Administrative Information

This section includes additional information about how the Trust Plans and other benefit arrangements are administered, claims information and a statement of your rights as a participant.

Important Information About Appeals

The following appeal procedures apply to any appeal involving eligibility or benefits not provided by Kaiser or Providence. These are medical and prescription drug benefits under the Trust Early Retiree Indemnity Medical Plan for PAT participants, the Trust Early Retiree Prescription Drug Plan and the Trust Early Retiree Voluntary Dental and Vision Plan. For the appeal procedures for benefits provided by Kaiser and Providence, refer to the procedures described in the booklets they provide. See *Contacts* for details.

How to Appeal an Administrative Decision

ELIGIBILITY/ENROLLMENT

If an enrollment or eligibility request submitted to the Trust Office is denied in whole or in part, the Trust Office will provide you with a notice identifying the reason(s) for the denial, any other information needed to consider your request and your right to obtain additional information about the Trust's eligibility and enrollment rules. You may appeal an adverse eligibility or enrollment decision by filing a written appeal with the Trust Office within 180 days of the denial. Appeals should be sent to the following address:

School District No. 1 Health and Welfare Trust Appeals
P.O. Box 12267
Seattle, WA 98102

The appeal shall identify the eligibility or enrollment determination involved, set forth the reasons for the appeal and provide any additional information you believe is relevant. Your appeal will not be considered and the denial by the Trust Office will be final if no appeal is received within 180 days.

Appeals Procedures for the Trust Vision Plan

Appeal of Denied Claims: Under the Plan, if a claim is denied in whole or in part, you or your authorized representative may request a full review of the denial. You may designate any person, including your provider, as your authorized representative.

Initial Appeal: The request must be made within 180 days following denial of a claim and should contain sufficient information to identify the Trust participant for whom the claim was denied, including the VSP enrollee's name, the VSP enrollee's member identification number, the Trust participant's name and date of birth, the provider's name, and the claim number. You may review during normal working hours any documents held by VSP pertinent to the denial. You may also submit written comments or supporting documentation concerning the claim to assist in VSP's review. VSP's response to the initial appeal, including specific reasons for the decision, will be provided and communicated to you as follows:

- Prior authorization for visually necessary or appropriate services: within 30 calendar days after receipt of your request for an appeal; and
- Denied claims for services rendered: within 30 calendar days after receipt of your or your authorized representative's request for an appeal.

Second Level Appeal: If you or your authorized representative disagrees with the response to the initial appeal of the claim, you or your authorized representative has the right to a second level appeal. Within 60 days after receipt of VSP's response to the initial appeal, you or your authorized representative may submit a second appeal to VSP along with any pertinent documentation. VSP will communicate its final determination to you or your authorized representative in compliance with applicable state and federal laws and regulations and will include the specific reasons for the determination.

Other Remedies: If you remain dissatisfied after completing the VSP appeals process, you may request that the Trust review your appeal. Details about how to access the Trust Claim Appeal Procedures are set forth below.

Determination on Submitted Claims

The Claim Administration Agent (Regence; Kaiser Permanente; Providence HealthPlan; VSP and CVS/Caremark) will process a properly filed claim within 30 days of its receipt. This 30-day period can be extended for 15 days if the circumstances require. If additional information is needed to process your claim, you will be notified of the additional necessary information and be given up to 45 days to produce it.

If your claim is denied in whole or in part, the Claim Administration Agent will provide you with a notice identifying the reasons for the denial, any additional information necessary to consider your claim, your right to obtain additional information and the Trust's claims appeal procedures. Please note that these procedures are partially modified (as discussed below) if your claim involves an urgent care claim.

Internal (Initial) Grievance or Appeal

You may appeal a benefit claim denial by filing with the Claim Administration Agent a written appeal within 180 days of the denial. The appeal shall identify the benefit determination involved, set forth the reasons for the appeal and provide any additional information you believe is relevant. Your appeal will not be considered and the denial by the Claim Administration Agent will be final if no appeal is received within 180 days.

Your Rights on Appeal

If you appeal, you or your authorized representative may, upon request and free of charge, have reasonable access to all documents relevant to your claim appeal. Relevant documents include documents relied on, submitted, considered or generated in making the benefit determination, including any internal guidelines or policies considered in processing your appeal. If the denial is based on a medical determination, an explanation of that determination, and its application to your medical situation, is also available upon request.

