Contact Lenses (subnormal)	Paid in full	$200
Contact Lenses (elective) In lieu of glasses (frame and lenses).	$150	$ 90
Contact Lenses (elective) – Participants under age 19	Paid in full ****	$ 90

* Paid in Full includes:

- Basic lenses
- Solid color coating and tinting (e.g. sun tints)
- Gradient tinting
- Mirror coating
- UV protection
- Polarized lenses or laminated lenses
- Photochromatic Light-sensitive glass lenses (light and dark shades, e.g. PhotoSun)
- Photochromatic Light-sensitive plastic lenses (such as Transitions); standard grades ***
- Progressive lenses (no-line bifocal); standard grades ***
- Polycarbonate lenses
- Special lens edge treatments (e.g. drilling, notching, grooving, beveling or polishing or coating edges)
- Anti-reflective coating
- Anti-reflective coating + scratch coating; standard grades ***
- Scratch coating; standard grades ***
- Oversize lenses
- Prism and double segments
- Slab off

** Limited to frames selection covered by the Trust Plan. Refer to page 26.

*** Plan pays for standard or basic styles. Patient pays any extra in cost of "Premium" progressives, photochromatic, scratch coating, or anti-reflective + scratch coat lens extras.

**** In-network benefit limit of $150 per 365 days does not apply.

Covered Services

Northwest Benefit Network

Northwest Benefits Network (NBN) has developed a network of providers to assure quality care while controlling costs. Your benefits will be maximized when you obtain service from a participating NBN network provider. However, if you wish to obtain services from a non-participating provider, you are free to do so under the Plan, although your out-of-pocket expenses will almost always be greater.

NBN network provider lists are updated periodically and are available from the Trust Administrative Office. A list of network providers can also be obtained by calling 206-726-3278 or 800-732-1123 or going online to the Northwest Administrators, Inc. website at www.nwadmin.com. On the website home page, just click on ***NBN Vision Provider Locator*** and add the applicable information for your search.

Schedule of Benefits

The Schedule of Benefits on page 25 summarizes the benefits under the Plan when services are performed by NBN network providers and non-participating providers. Before services begin, you may wish to discuss with your provider what is covered and what is your responsibility so you will know the benefits and amount of your out-of-pocket expense.

Benefit Descriptions and Limitations

Services provided under the Vision Plan are described below. Please note the limitations on these services to avoid any misunderstanding about eligibility or any potential out-of-pocket expenses you may incur. Any additional care, service and/or materials not covered by this Plan may be arranged between you and your provider at your own expense.

The 365 and 730-day time limitations are strictly enforced. When determining eligibility for lenses or frames, the 365 or 730 days are tracked from the date of service recorded on the claim form by the provider. You can verify coverage by calling the Trust Administrative Office or by visiting the Northwest Administrators, Inc. website at www.nwadmin.com. Using the website will require you to register and log in as a Plan Participant.

- Routine vision exam — A complete analysis of the eyes and related structure to determine the presence of vision problems, abnormalities or to determine the need for corrective lenses will be covered once every 365 days from the date of your last covered examination. If you are getting an examination for an eye injury, irritation, or disease, submit your claim for the examination to your medical plan.
- Lenses — If you require a new prescription or a change in your current prescription, the provider will order the proper single vision, bifocal, trifocal or lenticular lenses. One pair of lenses per person is covered once every 365 days from the date the last covered lenses were ordered.
- Frames — If you use a participating NBN network provider, your provider will show you the selection of frames covered in full by your Plan and those which will cost more than your allowed benefit. You may choose any frame you wish; however, if you select one which costs more

than allowed under the Plan, you will be responsible for the additional charge. Frames are covered once every 730 days (two full years) from the date the last covered frames were ordered.

