ALASKA PIPE TRADES
U.A. LOCAL 367
HEALTH & SECURITY TRUST

ACTIVE EMPLOYEES
LOCAL 262

Health and Security

Trust Fund

Summary Plan Description

Restated Effective January 1, 2020

KEY CONTACTS

If you have questions about these topics…	Contact…
Eligibility ▪ Hour Bank status ▪ COBRA **Enrollment** ▪ Claim/Enrollment Forms ▪ Adding dependents **Health Care Plans (Medical, Prescription Drug, Dental and Vision)** ▪ Your benefit coverage ▪ Submitting claims ▪ Checking on a claim's status ▪ Appealing a denied claim ▪ Protected Health Information (claims) ▪ Travel prior authorization	**TRUST FUND ADMINISTRATOR** Zenith American Solutions 111 West Cataldo, Suite 220 Spokane, WA 99201-3201 P.O. Box 5434 Spokane, WA 99205-0434 855-229-0720 (toll-free) www.zenith-american.com
Prescription Drug Benefits ▪ Locating a participating pharmacy ▪ Mail-order program	**CVS/CAREMARK** 866-818-6911 Fast Start: 866-273-5268 www.caremark.com
Life and AD&D Insurance ▪ Life Insurance or Accidental Death & Dismemberment coverage ▪ Designating a beneficiary ▪ Filing claims	**SYMETRA LIFE INSURANCE CO.** 800-943-2107 www.symetra.com
Bridge Health Non-emergency surgical services outside Alaska	**BRIDGE HEALTH** 855-456-9063 www.bridgehealth.com
Teladoc Physician visits by phone, video or through the Teladoc app	**TELADOC** 800-TELADOC (835-2362) www.teladoc.com

PREFERRED PROVIDERS

DIRECT CONTRACTS	NETWORK
Alaska Regional Hospital Surgery Center of Anchorage Mat-Su Regional Hospital Alaska Center for ENT Anchorage Fracture and Orthopedic Clinic (AFOC) / Alaska Medical Alliance, LLC (AMA)	**Aetna** To find an Aetna preferred provider, go to www.aetna.com. Select "Find a doctor." You may log in, or search as a guest. If you continue as a guest, use the Aetna Choice POS II (Open Access) plan.

WELCOME

ALASKA PIPE TRADES U.A. LOCAL 262 ACTIVE EMPLOYEES

The Alaska Pipe Trades U.A. Local 367 Health and Security Trust Fund provides you and your family with excellent health care benefits.

This Summary Plan Description shows the benefits and the main provisions of the Alaska Pipe Trades U.A. Local 367 Health and Security Trust Fund Plan as they exist on January 1, 2019.

Refer to this Summary Plan Description for detailed information about your Medical, Prescription Drug, Dental, Vision, Life and Accidental Death & Dismemberment (AD&D) coverage.

In the event of any conflict between the information in this Summary Plan Description and the Plan rules, the Plan documents and insurance contracts will govern. The Trust Fund Board of Trustees have the authority to interpret the terms of the Plan, determine benefits under the Plan and to administer the benefit plans offered through the Trust Fund.

Important Notices

- Benefits are administered in accordance with your Plan's self-funded Plan of benefits.
- Claims are paid in accordance with the Administrative Service Agreement between the Trust Fund Administrator and your Plan.
- If you need assistance with filing your claim or an explanation of how your claim was paid, please refer to the toll-free number and address shown on your Health Plan ID card or contact the Trust Fund Administrator.
- This Plan includes a Preferred Provider option and prior authorization requirements. Make sure you are aware of how these affect the Plan's payment for covered services.

TAKE ACTION

This Summary Plan Description provides detailed information about your benefit coverage and helps you to make the choices that are the best decisions for you and your family. To make the most of your benefits:

- **Read this Summary Plan Description to understand your choices and compare your options.**
- **Look for "KEY POINTS" and "TAKE ACTION" for important information that you need to know.**
- **If you have questions, please contact the organization listed in "Key Contacts."**
- **File this Summary Plan Description in a secure location to use for future reference.**

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ELIGIBILITY

ACTIVE EMPLOYEES

Only eligible active employees may become covered under the Alaska Pipe Trades Local 367 Health & Security Plan.

You are an eligible employee if you are an active collective bargaining employee or an active special agreement employee, as defined in this section.

To become covered under the Plan, you must:

1. Qualify as an eligible employee.
2. Reach an eligibility date.
3. Submit a completed and signed Claim/Enrollment Form to the Trust Fund Administrator.

When you become covered you will be covered for all of the employee coverage benefits that apply to your employment classification:

- Active Collective Bargaining Employees
- Active Special Agreement Employees

Active Collective Bargaining Employees

An eligible "active collective bargaining employee" is a person who is:

1. A member of Alaska Pipe Trades U.A. Local 262.
2. Working the required number of hours, as specified in this section, for a participating employer who makes the required monthly contributions to the Trust Fund on his or her behalf.
3. In a job classification covered by the terms of a collective bargaining agreement that apply to his participating employer, or an employee of an employer who is signatory to an agreement requiring contributions to the Alaska Pipe Trades Local 367 Health & Security Trust on his or her behalf.

Active Special Agreement Employees

An eligible "active special agreement employee" is a person who is:

- Actively working for a participating employer who makes the required monthly contributions to the Trust Fund on his or her behalf.
- In a job classification covered by the terms of a special agreement that apply to his participating employer.

A corporate officer, partner or proprietor, who is actively engaged in the conduct of the business of a participating employer, or a full-time non-bargaining unit employee of that contractor, is considered an eligible employee under the terms of a special agreement, providing that all full-time, active special agreement employees are provided coverage under the Plan.

Since the employer pays the full monthly contribution amount, active special agreement employees are not required to meet the Hour Bank eligibility requirements.

KEY POINT

You are eligible for employee benefits if you are an active collective bargaining employee or an active special agreement employee.

Eligibility Waiting Period

You must wait to be eligible for benefits until at least 405 paid work hours from a participating employer have been credited to your Hour Bank.

When Coverage Begins

Your coverage begins on your eligibility date, which is:

- The first day of the calendar month immediately *following* your eligibility waiting period.

The term "Hour Bank" means an account established in your name to which is credited all of your paid work hours for which contributions are made to the Trust Fund on your behalf.

KEY POINT

You will continue to be eligible for coverage as long as you have 130 hours or more in your Hour Bank.

For each month you are covered under the Plan, 130 hours will be deducted from your Hour Bank. You will continue to be eligible for coverage as long as you have 130 hours or more in your Hour Bank.

There is always a lag month (reporting month) between the "work month" and the "coverage month."

For example, hours worked in May will be counted toward July, but not June, eligibility. June would be considered the "lag month." The Trust Fund Administrator requires the lag month to receive and check employer reports and compile eligibility figures.

You may accumulate up to 780 hours in your Hour Bank, after 130 hours are deducted for the current month's eligibility.

To check your Hour Bank balance and verify your eligibility, contact the Trust Fund Administrator.

Continuation of Your Eligibility

You will remain eligible under the Plan as long as you continue to work for a participating employer who makes the required monthly contributions to the Trust Fund on your behalf and you have sufficient hours in your hour bank for coverage. These contributions must meet the terms and conditions that apply to your participating employer as established by the Board of Trustees.

Employer Contributions

Contributions are paid by your employer under the collective bargaining agreement. You do not have to pay any part of the cost of your employee coverage.

Hour Bank Example

Month	Hours Worked	Hour Bank Total	Less Benefit Hours	Hour Bank Balance	Eligibility Month
JUN	158	158	N/A	158	N/A
JUL	184	342	N/A	342	N/A
AUG	168	510	130	380	OCT
SEP	176	556	130	426	NOV
OCT	184	610	130	480	DEC
NOV	115 (vaca-tion)	595	130	465	JAN
DEC	145	610	130	480	FEB
JAN	160	640	130	510	MAR
FEB	160	670	130	540	APR
MAR	0 (no work)	540	130	410	MAY
APR	80	490	130	360	JUN
MAY	160	520	130	390	JUL

TAKE ACTION

Contact the Trust Fund Administrator to ensure you have enough hours in your Hour Bank for continued Plan coverage.

Benefit Changes

Benefit changes will take effect on the applicable date shown below:

- If your employment class changes, any corresponding benefit changes will take effect on the first day of the next calendar month following the date you qualify for the new class.
- If there is an amendment to the Plan, any resulting changes will take effect on the date stated in the amendment.

Working for Another Local

UA Local 262 will only accept Alaska Pipe Trades Local 367 Health & Security Plan hours from a Local that participates under the United Association Reciprocal Agreement. If you are going to work for a Local other than Local 262, confirm that the Local is signatory under this agreement.

If you are working for a Local outside the jurisdiction of Local 262, your Hour Bank hours will be prorated, depending on whether the outside Local has a higher or lower contribution rate than Local 262's.

If you work for a Local or a contractor using a prevailing rate that is lower than the current contracted rate for Local 262, you may buy the hours needed to raise your Hour Bank to provide one month of coverage, if you meet these requirements:

- You must have had "active" coverage in the month prior to the month for which you are purchasing coverage.
- You must have worked during the "work month" or have a minimum of one hour left in your Hour Bank from a previous month(s) to purchase coverage.
- Your last employment must have been for a Local or contractor who contributes a lower contribution rate than the current negotiated Alaska Pipe Trades Local 367 Health & Security Plan rate.
- You must notify the Trust Fund Administrator of your intent to purchase the hours needed by the 20th of the month for which coverage is being purchased

You must purchase the hours needed for eligibility prior to the last day of the month for which coverage is being purchased. For example, if the proration of the outside local's contribution rate results in only 120 hours under the Local 367 Health and Security Trust plan, you may purchase only the 10 hours at the current contribution rate necessary for eligibility for that month.

KEY POINT

If you work for a Local (other than Local 262) that contributes to your Hour Bank, you have the opportunity to "Self Pay" only those hours necessary so that your Plan coverage continues uninterrupted.

Your coverage will be granted when you pay the premium. Then the Trust Fund Administrator will adjust any previously denied claims and you may submit your prescription claims for reimbursement.

Timely notification and payment is required to avoid issues with hours being carried over to future months.

Many Locals outside of Alaska turn in their reports at different times and the Trust Fund Administrator cannot determine when the member has coverage until these reports are received.

Therefore, when the Trust Fund Administrator mails notices and invoices, you may still have hours that have not yet been reported. If you worked hours that are not shown in the report, please use your own judgment to determine whether purchasing hours is necessary.

Please remember that when you do not have sufficient hours for one month, the hours in your Hour Bank are carried over to the next month and those hours will be combined with the next months' work hours, which could give you coverage later.

If you Self Pay for the hours needed for coverage in a previous month, please keep in mind that you could cause the loss of eligibility coverage for future months.

When the hourly rate is lower than the current Local 262 rate, the lower prorated hours could cause you to eventually lose coverage for a period of time.

Calculating Prorated Hours

Here's how to calculate how many hours will be posted to your account each month:

1. Multiply the number of hours you work by the job's contribution rate to determine the total contribution.
2. Then divide the total contribution by Local 262's current contribution rate to determine the number of hours posted to your Hour Bank.

Here is an example of how this works:

A member works 160 hours in one month for a Local or contractor who is paying $8.00 per hour toward Alaska Pipe Trades Local 367 Health & Security Plan benefits.

Multiply 160 (the number of hours worked) by $6.00 (the job's contribution rate) to get the amount that the Local or contractor paid for that member (160 hours x $6.00 = $960.00).

The funds received are then divided by Local 262's current rate to get the prorated hours to post to the member's Hour Bank ($960.00 / $13.37 = 71.80 hours). The hours are rounded off to the nearest quarter hour (71.80 = 71.75), so 71.75 hours would be posted.

To obtain one month's coverage, 130 hours are needed; therefore, the 71.75 hours would not be enough and 58.25 hours would have to be taken from the member's Hour Bank balance.

If the member does not have enough hours worked or in his Hour Bank to make up the 130 hours needed, the member will not have coverage for that month and the hours will be carried over to the next month.

This is provided the member has already met his initial requirement of 405 hours.

For this example, at a contribution rate of $6.00 per hour, the member will have to work a minimum of 289.68 hours to receive coverage for one month without drawing from his Hour Bank balance. Any hours worked over the 289.68 would go to building the members bank for future coverage.

If you wish to Self Pay for hours needed you must contact the Trust Administrator prior to the end of the month for which coverage is being purchased.

TAKE ACTION

You must notify the Trust Fund Administrator of your intent to purchase the hours needed by the 20th of the month for which coverage is being purchased.

When Benefits End

Your eligibility will terminate on the earliest date shown below:

1. The date in which your Hour Bank has less than the required number of hours.
2. The date the Plan terminates.

Reinstatement of Eligibility-Continuing Your Coverage through COBRA

If your coverage ends because your Hour Bank account falls below the required number of hours, you may have the right to continue your coverage under COBRA Continuation of Coverage, provided you pay the required monthly contributions to the Trust Fund by the required deadline dates.

Please see the "COBRA Continuation Coverage" section for information on the benefit plans offered under COBRA.

Hour Bank Balances

If your Hour Bank has less than the required number of hours for a month of coverage, the hours accumulated during the most recent six-month period will be carried forward. Hours accumulated prior to the most recent six-month period will be forfeited.

If additional contributions are made on your behalf to the Trust Fund, hours will be added to your account and your eligibility will be reinstated on the first day

of the first calendar month following the month in which the required number of paid work hours are credited to your Hour Bank.

If no hours are added to your account during any six consecutive months, the hours remaining in your Hour Bank will be transferred to the general reserve of the Trust Fund and you must satisfy the initial eligibility requirements in order to again become eligible under the Plan.

Employment Classification Transfers

If you are covered under the Plan as a collective bargaining employee and then transfer to a special agreement employee, your Hour Bank account will be frozen as of the first day of the month following the month in which the transfer occurs.

If you transfer back to a collective bargaining employee, your Hour Bank account will be immediately available and your eligibility will be reinstated on the first day of the month following the month in which the transfer occurs, provided you have sufficient hours in your Hour Bank.

DEPENDENT ELIGIBILITY

Active

A person who meets the definition of "dependent" may become eligible for coverage under the Alaska Pipe Trades Local 367 Health & Security Plan.

To become covered the person must:

- Qualify as an eligible dependent.
- Be enrolled as a dependent.
- Reach an eligibility date.

You may only enroll your dependents for any benefit coverage for which you are enrolled as an employee.

When your dependents become covered they will be covered for all of the dependent coverage benefits that apply to your employment classification.