If you are not satisfied with the decision of the Internal Grievance or Appeal and your Appeal involves an Adverse Benefit Determination, you may request a voluntary second level internal appeal. If your case is eligible, it will be reviewed by the claims appeal panel.

Administrative Review of Appeal

The initial review of any appeal will be an administrative review done by the Trust Office in conjunction with the assistance of the Trust's medical review organization or other appropriate provider. The Trust Office will notify you of its decision within 30 days of receipt of your appeal. The administrative review decision shall:

- State the specific reason for the denial;
- Reference the plan provision(s) relied on;
- Describe any additional information necessary to perfect your claim and the reason it is necessary;
- Explain the Trust's claims procedures; and
- Describe what information is available to you.

The Trust Office's administrative review will be final and binding unless you submit a written request for review within 60 days of the denial. Upon receipt of a request for review the Trust Office may refer the matter to the Administrative Committee at its next meeting for informal consultation and comment. If this consultation does not resolve the appeal, the matter will be referred to the Claims Appeal Panel for formal review.

Trust Appeal Panel

The Trust's Administrative Committee serves as the Appeal Panel. The Appeal Panel will consider properly filed appeal requests at the next regularly scheduled Administrative Committee meeting following receipt of the appeal and the completion of any informal consultation process. If your request for Appeal Panel review is received within 20 days of the next regularly scheduled Administrative Committee meeting, your appeal will be heard at the second regularly scheduled Administrative Committee meeting.

The Appeal Panel will review all documents relevant to the appeal. The review will be de novo (i.e., without any deference to the original decision).

You or your authorized representative will be allowed to appear before the Appeal Panel and present evidence or witnesses. The Appeal Panel may in its discretion set conditions related to the conduct of an appeal, the testimony or attendance of any individual or other procedural and evidentiary matters.

The Claim Appeal Panel will notify the claimant of its decision within 10 days of the hearing. If any part of the appeal is denied, the written decision will set out the specific reason for the adverse decision, reference the plan provision involved, identify any internal rules or guidelines considered in making its decision, and a statement identifying what information is available to you upon request.

A vote by three of the four members of the Appeal Panel is required to constitute a decision. A decision of the Claims Appeal Panel will be final and binding unless the Appeal Panel refers the matter to the Board of Trustees or cannot reach a decision.

Referral to Board of Trustees

If a matter is referred to the Board of Trustees from the Appeal Panel, a decision will be made at the next regularly scheduled Board of Trustees meeting. You or your authorized representative may appear before the Board of Trustees if you appeared before the Appeal Panel. If the Board of Trustees is unable to make a decision at its next regularly scheduled meeting, you will be notified and the matter will be heard at its next subsequent meeting. The decision issued by the Board of Trustees will contain the same information as decisions issued by the Claim Appeal Panel. The Board of Trustees' decision will be final and binding.

Exhaustion of Claim(s) Appeal Procedures and Standard of Review

You must exhaust these claim(s) appeal procedures prior to undertaking any legal action with respect to a claim. In any action challenging a denial of benefits the standard of review shall be whether the Trustees were in error upon an issue of law, acted arbitrarily or capriciously or entered findings of fact that were unsupported by substantial evidence.

Special Rules for Urgent Care Claims

The Trust will modify its procedures in situations involving urgent care claims. Urgent care claims are claims for services where the application of the normal time frames for appeals could seriously jeopardize the life or health of the claimant or expose the claimant to severe pain. Urgent care claims may be filed, orally or in writing, by you or a health care provider with knowledge of your medical condition. Urgent care claims only involve services that have not been provided as a result of the Trust's denial.

The Trust Office will make an initial decision on an urgent care claim within 72 hours of receipt. If additional information is needed to process the claim, you or your health care provider will be notified and given 48 hours to provide additional information.

If you appeal an urgent care claim, a decision will be made within five (5) working days of the appeal. The Claims Appeal Panel may meet via teleconferencing to consider an urgent care claim. Given the shorter time frame there will be no right to a personal appearance.

Coordination of Benefits

Coordination of benefits applies when you or covered dependents have health care coverage under more than one plan. The following rules determine whether the benefits of the Trust's plan are paid before or after the benefits of another plan. The benefits of the Trust's plan will ***not*** be reduced when, under these rules, the Trust's plan pays benefits first. The benefits of the Trust's plan may be reduced when another plan pays benefits first.