- Elective contact lenses — When you choose to receive elective contact lenses in lieu of glasses (frame and lenses), the benefit allowance includes the contact lenses and fitting/evaluation. The contact lens benefit is available once every 365 days from the date your last contact lenses or lenses for glasses were ordered, whichever was later. Contact lenses are provided in lieu of all other hardware (frame and lenses) for 365 days. To be eligible for your contact lens benefit you must be eligible for your lenses (glasses) benefit at the time services for contact lenses begin (Evaluation/Fitting/Contacts). Contact lenses must be obtained by the patient in order to use the contact lens benefit. A contact lens evaluation/fitting fee submitted without contact lenses is not an eligible expense under the contact lens benefit. If you are unsure of your eligibility status, please contact the Administrative Office or review your eligibility status at www.nwadmin.com.

  Participants under age 19 – The NBN in-network benefit limit of $150 per 365 days for contact lenses is eliminated for covered participants (employees, spouses, and children) under age 19 and replaced with a limit of one set of contact lenses, or the equivalent of disposable lenses per 365 days, which will be covered in full. The non-network benefit limit of $90 per 365 days remains.

- Subnormal vision aid — Contact lenses prescribed as a subnormal vision aid are covered under the Plan for the following conditions:
  - After cataract surgery
  - Keratoconus (bulging cornea)
  - When vision acuity is not correctable to 20/70 in the better eye by use of conventional type lenses, but can be improved to 20/70 or better by the use of contact lenses.

If necessary, NBN will provide lenses and frames in addition to contact lenses after cataract surgery. You will again be eligible for an annual examination and lenses again after 365 days, frames after 730 days, and contact lens replacement after 730 days from the date of the subnormal vision service.

Your provider must obtain prior approval from NBN before ordering these lenses. One pair of subnormal vision aid contacts per person is covered once every 730 days from the date your last covered subnormal contact lenses were ordered.

When You are Covered as an Employee and a Dependent, or as a Dependent of Two Employees

If you have coverage under the Trust as an active employee and as a dependent of another employee covered by the Trust, or as a dependent of two covered employees, the coverages will be coordinated so that the sum of the benefits paid under this Plan plus benefits paid under all other plans will not exceed 100% of allowable expenses incurred. Benefits are not

transferable or assignable from one family member to another. For example, if you do not wear glasses, another family member may not receive an additional pair because you did not order or need a pair of glasses.

Example #1: Both spouses are covered by the Plan as employees. One spouse obtains elective contacts that cost $200. She submits a claim and the Plan pays $150. The other spouse may submit a claim for the remaining $50 and it will be processed under his coverage as a secondary plan. The Plan does not allow two pair of contacts or double coverage as an alternative to coordination of benefits.

Example #2: Both spouses are covered as employees and their dependents have coverage under both parents' Plans. A dependent child receives glasses from a network provider and one parent is billed for a $10 Plan copayment and $25 for the portion of the frames cost which exceeds the Plan's frame allowance. The other parent may then submit a claim on behalf of the child for the $35 which was not paid by the Plan. The Plan does not provide for two pair of glasses or double coverage as an alternative to coordination of benefits.

Exclusions

This Plan does not cover:

- The replacement of lenses or frames provided under this Plan that have been lost, damaged or broken, except at the normal intervals when services are otherwise eligible.
- Warranties, maintenance service, care kits, etc.
- Plano (non-prescription) lenses.
- Visual analysis which does not include refraction.
- Special procedures such as orthoptics, visual training, subnormal vision aids other than contact lenses, aniseikonia or similar procedures.
- Medical or surgical treatment of the eyes.
- Services or materials not listed as covered expenses.
- Any expense in excess of the usual, reasonable and customary amount.
- Services or materials provided as a result of any Workers' Compensation law or similar legislation, or received through or required by any government agency or program whether federal, state or any subdivision thereof. If the compensation does not cover the incurred expenses, coordination of benefits provisions will apply.
- Eye examinations required by:
  - An employer as a condition of employment which the employer is required to provide by virtue of a labor agreement; or
  - A government body.

- Dispensing or service fees related to ineligible materials.
- Charges incurred when not eligible.
- Contact lenses and glasses. The plan covers an exam, and either lenses, and frames; or an allowance towards contacts and fitting/evaluation. The glasses benefit and contacts benefit cannot be combined during a benefit period.
- Multiple contact lens claims in the same benefit period. The contact lens benefit may only be used once per 365-day benefit period; it cannot be used throughout the year on an "as-needed" basis. When using the contact lens benefit, plan participants are encouraged to obtain enough lenses to last until the next benefit period begins.