Eligible Dependents

The following individuals qualify as eligible dependents:

- Your properly enrolled spouse.
- Your properly enrolled natural child, adopted child or child placed for adoption, or step child, up to age 26. If you and the dependent child's natural parent separate (legally or not) or divorce, the child of the separated or divorced parent is no longer eligible under the Plan.
- A child will continue to qualify as a dependent regardless of any age limitation in the Plan if he or she becomes incapable of self-sustaining employment because of a physical or mental handicap which occurred prior to his or her 19th birthday and while participating as an eligible dependent under the Plan, and continually exists thereafter. The child must be chiefly dependent upon you for support and maintenance and you must complete and submit an "Attending Physician" statement (available from the Trust Fund Administrator). Coverage will continue while the child is enrolled in benefit coverage until the child recovers from the handicap or no longer chiefly depends on you for support and maintenance. The Plan may require periodically that the child must submit to an independent medical review at the expense of the Plan to confirm the child's continuing disability for purposes of entitlement to coverage under this provision of the Plan.
- "Eligible dependents" do not include someone on active duty in any armed forces, a legally separated spouse or an eligible employee.

Contributions

You may have to pay part or all of the cost of your dependent's coverage.

For active employees, your contribution for dependent coverage depends on the terms and conditions that apply to your participating employer and are established by the Trustees.

KEY POINT

Dependents become eligible for coverage on the same date as you, or if acquired later, on the first date they become eligible dependents.

When Dependent Coverage Begins

Your dependent's coverage begins on his or your eligibility date, or the date the person qualifies as your dependent (whichever is later). The following exceptions apply:

- Coverage for a child who is born while you are covered begins as of their birth date, when you provide proof of dependent status with the timely enrollment. The Claim/Enrollment Form must be provided as soon as possible, but no later than 60 days of the date of birth. In the event that you fail to provide the Claim/Enrollment Form within 60 days of the birth, the newborn will be covered for the first 31 days following birth and thereafter prospectively as of the first day of the month following receipt of the Claim/Enrollment Form.
- Coverage for an adopted child begins on the date of adoption or placement for adoption, when you provide proof of the adoption or placement for adoption with the timely enrollment. The Claim/Enrollment Form must be provided as soon as possible, but no later than 60 days of the date of adoption or placement for adoption.
- With respect to a child named in a Qualified Medical Child Support Order (see details in this section), coverage begins on the date specified in the court order, which you must provide with the timely enrollment.

When Dependent Coverage Ends

A dependent's coverage will end on the earliest date shown below:

- The date your employee coverage ends.
- The last day of the month in which the person no longer qualifies as a dependent. It is your responsibility to immediately notify the Plan in the event of a divorce or a dependent's loss of dependent eligibility.
- The date your employer is no longer a participating employer.
- The last day of the calendar month in which a surviving dependent fails to pay any required monthly premium on a timely basis, as determined by the Board of Trustees.

If an active employee's coverage ends, he/she may be able to continue dependent coverage through COBRA continuation coverage. The employee must pay any required monthly contributions to the Trust Fund on time.

KEY POINT

Dependent coverage ends when your coverage ends, the dependent is no longer eligible, or the required premium is not paid. It is your responsibility to immediately notify the Plan of any event which causes dependent coverage to end, such as divorce.

Qualified Medical Child Support Order (QMCSO)

If not already enrolled, the Trust Fund Administrator will enroll for immediate coverage any alternate recipient who is the subject of a Medical Child Support Order or National Medical Support Notice that is a Qualified Medical Child Support Order (QMCSO).

The Trust Fund Administrator will verify that any order meets the standards for qualification described below.

An alternate recipient means any child of a covered person who is recognized under a Medical Child Support Order or under a National Medical Support Notice as having a right to enrollment under this Plan as the covered person's eligible dependent. For purposes of the benefits provided under this Plan, an alternate recipient shall be treated as an eligible dependent, but for purposes of the reporting and disclosure requirements under ERISA, an alternate recipient shall have the same status as a covered person.

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

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

A **National Medical Support Notice (NMSN)** means a notice that contains the following information:

- Name of an issuing state agency
- Name and mailing address (if any) of an employee who is a covered person under the Plan
- Name and mailing address of one or more alternate recipients; in other words, the child or children of the covered person or the name and address of a substituted official or agency that has been substituted for the mailing address of the alternate recipient(s)
- Identity of an underlying child support order.

A **Qualified Medical Child Support Order (QMCSO)** is a Medical Child Support Order or National Medical Support Notice that creates or recognizes the existence of an alternate recipient's right to, or assigns to an alternate recipient the right to, receive benefits for which a covered person or eligible dependent is entitled under this Plan. In order for such order to be a QMCSO, it must clearly specify the following:

- The name and last known mailing address (if any) of the covered person and the name and mailing address of each alternate recipient covered by the order
- A reasonable description of the type of coverage to be provided by the Plan to each alternate recipient, or the manner in which such type of coverage is to be determined
- The period of coverage to which the order pertains
- The name of this Plan

Survivor Benefits: Active Employees

If you are an active employee of Local 262, and you die while your dependents are covered, your dependents will continue to be covered under the Plan on the same basis as prior to your death, as long as at least the required number of hours necessary for coverage remains in your Hour Bank account.

After your Hour Bank account is exhausted, your dependents may remain covered under COBRA Continuation of Coverage for up to 36 months from the date of your death, provided your dependents timely enroll in COBRA and pay the required monthly contributions to the Trust Fund by the required deadline dates. Please contact the Trust Fund Administrator for information on the benefit plans offered under COBRA.

ENROLLMENT

ACTIVE PLAN ENROLLMENT

Enrollment

Once you have met the eligibility requirements in the preceding section entitled Eligibility, you are entitled to enroll for benefits under the Plan upon receipt by the Trust Fund Administrator of the completed Claim/Enrollment Form.

Misrepresentation

An individual who knowingly represents a false or fraudulent claim for payment or knowingly misrepresents facts relating to the eligibility for benefits (including failure to timely notify the Trust of a dependent's loss of eligibility) will be subject to liability for reimbursement of the claim, for audit fees, attorney fees, and costs incurred by the Plan on account of such misrepresentation, as well as potential criminal liability. Knowingly misrepresenting eligibility, failing to timely notify the Plan of a dependent's loss of eligibility, or submission of fraudulent claims is considered an intentional and material misstatement of fact to the Plan and may result in retroactive termination of coverage for the participant, spouse and dependents. The Trust reserves the right to offset such ineligible benefits paid against you or your eligible dependent's future benefits.

TAKE ACTION

To receive benefits, you must submit a Claim/Enrollment Form to the Trust Fund Administrator for each participant. You are required to provide documents for each eligible dependent as applicable, in order to verify your dependent's eligibility under the Plan.

Claim/Enrollment Form

To receive benefits, you must submit an updated Claim/Enrollment Form, available from the Trust Fund Administrator. All new members must fill out the Claim/Enrollment Form and provide proof of dependent status.

- If you already completed a Claim/Enrollment Form and there are no changes to the status of your information, such as no new dependents or change in marital status, you will not be required to fill out the Claim/Enrollment Form each year.
- You must submit a Claim/Enrollment Form for a newly acquired dependent as soon as possible and within 60 days from the date of marriage for a spouse, or the date of birth, adoption, or legal guardianship for a dependent child. If the Claim/Enrollment Form is received within 60 days of the date the dependent was acquired, the enrollment will be retroactive to the date the dependent was acquired.
- If a Claim/Enrollment Form is not submitted within 60 days, the dependent will be enrolled prospectively only, as of the first day of the month following receipt of the Claim/Enrollment Form, except in the case of a newborn dependent; in which case the newborn will be covered for the first 31 days following birth, and thereafter prospectively as of the first day of the month following receipt of the Claim/Enrollment Form.

Claims will not be paid for any participant until the Trust Fund Administrator receives a completed and updated Claim/Enrollment Form and proof of dependent status (for example, a birth certificate or marriage license), provided it is received within one year from the date of service of the claim.

If your address changes, please notify the Trust Fund Administrator by phone, letter or email.

Special Enrollment Due to Loss of Medical Coverage

This provision applies only to special agreement employees and their dependents.

An eligible employee or dependent, as specified above, may be enrolled under the Plan at any time after his/her initial eligibility date if all of the following three requirements are met:

1. At the time of initial enrollment, the person was covered under another medical plan and certified, at the time of initial enrollment, that coverage under the other medical plan was the reason for declining coverage.
2. The person has lost or will lose coverage under the other plan because of:
    - Termination, or change in status, of employment of the individual or of a person through whom the individual was covered as a dependent
    - Termination of the other employer's medical plan
    - Cessation of an employer's contributions toward an employee's or a dependent's medical coverage
    - Death of a person through whom the person was covered as a dependent
    - Legal separation, dissolution of marriage, or divorce
    - Loss of coverage under a federal continuation provision and the coverage under that provision was exhausted
    - Any other event that the Trust has determined to be a qualifying event, as allowed by law
3. The person must enroll for medical coverage under the Plan within 60 days after termination of the other medical coverage or cessation of the other employer's contributions toward the other medical coverage.

Effective Date for a Special Enrollment Due to Loss of Medical Coverage

The effective date of coverage for a person enrolled as a result of a special enrollment due to loss of coverage will be as follows.

For an employee:

- If you enroll within 60 days after loss of coverage, the first day of the calendar month in which your coverage terminates
- If you enroll prior to loss of coverage, the first day of the calendar month next following the date you sign up for a change of coverage option—provided you submit proof of prior coverage and any required monthly premium to the Trust Fund Administrator

For a dependent, the later of:

- Your effective date of coverage
- The first day of the calendar month in which a dependent's coverage terminates

TAKE ACTION

If your dependents lose other coverage, enroll them within 60 days of the loss of other coverage.

Special Enrollment Due to Marriage, Birth, Adoption or Placement for Adoption

Active collective bargaining employees and active special agreement employees who are enrolled under the Plan may enroll any dependents acquired as a result of marriage, birth, adoption or placement for adoption.

Dependents must be added within 60 days (even if the coverage is being waived) or they will be added prospectively upon receipt of a completed Claim/Enrollment Form.

COBRA CONTINUATION COVERAGE

As an alternative to COBRA Continuation Coverage you may wish to research coverage available in the marketplace through one of the exchanges. The available coverage offers a greater range of benefit options and may prove to be less expensive.

The Consolidated Omnibus Budget Reconciliation Act (known as COBRA) requires that employees and their families be allowed, under certain circumstances, to self-pay for a temporary extension of health coverage, including medical, dental and vision, through this Plan when coverage would otherwise terminate.

This continuation of coverage provides that employees, spouses, and any eligible dependent children can purchase health coverage for either 18, 29 or 36 months, depending upon the qualifying event, when the loss of coverage is due to:

- Termination of employment (except for gross misconduct)
- Reduction of hours worked
- Death of an employee
- Divorce or legal separation
- A dependent ceases to be an eligible dependent as defined by the Plan

KEY POINT

COBRA provides certain former employees, spouses, former spouses and dependent children the right to temporary continuation of health coverage at group rates, when coverage is lost because of certain specific events. COBRA participants generally pay the entire premium themselves.

If any of the above COBRA qualifying events occur, and you wish to continue your coverage through COBRA, contact the Trust Fund Administrator for information regarding your rights and responsibilities under COBRA.

You must contact the Trust Fund Administrator within 60 days of the actual date of the qualifying event—or else you forfeit your rights to purchase coverage—if your qualifying event is due to an employee's death, divorce or legal separation, or the loss of a dependent's eligibility.

The Trust Fund Administrator will advise you of your rights and responsibilities for all qualifying events.

Continuation of Coverage Under COBRA

The continuation of coverage provision will apply to all health coverage (medical, prescription, dental, and vision) that you are currently eligible for by virtue of your collective bargaining agreement.

This provision does not include: Life or Accidental Death & Dismemberment (AD&D) benefits.

18-Month Coverage

You may elect to continue health coverage for yourself and your covered dependents for up to 18 months from the day your eligibility ends because:

- Your employment terminated (other than due to gross misconduct)
- You no longer satisfy the requirements for hours worked
- Your special agreement was terminated

If your dependents have more than one qualifying event, as listed in this section, they may be eligible for an additional period of coverage. In the event of a second qualifying event, contact the Trust Fund Administrator as soon as possible.

11-Month Disability Extension

If you or a covered dependent are considered to be totally disabled by the Social Security Administration, the COBRA

Disability Extension entitles you or your covered dependent to 11 additional months of COBRA coverage, in addition to the regular 18 months of coverage. Both of these conditions must be met:

- The individual was disabled (as determined by the Social Security Act) prior to the first 60 days of COBRA continuation coverage
- The individual notifies the Trust Fund Administrator of the Social Security disability determination both within the original 18-month COBRA period and within 60 days of such determination

36-Month Coverage

Your covered spouse and/or any covered dependent child may elect to continue health coverage for as long as 36 months from the day the eligibility ends because:

- You become entitled to Medicare benefits
- You die
- You and your spouse are legally separated
- Your marriage is ended by divorce
- A child is no longer an eligible dependent

Note: If a retired employee voluntarily deletes dependents from coverage, COBRA will not be available to the dependents.

TAKE ACTION

You or your eligible dependents have the responsibility to inform the Trust Fund Administrator of a loss of coverage resulting from a divorce or separation, or a child losing dependent status. Failure to do so within 60 days of the event will cause you to forfeit your right to elect COBRA continuation coverage.

Reporting Responsibilities

Within 60 days after your eligibility ends:

- The Trust Fund Administrator will advise you when your health coverage will end because your employment terminated (other than due to gross misconduct), you no longer satisfy the requirements for hours worked or your special agreement was terminated.
- You are responsible for notifying the Trust Fund Administrator when health coverage ends because the member becomes entitled to Medicare benefits, dies, is legally separated or divorced, or his/her child is no longer an eligible dependent

The Trust Fund Administrator will send you or your dependent written notice of the right to continue health coverage within 14 days of receiving notice.

You or your dependent must then submit to the Trust Fund Administrator a written request to continue health coverage by the later of:

- 60 days after the date health coverage ends
- 60 days after the notice is sent

TAKE ACTION

A written election must be made in writing within 60 days from the date coverage would otherwise end, or 60 days from the date the notification is received from the Trust, if later.

When Coverage Begins

COBRA continuation coverage may only begin on the date after health coverage under the Plan ends.

You or your dependents must pay the required premium, including any retroactive premium, from the date the coverage would have otherwise ended.

The Trust Fund Administrator will inform you or your dependent of the monthly premium to pay. The premium must be paid to the Trust Fund Administrator

within 45 days after the date continued coverage is elected.

Note: You have 60 days to add newly acquired dependents, provided the premium is paid back to the qualifying event.

Termination of COBRA Coverage

Any covered person's continued health coverage will end at midnight on the earliest date shown below:

- The date the premium is due and unpaid
- The date a covered person again becomes covered under the Plan
- The date a covered person becomes entitled to benefits under Medicare
- The date health coverage has been continued for the maximum period of time as specified in this section
- The date other health coverage is obtained and effective
- The date the employer ceases to provide any group health plan to any employee

Benefits for COBRA Participants

When your coverage would otherwise terminate and you are eligible for COBRA continuation coverage, you will have the option to elect COBRA coverage.

You must pay the full cost of the continuation coverage to the Trust Fund Administrator. Your benefit Plan election cannot be changed during the COBRA continuation coverage period.

Life Insurance and Accidental Death & Dismemberment (AD&D) benefits are not included under the COBRA Plans.