When there is a basis for a claim under the Trust's plan and another plan, the Trust's plan is the secondary plan (which pays benefits after the other plan) unless:

- The other plan has rules coordinating its benefits with those of the Trust's plan
- The rules of both plans require that the Trust's plan's benefits be paid before those of the other plan, as follows:

The Trust's plan determines its order of benefits by the first of the following rules that applies:

- The benefits of the plan that cover a person as an employee are determined before the benefits of the plan that cover a person as a dependent.
- When the Trust's plan and another plan cover the same child as a dependent of both parents:
  - The benefits of the plan of the parent whose birthday falls earlier in the calendar year are determined before those of the plan of the parent whose birthday falls later in the year

  - If both parents have the same birthday, the benefits of the plan that has covered a parent for the longer time are determined before the benefits of the plan that has covered a parent for the shorter time
  - If the other plan has a rule based on gender of the parents instead of birthdays, the other plan's rule will determine the order of benefits.
- If two or more plans cover a dependent child of divorced or separated parents, benefits for the child are determined in this order:
  - First, the plan of the parent with custody of the child
  - Second, the plan of the spouse of the parent with the custody of the child
  - Third, the plan of the parent without custody of the child.
- However, if a court decree states that one of the parents is responsible for the health care expenses of the child, the benefits of that plan are determined first.
- The benefits of a plan that covers a person as an active employee or dependent of an active employee will be determined before the benefits of a plan that covers a person as an early retiree, continuation coverage, self-pay or laid off employee or the dependent of such a person. This rule is ignored if the other plan does not have the same rule and if, as a result, the plans do not agree on the order of payment.
- If none of the previous rules determine the order of benefits, the plan that has covered the early retiree or dependent for a longer time determines benefits before the plan that has covered the person for a shorter time.

Effect on Plan Benefits

If you have other health care coverage, the benefits payable under the Trust Early Retiree Preferred Provider and Indemnity Medical Plans, and the Trust Early Retiree Voluntary Dental/Vision Plan may be reduced.

THE TRUST EARLY RETIREE MEDICAL PLANS

If you have other health care coverage, the benefits payable under the Trust Early Retiree Plan 1 (Closed) and the Trust Early Retiree Plan 2 (Open) may be reduced, as follows:

- ***If the other plan providing health care coverage does not have a coordination of benefit provision:*** The Trust Early Retiree Medical Plans (Plan 1 and Plan 2) will reduce the amount they pay so that the amount paid under both plans does not exceed 100% of covered expenses. The benefits payable under each plan will be reduced proportionally to assure that benefits do not exceed the amount of the covered expenses.

- ***If the other plan providing health care coverage has a coordination of benefits provision:*** The coordination of benefits provision will be followed to determine which plan pays secondary. If the Trust Early Retiree Medical Plans (Plan 1 and Plan 2) pay secondary, they will not pay more than the amount of benefits they would have paid for the covered service or supply had they been the primary plan. The Trust, however, will keep a record of the difference between what was paid and what would have been paid if the Trust Early Retiree Medical Plans (Plan 1 and Plan 2) were the primary payer. These savings will be applied to other covered expenses you incur during the same calendar year. These savings cannot be used for expenses other than covered expenses under the Trust Early Retiree Medical Plans (Plan 1 and Plan 2) and cannot be carried forward beyond the calendar year in which the savings were recognized.

The Trust Early Retiree Voluntary Dental/Vision Plan

If you have other health care coverage, the benefits payable under the Trust Early Retiree Voluntary Dental/Vision Plan may be reduced, as follows:

- ***If the other plan providing dental/and or vision coverage does not have a coordination of benefit provision:*** The Trust Early Retiree Voluntary Dental/Vision Plan will reduce the amount it pays so that the amount paid under both plans does not exceed 100% of covered expenses. The benefits payable under each plan will be reduced proportionally to assure that benefits do not exceed the amount of the covered expenses.
- ***If the other plan providing dental and/or vision coverage has a coordination of benefits provision:*** The coordination of benefits provision will be followed to determine which plan pays secondary. If the Trust Early Retiree Voluntary Dental/Vision Plan pays secondary, it will not pay more than 100% of the allowed amount for the covered service. The Trust, however, will keep a record of the difference between what was paid and what would have been paid if the Trust Early Retiree Voluntary Dental/Vision Plan were the primary payer. These savings will be applied to other covered expenses you incur during the same calendar year. These savings cannot be used for expenses other than covered expenses under the Trust Early Retiree Voluntary Dental/Vision Plan and cannot be carried forward beyond the calendar year in which the savings were recognized.