Limitations

If you select extras or features that are not included, such as high index lenses for cosmetic reasons, a frame that costs more than the Plan allowance, premium or non-standard progressives or, etc., you must pay the extra charge.

Plan Administration

PLAN ADMINISTRATION

About the Privacy of Your Health Information

As part of the normal process of administering its health care plans, the Trust, the Plan Sponsor (which is the Board of Trustees) and its health care claims administrators may receive personal health information about you and your covered dependents. Effective April 14, 2003, the use and disclosure of certain types of health information (called protected health information) will be governed by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), a federal law that governs the privacy of individuals' protected health information.

The Plan Sponsor and the Trust group health care plans (the vision plan described in this booklet) are subject to HIPAA's privacy requirements beginning on April 14, 2003, and HIPAA's privacy protections apply to them.

Participants will receive a copy of the Trust's HIPAA privacy notice separately.

Coordination With Other Vision Benefits

Coordination of Benefits or COB refers to how the Plan coordinates benefits when you or your dependents have vision coverage under more than one plan. COB ensures the total paid under this Plan and all other group plans does not exceed the actual charge for treatment or service.

Definitions

For the purposes of COB, the following definitions apply:

Plan — Means vision benefits provided under any:

- Insured or non-insured group, service, prepayment or other program arranged through an employer, trustee, union or association
- Program required or established by state or federal law (including Medicare Parts A and B, but excluding Medicaid)
- Program sponsored by or arranged for students through a school or other educational institution.

The term *Plan* does not include benefits provided under a student accident policy or under a state medical assistance program where eligibility is based on financial need.

Plan applies separately to parts of any program that contain COB provisions and separately to parts of any program that do not contain COB provisions.

Allowable Expense — All prevailing charges for treatments or services when at least part of those charges is covered under at least one of the plans then in force for the covered person. If a plan provides benefits in other than cash payments, the cash value of those benefits will be both an allowable expense and a benefit paid.

Claim Determination Period — The part of a calendar year when you would receive benefit payments under this Plan if this section were not in force.

Effect on Benefits

Benefits otherwise payable under this Plan for allowable expenses during a claim determination period may be reduced if:

- Benefits are payable under any other plan for the same allowable expenses
- Under the rules listed below, benefits payable under the other plan are to be determined before benefits payable under this Plan.

The reduction will be the amount needed to ensure that the sum of payments under this Plan plus benefits under the other plan is not more than the total of allowable expenses. Each benefit that would be payable without this section will be reduced proportionately. The total amount paid will be charged against any applicable benefit limit of this Plan.

For this purpose, benefits payable under other plans will include those that would have been paid if claims had been made for them. Also, for any person covered by Medicare Part A, benefits payable will include benefits provided by Medicare Part B, whether or not the person is covered under Part B.

Order of Benefit Determination

Except as described in the section Medicare Exception below, the benefits payable by a plan that does not have a COB provision will be determined before those of a plan that does have a COB provision. In all other instances, the order of determination will be:

1. **Employee/Dependent —** The benefits of a plan that covers the person as an employee participant are determined before those of a plan that covers the person as a dependent participant.

2. **Dependent Child — Parents Not Separated or Divorced.** When this Plan and another plan cover the same child as a dependent of parents who are not separated or divorced, benefits of the plan of the parent whose birthday falls earlier in a calendar year are determined before those of the plan of the parent whose birthday falls later in that year. If both parents have the same birthday, the benefits of the plan that covered the parent longer are determined before those of the plan that covered the other parent for a shorter time.

3. **Dependent Child — Parents Separated or Divorced.** If two or more plans cover a dependent child of divorced or separated parents, and if there is no specific court decree that determines responsibility for the

child's health care expenses, benefits for the child are determined in this order:

- First, the plan of the parent with custody of the child
- Then, the plan of the spouse of the parent with custody of the child, if applicable
- Finally, the plan of the parent not having custody of the child.