To continue the member's Life and AD&D coverage, the member must request a Conversion Notice from the Trust Fund Administrator, complete it and remit it to the Life Insurance provider within the required time frame.

Benefit provisions for covered services, including copays, percentage payables, benefit maximums, exclusions and limitations are the same as the active benefit Plan.

MEDICAL PLAN

HOW THE PLAN PAYS BENEFITS

Medical Benefits and Covered Charges

A "medical benefit" is the amount, if any, that the Plan pays for covered medical charges incurred by a covered person. The amount of a medical benefit is the amount the Trust Fund Administrator calculates in the steps shown below:

1. The charges for which a claim is submitted to the Trust Fund Administrator are tested against the covered medical charge definition. Those that meet all of the tests are the covered medical charges.
2. Any deductible amount that applies to the charges and that has not yet been met is subtracted from the amount of covered medical charges.
3. The amount of covered medical charges that remains is then multiplied by the applicable percentage payable.
4. If any part of the amount calculated exceeds an applicable benefit maximum, then that part is subtracted and the remainder is the amount of the medical benefit.

Medical Deductible

The medical deductible amount:

- Applies to all covered medical charges unless stated otherwise
- Applies separately to each covered person during each calendar year
- Must be accumulated during the calendar year

No charge will be subject to more than one medical deductible during a calendar year (the hospital admission deductible is a separate deductible and will apply to each admission). Only those charges to which the medical deductible applies can be used to satisfy that deductible.

Family Medical Deductible: If the family medical deductible is satisfied in any one calendar year by covered persons in your family, then the medical deductible will not be applied to any other charges incurred in that calendar year by covered persons in your family. As used here, "family" means you and all of your dependents who are covered under this plan.

Common Accident: If you and your dependents incur covered medical charges as a result of injuries suffered in a common accident, then just one medical deductible will be applied during each calendar year to those charges. If greater medical benefits would be paid in the absence of this provision, then it will not apply.

Percentage Payable

The Plan pays a percentage payable of covered medical charges, as described in this booklet. The percentage payable:

- Is applied after any applicable deductible amount has been met
- Applies separately to each covered person

KEY POINT

Any charge in excess of the Usual, Customary and Reasonable (UCR) charge will be your responsibility.

Usual, Customary and Reasonable Charge

The Usual, Customary and Reasonable (UCR) charge is the average charge for a given service or supply, based on geographical location, skill of the provider of service and the complexity of the service performed. The Trust Fund Administrator determines the UCR charge.

The percentage payable is multiplied by this amount to determine your benefit coverage.

Sometimes, the provider's billed amount may exceed the UCR charge. You are responsible for 100% of any amount exceeding what the Plan pays.

Out-of-Pocket Maximum

After a covered person has satisfied his/her individual deductible, or is a member of a family that has satisfied the family deductible during a calendar year, then the Plan will pay medical benefits for covered charges at a rate of 80% for that individual.

When the 20% you are required to pay totals $3,000 for an individual and $8,200 for a family (not including the deductible), the Plan will pay benefits for any additional covered charges at 100% for that individual for the remainder of that calendar year.

Covered expenses paid at a percentage less than 80% are not subject to the above out-of-pocket limit and will remain payable at the reduced rate.

Charges at a non-PPO provider will be payable at 60% of the contracted PPO charge regardless of the amount you are required to pay. Use of a non-PPO provider for orthopedic surgery will not be covered. Use of a non-PPO provider can result in significant out-of-pocket cost to you.

Lifetime Maximum

The Plan has an unlimited maximum for all covered medical charges incurred by a covered person during his lifetime.

PRIOR AUTHORIZATION

For inpatient confinement (hospitalization), your provider must obtain prior authorization before you or your dependent:

- Enters a hospital as an inpatient
- Undergoes any surgery at a hospital as an inpatient

Prior authorization is also required for some outpatient services.

You are required to receive prior authorization if you need to travel to obtain healthcare services. If prior authorization is not obtained before travelling, travel expenses will not be reimbursed. For prior authorization of travel, call Zenith American Solutions (see Key Contacts at the front of this booklet).

In the case of a medical emergency, if a covered person is admitted to a hospital, or undergoes surgery, the terms of this provision will apply only if the Plan's review agency is not notified within three days following the admission or surgery.

TAKE ACTION

Prior authorization of travel is required. For prior authorization of travel, call Zenith American Solutions (see Key Contacts at the front of this booklet).

PREFERRED PROVIDER ORGANIZATION

The Trust uses the Aetna Preferred Provider Organization (PPO) in order to reduce the cost of medical care for each covered person and for the Trust.

The Aetna PPO is a network of facilities that have agreed to furnish medical services and supplies to covered persons for a contracted charge.

To avoid non-PPO penalties, participants must use PPO providers.

The agreement with Aetna **does not affect the direct PPO agreements with Alaska Regional Hospital, the Surgery Center of Anchorage, or Mat-Su Regional Hospital.** All inpatient and outpatient services provided within Anchorage must be received at Alaska Regional Hospital or the Surgery Center of Anchorage to receive the PPO level of reimbursement.

KEY POINT

Use PPO providers to obtain the best pricing and avoid non-PPO penalties.

Inpatient/Outpatient Facility Services with the Municipality of Anchorage

Within the Municipality of Anchorage PPO benefits are payable only at: Alaska Regional Hospital and the Surgery Center of Anchorage.

Any other facility within the Municipality of Anchorage that furnishes services available at Alaska Regional Hospital or the Surgery Center of Anchorage shall be considered a non-PPO facility, subject to the hospital confinement deductible and the percentage payable for non-PPO facilities.

In addition, if you use a non-PPO facility, you must pay the difference between what a PPO facility would have charged for the same services and the non-PPO facility charges.

PPO penalties applied by the primary payer will not be considered an allowable charge by this Plan as the secondary payer.

Charges at a non-PPO facility within the PPO service area will be payable at 60% of the covered charge regardless of the amount you are required to pay, even if you reach the out-of-pocket limit in a calendar year.

Note: Alpine Surgery Center in Anchorage is not a covered provider and the plan will provide no benefit for any services provided by Alpine Surgery Center.

Use of a non-PPO facility within the PPO service area can result in significant out-of-pocket cost to you. For example:

	PPO Facility	**Non-PPO Facility**
Billed Amount	$10,000	$10,000
PPO Contracted Charge	$5,000	$5,000
PPO Penalty	$0	$200
Plan Payment	$4,000 Plan Pays 80%	$2,880 Plan Pays 60%
You Pay	**$1,000**	**$7,120** You pay your coinsurance plus the difference between the Billed Amount and the PPO Contracted Charge

This example assumes the annual deductible has been met.

The outpatient dialysis benefits provisions may supersede other provisions for Network Providers providing outpatient dialysis services. Please see the outpatient dialysis provisions for specific information about such benefits.

KEY POINT

You may choose any hospital for inpatient care; however, when you choose a PPO facility, you'll save money because the PPO charges a discounted rate and the Plan pays a higher percentage.

Emergency Care

In an emergency, you may use any provider without incurring the PPO penalty, provided you seek emergency care at the closest facility capable of providing the needed care.

However, if as a result of the emergency you are hospitalized at a non-PPO facility, you must transfer to a PPO provider as soon as it is confirmed your medical condition will allow for such a transfer. If you remain hospitalized in the non-PPO facility, the non-PPO provisions will apply starting on the date at which you were able to transfer to a PPO facility.

KEY POINT

If you experience a medical emergency, you may go to the closest facility. If you are hospitalized as a result of the emergency within the Municipality of Anchorage, you must transfer to Alaska Regional Hospital as soon as it is medically possible.

Orthopedic Surgery

The plan will provide no coverage for non-emergency orthopedic surgery performed by non-PPO providers. For example, if you use a non-PPO surgeon, the plan will cover none of the surgeon's charges. If the surgery is performed at a non-PPO hospital or surgery center, the plan will cover none of the facility charges. This provision applies regardless of the location of services.

In the Municipality of Anchorage, the PPO providers for Orthopedic Surgery are Alaska Regional Hospital, the Surgery Center of Anchorage, and Alaska Fracture and Orthopedic Clinic (AFOC) / Alaska Medical Alliance, LLC (AMA). All other providers in the Municipality of Anchorage will be considered non-PPO. Outside of Anchorage, you may use any Aetna PPO provider or arrange surgery through BridgeHealth.

All Other Orthopedic Services

Anchorage Fracture and Orthopedic Clinic (AFOC) / Alaska Medical Alliance, LLC (AMA) is the preferred provider for orthopedic services in the Municipality of Anchorage. If you use an Anchorage orthopedic provider other than AFOC/AMA, the plan will reduce its reimbursement percentage to the non-PPO level. This applies even if the provider is in the Aetna network. This does not affect services provided outside of the Municipality of Anchorage.

Contracted Charge

A "contracted charge" is the amount negotiated with a PPO provider for a medical service or supply.

The contracted charge may be less than the charges made for a medical service or supply furnished by a non-PPO provider.

In no event will the contracted charge exceed the amount billed or the amount for which the covered person is responsible.

BRIDGEHEALTH SURGERY BENEFIT

BridgeHealth helps you find cost-effective options for non-emergency surgery if you are willing to travel outside Alaska to obtain services. BridgeHealth contracts with a network of providers who offer negotiated rates on surgical services. Examples may include orthopedic surgeries and joint replacement, spinal surgery, women's health, certain cardiac and vascular procedures, hernia surgery, thyroid surgery and bariatric surgery.

The BridgeHealth Surgery Benefit is only available to you and your eligible dependents if coverage under this Plan is primary. If you and/or your eligible dependents have other health coverage

that causes this Plan to pay secondary you and/or your eligible dependents may not be eligible for benefits under the BridgeHealth Surgery Benefit.

Covered expenses include all medical costs incurred under the BridgeHealth Surgery Benefit, with no copay, deductible or coinsurance applied as well as first class round-trip transportation, lodging, meals and incidentals for the covered person and one (1) companion.

For a list of covered surgical procedures, please contact BridgeHealth, Inc. at www.bridgehealthmedical.com or toll-free at 855-456-9063. Although a surgical procedure may be covered by Bridge-Health, Inc. it is only covered under the Plan as long as the surgical procedure is medically necessary as determined by the utilization review provider and not otherwise excluded under the terms of the Plan.

- Transportation and lodging includes first class round-trip transportation for the patient and one (1) companion between the patient's home location and the location of the BridgeHealth provider where treatment is to be performed; and hotel accommodations near the BridgeHealth provider. Hotel accommodations are limited to one (1) room to be shared by the patient and companion. All transportation and lodging must be reserved and scheduled through BridgeHealth Medical, Inc.
- Meals and incidentals include a daily allowance calculated for the number of days the patient and companion are at the destination and is intended to cover incidental and "out-of-pocket" expenses incurred by the patient in connection with his/her treatment. The meals and incidentals allowance shall be established and payable at initiation of the travel associated with such treatment.

Certain examinations, tests, treatments or other medical services may be required prior to or following travel for care under the BridgeHealth Surgery Benefit. Any medical services performed by anyone other than a BridgeHealth provider, including pre and post-operative care as may be required, shall be subject to the coverage limits and other terms of the Plan (including any required cost sharing).

The BridgeHealth Surgery Benefit is included toward and subject to any annual maximum for Covered Expenses under the Plan. The Plan shall remain responsible for BridgeHealth Surgery Benefit costs, in accordance with the applicable terms of the Plan, if a change is required once travel and accommodations have been made. The Plan will also cover any medical emergency required as a result of any medical procedures or health services received by the covered person under the BridgeHealth Surgery Benefit, subject to the applicable coverage limits of the Plan (including any required cost-sharing).

The non-medical benefits provided under the BridgeHealth Surgery Benefit may be subject to taxation as income to the covered person; particularly any amounts paid to a covered person as meals and incidentals. BridgeHealth will provide appropriate documentation for benefits paid under the BridgeHealth Surgery Benefit.

KEY POINT

The plan pays 100% for surgery through BridgeHealth, including first class travel costs for you and a companion. Your deductible is waived.

TELADOC

You can seek medical consultation without leaving your home or your worksite. Through Teladoc, you have access to board certified, state licensed physicians available 24/7/365 to diagnose, treat and prescribe medication if necessary.

- You may request an appointment via the web, phone, or mobile app.
- You do not have to satisfy your deductible and you pay $0!

Contact Teladoc at 1-800-TELADOC (835-2362) or www.teladoc.com.

HOSPITAL SELF AUDIT PROGRAM

This program applies only to billing errors made by the hospital.

If you find an error in a hospital bill paid by the Medical Plan, the Plan will share any resulting savings with you. You will be paid 50% of the savings upon recovery of the funds.

Hospitals submit your bill to the Trust Fund Administrator for you, so you'll need to ask the hospital for an itemized copy of your hospital bill.

When you receive the Explanation of Benefits form from the Trust Fund Administrator, examine your hospital bill and the Explanation of Benefits form. If you find an error in your hospital bill, contact the hospital and ask that the billing be corrected. You will receive a new Explanation of Benefits form.

KEY POINT

If you find a hospital billing error that the Plan paid, you'll receive 50% of the hospital's refund.

Here are some suggestions on how to look for errors:

- Are there any duplicate charges on your bill? This is the most fruitful area to review. Most hospital bills are computer-generated, and duplicate charges are easily entered.
- Is the number of days of hospitalization correct? You should be charged beginning with your admission day (no matter what time you check in) through the day before discharge. The actual day of discharge would not count as a day of hospitalization if you leave before the hospital's standard checkout time.
- Were you charged for the right type of room (private, semi-private, intensive care) and the correct corresponding number of days?
- If you had pre-admission testing, were you billed for the standard battery of admission tests when you entered the hospital, even though you never had them?
- Were you charged for services or treatment you did not receive (such as laboratory procedures, X-rays, therapy and drugs)?
- Did you have all the X-rays that were billed?
- Were you billed for tests or services that were ordered but later cancelled?
- Were drugs prescribed for you to take home actually received?
- Do any charges seem unusually high (for example, aspirin at $50 a tablet instead of 50 cents)? Remember, a misplaced decimal point can add hundreds of dollars to your bill.

ACTIVE PLAN: HEALTH CARE BENEFIT OVERVIEW

The following charts provide an overview of the Medical, Prescription Drug, Dental and Vision Plan benefits. Keep in mind that Medical Plan payment is based on the covered charge for each service or supply (not the billed amount). You must pay any required copays and satisfy the annual deductible, if required, before the Plan pays benefits.