Right to Receive and Release Necessary Information

Certain information is needed to coordinate benefits. The plan has the right to determine what facts are needed and may obtain them from, or provide it to, any other organization or person. Your consent is not required to obtain necessary information or provide it to a third party. Each person claiming benefits under this plan must give the Plan Administrator any information needed to pay the claim.

Facility of Payment

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

Right of Recovery

If the plan pays benefits exceeding what should have paid under the coordination of benefits provision, the plan may recover the excess from one or more of:

- The person it has paid or for whom it has paid
- Insurance companies
- Other organizations.

The amount of the payments includes the reasonable cash value of any benefits provided in the form of services.

A secondary plan that provides benefits in the form of services may recover the reasonable cash value of the services from the primary plan if the services are covered, but not paid or provided, by the primary plan. However, a plan is not required to reimburse a covered person in cash for the value of benefits provided in the form of services.

Plan Not Responsible for Quality of Medical Care

You and your covered dependents have the exclusive right to select dental and vision providers. The plan is not responsible for the quality of dental and vision services you receive, because all providers are independent contractors who are not employees of the plan or related to the plan in any way. The plan cannot be held liable for any claim or damages related to injuries suffered by a covered person while receiving dental or vision services or supplies.

Benefits Not Transferable

Only you and your enrolled dependents are entitled to benefits under the plan. These benefits may not be assigned or transferred to anyone else. Any attempt to assign or transfer the benefits will not be binding on the plan.

Uncashed Checks

Checks issued to participants or providers which are not negotiated within 12 months of issuance will be re-credited to the Trust general assets. If a participant or other appropriate payee requests a reissuance of the check within 12 months of the re-crediting of the check to the Trust's general assets, a new check will be issued. If a request is not made within this time period, the participant or payee's right to payment will be deemed forfeited.

Important Information About Your Trust Medical Benefits

Please review this section carefully, as it explains important information about your medical plan benefits.

Medicare

If you enroll in Medicare because of end-stage renal disease (ESRD) and have coverage under a Trust Early Retiree Medical Plan, Medicare is the secondary payer for the first 30 months that you qualify for Medicare because of ESRD, and Medicare is primary thereafter.

Benefits from Other Sources

Please review this section carefully. It provides information on benefits from other sources.

THIRD-PARTY LIABILITY

There may be situations in which you have a legal right to recover the cost of medical care from a third party who may be responsible for the illness or injury. For example, if you are injured in a store, the owner may be responsible for expenses related to the injury.

If you have such a claim against a third party, the following rules apply (as used in this section, “you” means you or your covered dependent):

- If the plan has paid any benefits to you (or on your behalf), the plan is entitled to recover the amount paid from the proceeds of any settlement or recovery you receive from the third party or by one or more insurers whose insurance policies have become applicable. Insurance includes, but is not limited to, automobile liability, automobile no-fault, uninsured or underinsured motorist, business or commercial liability or umbrella liability regardless of whether such insurance is maintained by the third party, you or any other person or entity. If you continue to receive medical treatment for the illness or injury after obtaining the settlement or recovery, benefits will not be paid for the continuing treatment unless you can prove that the total cost of treatment (including the cost of obtaining the settlement or recovery) is more than the amount you have recovered or expect to recover.
- If you recover any amount from the third party, the plan is entitled to full reimbursement for all related benefits paid to you (or on your behalf) immediately upon the recovery (whether by action of law, settlement or otherwise), regardless of whether you have been made whole. The plan will reduce its reimbursement amount only by a proportionate share of your actual attorneys’ fees and costs up to a maximum reduction of one-third. You must hold the proceeds of the recovery in trust for the plan, which will have a security interest in, and lien on, any recovery you make, to the extent of the benefits the plan has paid and the expenses it has incurred in obtaining the recovery.
- The Trust may require you to sign and deliver any legal documents necessary to secure the plan’s rights of subrogation. If the Trust asks you to sign an agreement to hold the proceeds of any recovery in trust, you must do so before any benefits will be paid.
- If you do not take legal action against a third party, the plan may initiate such action, and you must authorize the plan to sue, compromise or settle any third-party claim in your name. You must cooperate fully with the plan in any proceeding against a third party to reimburse the plan for benefits that were paid to you (or on your behalf) and related to the third-party claim.
- Any dispute regarding the interpretation, application or administration of the Trust’s third-party reimbursement provision will be resolved through arbitration. Arbitration will be conducted in accordance with the Oregon Uniform Arbitration Act, ORS 36.600, et. seq. The parties will split the cost of arbitration unless the Arbitrator orders otherwise. Each party will bear its own attorneys’ fees. In reviewing any issue, the Arbitrator’s scope of review will be whether the Board of Trustees was in error on an issue of law, acted arbitrarily or capriciously in the exercise of its direction, or its findings of fact were unsupported by substantial evidence.