However, if the specific terms of a court decree state that one of the parents is responsible for the child's health care expenses, and the entity obligated to pay or provide benefits for the plan of that parent has knowledge of those terms, the benefits of that plan are determined first. (This does not apply to any claim determination period or plan year when any benefits are actually paid or provided before the entity has that knowledge.)

If the specific terms of a court decree state that both of the parents are responsible for the child's health care expenses, benefits of the plan of the parent whose birthday falls earlier in a calendar year are determined before those of the plan of the parent whose birthday falls later in that year.

4. **Active/Inactive Employee.** The benefits of a plan that covers a person as an employee who is neither laid off nor retired, or as that employee's dependent, are determined before the benefits of a plan that covers that person as a laid-off or retired employee or as that employee's dependent. If the other plan does not have this rule, and if, as a result, the plans disagree on the order of benefits, this rule will not apply.

5. **Longer/Shorter Length of Coverage.** If none of the above rules determines the order of benefits, the benefits of the plan that has covered a person longer are determined before those of a plan that has covered the person for a shorter time.

Benefit Credit Provision

This provision applies only to the Trust's medical benefits.

Claim Review and Appeal Procedures

The Washington Teamsters Welfare Trust plans have adopted specific procedures and timeframes, required by law, to evaluate and process claims for benefits, as well as appeals of denied claims. The timeframes and rules for making decisions on claims and appeals vary, depending on the type of claim and the benefit plan involved. This section provides information about the specific timelines and information requirements that apply to your vision plan claims and appeals filings and the claim administrator's claims and appeals determinations. The claim administrator, unless otherwise specified, is the Trust Administrative Office.

If your claim for benefits is wholly or partially denied, you or your duly authorized representative may submit a written request for a review of the claim by the Washington Teamsters Welfare Trust Appeals Committee (Appeals Committee). The request for review must be submitted to the Trust office within the timeframe applicable for that benefit plan and type of claim, as described in the following pages.

The length of time the claim administrator has to evaluate and process your claim generally begins on the date the claim is received. The claim administrator will consider the claim and notify you of an adverse decision on the claim, in writing, within the appropriate timeframes described below, unless the claim administrator determines that special circumstances require an extension of time to process the claim. If such an extension is necessary under any of the plans, the claim administrator will notify you of any such extension, the reasons for it, and the date by which the claim administrator expects to render the decision, within the original decision timeframe.

The claim administrator is the Trust Administrative Office.

If you believe that you are entitled to a benefit under the Washington Teamsters Welfare Trust vision plan, or that you are entitled to a greater benefit than the amount you received, then you, your beneficiary (if applicable) or your authorized representative may file a written claim with the Trust Administrative Office.

The claim review and appeal procedures apply to these types of claims:

Urgent Health Care Claim (before health care treatment)	A claim or pre-approval request for a vision benefit where treatment delay could seriously jeopardize life, health, the ability to regain maximum function or, in the opinion of a physician who knows the medical condition, would subject the patient to severe pain that cannot be adequately managed without care or treatment that is the subject of the claim.
Pre-Service Health Care Claim (before health care treatment)	Any claim or pre-approval request for a vision benefit, where receipt of benefit is conditioned, in whole or in part, based on advance approval.
Concurrent H ealth Care Claim (changes in health care treatment)	Any claim involving the reduction or termination of an ongoing course of treatment before the end of that course of treatment if the treatment was previously authorized by the Plan, or a request to extend treatment beyond the authorized time or number of treatments.
Post -Service Health Care Claim (after health care treatment)	Any claim for a vision benefit that is not a pre-service claim.

Vision Plan Claim Procedures

Timeframe for Initial Claim Decisions

The claim administrator will provide notice of an initial claim approval or denial within 30 days. If more time is needed to process claims due to circumstances beyond the claim administrator's control, an extension of up to 15 days is allowed, provided you are notified of the extension within the original 30-day period.

Incomplete Post-Service Claims

If more information is required to process your post-service vision plan claim, you'll be notified within the original 30-day period. If you are notified of the need to provide additional information for a post-service vision plan claim, you will have at least 45 days to supply this information. If you supply the requested information within the 45 days and your claim is denied, the claim administrator will notify you of the denial within 15 days after the requested information is received. If you do not supply the requested information within 45 days, your claim may be denied.