MEDICAL PLAN–ACTIVE EMPLOYEES		
	PPO Provider	**Non-PPO Provider**
Deductible The amount of covered services you pay each calendar year before the Plan pays benefits	$500/person $1,000/family	
Out-of-Pocket Limit The maximum you pay in coinsurance each calendar year, after which the Plan pays 100% for most covered services	$3,000/person $8,200/family	Not applicable
Lifetime Maximum The most the Plan will pay for any covered person throughout his/her lifetime	Unlimited	
Physician Services: Office visits, surgery and maternity services	Plan pays 80% after deductible	Plan pays 40% after deductible
Preventive Care Physical exams and related laboratory and X-ray services, routine mammograms, immunizations	Plan pays 100%, no deductible required	Plan pays 100%, no deductible required
Facility Charges $500 Emergency Room penalty applies for non-emergency visits	Plan pays 80% after deductible	Plan pays 40% after deductible $200 hospital confinement deductible applies for inpatient services No coverage at Alpine Surgery Center in Anchorage
Orthopedic Surgery (facility and physician)	Plan pays 80% after deductible	No coverage
Air Transportation	Plan pays 80% after the deductible.	Plan pays 40% after deductible
Skilled Nursing Facility Up to 100 days inpatient care per illness or injury	Plan pays 80% after the deductible.	Plan pays 40% after deductible
Home Health Care Up to 100 visits	Play pays 100%, no deductible required	Plan pays 40%, no deductible required
Rehabilitation Hospital Up to 100 days inpatient care per illness or injury or 60 days outpatient	Plan pays 80% after the deductible.	Plan pays 40% after deductible
Hospice Services	Play pays 100%, no deductible required	Plan pays 40%, no deductible required

MEDICAL PLAN–ACTIVE EMPLOYEES		
	PPO Provider	**Non-PPO Provider**
Physical Therapy	Plan pays 80% after deductible	Plan pays 40% after deductible
Chiropractic Services Up to 15 visits per calendar year	Plan pays 80% after deductible	Plan pays 40% after deductible
Acupuncture Services Up to 15 visits per calendar year	Plan pays 80% after deductible	Plan pays 40% after deductible
Mental Health and Substance Abuse	Plan pays 80% after deductible	Plan pays 40% after deductible
Diagnostic Testing	Plan pays 80% after deductible	Plan pays 40% after deductible
Dialysis Treatment - Outpatient	100% of the Usual and Reasonable Charge after all applicable deductibles and coinsurance. Please refer to Dialysis Treatment Outpatient.	
Bridge Health	Plan pays 100%, no deductible required	Not applicable
Teladoc	Plan pays 100%, no deductible required	Not applicable

PRESCRIPTION DRUG PLAN–ACTIVE EMPLOYEES	**RETAIL** (30-day supply) OR **MAIL ORDER** (100-day supply)
Generic Drug	You pay 10%
Formulary Brand-Name Drug (when no generic is available)	You pay 15%
Non-Formulary Brand-Name Drug (when no generic is available)	You pay 25%
Brand-Name Drug (when a generic is available)	Generic copay plus difference between cost of brand-name drug and generic drug
Specialty Drug – Must be preauthorized and purchased through CVS Caremark	You pay 15%, maximum $150 / script Maximum is 1 fill or not more than a 30-day supply per month

Prescription Drug Plan Out-of-Pocket Limit:

The Out-of-Pocket limits for the prescription drug program are $2,500 per individual and $5,000 per family.

DENTAL PLAN–ACTIVE EMPLOYEES	
Deductible	$50/person, $150/family
Calendar Year Maximum Does not apply to children under age 18	$2,000/person
Preventive Services	Plan pays 80%; no deductible required
Basic Services	Plan pays 80%
Major Services	Plan pays 80%

VISION PLAN–ACTIVE EMPLOYEES	
Deductible	None
Percentage Payable	Plan pays 90% of the UCR charge
Examinations	One exam every 12 consecutive months 12 month limit does not apply to any child under 19 years of age.
Lenses: ▪ Single Vision Prescription ▪ Bifocal Prescription ▪ Trifocal Prescription ▪ Lenticular Lenses	One pair every 12 consecutive months 12 month limit does not apply to any child under 19 years of age.
Frames Plan pays up to $140 maximum for one pair of frames	One pair every 12 consecutive months 12 month limit does not apply to any child under 19 years of age.
Contact Lenses	12 month supply (in lieu of one pair of lenses and one pair of frames)
Corrective Eye Surgery Employee and spouse only	Plan pays 80%, up to $2,000 lifetime maximum

Limits on exams, lenses and frames, etc., do not apply to dependent children under age 19.

This chart provides a brief overview of Plan benefits. Please refer to the detailed information in this Summary Plan Description to understand the terms and conditions of the Plan, including, but not limited to, all definitions, general exclusions and limitations and Plan amendments.

COVERED MEDICAL CHARGES

Covered Medical Charge Definition

A "covered medical charge" is a charge that meets all of the tests listed below:

1. It is included in the description of covered charges in this Summary Plan Description.
2. It is incurred by a covered person while the person is covered for the comprehensive medical benefits. A charge is deemed to be incurred at the time the service is rendered or the supply is furnished for which the charge is made.
3. It is not excluded by the general health limitations.
4. It is for a service or supply that:
    - Is rendered for the treatment or diagnosis of an injury, medical condition or disease, including premature birth, congenital defects, birth defects, and necessary therapeutic abortion.
    - Is not mainly for the convenience of the covered person or of the covered person's physician or other provider.
    - Is generally accepted as meeting professionally recognized standards.
    - In accordance with professionally recognized standards, is:
        - Consistent with the symptoms or diagnosis
        - Rendered for an appropriate duration and frequency for the severity of the injury or disease
        - The most appropriate supply or level of service needed to provide safe and adequate care. When applied to confinement in an acute care hospital or other facility
        - Means that the covered person needs to be confined as an inpatient due to the nature of the services rendered or due to the covered person's condition and that the covered person cannot receive safe and adequate care through outpatient treatment
5. It does not exceed the smallest of the covered charge limits that apply to the service or supply for which the charge is made. The part of a charge that does not exceed the smallest of the covered charge limits shall be considered a covered medical charge if it meets all the tests in this provision.

Covered Charge Limits

The "covered charge limits" that apply to each service or supply are:

1. The usual charge for the service or supply
2. The customary charge for the service or supply
3. Any limit specified in this Summary Plan Description

For non-PPO facility charges in the Municipality of Anchorage, the covered charge will be the contracted rate at Alaska Regional Hospital for inpatient services. The contracted rate for outpatient services will be the case rate at Alaska Regional Hospital, if any, or 50% of the billed charges if no case rate is available.

COVERED SERVICES

Routine Wellness Exams and Preventive Care Services

The Plan covers preventive care, with no out-of-pocket expense (not subject to the calendar year deductible or coinsurance) including:

- Evidence-based items or services that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force (Task Force) with respect to the individual involved.
- Immunizations for routine use in children, adolescents and adults that have in effect a recommendation from

the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention (Advisory Committee) with respect to the individual involved. A recommendation of the Advisory Committee is considered to be "in effect" after it has been adopted by the Director of the Centers for Disease Control and Prevention. A recommendation is considered to be for routine use if it appears on the Immunization Schedules of the Centers for Disease Control and Prevention.

- With respect to infants, children and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration (HRSA).
- With respect to women, evidence-informed preventive care and screening provided for in comprehensive guidelines supported by HRSA (not otherwise addressed by the recommendations of the Task Force).

The complete list of recommendations and guidelines that must be covered by plans is located at:

http://www.HealthCare.gov/center/regulations/prevention.html.

Generally, covered preventive care includes:

- Routine wellness or physical exams
- Mammograms
- Pap smears
- Prostate Specific Antigent (PSA) tests
- Diabetes education
- Colorectal cancer screening, and
- Immunizations, including Hepatitis A and B vaccinations.
- Contraceptive coverage

Recommended services may be subject to age, gender and family history.

KEY POINT

Most preventive care is covered at 100%, and the deductible is waived.

Healthy Diet Counseling

Expenses for healthy diet counseling are covered at 100%, not subject to the deductible for 1 visit per individual per year only if the provider is a preferred provider.

Professional Services Charged by a Physician

- Office visits, visits in an acute care hospital, at the patient's home, or at any other place, but not for more than one visit per day
- Surgery, subject to the surgery guidelines shown below
- Radiation treatment
- Anesthesiology, subject to the surgery guidelines shown below

Surgery Guidelines

- If two or more surgical procedures are performed at the same time, the covered medical charges will be limited to those incurred for the major procedure plus 50% of those incurred for each lesser procedure that adds significant time or complexity
- The benefit for performing surgery includes normal follow-up care and the administration of any local, digital block, or topical anesthesia
- Reduced benefits may be paid for the administration of other anesthetics if done by the operating or assisting surgeon
- The services of an assistant surgeon are reimbursed up to 20% of the maximum amount payable for the primary surgeon. If the assistant surgeon is not an MD or DO, charges related to the assistant surgeon will be reimbursed up to 10% of the maximum amount payable for the primary surgeon

Second Surgical Opinion

The Plan pays 100%, no deductible required, for covered expenses for second surgical opinions, as described below.

Covered medical charges include the surgical opinion charges incurred for a second surgical opinion. The charges for a third surgical opinion will also be covered medical charges if the second surgical opinion does not confirm that the surgery meets the tests of item 4 of the covered medical charge definition.

Surgical opinion charges include only:

- The charge for the professional services of a physician
- The charge for a laboratory test or X-ray examination that does not duplicate a prior test or examination

If a physician who gives a second or third opinion later performs the surgery, any deductible waiver or percentage payable increase will not apply to the surgical opinion of that physician.

Labs, Tests, Supplies

The Plan pays for covered expenses for provider charges for labs, tests and supplies, as described below:

- The charge of a physician or laboratory for a laboratory test or X-ray examination. However some preventive services may be payable at 100% under the preventive care provisions.
- The charge of a physician for casts, splints, surgical dressings, and other medical supplies

Pre-Admission Testing

The Plan pays for covered expenses for pre-admission testing, as described below.

Covered medical charges include charges for pre-admission testing.

"Pre-admission testing" means only laboratory tests and X-ray examinations of a covered person that are prerequisite to surgery and are performed on an outpatient basis within the seven-day period preceding the covered person's scheduled admission to a facility for surgery.

Post-Mastectomy Benefit

The Plan pays for post-mastectomy benefits.

The charges shown below that are incurred by a covered person as the result of a mastectomy on one or both breasts, and in a manner determined in consultation between the attending physician and the patient, are covered medical charges.

Any exclusion of benefits for a procedure performed mainly to improve the appearance of the covered person does not apply to this benefit.

Covered medical charges include:

- Reconstruction of the breast on which the mastectomy has been performed
- Surgery on and reconstruction of the non-diseased breast to produce symmetry between the breasts
- Prostheses
- Treatment of physical complications, including lymphedemas, at all stages of mastectomy

Pregnancy Benefit

The Plan pays for pregnancy benefits.

Medical benefits will be payable for the covered medical charges that are incurred by an eligible dependent for treatment of pregnancy and prenatal care on the same basis as medical benefits are paid for treatment of a disease.

The charges for well-baby care that are listed below are covered medical charges.

- The charge of an acute care hospital for routine nursery care furnished to a newborn well baby while the mother is an inpatient
- The charge of a physician for the initial examination of a newborn and the examination performed immediately before the child is released from nursery care

The covered medical charges for pregnancy care, prenatal care, and well-

baby care described above:

- Are payable for at least 48 hours of inpatient care following a vaginal delivery, or 96 hours of inpatient care following a caesarean section
- Are not subject to item 4 of the covered medical charge definition

Prior authorization review is not required for inpatient lengths of stay of 48 hours or less following a vaginal delivery, or 96 hours or less following a caesarean section; otherwise, prior authorization review is required.

The Plan does not cover pregnancy or well-baby care for a pregnancy resulting from surrogacy or for a participant who is a gestational carrier.

Well-Baby Care

The Plan pays for well-baby care from birth to 24 months of age.

The well-baby care covers exams, tests and inoculations where there is no diagnosis of injury or disease.

Hospital Room and Board and Services and Supplies

The Plan's daily limit:

- For routine care is the hospital's average semi-private room rate
- For intensive care is the hospital's average intensive care room rate

The room and board charge of an acute care hospital for each day a covered person is an inpatient is a covered charge.

The covered medical charge for room and board for each day of confinement shall not be more than:

- The room and board daily limit for each day the covered person is an inpatient in a routine care unit
- The intensive care daily limit for each day the covered person is an inpatient in an intensive care unit
- The room and board daily limit for each day the covered person is an inpatient in a special care unit other than an intensive care unit

Covered charges of an acute care hospital, other than room and board charges, include:

- Medical services and supplies furnished to a covered person who is an inpatient
- Medical services and supplies furnished on an outpatient basis

Skilled Nursing Facility

The Plan pays for covered expenses for skilled nursing confinement, as described below.

The Plan's daily limit is the facility's average semi-private room rate.

The Plan pays benefits for up to a maximum of 100 days for all confinements that result from the same or related sickness or injury.

The charges of a skilled nursing facility for the confinement of a covered person as an inpatient, but only if the confinement:

- Follows a stay of at least three days as an inpatient in an acute care hospital
- Starts within 14 days after the covered person is discharged from that hospital stay

The covered medical charge for all charges for each day of confinement shall not be more than the skilled nursing facility daily limit.

The Plan will not pay for more than 100 days for all skilled nursing facility confinements that result from the same or related injury or disease.

Rehabilitation Hospital

The Plan pays up to 60 days per individual per year for the charges of a rehabilitation hospital for medical services and supplies furnished on an outpatient basis, as described below.

The Plan's daily limit is the rehabilitation hospital's average semi-private room rate.

The Plan pays benefits for up to a maximum of 100 days for all confinements that result from the same or related sickness or injury.

The charges of a rehabilitation hospital for the confinement of a covered person as an inpatient, but only if the confinement:

- Follows a stay of at least three days as an inpatient in an acute care hospital
- Starts within 14 days after the covered person is discharged from that hospital stay

The covered medical charge for room and board for each day of confinement shall not be more than the rehabilitation hospital daily limit.

Private Duty Nursing

The charge for the professional services of a nurse for private duty nursing, limited to 100 visits per individual per year but only during a period for which:

- Nursing services meet the covered charge definition
- For outpatient nursing, the covered person would be an inpatient at an acute care hospital, a rehabilitation hospital, or a skilled nursing facility in the absence of those nursing services.

Home Health Care Benefit

The Plan pays for covered charges for home health care, as described below.

The Plan pays benefits for up to a maximum of 100 visits per calendar year.

The Plan will not pay for home health care unless:

- The plan of home health care is drawn up, or approved, by the covered person's physician
- The home health care meets the covered medical charge definition
- In the absence of the home health care, the covered person would be an inpatient at an acute care hospital, a rehabilitation hospital, or a skilled nursing facility
- The home health care begins within seven days following the end of a hospital stay for the same or related condition.

Home Health Care Charges Include:

- The charge for the professional services of a nurse or a home health aide on a part-time or intermittent basis.
- The Plan will not pay for more than 100 home health care visits by a nurse or a home health aide during any one calendar year. One home health care visit is a visit of 8 hours or less.
- The charge for nutrition counseling.
- The charge for physical, occupational, or speech therapy furnished by an allied health professional practicing within the scope of his license.
- Provider charges and medical support charges.

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

A "home health agency" is an agency that:

- Meets any legal licensing required by the state or other locality in which it is located; or
- Qualifies as a participating home health agency under Medicare.