Motor Vehicle Accidents

A motor vehicle accident in which you may have a legal right to recovery is a form of third-party liability. Therefore, the above rules on claims against the third party apply. Before benefits will be paid, you must provide the Trust with the name and address of the other vehicle's driver and his or her insurance company.

Additionally, if you are injured in or by a motor vehicle operated by you or a dependent, the plan will not pay expenses that would be covered as primary by personal injury protection benefits where such coverage is required by law. This exclusion will apply even if you failed to obtain such mandatory coverage. Amounts recovered under any auto insurance policy including automobile liability, automobile no-fault, uninsured and underinsured motorist, business or commercial liability or umbrella liability regardless of whether such insurance is maintained by a third party, you or any other person or entity, are subject to the Trust's third-party reimbursement provisions. Coverage under this plan will be secondary where allowed by law.

Before the plan pays benefits:

- You must have the minimum legally required motor vehicle insurance
- You must provide the Trust with information about any motor vehicle insurance payments made available to you or your covered dependent
- If the Trust requests, you must sign an agreement to hold the proceeds of any recovery in trust for the plan.

Workers' Compensation

The plan does not pay benefits for illness or injury covered under workers' compensation law. For example, if you become ill or are injured as a result of, or in the course of, your employment, your employer or a workers' compensation insurer may be responsible for health care expenses related to the illness or injury. If you filed a claim for workers' compensation that was denied and are in the process of appealing the denial, benefits will be paid to you subject to the following conditions:

- Prior to paying benefits, the plan must receive notice of the denial from your workers' compensation insurer;
- You must provide the Trust Office with a signed agreement to reimburse the plan in the event your workers' compensation claim is paid or settled; and
- You must reimburse the plan for all benefits paid to you for the illness or injury for which you are entitled to compensation by the settlement or disposition of your workers' compensation claim.

Recovery of Benefits Paid in Error

If the Trust mistakenly pays benefits to which you are not entitled or pays a person who is not eligible for payment, the plan has the right to recover that payment from the person paid or from anyone who has benefited from the payment. The plan may recover the improperly paid benefits from any individual who has provided misinformation to the Trust or from you if you have failed to notify the Trust of your dependent's loss of eligibility and these actions have resulted in the payment of improper benefits. The plan may recover improperly paid benefits by deducting future benefits payable to the employee through whom the recipient of the improper benefits has eligibility or any dependents of the employee. The Trust's right to deduct future benefits will apply to any failure to reimburse the plan from any settlement or recovery when benefits have been advanced pursuant to the plan's third-party liability provisions.

Notice of Creditable Prescription Drug Coverage

This notice is most relevant for people who are eligible for Medicare or those who will soon become eligible for Medicare. As an early retiree of the School District No. 1 Health and Welfare Trust, in most cases you and your spouse or domestic partner are not eligible for the Trust's early retiree plans if you are eligible for Medicare, so this information does not affect you. However, this notice would apply to the following Medicare-eligible people who are covered by the Trust's early retiree plans:

- Disabled dependent children
- People who have end-stage renal disease and are in the first 30 months of Medicare eligibility.

Medicare prescription drug coverage became available in 2006 to everyone who is eligible for Medicare. All Medicare prescription drug plans will provide at least a standard level of coverage set by Medicare. Some plans might also offer more coverage for a higher monthly premium.

The Trust has determined that the prescription drug coverages for early retirees and their dependents enrolled in the following Trust plans are on average expected to pay out at least as much as the standard Medicare prescription drug coverage will pay:

- Trust Early Retiree Prescription Drug Plan (for members enrolled in the Providence Personal Option Plan)
- Trust Early Retiree Indemnity Medical Plan (Plan 1)
- Trust Early Retiree PPO Plan (Plan 2).