Notice of Initial Claim Denial

If the claim administrator denies the claim, you'll receive written or electronic notice containing:

- Specific reasons for the denial
- References to specific plan provisions on which the denial is based
- List of any additional material or information necessary for you to perfect the claim and an explanation of why it is necessary
- Description of the plan's claim appeal procedure (and applicable time limits), including a statement of your right to bring a civil action under ERISA Section 502(a) if your appeal is denied
- Certain other information in accordance with applicable U.S. Department of Labor regulations.

Claim Appeal Procedures

You can use these appeal procedures, if, in response to your claim, you received:

- No reply after the initial decision period, as listed above
- Notice of an extension to the initial decision period, as listed above, then no reply before the end of an extension
- A denial from the claim administrator.

If the vision plan claim is denied, in whole or in part, or if you believe plan benefits have not been properly provided, you, your beneficiary (if applicable), or your authorized representative may appeal the denial. The claim administrator will provide details about your right to appeal, along with the appeals process, address for filing an appeal, and timeframes. If you do not appeal within the designated timeframes, you may lose your right to later file suit in court.

To appeal a claim denial, you must file a written request for appeal pursuant to the procedure provided by the claim administrator within a certain period after receiving the claim denial, as described herein. The appeal must set forth all the grounds on which it is based, all the facts in support of the request, and other matters which you deem pertinent. Plan provisions require that you pursue the claim and appeal rights described here before seeking other legal recourse.

During the appeal, you will receive, upon request and free of charge, reasonable access to and copies of all documents, records and other information relevant to your benefit claim. For this claim procedure, a document, record or other information is considered relevant to a claim if it:

- Was relied on by the claim administrator in making the initial claim decision
- Was submitted, considered or generated in the course of deciding the claim, without regard to whether the document, record or other information was relied upon by the claim administrator in reaching the claim decision
- Demonstrates compliance with the administrative processes and safeguards required under Department of Labor regulations in making the benefit determination.

You may submit any written comments, documents, records or other information relating to your claim. In making its determination on health care claim appeals, the Appeals Committee of the Washington Teamsters Welfare Trust will take into account all the comments, documents, records and other information you submitted relating to the claim, without regard to whether they were submitted or considered by the claim administrator in making the initial claim decision.

The Appeals Committee will conduct a review and make a final decision within a certain period after receiving your written request for review, as described below and on page 37. For certain plans, if the Appeals Committee needs more than this initial period to make a decision due to special circumstances, it will notify you in writing within the initial decision timeframe and explain why more time is required and the date the plan expects to make a decision.

The Appeals Committee will review your denied claim. You or your authorized representative has the right to present relevant information or testimony at the quarterly Appeals Committee meeting scheduled to hear your appeal. You will be notified of the meeting time and date, however a personal appearance is not required. The appeal review will not be conducted by the individual who denied the initial claim or that person's subordinate. The Appeals Committee will not give deference to the original decision on your claim; that is, they will take a fresh look and make an independent decision about the claim within the timeframes.

If your claim was denied based on a medical judgment, the Appeals Committee will consult with a health care professional who has appropriate training and experience in the field of medicine involved in your claim. The health care professional will not be the same person as the one consulted on the initial decision (or a subordinate of that person). A medical judgment includes whether a treatment, drug or other item is experimental, investigational or not medically necessary or appropriate. You also have the right to learn the identity of any medical or other experts who advised on your original claim decision, whether or not the Plan relied on their advice.

Timeframes for Filing and Determination of Vision Plan Appeals

You have 180 days from the date you receive notice of a vision plan claim denial to file your appeal. The Trust Administrative Office will provide notice of appeal decision within five days after the next quarterly meeting of the Appeals Committee if the appeal is received at least 30 days before the meeting, otherwise the decision will be provided within five days after the second quarterly meeting that follows receipt of the appeal. If special circumstances require an extension of time for rendering a decision, the claim administrator will provide notice of the extension within the initial decision timeframe, and a decision will be rendered at the next quarterly meeting, with notice provided within five days after that meeting.