Hospice Care Benefit

The Plan pays for covered charges for hospice care, as described below.

The Plan pays benefits for up to a maximum of six months combined inpatient and outpatient per individual while covered under the Plan.

The charges for hospice care that are listed below and that meet all the tests of the covered medical charges definition are covered medical charges. Benefits will be paid for hospice care charges that are incurred only:

- During a period for which the covered person is a terminally ill patient
- During the bereavement period.

The Plan will not pay more than the maximums listed for all hospice care charges incurred either by the terminally

ill patient or the family unit before the death of the terminally ill patient.

Hospice care covered charges shall not be subject to any provision of the Plan that otherwise would exclude benefits payable for:

- custodial care
- medical social services
- palliative care

Hospice care charges include:

- The charge for the confinement of a terminally ill patient as an inpatient.
- The charge for home health care furnished to the terminally ill patient in the patient's home. The charges for home health care include:
    - The charge for the services of a home health aide.
    - The charge for the professional services of a nurse.
    - The charge for physical therapy or other therapy furnished by an allied health professional practicing within the scope of his license.
    - The charge for nutrition counseling and special meals.
    - Medical support charges.
- The charge for medical social services furnished to the terminally ill patient or to the family unit.

For hospice care only, covered medical charges include custodial care, medical social services, and palliative care.

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

"Hospice care" is care that:

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

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

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

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

A "terminally ill patient" is a covered person whose physician has certified that the covered person is terminally ill and expected to live 6 months or less.

Medical Supplies

The Plan pays for medical supplies, as described below.

- The Plan will pay up to a maximum charge of $105 for the purchase of a blood pressure monitor.
- The charge for a prosthetic device, but not for the replacement or repair of such a device.
- The charge to rent or to buy durable medical equipment, but not to replace or repair such equipment. Rental, up to the purchase price, of durable medical equipment and supplies is covered. Any accrual of charges for the rental of medical equipment that is in excess of the normal purchase price for that medical equipment is not a covered expense.

- The charge for oxygen, blood, blood products, anesthetics, or other medical supplies that can be lawfully obtained only with the prescription of a physician.
- The charge for a drug or medicine that can be lawfully obtained only with the written prescription of a physician or dentist, but not including any charge that is a covered prescription charge under the outpatient prescription drug coverage, if applicable.

Travel Expenses

Prior authorization is required for reimbursement of travel expenses, except in case of emergency. If prior authorization is required and is not obtained, no benefits will be payable for travel.

- The Plan pays travel and ambulance costs within the contiguous limits of the United States, the State of Alaska and the State of Hawaii. This includes:
    - Transportation to the nearest hospital by Professional Ambulance.
    - Round-trip transportation, not exceeding the cost of coach class commercial air transportation from the site of the illness or injury to the nearest professional treatment. If you use ground transportation and the most direct one-way distance exceeds 100 miles, reimbursement of expenses for ground transportation shall be calculated by applying the IRS mileage allowance for the distance traveled. Frequent flyer miles are not reimbursable. If you obtain services in a location other than the site of the nearest professional treatment, the maximum covered charge will be the cost of travel to the site of the nearest professional treatment, as determined by the Plan.
- If the patient is a child under 18 years of age, a parent's or legal guardian's transportation charges are allowed. The Plan covers travel costs for a companion of an incapacitated adult. An incapacitated adult means the individual either due to physical or mental disability cannot:
    - Make rational decisions on their own behalf, or
    - Cannot transport themselves without the assistance of another individual, and only being wheelchair bound or on crutches does not qualify as incapacitated.
- When authorized by the Trust Fund Administrator, travel charges for a physician or a registered nurse are covered.
- Travel does not include the cost of food and lodging (except as specified), or local ground transportation such as airport shuttles, cabs, or car rental.
- Travel benefits apply only to the conditions covered under the Medical Plan. They do not apply to the audio, dental, or vision plans.
- Once travel benefits are preauthorized, if the services incurred change as a result of the provider's medical judgment, the benefits will be paid according to the original preauthorization. For example, if travel is preauthorized for treatment not available locally, and after the participant travels to the location of treatment the provider determines the anticipated treatment cannot or should not be provided, travel expenses will still be covered by the Plan.

Travel, as described above, is covered **only** in the circumstances set forth in the sections below.

<u>Emergencies</u>

Travel is covered if you have an emergency condition requiring immediate transfer to a hospital with special facilities for treating your condition. Preauthorization is waived if you are immediately transferred in a ground or air ambulance; you do not need to call the

Trust Fund Administrator before this occurs.

An emergency medical condition is a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in:

- placing the health of the individual (or with respect to a pregnant woman, the health of the woman and/or her unborn child) in serious jeopardy,
- serious impairment to bodily functions, or
- serious dysfunction of any bodily organ or part,

as determined by the Trust Fund Administrator.

Treatment Not Available Locally

Travel is covered for you to receive treatment which is not available in the area you are located when the need for treatment occurs.

Treatment must be received for travel to be covered, unless your provider determines the services cannot or should not be administered.

These benefits are limited during each benefit year to:

- One visit and one follow-up visit for a condition requiring therapeutic treatment. Therapeutic treatment **does not** include:
    - Diagnostic office visits and tests;
    - Writing a prescription for medication or treatment; or
    - Formulation of a treatment plan.
- One visit for prenatal or postnatal maternity care and one visit for the actual maternity delivery;
- One visit for each allergic condition; and
- One pre-surgical or post-surgical visit and one visit for the surgical procedure. If you require preoperative testing within 7 days prior to surgery, the Plan will cover food and lodging for the days on which you actually receive preoperative testing, as follows: — The Plan will reimburse actual expenses up to an Allowable Expense of $31 per day without overnight lodging or
    - $80 per day if overnight lodging is required; and
    - If a parent or legal guardian accompanies a child under age 18 or a companion accompanies an incapacitated adult, the Plan pays up to an additional $31 per day.
    - You must submit your receipts for the actual expenses to the Claims Administrator in order to receive reimbursement for food and lodging.

Second Surgical Opinions

Travel is covered if you require a second surgical opinion, which cannot be obtained where you are currently located. This will count as a pre-surgical trip as shown.

Diagnostic Testing Not Available Locally

Travel is covered for you to receive diagnostic testing which is not available in the area in which you are located. Diagnostic testing must be received for travel to be covered and you must:

- Ensure your completed travel preauthorization form is signed by a local referring health care provider and clearly states the reasons the diagnostic testing is recommended, and
- You must travel to the city in which the testing will be provided no earlier than 24 hours prior to the time in which the services are scheduled and return no later than 24 hours after testing is completed, unless it is Medically Necessary to arrive earlier or remain for a specified period after service is provided, or if there is no

scheduled air or ferry service within the required time frames.

The Plan will pay 50% of Allowable Expenses for travel, and your out-of-pocket costs will not apply to your Out-of-Pocket Maximum. These benefits are limited to one diagnostic trip per Plan Year.

Surgery In Other Locations

Travel is covered if you have surgery which is provided less expensively in another location.

If the actual total cost of surgery, hospital room and board, necessary lodging and travel to another location for the surgery is less expensive than the Plan's Allowable Expense for the same services at the nearest location you could obtain the surgery, your travel costs may be paid. Preauthorization is required and the surgery must be Medically Necessary

The Plan's coverage for necessary overnight lodging is limited to a maximum of $80 per day.

To use this benefit, you will need to provide the Trust with documentation showing the savings for obtaining services in another location. Send your documentation, including a comparison between the charges that would have been incurred for local care and the actual cost of the out-of-area care covered by the Plan, including travel receipts to the Claims Administrator. The amount of reimbursement, if any will be determined when the claim is processed.

The **BridgeHealth Surgery Benefit** covers first class round-trip transportation, lodging, meals and incidentals for the covered person and one (1) companion. Please see the BridgeHealth Surgery Benefit.

Mental Health and Substance Abuse

The Plan pays for covered charges for mental health treatment and treatment of substance abuse.

Physical Therapy Services

The Plan pays for physical therapy services.

Chiropractic Services

The Plan pays for covered charges for chiropractic services.

Charges incurred for chiropractic services received by a covered person as an outpatient are covered medical charges.

"Chiropractic services" means the diagnosis and treatment of the spine by manual or mechanical means provided by a chiropractor.

Such charges will be limited to the covered medical charges a covered person incurs for no more than 15 outpatient visits during any calendar year.

Acupuncture Services

The Plan pays for covered charges for acupuncture services.

Charges incurred for acupuncture services provided by a licensed acupuncturist and received by a covered person as an outpatient are covered medical charges. Such charges will be limited to the covered medical charges a covered person incurs for no more than 15 outpatient visits during any calendar year.

Orthotic Benefit

The Plan pays for covered charges for orthotic benefits.

Prescribed charges for orthopedic shoes and orthotics are covered charges.

The Plan pays benefits up to a maximum of one pair of orthopedic shoes or one set of orthotics per individual in a calendar year.

Cranial Prosthesis / Wigs

The Plan pays for covered charges for cranial prosthesis/wigs.

The Plan will pay for one wig per participant while covered under the Plan.

Hearing Benefit

The Plan pays for covered charges for hearing benefits as described below.

The Plan pays benefits up to a maximum of one hearing exam per individual in a calendar year or 1 hearing aid purchase, repair or maintenance limited to $4,000 per individual in any two (2) calendar years.

The charges for hearing examinations and a hearing aid device that are listed below are covered medical charges.

Covered medical charges include:

- An otologic examination made by a physician
- An audiologic examination made by a certified or licensed audiologist, including one follow up visit
- The purchase of a hearing aid device (monaural or binaural) prescribed as a result of such examinations, but only if the examining physician or audiologist certifies that the covered person's hearing loss may be lessened by the use of a hearing aid device. Such charges include:
    - The actual hearing aid device
    - Ear molds
    - The initial batteries, cords, and other necessary ancillary equipment
    - A warranty
    - A follow up visit within 30 days after delivery of the hearing aid device

Exclusions

No hearing benefit will be paid for any charge excluded by the general health limitations or for any:

- Replacement of a hearing aid more than once during any period of two consecutive calendar years
- Batteries or other ancillary equipment, except the necessary equipment obtained upon purchase of the hearing aid device
- Repair, servicing, or alteration of hearing aid equipment
- Hearing aid device which exceeds the specifications prescribed for correction of the hearing loss
- Charges incurred after the date the covered person's coverage under this Plan ends, except for charges incurred for a hearing aid device that was ordered prior to and delivered within 30 days after the date of termination

DIALYSIS TREATMENT – OUTPATIENT

This section describes the Plan's Dialysis Benefit Preservation Program (the Dialysis Program). The Dialysis Program shall be the exclusive means for determining the amount of Plan benefits to be provided to Plan members and for managing cases and claims involving dialysis services and supplies, regardless of the condition causing the need for Dialysis.

Reason for the Dialysis Program: The Dialysis Program has been established for the following reasons:

- the concentration of dialysis providers in the market in which Plan members reside may allow such providers to exercise control over prices for dialysis-related products and services,
- the potential for discrimination by dialysis providers against the Plan because it is a non-governmental and non-commercial health plan, which discrimination may lead to increased prices for dialysis-related products and services charged to Plan members,
- evidence of:
    - significant inflation of the prices charged to Plan members by dialysis providers
    - the use of revenues from claims paid on behalf of Plan members to subsidize reduced prices to other types of payers as incentives, and
    - the specific targeting of the Plan and other non-governmental and non-commercial plans by the dialysis providers as profit centers, and,
- the fiduciary obligation to preserve Plan

assets against charges which:

- exceed reasonable value due to factors not beneficial to Plan members, such as market concentration and discrimination in charges, and
- are used by the dialysis providers for purposes contrary to the Plan members' interests, such as subsidies for other plans and discriminatory profit-taking.

Dialysis Program Components. The components of the Dialysis Program are as follows:

Application. The Dialysis Program shall apply to all claims filed by, or on behalf of, Plan members for reimbursement of products and services provided for purposes of outpatient dialysis, regardless of the condition causing the need for dialysis ("dialysis-related claims").

Claims Affected. The Dialysis Program shall apply to all dialysis-related claims received by the Plan on or after April 1, 2014, regardless when the expenses related to such claim were incurred or when the initial claim for such products or services was received by the Plan with respect to the Plan member.

Mandated Cost Review. All dialysis-related claims will be subject to cost review by the Plan to determine whether the charges indicate the effects of market concentration or discrimination in charges.

In making this determination the Plan shall consider factors including:

- Market concentration: The Plan shall consider whether the market for outpatient dialysis products and services is sufficiently concentrated to permit providers to exercise control over charges due to limited competition, based on reasonably available data and authorities. For purposes of this consideration multiple dialysis facilities under common ownership or control shall be counted as a single provider.
- Discrimination in charges: The Plan shall consider whether the claims reflect potential discrimination against the Plan, by comparison of the charges in such claims against reasonably available data about payments to outpatient dialysis providers by governmental and commercial plans for the same or materially comparable goods and services.

In the event that the Plan's charge review indicates a reasonable probability that market concentration and/or discrimination in charges have been a material factors resulting in an increase of the charges for outpatient dialysis products and/or services for the dialysis-related claims under review, the Plan may, in its sole discretion, determine that there is a reasonable probability that the charges exceed the reasonable value of the goods and/or services. Based upon such a determination, the Plan may subject the claims and all future claims for outpatient dialysis goods and services from the same provider with respect to the Plan member, to the following payment limitations, under the following conditions:

- Where the Plan deems it appropriate in order to minimize disruption and administrative burdens for the Plan member, dialysis-related claims received prior to the cost review determination may, but are not required to be, paid at the face or otherwise applicable rate.
- Where the provider is or has been a participating provider under a Preferred Provider Organization (PPO) available to the Plan's members, upon the Plan's determination that payment limitations should be implemented, the rate payable to such provider shall be subject to the limitations of this Section.
- Maximum Benefit. The maximum Plan benefit payable to dialysis-related claims subject to the payment limitation shall be the Usual and Reasonable Charge for covered services and/or supplies, after deduction of all amounts payable by coinsurance or deductibles.

- Usual and Reasonable Charge. With respect to dialysis-related claims, the Plan shall determine the Usual and Reasonable Charge based upon the average payment actually made for reasonably comparable services and/or supplies to all providers of the same services and/or supplies by all types of plans in the applicable market during the preceding calendar year, based upon reasonably available data, adjusted for the national Consumer Price Index medical care rate of inflation.

  The Plan may increase or decrease the payment based upon factors concerning the nature and severity of the condition being treated.

- Additional Information related to Value of Dialysis-Related Services and Supplies. The Plan member, or where the right to Plan benefits has been properly assigned to the provider, may provide information with respect to the reasonable value of the supplies and/or services, for which payment is claimed, on appeal of the denial of any claim or claims. In the event the Plan, in its sole discretion, determines that such information demonstrates that the payment for the claim or claims did not reflect the reasonable value, the Plan shall increase or decrease the payments (as applicable) to the amount of the reasonable value, as determined by the Plan based upon credible information from identified sources. The Plan may, but is not required to, review additional information from third-party sources in making this determination.