Individuals can enroll in a Medicare prescription drug plan when they first become eligible for Medicare and each year from October 15 through December 7. However, because you have existing prescription drug coverage through the Trust that, on average, is as good as Medicare coverage, you can choose to keep the Trust's prescription drug coverage as long as you are eligible for it, and join a Medicare prescription drug plan later. You may also be eligible for a special enrollment period to sign up for a Medicare prescription drug plan at the time you lose eligibility for Trust coverage.

If you decide to enroll in a Medicare prescription drug plan and you are still eligible for Trust early retiree coverage according to plan eligibility and as summarized above, you may also continue your Trust prescription drug coverage. If you decide to enroll in a Medicare prescription drug plan and drop your Trust coverage, be aware that you will drop both medical and prescription drug coverage, and Medicare will be your only payer.

You should also know that if you drop or lose your coverage with the Trust and don't promptly enroll in Medicare prescription drug coverage after your Trust coverage ends, you may pay more to enroll in Medicare prescription drug coverage later. If you go 63 days or longer without prescription drug coverage that is at least as good as Medicare's prescription drug coverage, your monthly premium for a Medicare prescription drug plan will go up at least 1% per month for every month after your initial enrollment period that you did not have that coverage. For example, if you go 19 months without coverage, your Medicare prescription drug plan premium will always be at least 19% higher than what most other people pay. You will have to pay this higher premium as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following November to enroll.

The Trust will provide you with a notice of creditable coverage. You may receive this notice at other times in the future such as before the next period you can enroll in Medicare prescription drug coverage, if this coverage changes, or upon your request.

Notice of Privacy Practices

The HIPAA Privacy Rules require that the School District No. 1 Health and Welfare Trust not use or disclose Protected Health Information ("PHI") unless it is for Payment, Treatment or Health Care Operations or authorized by the affected Individual. Under the Privacy Rules, all disclosures of PHI shall be limited to the minimum necessary requirements.

This Policy and Procedures is enacted to document School District No. 1 Health and Welfare Trust's compliance with the requirements of the HIPAA Privacy Rules and to provide guidance for handling issues which may arise under the HIPAA Privacy Rules. Other Covered Entities with which the Trust contracts will follow their own privacy policies adopted pursuant to the HIPAA Privacy Rules. This Policy and Procedures will be interpreted in accordance with the governing regulations and other legal requirements. This notice is also available on the Trust's web site, www.sdtrust.com.

Use and Disclosure of Health Information

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

To Make or Obtain Payment

The Trust may use or disclose your health information to make payment to or collect payment from third parties, such as other health plans or providers, for the care you receive. 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.

To Facilitate Treatment

The Trust may disclose information to facilitate treatment that 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 de-identified health information to the Board of Trustees (which is the plan sponsor) and to necessary advisors who assist the Board of Trustees in performing plan administration functions, such as handling claim appeals.

The Trust also may provide summary health information to the Board of Trustees so that it may solicit bids for services or evaluate its benefit plans. Summary health information is information that summarizes participants' claims information but from which names and other identifying information have been removed. The Trust may also disclose information about whether you are participating in the Trust or one of its available options.

Disclosure Where Required by Law

In addition, the Trust will disclose your health information where applicable law requires. This includes:

- **In connection with judicial and administrative proceedings —** The Trust will, in response to an order from a court or administrative tribunal, disclose protected health information in accordance with the express terms of such an order. The Trust may also disclose protected health information in response to a subpoena or other lawful process if the Trust receives satisfactory documentation that you have received notice of the subpoena or legal process, the notice provided sufficient information to allow you to raise an objection and the time for raising an objection has passed and either no objections were filed or were resolved by the court or administrative tribunal. Alternatively, the party requesting disclosure may provide satisfactory documentation you have agreed to the disclosure or that it has obtained a qualified protective order which meets the requirements of the Privacy Rules and which allows for disclosure. For example, if the Trust receives a court order requiring it to disclose certain information, it will respond to the court order.
- **When legally required and for law enforcement purposes —** The Trust will disclose your protected health information when it is required to do so for law enforcement purposes. This may include compliance with laws which require reporting certain types of injuries, pursuant to court issued legal process; or a grand jury subpoena or other administrative requests if satisfactory documentation is provided that the request is relevant to a legitimate law enforcement purpose, the request is reasonably tailored to meet this legitimate law enforcement purpose and de-identified information cannot be reasonably provided as an alternative. Additionally, limited disclosure may be made for purposes of identifying or locating a suspect, fugitive, material witness or missing person, identifying a victim of a crime or in connection with a criminal investigation that occurred on Trust premises. For example, the Trust could upon request of a law enforcement agency provide information concerning the address of a fugitive.
- **To conduct public health and health oversight activities —** The Trust may disclose your health information to a health oversight agency for authorized activities (including audits, civil administrative or criminal investigations, inspections, licensure or disciplinary action), government benefit programs for which health information is relevant, or to government agencies authorized by law to receive reports of abuse, neglect or domestic violence as required by law. The Trust, however, may not disclose your health information if you are the subject of an investigation and the investigation does not arise out of or is not directly related to your receipt of health care or public benefits.

- **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.
- **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.
- **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.
- **To your personal representative —** The Trust may disclose your health information to an individual who is authorized by you or applicable law to serve as your personal representative.

Authorization to Use or Disclose Health Information

Other than as stated earlier, 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 or from the Trust web site, www.sdtrust.com. (See "Privacy Contact Person" on page 59 for details.)

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. (See "Privacy Contact Person" on page 59 for details.)

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. They do not include summary information about your mental health treatment or information about medications, session stop and start times, the diagnosis and other basic information. The Trust may use and disclose psychotherapy notes when needed to defend against litigation filed by you or as necessary to conduct treatment, payment and health care operations.

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.

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 proceedings. 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. (See "Privacy Contact Person" on page 59 for details.) If you request a copy of your health information, the Trust may charge a reasonable fee for copying, assembly costs and postage, if applicable, associated with your 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 communicate with you only at a certain telephone number or by email. If you wish to receive confidential communications, please make your request in writing to the Privacy Contact Person. (See "Privacy Contact Person" on page 59 for details.) The Trust will attempt to honor reasonable requests for confidential communications.

Right to Amend Your Health Information

If you believe that your health information records are inaccurate or incomplete, you may request that the Trust amend the records. That request may be made as long as the information is maintained by the Trust. A request for an amendment of records must be made in writing to the Trust's Privacy Contact Person. (See "Privacy Contact Person" on page 59 for details.) 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. (See “Privacy Contact Person” on page 59 for details.) The request should specify the time period for which you are requesting the information. No accounting will be given of disclosures made: to you; for treatment, payment or health care operations; disclosures made before April 14, 2003; disclosures for periods of time going back more than six years; or in other limited situations. The Trust will provide the first accounting you request during any 12-month period without charge. Subsequent accounting requests may be subject to a reasonable cost-based fee. The Trust will inform you in advance of the fee, if applicable.

Right to a Paper Copy of this Notice

You have a right to request and receive a paper copy of 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. (See “Privacy Contact Person” on page 59 for contact information.) You also may obtain a copy of the current version of the Trust’s notice at its web site, www.sdtrust.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.

Privacy Contact Person

Ms. Charlene Lind
Northwest Administrators, Inc.
2323 Eastlake Ave. E
Seattle, WA 98102
Phone: (206) 726-3281
E-mail: clind@nwadmin.com

Privacy Official

Ms. Charlene Lind
Northwest Administrators, Inc.
2323 Eastlake Ave. E
Seattle, WA 98102
Phone: (206)726-3281
E-mail: clind@nwadmin.com

Duties of the Trust

The Trust is required by law to maintain the privacy of your health information as set forth in this notice and to provide to you this notice summarizing its privacy practices and duties. The Trust is required to abide by the terms of this notice, which may be amended from time to time. The Trust reserves the right to change the terms of this notice and to make the new notice provisions effective for all health information that it maintains. If the Trust changes its policies and procedures, the Trust will revise the notice and will provide you a copy of the revised notice within 60 days of the change. You have the right to request a paper copy of the notice at any time. You may also obtain it from the Trust web site at www.sdtrust.com.

You have the right to express complaints to the Trust and to the Secretary of the Department of Health and Human Services if you believe that your privacy rights have been violated. Any complaints to the Trust should be made in writing to the Privacy Official identified above. The Trust encourages you to express any concerns you may have regarding the privacy of your health information. You will not be retaliated against in any way for inquiring about or filing a complaint about privacy matters.