Notice of Decisions on Appeal

The decision on appeal will be in writing. If your appeal is denied, the notice will include:

- Reasons for the denial
- References to specific plan provisions on which the denial is based
- A statement of your right to access and receive copies, upon request and free of charge, of all documents and other information relevant to the claim for benefits
- A statement of your right to bring a civil action under ERISA Section 502(a)
- Certain other information in accordance with applicable U.S. Department of Labor regulations.

If the Appeals Committee does not respond within the applicable timeframe, you should generally consider the appeal denied. Contact the Trust Administrative Office if you have questions.

Request for External Review

You must complete the internal claims appeal process discussed above before requesting an external review. Once the internal claim appeal process is completed by the Appeals Committee making its decision, you will have 120 days from the date you receive that decision to file a request for an external review.

You may request external review for any denied claim except for denials based on finding that you did not satisfy the eligibility requirements for a benefit under the terms of the applicable Plan.

Requests for external reviews should be sent to:

External Review Appeals
PO Box 12267
Seattle, WA 98102

Preliminary Review of External Review Request

Within five (5) business days of receiving a request for external review, the Trust will complete a preliminary review of the request to make sure that:

- The patient is or was covered under the Trust at the time the health care item or service was requested or, in the case of a retrospective review, was covered under the Trust at the time the health care item or service was provided;
- The decision being appealed does not relate to any failure to meet the applicable eligibility requirements;
- The Trust's internal claims appeal process has been completed;
- All the information and forms required to process an external review have been received;
- The matter appealed involves either medical judgment or rescission.

Within one business day after completion of this preliminary review, the Trust will issue notification of its decision. If the request is not eligible for external review, the Trust's notice will explain the reasons and provide any other information required, including contact information for the U. S. Department of Labor's Employee Benefits Security Administration (EBSA). If the request for external review is incomplete, the Trust will identify what is needed and you will have the longer of 48 hours or the remaining portion of the four-month external review request period to provide the information. If the external review request is complete and eligible for external review, the Trust will refer the matter to an Independent Review Organization (IRO).

Review by Independent Review Organization

After a properly filed request for external review is referred, the Trust will provide the IRO with the required documentation in the time required by applicable Federal regulations. The IRO will notify both you and the Trust of its decision within 45 days after it has received the request to review.

Expedited External Review

You may request the IRO to provide you an expedited external review if you received:

- An adverse benefit determination involving a medical condition of the patient for which the time frame for completion of the Trust's expedited internal review process would seriously jeopardize the life or health of the patient or would jeopardize the patient's ability to regain maximum function and you have filed a request for an expedited internal appeal; or

- A final adverse benefit determination, if the patient has a medical condition where the timeframe for completion of a standard external review would seriously jeopardize the life or health of the patient or would jeopardize the patient's ability to regain maximum function, or if the final adverse benefit determination concerns an admission, availability of care, continued stay, or health care item or service for which the patient received emergency services, but has not been discharged from a facility.

If the Trust receives a request for expedited external review, it will proceed immediately to determine whether the request meets the reviewability requirements for a standard external review and will notify you of its determination. If the Trust determines that the appeal is eligible for a standard external review, the Trust will assign an IRO and will provide all necessary documents and information considered in making the adverse benefit determination or final adverse benefit determination to the IRO electronically or by any other available expeditious method. The IRO will notify the Trust and you of its determination as expeditiously as the patient's medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request for an expedited external review. If the notice from the IRO is not in writing, within 48 hours after the date of providing the notice, the IRO will provide both you and the Trust written confirmation of the decision.

Actions Following the Decision of the IRO

If the IRO directs that benefits be paid, the Trust will provide benefits under the applicable Plan in accordance with the decision. If the decision is adverse, you will have the right to pursue a suit pursuant to 29 U.S.C. 1132(a). Any legal action seeking to overturn a denial or an action that has otherwise adversely affected a claimant must be brought within 180 days of the latest of the following events: the initial denial with no appeal being made; the final adverse benefit determination by the Trust; or the IRO's denial.