  - All charges must be billed by a provider in accordance with generally accepted industry standards.

- Provider Agreements. Where appropriate, and a willing appropriate provider acceptable to the Plan member is available, the Plan may enter into an agreement establishing the rates payable for outpatient dialysis goods and/or services with the provider, provided that such agreement must identify this Section of the Plan and clearly state that such agreement is intended to supersede this Section.

- Discretion. The Board of Trustees shall have full authority and discretion to interpret, administer and apply this Section, to the greatest extent permitted by law.

COVERAGE FOR INDIVIDUALS PARTICIPATING IN APPROVED CLINICAL TRIALS

The Plan provides coverage for the routine patient care costs associated with participation in high-quality clinical trials (phases I to IV) for cancer or other life-threatening disease or condition.

Coverage will extend to clinical trials conducted outside the state in which the patient resides. Coverage is provided for out of network services as those benefits are currently provided under the Plan.

The ACA defines routine costs to include all items and services that are typically covered for a patient who is not enrolled in a clinical trial. This includes items such as hospital visits, imaging or laboratory tests, and medications. Any experimental drugs used in the clinical trial will remain excluded items under the Plan.

The clinical trial provision does *not* include:

- The investigational treatment, device or service itself, which is typically covered by the trial's sponsor, such as the National Cancer Institute (NCI) or a pharmaceutical company.
- Items and services that are provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient.
- A service that is inconsistent with widely accepted and established standards of care for a particular diagnosis.

EXCLUDED CHARGES LIST

Section A

No benefit, other than a life benefit, will be paid for or in connection with any injury or disease:

- That is intentionally self-inflicted while sane or that is self-inflicted while insane; except that, effective January 1, 2002, this exclusion does not apply to the medical coverage under the Plan for any self-inflicted injury or disease that is the result of a medical condition
- That results from or arises out of any past or present employment or occupation for compensation or profit, including surrogacy.
- That results from:
    - Any act of war
    - The covered person's commission of a felony
    - Non-therapeutic release of nuclear energy

Section B

(Note: This section does not apply to any AD&D Insurance that may be provided.) No benefit will be paid under the medical, outpatient prescription drug, vision care, or dental coverage for or in connection with any:

- Charge, or part of a charge, that the covered person is not obligated to pay or for which the covered person would not have been billed except for the fact that the covered person was covered under the Plan
- Experimental or investigational treatment, as defined in the "Claims and Appeals" section
- Service or supply provided by a hospital that is owned or run by the United States government for treatment of an injury or a disease sustained during service in any armed forces.

Section C

This section applies only to the medical coverage under the Plan. No benefit will be paid under the medical coverage for or in connection with any:

- Charge that does not meet all of the tests of the covered medical charge definition
- Service or supply that is not prescribed by a physician or by an allied health professional who is practicing within the scope of his license
- Non-surgical treatment of feet, including but not limited to orthotics (custom made foot support), except as stated under Medical Plan Covered Charges
- Custodial care, regardless of who prescribes or renders such care, except as stated in the hospice care benefit
- Replacement or repair of a prosthetic device or of durable medical equipment
- Eye refractions, orthoptics, glasses, contact lenses, or the fitting of glasses or contact lenses, except for the first pair of glasses or first pair of lenses for use after cataract surgery
- Hearing aids or the fitting of hearing aids, except as stated under Medical Plan Covered Charges
- Reversal of sterilization
- Procedure performed mainly to improve the appearance of the covered person, unless it is cosmetic surgery for repair of damage sustained in an accident and the charges are incurred within one year from the date of the accident
- Treatment of obesity, whether or not such obesity is classified as morbid obesity, including but not limited to: gastric stapling, gastric bubble, bypass surgery, diet-based weight loss programs, exercise, or gym programs; this limitation will not apply to treatment of medical conditions caused by or resulting from obesity

- Service or supply to diagnose, treat, repair, or replace the teeth, gums, or supporting structure of the teeth, unless it is rendered:
  - For treatment of tumors
  - For repair of damage to sound natural teeth if the damage is sustained in an accident and the charges are incurred within one year from the date of the accident

  The term "sound natural tooth" means a tooth that:
  - Is organic and formed by the natural development of the body (not manufactured)
  - Has not been extensively restored
  - Has not become extensively decayed or involved in periodontal disease
- Treatment of infertility, including:
  - Artificial insemination
  - In vitro fertilization or other procedures involving the eggs and sperm
  - Implantation of an embryo developed in vitro
  - Drug therapy
  - Ovulation induction therapy
  - Monitoring laboratory, radiology and ultrasound studies; this limitation will not exclude diagnostic testing to determine the cause of the infertility
  - Surrogacy
- Drug or medicine used to treat sexual dysfunction, including but not limited to Viagra
- Copayments under the Wellness Plan
- Corrective eye surgery resulting in an improvement in visual acuity that is not permanent, regardless of the surgical technique (except as specifically provided under the Vision Plan)
- Massage therapy
- Any injury, or sickness caused by the act or omission of another person or entity (known as a "third party"), where an opportunity for recovery exists from the third party and/or under an automobile (including underinsured or uninsured motorist policies), homeowners, commercial premises, renter's, medical malpractice, or other insurance or liability policy, unless the participant executes and returns a Subrogation Agreement per the terms of the Plan.

PRESCRIPTION DRUG PLAN

The Plan will pay a prescription benefit for the covered prescription charges a covered person incurs while covered for the outpatient prescription drug coverage.

A "prescription benefit" is the amount that will be paid for the covered prescription charges incurred by a covered person.

KEY POINT

You must choose a participating retail pharmacy (if available) to purchase prescriptions under this Prescription Drug Plan. To locate a participating pharmacy near you, go to www.caremark.com and enter your state or zip code.

Covered Prescription Charge

A "covered prescription charge" is a charge that meets all of the tests listed below:

1. It is made for a covered drug supply that is prescribed for a covered person
2. It is incurred by a covered person while the covered person is covered for the outpatient prescription drug coverage. A charge is deemed to be incurred at the time the drug, medicine or supply is furnished for which the charge is made.
3. It is not excluded by the prescription exclusions or the general health limitations.
4. It is made for a supply that is rendered for the treatment or diagnosis of an injury or disease, including premature birth, congenital defects, and birth defects.
5. It is made for a supply that is not mainly for the convenience of the covered person or of the covered person's physician or other provider.
6. It is made for a supply that is generally accepted as meeting professionally recognized standards.
7. In accordance with professionally recognized standards, it is appropriate for the symptoms and consistent with the diagnosis.
8. It is made for a supply that is the most appropriate drug, medicine or supply needed to provide safe and adequate care.

Covered Drug Supply

A "covered drug supply":

1. Is a drug, medicine or supply that can be lawfully obtained only with the written prescription of a physician or dentist
2. Is limited to a 30-day supply; however, if you order through the Plan's mail-order pharmacy, a covered drug supply is limited to a 100-day supply instead of a 30-day supply. In no case can the supply be larger than that normally prescribed by a physician or dentist. Please contact the Trust Fund Administrator for any exceptions to these supply limits.
3. Compounds that cost over $300 must be pre-authorized.

Specialty Drugs:

The Plan has adopted the prescription benefit manager's recommended step-therapy approach for certain specialty medications. This requires the trial and failure of certain preferred medication(s) before access to other alternatives (non-preferred medicines) may be available. If you choose non-preferred medicine(s) without first trying preferred medication(s), you may be responsible for the full cost of the non-preferred brand medicine.

Specialty drugs must be preauthorized through CVS Caremark. CVS Caremark Specialty Pharmacy is the preferred pharmacy provider for specialty medications. CVS Caremark Specialty Pharmacy will coordinate delivery of specialty drugs in accordance with the manufacturer shipping and storage guidelines to the location of your choice.

Associated medical supplies and disposable kits for needles/syringes are also available upon request from CVS Caremark pharmacy for use in conjunction with injectable specialty drugs. CVS Caremark offers a team of patient care representatives to provide individualized support, review dosing and schedules, monitor supplies, ordering needs and more.

Specialty medications will be limited to one fill or not more than a 30-day supply per month.

CVS Caremark Specialty Pharmacy is the Plan's preferred provider of specialty medications.

If you have additional questions about your benefit in general, please call 866-818-6911 or log on and register at www.caremark.com. To learn more or get started with CVS Caremark Specialty Pharmacy please call 800-237-2767 or visit www.cvscaremarkspecialtyrx.com.

KEY POINT

You'll save money when you purchase medication you take on a regular basis through the mail-order service. To get started, call Caremark's Fast Start service at 866-273-5268 (toll-free).

Prescription Exclusions

No prescription benefit will be paid for any charge excluded by the general health limitations or for any:

- Drug, medicine or supply that is purchased at a non-participating pharmacy if a participating pharmacy is available
- Drug, medicine or supply that does not meet the definition of a covered prescription charge
- Drug, medicine or supply that is not prescribed by a physician or by an allied health professional who is practicing within the scope of his license
- Over the counter drugs, including but not limited to medicines or supplies, whether or not prescribed by a physician
- Device of any type, except as stated below in the exception for insulin and diabetic supplies; this exclusion includes, but is not limited to: diaphragms; therapeutic devices and appliances; hypodermic needles and syringes; and similar devices
- Experimental drug or drug that is labeled: "caution - limited by federal law to investigational use"
- Drug or medicine that is to be taken by or administered to a covered person in whole or in part while the covered person is a patient in: a hospital; a sanitarium; a rest home; a skilled nursing facility; an extended care facility; a nursing home; or a similar institution
- Drug, medicine or supply that is administered in or dispensed by a physician's or dentist's office, or dispensed by a home health care agency
- Refills that are in excess of the number prescribed by the physician, or that are dispensed more than one year after the order of a physician
- Biological sera, blood, blood products, or immunization agents other than allergy sera
- Drug, medicine or supply to treat an addiction to or dependence on tobacco or tobacco products, including nicotine
- Anorectic, dietary supplement, or any other weight control drug or medicine, except for Dexedrine, Desoxyn, or Adderall for a covered person up to age 18
- Infertility drug or medicine
- Drug or medicine used for cosmetic purposes to improve the appearance of the covered person, including but not limited to Minoxidil, Tretinoin for a covered person over age 25, and other similar products

- Drug or medicine used to treat sexual dysfunction, including but not limited to Viagra
- Anabolic steroids used for bodybuilding

Exception for Insulin and Diabetic Supplies

A covered drug supply includes charges for a 90-day supply of insulin, syringes and needles.

Drugs with Generic Equivalents: Limitation

For prescription drugs for which a generic equivalent exists, this Plan will allow the covered person to choose either the generic drug or the brand-name drug.

However, if the covered person refuses the generic equivalent, the pharmacist will dispense the brand-name drug after the covered person pays the applicable prescription copay and an amount equal to the difference between the cost of the brand-name drug and the cost of the generic drug that would have been dispensed.

Brand-Name Drugs

When a generic equivalent is not available, that means there is no generic drug that has the same ingredients and is a direct substitute for the particular brand-name drug in question.

This does not apply to a situation where a generic substitute is available on the market but the pharmacy happens to be out of the generic you may require.

If the pharmacy simply does not have the generic substitute in stock, you will have to make a choice of either paying for the difference between the cost of the brand-name drug and the generic equivalent or go to a pharmacy that has the generic equivalent that you require in stock.

This applies to retail and mail order prescription copays.

Cost Effectiveness Plan Design Program

The Plan will exclude from coverage any new drug or any new indication for an existing drug approved by the FDA with an incremental cost-effectiveness ratio greater than:

- $100,000 per additional quality-adjusted life-year for drugs not indicated in rare conditions
- $150,000 per additional quality-adjusted life-year for drugs indicated in rare conditions, unless the drug or indication has been granted breakthrough therapy designation by the FDA.

The Plan or CVS/Caremark determines which drugs or indications exceed the incremental cost-effectiveness ratio threshold using the following resources:

- Reports issued by the Institute for Clinical and Economic Review or similar organization
- Peer-reviewed, published cost-effectiveness analysis
- Consultation with qualified health care professionals
- Other unbiased sources

Coordination of Benefits

If this Plan is secondary, expenses for prescription drugs under coordination of benefits are payable at 100%.

No copay is required, and the calendar year deductible does not apply, regardless if the prescription is purchased at a participating or non-participating pharmacy.

Veterans Administration

Prescription drugs purchased through the V.A. are covered at 80% and subject to the calendar year medical deductible.

Experimental and Investigational Treatment

No benefit will be paid by the Plan for any drugs, devices, medical treatments or procedures that are considered to be experimental or investigational, as defined below. This limitation applies to the medical, outpatient prescription drug, vision care, and dental coverage provided under the Plan.

The term "experimental or investigational treatment" means that the drug, device, medical treatment or procedure:

- Cannot be lawfully marketed without the approval of the U.S. Food and Drug Administration, and approval for marketing has not been given for regular non-experimental or non-investigational purposes at the time such treatment is furnished
- Has been determined to be experimental or investigational by the treating facility's Institutional Review Board or other body serving a similar function, and the patient has signed an informed consent document acknowledging such experimental status
- Has been classified by federal law under an investigative program
- According to reliable evidence, is the subject of ongoing Phase I or Phase II clinical trials or is otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with standard means of treatment or diagnosis, except as provided below.

For the purposes of this provision, "reliable evidence" means only:

- Published reports and articles in peer reviewed authoritative medical and scientific literature
- The written protocol or the written informed consent used by the treating facility or another facility studying substantially the same drug, device, medical treatment or procedure

Exception: A service or supply will **not** be considered experimental or investigational if it is part of an approved clinical trial. An approved clinical trial is one that meets each of these criteria:

1. The trial is a Phase III or Phase IV trial approved by the National Institutes of Health, the U.S. Food and Drug Administration, the Department of Veteran Affairs, or an approved research center
2. The trial has been reviewed and approved by a qualified institutional review board
3. The facility and personnel have sufficient experience or training to provide the treatment or use the supplies

The Trust Fund Administrator, with the agreement of Medical Rehabilitation Consultants, will investigate each claim for benefits which might include experimental or investigational treatment.

The Trust Fund Administrator will consult with medical professionals, including its own staff, to determine whether the treatment is excluded as experimental or investigational, or whether it is covered as one of the exceptions specified above.

DENTAL PLAN

Dental Plan coverage is applicable to employees and dependents enrolled in the Active Plan.

Dental Benefits and Covered Charges

The Plan will pay a dental benefit as determined below for the covered dental charges a covered person incurs.

Pediatric Dental Services are dental services provided to a child under the age of 18. Any annual dollar limit under the Dental Plan will not apply to these services.

KEY POINT

You may choose any licensed dentist to provide dental services

Dental Deductible

The dental deductible:

- Applies to all covered dental charges unless stated otherwise
- Applies separately to each covered person during each calendar year
- Must be accumulated during the calendar year

Only those charges to which a deductible applies can be used to satisfy that deductible.

Family Dental Deductible

If the dental deductible "per family" shown in the schedule of benefits is satisfied in any one calendar year by covered persons in your family, then the dental deductible will not be applied to any other charges incurred in that calendar year by covered persons in your family. As used here, "family" means you and all of your dependents who are covered for the dental coverage.