Post-Mastectomy Reconstruction Surgery Notice

The Women's Health and Cancer Act requires the Trust to notify retirees of the reconstructive surgery benefit following a mastectomy. All Trust provided medical plans cover post-mastectomy reconstructive surgery, including:

- Reconstruction of the breast on which a mastectomy has been performed
- Surgery and reconstruction of the other breast to produce a symmetrical appearance
- Prostheses
- Physical complications of all stages of mastectomy (including lymphedema).

Plan Information

Plan Name

The legal name of this plan is the School District No. 1 Health and Welfare Trust. This handbook describes the eligibility, enrollment, appeal and general administrative provisions that apply to the Trust's early retiree plans. It also describes your continuation rights and provides notices required by the benefit program commonly known as the Trust Early Retiree Medical Plan.

Type of Plan

The plan is a health and welfare plan that provides medical, prescription drug, dental and vision benefits to certain eligible early retirees and their eligible dependents. This handbook describes the hospital, medical and surgical benefits provided under the plan.

Administrative Administrator

- Employer Identification Number (EIN) of the plan sponsor: 93-6090239
- Plan Number (PN): 001
- Benefit Year: January 1 through December 31
- 2016 Open Enrollment Year: February 1 through December 31
- 2017 Open Enrollment Year: January 1 through December 31
- Financial Plan Year: November 1 through October 31

Plan Administrator

The plan is sponsored and administered by a joint labor-management Board of Trustees with the assistance of Northwest Administrators, a contract administration organization. Northwest Administrators is referred to as the Trust Office throughout this booklet and may be contacted at the following address:

School District Trust Office
700 NE Multnomah St., Suite 350
Portland, OR 97232
(844) 203-0239

Board of Trustees

Leonard Anderson	Emma Ford	Jack Roy
Michelle Batten	Le Huynh	Michelle Riddell
John Berkey	Paul Anthony	Gwen Sullivan
Terri Burton	Marty Pavlik	Kerry Young
Siobhan Murphy	Russ Peterson	Yousef Awwad
Pat Christensen	Belinda Reagan	Kathy Muir

All Trustees can be contacted through:

School District Trust Office
700 NE Multnomah St, Suite 350
Portland, OR 97232
(844) 203-0239

Agent for Service of Legal Process

The person designated as the plan's agent for service of legal process is:

David Barlow
McKenzie Rothwell Barlow & Coughran
1325 Fourth Avenue, Suite 910
Seattle, WA 98101
(206) 224-9900

In addition, legal process on the plan may be served on the Board of Trustees at the above address or on any individual Trustee listed above.

Type of Administration

The plan is administered directly by the Board of Trustees of the School District No. 1 Health and Welfare Trust.

Future of the Plan and Trust Fund

The Board of Trustees has the authority to terminate the Trust Fund. 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 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 continuation of the benefits provided by the then existing benefit plans, until such monies and assets have been exhausted.

Funding of Benefits

The plan pays benefits directly from the general assets of the School District No. 1 Health and Welfare Trust.

Source of Contributions

The plan is funded by contributions the District makes to the Trust for eligible employees, retirees and their dependents, and payments made by individuals eligible for benefits under this Trust, on a month-to-month basis, according to collective bargaining agreements or special agreements.

Interpretation of the Plan

The Board of Trustees has the discretionary authority to interpret and construe the terms of its benefit plans and to determine an individual's eligibility for benefits. In administering the plan, the Trust's claims administrator, or medical review organization, may use internal guidelines and medical protocols to determine if specific services are covered under the terms of the plan.

Collective Bargaining Agreements

The plan is maintained according to one or more collective bargaining agreements. Upon written request to the unions and payment of any copying charges, plan participants and beneficiaries may obtain copies of any such agreements. They may also inspect the agreements at the unions' principal offices.

Status as a Grandfathered Plan

School District No. 1 Health and Welfare Trust believes the medical plans it offers to the PAT retirees constitute "grandfathered health plans" under the Patient Protection and Affordable Care Act (the Affordable Care Act). If this status changes in the future, you will receive a notice of the change. As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans; for example, the requirement for the provisions of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act; for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the Trust Office. You may also contact the U.S. Department of Health and Human Services at www.healthreform.gov.