Administrative Details

The Employee Retirement Income Security Act of 1974 (ERISA) as amended, requires that certain information be furnished to Plan participants and beneficiaries:

Name of Plan

This Plan is known as the Washington Teamsters Welfare Trust Vision Plan EXT.

Name, Address and Telephone Number of Board of Trustees as Plan Sponsor

This Plan is sponsored by a joint labor-management Board of Trustees:

Board of Trustees of the Washington Teamsters Welfare Trust
2323 Eastlake Avenue East
Seattle, Washington 98102-3393
206-329-4900

You can obtain information on whether a particular employer or employee organization is a Plan sponsor (and, if so, their address) by writing to the Trustees. This information is also available to examine at the Trust Administrative Office. The Trustees may impose a reasonable charge for furnishing this information. You may want to inquire about the charge before requesting information.

Employer Identification Number and Plan Number

The employer identification number assigned to the Board of Trustees by the Internal Revenue Service is EIN 91-6034673.

- The Plan number is 501.
- This Plan is a welfare plan that provides vision benefits.

Type of Administration

The Plan's benefits are administered by the Board of Trustees with the assistance of this administrative organization:

Northwest Administrators, Inc.
2323 Eastlake Avenue East
Seattle, Washington 98102-3393
206-329-4900

Name and Address of Agent for Service of Legal Process

Each member of the Board of Trustees is designated as an agent for accepting service of legal process on behalf of the Plan. The names and addresses of the Trustees are below:

Legal process can also be served upon:

Northwest Administrators, Inc.
2323 Eastlake Avenue East
Seattle, Washington 98102-3393

Names and Addresses of Board of Trustees

Employer Trustees

Jerry D'Ambrosio
11019 SE 60th Street
Bellevue, Washington 98006

Anthony DeCosmo
Albertsons-Safeway
6900 S Yosemite St
Centennial, CO 80112-1418

Brian Person
United Parcel Service
4455 7th Avenue S
Seattle, WA 98108-1731

Scott Powers
Allied Employers, Inc.
811 Kirkland Avenue Suite 100
Kirkland, WA 98033-8140

H.L. "Buzz" Ravenscraft
Sahara, Inc.
6631 113th Place SE
Bellevue, Washington 98006-6429

Nick Scarsella
Scarsella Bros., Inc.
PO Box 68697
Seattle, WA 98168

Bill Seehafer
UNFI
11840 Valley View Road
Eden Prairie, MN 55344

Randy Zeiler
Allied Employers, Inc.
4030 Lake Washington Boulevard NE
Suite 201
Kirkland, Washington 98033-7870

Employee Trustees

Brian Blaisdell
Teamsters Local Union 252
217 East Main Street
Centralia, WA 98531-4449

Leonard Crouch
Teamsters Local Union 760
1211 West Lincoln Avenue
Yakima, WA 98902-2535

Rich Ewing
Teamsters Local Union 231
1700 North State Street
Bellingham, WA 98225-4638

Mark Fuller
Teamsters Local Union 589
11871 Silverdale Way NW Suite 111
Silverdale, WA 98383

Rick Hicks
Teamsters Local Union No. 174
14675 Interurban Ave S, Suite 303
Tukwila, Washington 98168-4614

Val Holstrom
Teamsters Local Union No. 690
1912 North Division Suite 200
Spokane, WA 99207-2271

Samantha Kantak
Teamsters Local Union No. 38
2601 Everett Avenue
PO Box 1548
Everett, Washington 98206

Robert McDonald
Teamsters Local Union 313
220 South 27th Street
Tacoma, WA 98402

John Scearcy
Teamsters Local Union No. 117
14675 Interurban Avenue S Ste 307
Tukwila, WA 98168-4614

Russell Shjerven
Teamsters Local Union 839
1103 W Sylvester Street
Pasco, WA 99301-4873

Scott Sullivan
Teamsters Local Union No. 763
14675 Interurban Avenue S Ste 305
Tukwila, WA 98168-4617

Description of Collective Bargaining Agreements

This Plan is maintained under many collective bargaining agreements between various employers and labor organizations. You may obtain a copy of these collective bargaining agreements by writing to the Trust Administrative Office. This information is also available to examine at the Trust Administrative Office. The Trustees may impose a reasonable charge for furnishing the collective bargaining agreements. You may want to inquire about the charge before requesting a copy.