Dental Percentage Payable

Each percentage payable and the charges to which it applies are shown in the schedule of benefits. A percentage payable:

- Is applied after any applicable deductible amount has been met
- Applies separately to each covered person

Dental Benefit Maximum

The Plan will not pay more than the calendar year maximum for all covered dental charges incurred by a covered person during any one calendar year.

KEY POINT

After you pay the annual deductible, the Dental Plan pays the dentist's charges for covered expenses shown in the dental services list

Voluntary Dental Clinic

The Trustees have entered into an agreement with Pacific Dental Alliance doing business as Affordable Dental Care to provide plan participants with a low cost dental care alternative. If you use either of these providers **there will be no out-of-pocket costs to you.**

The dental providers are:

In Anchorage:

Affordable Dental Care
4001 Lake Otis Parkway, Suite 200
(907) 222-0400

In Wasilla:

Affordable Dental Care
701 E. Parks Highway, Unit 212, suite 209
(907) 376-3368

Use of these providers is strictly voluntary, however their use will result in savings to both you and the Plan.

Covered Dental Charges

A "covered dental charge" is a charge that meets all of the tests listed below:

1. It is made by a dentist or dental hygienist for a covered dental service that is furnished to a covered person
2. It is incurred by a covered person while the covered person is covered for the dental coverage. A charge is

deemed to be incurred at the time the service is rendered for which the charge is made. The date a dental service is deemed to be rendered is shown in the "Date Dental Service Rendered" section.

3. It is not excluded by the dental exclusions or the general health limitations.
4. It does not exceed the smallest of the covered charge limits that apply to the service for which the charge is made. The part of a charge that does not exceed the smallest of the covered charge limits shall be considered a covered dental charge if it meets the tests in items 1, 2, and 3 above.

Covered Charge Limits

The "covered charge limits" that apply to each dental service are:

- The usual charge for the service
- The customary charge for the service
- Any limit specified in the dental services list

Dental Services List

If a procedure is not shown in the dental services list and is not excluded by any of the terms of the Plan document, the Health Trust Claims Administrator shall determine which category of dental service the procedure falls under.

Preventive Dental Services

Covered preventive dental services include the services shown below. A number in parentheses after the service refers to a coverage limit listed below that applies to that service.

- Fluoride treatment (5)
- Oral examination (1)
- Prophylaxis, routine, dental (2)
- Sealants (6)
- X-ray, bitewing (4 X-rays/set, 2 sets/year)
- X-ray, complete mouth survey (3)
- X-ray, extra-oral
- X-ray, individual, periapical
- X-ray, occlusal
- X-ray, panoramic (3)

1. For all covered dental charges incurred for oral examinations during any one calendar year, the dental benefits shall be limited to the benefits payable for two such examinations.
2. For all covered dental charges incurred for routine dental prophylaxis during any one calendar year, the dental benefits shall be limited to the benefits payable for all such charges incurred during the first two dental visits of that calendar year at which any such charges are incurred.
3. For all covered dental charges incurred for complete mouth surveys or panoramic X-rays during any period of three consecutive calendar years, the dental benefits shall be limited to the benefits payable for the charges incurred for one complete mouth survey X-ray or one panoramic X-ray, but not both.
4. For all covered dental charges incurred for bitewing X-rays during any one calendar year, the dental benefits shall be limited to the benefits payable for the charges incurred for two sets of bitewing X-rays (four X-rays per set).
5. For all fluoride treatments rendered during a calendar year, the dental benefits shall be limited to the benefits payable for one such treatment.
6. A dental benefit for sealants is payable only for sealants on the occlusal surfaces of unrestored permanent first and second molars of a dependent child under age 16. The dental benefits shall be limited to one sealant per tooth during any four-year period.

Basic Dental Services

Covered basic dental services include the services shown below. A number in parentheses after the service refers to a coverage limit listed below that applies to that service.

- Anesthesia, general (5)
- Apicoectomy and retrograde filling
- Biopsy
- Cast, diagnostic
- Culture, bacteriologic
- Cyst, removal
- Denture relining (3)
- Filling, sedative (2)
- Extraction, simple
- Extraction, surgical, including extraction of impacted teeth
- Hemisection
- Incision and drainage
- Injection, therapeutic drug
- Palliative treatment (2)
- Periodontal prophylaxis (4)
- Pin retention
- Pulpotomy
- Recement crowns, inlays, and bridges (3)
- Repairs, bridges (3)
- Repairs, full dentures (3)
- Repairs, partial dentures (3)
- Restorations, amalgam (1)
- Restorations, composite (1)
- Restorations, plastic (1)
- Restorations, silicate (1)
- Root canal therapy
- Root recovery
- Space maintainers

1. The dental benefit for a two-surface restoration on an anterior tooth shall be limited to the benefits payable for a single-surface restoration if the incisal surface is not involved. The dental benefit for a three-surface restoration on an anterior tooth shall be limited to the benefits payable for a two-surface restoration if the incisal surface is not involved.
2. A separate dental benefit is payable for a sedative filling or a palliative treatment only if no other dental service, other than X-rays, is rendered during the dental visit.
3. A dental benefit is payable for relining of dentures, or repair or re-cementing of crowns, inlays, full or partial dentures, or bridges. The dental benefits shall be limited to one relining or rebasing during any three-year period.
4. A dental benefit shall be payable for periodontal prophylaxis only after comprehensive periodontal therapy. Dental benefits for periodontal prophylaxis shall be limited to the benefits for four such procedures during any twelve-month period, for three years following the date of comprehensive periodontal therapy. Thereafter, dental benefits shall be payable for periodontal prophylaxis only if the covered person submits to the Trust Fund Administrator a treatment plan made out by the attending dentist and receives the Trust Fund Administrator's approval of such treatment. In no event will dental benefits be paid for more than four routine and periodontal prophylaxis during any calendar year.
5. A separate dental benefit is payable for general anesthesia only when it is required for complex oral surgical procedures as determined by the Health Trust Claims Administrator.

Major Dental Services

Covered major dental services include the services shown below. A number in parentheses after the service refers to a coverage limit listed below that applies to that service.

- Alveoloplasty
- Bridges, fixed
- Crown build-up
- Crowns, gold
- Crowns, stainless steel
- Denture adjustment
- Denture full
- Dentures, partial
- Excision of hyperplastic tissue
- Frenectomy
- Gingival Curettage (2)
- Gingivectomy (2)
- Gold inlays and onlays (3)
- Grafts, osseous (2)
- Grafts, soft tissue
- Implants
- Laminate veneers
- Mucogingival surgery (2)
- Occlusal adjustment
- Periodontal appliance
- Post and core
- Provisional splinting
- Removal of exostosis
- Restoration, gold
- Restoration, porcelain
- Scaling and root planing (1)
- Stomatoplasty
- Surgical exposure of
- Impacted tooth to aid eruption
- Tooth replantation
- Tooth transplantation
- Vestibuloplasty

1. For all covered dental charges incurred for scaling and root planing during any one calendar year, the dental benefits shall be limited to the benefits payable for two such services per quadrant.
2. For all covered dental charges incurred for gingivectomy, gingival curettage, mucogingival surgery, and osseous surgery during a calendar year, dental benefits shall be limited to the benefits payable for one such procedure per area of the mouth.
3. A dental benefit shall be payable for a gold inlay only if it is provided with an onlay on the same tooth.

Date Dental Service Rendered

For the purpose of determining dental benefits, a covered dental service shall be deemed to be rendered on the date shown below that applies to the service.

- Dentures or Partial Dentures: The date the final impression is taken
- Fixed Bridges, Crowns, Inlays, Onlays: The date the teeth are first prepared
- Root Canal Therapy: The date the pulp chamber is opened and canals explored to the apex
- Periodontal Surgery: The date the surgery is actually performed
- All Other Services: The date the service is performed

After Termination of Coverage

The only dental benefits that will be paid on behalf of a covered person after the covered person's dental coverage ends shall be for covered dental charges incurred for treatment that:

- Is rendered while the covered person is covered for the dental coverage
- Is completed within 30 days of the date the covered person's dental coverage ends

Dental Proof

The written proof required by the Health Trust Administrator shall include the following items:

- A complete dental chart that shows extractions, missing teeth, fillings, prostheses, periodontal pocket depths, orthodontic relationships, and the date of any previous treatment
- An itemized bill for all dental care
- X-rays and study models
- Laboratory and hospital reports

Dental Exclusions

No dental benefit will be paid for any charge excluded by the general health limitations or for any of the items listed below:

- Procedure that is not necessary or that does not meet professionally recognized standards
- Crown that:
  - Is for a tooth that can be restored by other means
  - Is for the purpose of periodontal splinting
  - Is for a tooth that does not demonstrate extensive decay or fracture
- Procedure relating to:
  - The change of vertical dimension
  - Restoration of occlusion
  - Bite registration
  - Bite analysis
- Procedure that is performed mainly to improve the appearance of the covered person
- Replacement of any of the following items within five years of the date it was installed:
  - A bridge
  - A partial denture
  - A full denture
  - An inlay
  - A crown
- An exception will be made to this exclusion if the replacement is made necessary by:
  - An injury to sound natural teeth (other than a chewing injury) if the injury is sustained in an accident
  - The extraction of a sound natural tooth
  - Provided that the replacement is completed within 12 months of the date of the injury or extraction
- Replacement of any of the following items if they can be repaired to meet professionally recognized standards:
  - A bridge
  - A partial denture
  - A full denture
  - A crown
  - An inlay
- Facing on a crown or on a plastic or composite restoration when the crown or restoration is on a molar
- Replacement of an item that has been lost or stolen
- Broken appointment
- Orthodontia treatment
- The following items and services:
  - An athletic mouth guard
  - A specialized appliance
  - A precision or semi precision attachment
  - A denture duplication
  - Oral hygiene instruction
  - Treatment for fractures
  - Myofunctional therapy
  - Orthognathic surgery
- Charge:
  - For a procedure for which any benefit is provided under a medical

or orthodontia expense plan that is supplied by the Plan

  - That is used to satisfy a deductible under any such plan

- Treatment of temporal mandibular joint (TMJ) disorders

For a person who is covered for both the dental coverage and the medical coverage under the Plan, no dental benefit will be paid for:

- Treatment of a fractured jaw
- Biopsy
- Excision of a tumor, cyst, or foreign body
- Excision of tori
- Removal of salivary stones
- Orthognathic surgery
- Treatment of damage to a sound natural tooth if the damage is sustained in an accident and the charges are incurred within one year from the date of the accident

The terms of the medical coverage will determine the benefits, if any, that will be paid under the Plan for those items.

VISION PLAN

The Plan will pay a vision benefit as described in this section for the covered vision charges a covered person incurs.

A "vision benefit" is the amount that will be paid for covered vision charges incurred by a covered person. The amount of the vision benefit is the amount of the covered vision charges incurred.

Pediatric Vision Services are vision services provided to a child under the age of 18. Any annual dollar limit under the Vision Plan will not apply to these services.

KEY POINT

You may choose any licensed vision care provider to obtain services and purchase frames and lenses.

Covered Vision Charge

A "covered vision charge" is a charge that meets all of the tests listed below:

1. It is made by a physician, an optometrist, or an optician for a service or supply that is listed in the covered charges list and is furnished to a covered person.
2. It is incurred by a covered person while the covered person is covered for the vision care coverage. A charge is incurred at the time the service is rendered or the supply is furnished for which the charge is made.
3. It is not excluded by the vision exclusions or the general health limitations.
4. It does not exceed the smallest of the covered charge limits that apply to the service or supply for which the charge is made. The part of a charge that does not exceed the smallest of the covered charge limits shall be considered a covered vision charge if it meets the tests in items 1, 2, and 3 above.

Covered Charge Limits

The "covered charge limits" that apply to each service or supply are:

- The usual charge for the service or supply
- The customary charge for the service or supply
- Any applicable maximum amount shown in the vision care coverage section of the schedule of benefits
- The limit on eyeglasses and frames will not apply for any child under 19 years of age.

Contact Lenses

The maximum payment for a 12 month supply of contact lenses will be equal to the maximum payment for single vision lenses **plus** frames ($140), unless:

- The contact lenses are prescribed after cataract surgery
- The vision can be corrected to 20/70 or better only by the use of contact lenses

KEY POINT

You may choose the services and products you need each year, and the Plan pays benefits up to the benefit period maximums.

Eye Surgery Benefit

The Plan pays 80%, after you meet the deductible, for covered charges for eye surgery benefits as described below.

The Plan pays benefits up to a maximum $2,000 lifetime benefit.

This benefit is available for active employees and spouses only (not applicable to dependent children)

Charges incurred for eye surgery to treat a refractive error of the eye to correct vision to 20/70 or better are covered medical charges, provided the procedure is not performed mainly to improve the appearance of the covered person.

Covered charges also will include pre and

post visits in connection with the procedure. Benefits will be payable whether or not these charges meet the tests of item 4 of the covered medical charge definition, but only if the attending physician can reasonably certify that the need for eye glasses will be eliminated after surgery.

Expenses incurred for eye surgery resulting in an improvement in visual acuity that is not permanent, regardless of the type of surgery performed, will not be covered.

Covered Charges List

The charges in this list that meet all the tests of the covered vision charge definition are the covered vision charges.

- The charge for a vision examination, but not for more than one examination during the applicable benefit period
- The charge for lenses, but not for more than one pair of lenses during the applicable benefit period
- The charge for frames, but not for more than one pair of frames during the applicable benefit period

The benefit periods are shown in the Vision Plan benefit schedule.

Vision Exclusions

No vision benefit will be paid for any charge excluded by the general health limitations or for any:

- Lens that does not require a prescription
- Tinted lens, except pink no. 1 and pink no. 2
- Sunglasses
- Service or supply that is not necessary or that does not meet professionally recognized standards
- Eye examination:
  - That a covered person is required to have as a condition of employment
  - That is required by a government body
- Service or supply that is furnished:
  - As part of special vision procedures such as orthoptics, visual training, or aids for subnormal vision
  - As part of medical or surgical treatment
- Replacement of lost, stolen, or broken lenses or frames, except during the applicable benefit period

Benefits after Termination of Coverage

The Plan will not pay for any vision charges that were incurred after the participant loses coverage.

LIFE AND AD&D COVERAGE

The Trust provides Life and Accidental Death & Dismemberment (AD&D) Insurance for Local 262 active employees only.

Life and AD&D Benefits	
Employee Life Insurance	$5,000
Employee AD&D Insurance	Full Benefit: $5,000

Note: Earnings do not determine coverage under the Life and AD&D Plans.

EMPLOYEE LIFE INSURANCE

Symetra will pay an employee life benefit if you die while insured for the employee life insurance.

The amount of the employee life benefit is the amount shown above. The employee life benefit will be paid to your beneficiary in one sum unless a settlement option is in effect.

Eligibility

The eligibility for life insurance is the same as for health coverage.

Beneficiary

A "beneficiary" is the person, or one of the persons, you designate to receive any benefit to be paid under the group policy for the loss of your life.