Eligibility and Benefits

Employees are entitled to participate in the Plan if they work under a collective bargaining agreement requiring contributions on their behalf and the employer makes those contributions to the Trust. The eligibility rules describing which employees and dependents are entitled to benefits begin on page 10. The benefits are described beginning on page 25.

Termination of Eligibility

An employee or dependent who is eligible for benefits may become ineligible as a result of one or more of the following circumstances:

- The employee's failure to work the required hours to maintain eligibility (or failure to make a self-payment, where authorized). See When Coverage Ends on page 11 and COBRA Self-Pay Option on page 20.
- The failure of the employee's employer to report the hours and remit contributions on the employee's behalf to the Trust Fund.
- An eligible dependent is no longer a dependent as described on page 12 or attains a disqualifying age as shown on page 12.
- Termination of the governing collective bargaining agreement or the Trust.

Future of the Plan and Trust Fund

The Board of Trustees has authority to terminate the Trust Fund. The Trust Fund will also terminate when collective bargaining agreements and special agreements requiring the payment of contributions expire. In the event of termination, the Board of Trustees will:

- Use the Trust Fund to pay expenses incurred up to the date of termination and expenses incident to the termination.
- Distribute the balance, if any, of Trust Fund assets to carry out the purpose of the Trust.
- Upon termination, the Board of Trustees may transfer remaining Trust Fund assets to the Trustees of any fund established to provide substantially the same or greater benefits than this Plan. In no event will any of the funds revert to or be recoverable by any employee, employer or union.

Source of Contributions

This Plan is funded through employer contributions; the amount is specified in the collective bargaining agreements. Also, self-payments by employees are permitted as outlined in this Plan booklet. The amount of the total plan cost is changed from time to time by the Board of Trustees, including employer contributions alone or a combination of employer contributions and employee self-payments.

Entities Used for Accumulation of Assets and Payment of Benefits

Employer contributions are received and held in trust by the Board of Trustees pending the payment of benefits or premiums. The Trustees pay benefits directly from the Trust Fund.

Plan Year

This Plan is on a 12-month fiscal year basis beginning July 1 and ending the following June 30.

ERISA Rights and Protections

As a participant in the Trust, you are entitled to certain rights and protections under ERISA, which provides that all Plan participants be entitled to:

- Examine, without charge, at the Trust Administrative Office and at other specified locations, such as work sites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the Department of Labor and available at the Public Disclosure room of the Employee Benefits Security Administration.
- Obtain, upon written request to the Trust Administrative Office, copies of documents governing Plan operation, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Trust Administrative Office may make a reasonable charge for the copies.
- Receive a summary of the Trust's annual financial report. The Trust Administrative Office is required by law to furnish each participant with a copy of this summary annual report.
- 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 to learn the rules governing these COBRA continuation coverage rights.
- Reduce or eliminate exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan. You should receive a certificate of creditable coverage, free of charge, from your Plan or insurer when you lose coverage under the Plan, when you become entitled to elect COBRA continuation coverage and 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 enrolling.

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for operation of the Plan. The people who operate your Plan, called "fiduciaries," have a duty to do so prudently and in the interest of you and other participants and beneficiaries. No one, including your employer, your union or any other person, may fire you or

otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

If your claim for a welfare benefit is denied or ignored, in whole or in part, you must receive a written explanation of the reason for the denial. You have the right to have the Plan review and reconsider your claim.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of documents or the latest annual report for the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Trust to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the Trust's control. If your claim for benefits is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the Plan's decision or lack of decision concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in federal court. If fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the Department of Labor or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

If you have any questions about your Plan, contact the Trust Administrative Office. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Trust Administrative Office, contact the nearest office of the Employee Benefits Security Administration, Department of Labor, listed in your phone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, Department of Labor 200 Constitution Avenue NW, Washington, DC 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration or through the website on the internet at www.dol.gov/ebsa.