You must designate your beneficiary in writing to the Trust Fund Administrator:

- You may designate anyone as your beneficiary
- You may change your beneficiary designation at any time

The consent of a beneficiary is not required. Symetra shall not be held liable for a payment made to another person before your written request is received at the Trust Fund Administrator's office.

Benefits will be paid in equal shares to your beneficiaries unless you state otherwise in your beneficiary designation. The share of a beneficiary who does not live to receive payment will pass equally to those who survive unless you state otherwise in your beneficiary designation.

KEY POINT

Employee Life and AD&D Insurance provide financial security for yourself and your family in the event of your death or serious injury.

Beneficiary Not Designated

If you do not designate a beneficiary or if no beneficiary lives to receive payment, then the benefits shall be paid, at Symetra's option to:

1. Your estate
2. Your spouse
3. Your children
4. Your parents
5. Your siblings

If the beneficiary is a minor or otherwise incapable of giving a valid release, Symetra may, at its option, and until claim is made by the duly appointed guardian, pay the benefit to any person or institution appearing to have assumed the custody and support of the beneficiary.

The benefit will be paid monthly at a rate not to exceed $50 per month. Symetra's liability is discharged to the extent of the payment.

Settlement Options

Death benefits may be paid under a settlement option. Any option offered by Symetra may be chosen. The employee may choose the option and change it at any time. If no option is in force at the time of death, the beneficiary may choose one. Benefits will not be paid under an option to: an executor, an administrator,

a trustee, a corporation, a partnership or an association. The interest rate will be Symetra's current option rate for the year of death. The minimum rate is 3% per year.

Waiver of Premium Benefit

Symetra will waive the life insurance premiums for an employee who becomes disabled. Symetra must receive proof that the employee:

- Became disabled:
  - Prior to the employee's sixtieth birthday
  - While you are insured for life insurance under this Plan
- Has been totally disabled for nine consecutive months
- Was continuously insured:
  - For at least 12 months prior to becoming disabled
  - Under this policy from the effective date

Notice of Disability

If an employee becomes disabled, written notice must be given to Symetra. Notice must be received by Symetra, within 3 months after the employee has been disabled for 9 months.

Symetra must receive annual written medical proof that the employee remains disabled. Symetra may, at its own cost, require physical examinations of the employee as often as reasonably necessary while a claim is pending.

Termination of Waiver of Premium

Waiver of premium will end on the earliest of the dates that follow:

- The date you stop being totally disabled.
- The date Symetra requests proof of your total disability, if you fail to furnish the proof.
- The date Symetra requests that you have an examination, if you fail to have the examination.
- The date you attain age 65

Conversion Privilege

The employee may convert his/her life insurance as described below.

If all or a part of an employee's insurance ends solely because

- The employee's employment ends while this policy remains in force
- Or the employee's status changes…

…then the employee may convert all or a portion of their life insurance to an individual policy. The largest amount that can be converted is the amount of insurance which ended.

If an employee's insurance ends because of one of the following:

- This policy ends
- All employee life insurance for a policyholder's associated company ends
- All employee life insurance under this policy ends
- The employee life insurance for an entire class ends

…and if the employee has been continuously insured under this policy for at least 5 years on the date insurance ends…

…then the employee may convert. The largest amount that can be converted is the amount which ended less any amount of employee group life insurance for which the employee becomes eligible within 31 days after this insurance ends.

Conditions

No proof of good health is required.

Written application must be made to Symetra. It must be delivered or mailed to Symetra with the first premium within 31 days after insurance ended.

Symetra will issue any of its current conversion policies. A conversion policy is

any individual life insurance policy except term insurance.

The effective date will be 31 days after this insurance ends.

Symetra will base the premium on:

- Its current rates
- Attained age
- Class of risk
- The type and amount of insurance

Benefit for Death During the Conversion Period

If an employee dies while eligible for conversion, Symetra will pay a death benefit. This benefit is the largest amount that could have been converted. This benefit is payable whether or not application was made for the conversion policy.

Death Prior to Submission of Proof of Disability

Symetra will pay a death benefit if it receives proof that an employee:

- Became disabled:
  - Prior to the employee's sixtieth birthday
  - While you are insured for life insurance under this Plan
- Was continuously disabled
- Was continuously insured:
  - For at least 12 months prior to becoming disabled
  - Under this policy from the effective date.

Death While Premiums are Being Waived

If an employee dies while premiums are being waived, Symetra will pay the death benefit.

EMPLOYEE AD&D INSURANCE

Symetra will pay an Accidental Death & Dismemberment (AD&D) benefit if an employee suffers any of the following losses due to injury and meets all of the stated conditions. The benefit amount is expressed as a percentage of the amount shown in the chart.

The AD&D benefit for loss of life will be paid to your beneficiary as stated in the beneficiary provision of the employee life insurance. All other AD&D benefits will be paid to you.

If an employee suffers more than one of the scheduled losses, the benefit amount percentages are accumulated to a maximum of 100% for any one accident.

Conditions

Symetra will pay only if:

- The injury occurred while the employee was insured under this coverage
- The loss occurred within 180 days after the injury
- The loss was directly and solely due to external, violent and accidental means

Symetra will only pay for the loss of thumb and index finger benefits if the loss of hand benefit is not also payable for an injury to the same hand which is the result of the same accident.

Loss	Benefit Amount	Definition
Loss of Life	100%	Death
One hand or one foot by dismember-ment	50%	"Loss of hand or foot" means total and irrecoverable loss my actual severance of the hand or foot at or above the wrist joint or ankle joint.
Sight in one eye	50%	"Loss of sight" means a total and irrecoverable loss which cannot be medically or surgically treated by artificial means.
Thumb and index finger of same hand	25%	"Loss of thumb and index finger" means actual severance of each joint at or above the metacarpopha-langeal joints.

Seat Belt Benefit

Symetra will pay an additional benefit if it receives proof that the employee died as a result of an automobile accident and meets all the conditions stated in this section.

The additional benefit amount is 100% of the AD&D amount listed for loss of life.

"Automobile" means a motor vehicle licensed and registered for use on public highways.

"Seat belt" means a lap restraint or lap and shoulder restraint installed by the manufacturer of the automobile.

Conditions for Seat Belt Benefit

Such accidental death must occur while:

- A passenger in, or a licensed operator of a registered automobile
- Wearing a seat belt, as verified in the police accident report
- Driving on a public road, private driveway or parking lot

The AD&D death benefit must be payable.

Exclusions for Seat Belt Benefit

This benefit does not cover accidental loss if the employee was operating the automobile while legally intoxicated as defined by the laws of the state in which the accident occurred, or under the influence of any excitant, hallucinogen, narcotic or other drug of similar substance, unless administered under the advice of a physician.

General AD&D Limitations

The total amount Symetra will pay for all losses due to any one accident will not exceed the sum of:

- The maximum amount the employee is eligible for
- The maximum amount of any additional benefits

General AD&D Exclusions

Symetra will not pay for any loss caused wholly or partly, directly or indirectly, by:

- Sickness, bodily or mental infirmity, or diagnosis or treatment thereof
- Ptomaines or any infection, other than a pyogenic infection occurring through, and at the time of, an accidental cut or wound
- Suicide or attempted suicide, while sane or insane
- Intentionally self-inflicted injury while sane or insane
- Declared or undeclared war or act of war
- Inciting or taking part in any form of public violence
- Committing or attempting to commit an assault or felony

Payment of Benefits

Symetra will pay to the employee if living, otherwise to the beneficiary. The beneficiary and settlement provisions

apply to this coverage. The claim provisions apply to this coverage.

LIFE AND AD&D CLAIM PROVISIONS

If an employee suffers a covered loss, notice of claim must be given to Symetra. The notice must be:

- Received by Symetra within 20 days after loss begins or occurs, or as soon as reasonably possible
- Identify the employee
- Be given either to Symetra at its home office or to its authorized agent or the Trust Administrator

Claim Forms

When Symetra receives notice of a claim it will send the appropriate claim forms to the employee. If Symetra fails to furnish the claim forms the employee or his/her representative may still provide proof of loss. To do so, the employee or his/her representative must provide written proof covering the occurrence, character, and extent of loss.

To Whom Benefits Are Payable

Any health benefits payable for loss of your life will be paid to the beneficiary you have designated to receive such benefits. Except as set forth below, any other benefits that have not been paid when you die may be paid, at the option of Symetra either to your beneficiary or to your estate. All other amounts will be paid to you, except that Symetra at its option may pay benefits directly to the provider of hospital, medical, surgical or other services.

Proof of Loss

Symetra must receive written medical proof of loss within these time limits:

- For all disability income coverages, 90 days after the end of Symetra's period of liability
- For all other coverages, 90 days after the date of the loss

Symetra will accept proof of loss after the time periods specified above only if the employee shows that:

- It was not reasonably possible to furnish proof within the required time
- Proof was furnished as soon as reasonably possible

Except in the absence of legal capacity, Symetra will not accept proof of loss more than one year from the time proof is otherwise required.

Physical Examination and Autopsy

Symetra may, at its own cost, required physical examinations of the employee as often as reasonably necessary while a claim is pending. In case of death, Symetra may, at its own cost, require an autopsy where legal.

Time of Payment of Claims

Symetra will pay benefits upon receipt of due proof. For all disability income benefits, Symetra will make regular payments at least as often as monthly. Symetra will pay any remaining balance at the end of its period of liability.

Benefits Unpaid at Death; Incompetency

The Plan may pay, to any person or institution that the Plan finds to be entitled to the payment, as much as $500 of any benefits that:

- Are to be paid at the time of your death
- Are to be paid to a person who is a minor or who is not able to execute a valid release and for whom no guardian has been appointed

To the extent of the payment, the Plan will have no more liability under the group Plan.

Continuation During Absence from Full-Time Work

In the following circumstances, employment will be deemed to continue as shown or until the policyholder, acting under rules that preclude individual selection, terminates the employment.

Cause of Absence	Period in which Employment Coverage Is Deemed to Continue	Type of Coverage This Applies To
Sickness or Injury	Indefinite	All Coverages
Labor Dispute	6 Months	All Employee Life Insurance Coverages
Temporary Lay-Off	2 Months	All Employee Life Insurance Coverages
Other Leave	2 Months	All Employee Life Insurance Coverages

Upon written request from the policyholder, Symetra may agree in writing to continue the employee's insurance for an additional number of months during lay-off or leave of absence.

"Disabled" and "Disability" refer to any disability which:

- Results from a disease or injury
- Occurs while the employee is insured
- Totally and continuously prevents the employee from working in any occupation for wage or profit
- Is expected to last for the rest of the employee's life

CLAIMS AND APPEALS

These notice, proof, and payment of health claims provisions apply to all coverages **other than any life and AD&D insurance under the Plan.**

NOTICE, PROOF, AND PAYMENT OF HEALTH CLAIMS

Time of Notice

You must send written notice of a health claim to the Trust Fund Administrator's office within 60 days after an expense or a loss occurs. If you cannot send it within that time, you must send it as soon as reasonably possible. The Plan will not pay claims that are submitted more than 12 months from the date the charges or services were incurred.

KEY POINT

Present your Health Plan ID card to your provider at the time of service. This helps your provider submit your claims efficiently and quickly. Your Health Plan ID card does not guarantee eligibility for coverage of your claims.

Forms

For medical, dental and vision claims, once you have completed and remitted the Claim/Enrollment form (available from the Trust Fund Administrator) for the Plan Year, you do not need to remit a claim form with each claim filed.

You will need to remit the detailed invoice received from the physician or hospital and be sure that the member's name and social security number are clearly marked on the invoice.

Remit all claims to the Trust Fund Administrator (see Key Contacts at the front of this booklet).

For Life Insurance or Accidental Death & Dismemberment (AD&D) claims, please contact the Trust Fund Administrator for a claim form.

If you are unable to obtain a Claim/Enrollment form or claim form within 15 days of the expense or loss, you will be deemed to comply with the proof of loss requirements by sending written proof of loss. The written proof must show:

- The date the loss occurred or began
- The cause of the loss
- The extent of the loss

Proof of Loss

In the case of a health claim for expense or loss for which a periodic benefit is paid while the loss continues, you must send written proof of loss to the Trust Fund Claim Administrator (see address in the Key Contacts section at the front of this booklet). Submit proof within 90 days after the end of each period for which the benefits are to be paid.

In the case of a health claim for any other expense or loss, you must send written proof of loss to the Trust Fund Administrator within 90 days after the date the expense or loss is incurred.

Your claim will not be reduced or denied due to the fact that you are not able to send the proof of loss within 90 days, if you send the proof of loss to the Trust Fund Administrator:

- As soon as it is reasonably possible to do so
- In no case, but for the lack of legal capacity, more than one year (12 months) after it is otherwise required

No Waiver of Claim Paid in Error – Recovery by Trust

If a claim is paid erroneously or if payment is made because of incomplete or inaccurate information furnished to the Plan, or if payment is made in an incorrect amount due to a clerical error, payment of the claim will not constitute a waiver of applicable Plan eligibility requirements, or any Plan limitation or exclusion. The Plan

may recoup the erroneous payment from the provider, covered participant, Spouse or Dependent, or the Plan may offset future benefit payments of the covered participant, or other family members by the amount of the claim paid in error. The Plan may also take appropriate legal action to recover the amount of the overpayment.

Misrepresentation

An individual who knowingly presents a false or fraudulent claim for payment or knowingly misrepresents facts relating to the eligibility for benefits will be subject to liability for reimbursement of the claim, for audit fees, attorney's fees and costs incurred by the Plan on account of such misrepresentation, as well as potential criminal liability. **Knowingly misrepresenting eligibility or submission of fraudulent claims is considered an intentional and material misstatement of fact to the Plan and may result in retroactive termination of coverage for the covered participant, spouse, and dependents.**

Anti-Alienation

The Trust, and benefits payable in accordance with the Plan, shall not be subject in any manner to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance or charge by any person, provided that the trustees may recognize assignments of benefits from a covered participant to a physician, hospital, or other person or institution that has treated or cared for, or provided services or goods to the covered participant, and the Plan shall recognize a Qualified Medical Child Support Order.

Time of Payment

If you send written proof of loss to the Trust Fund Administrator as required:

- The Plan will pay periodic health benefits as they accrue, at least once each month
- Any balance that has not been paid at the end of the period of liability will be paid as soon as the Trust Fund Administrator receives due written proof
- The Plan will pay all other health claims as soon as proof of loss is received

Exception for Medical Assistance Benefits

If a public health department of a state:

- Pays all or part of the cost of services and supplies furnished to a covered person for which benefits are payable under the Plan
- Submits a proper claim to the Trust Fund Administrator before the benefits have been paid to the covered person or an assignee

then the Plan, with or without an assignment by the covered person, may pay the benefits to the state department. To the extent of the payment, the Plan will have no more liability.

Exception for a Dependent Child Named in a Qualified Medical Child Support Order

The Plan may pay benefits:

- To a custodial parent or legal guardian if claim is made for reimbursement of benefits paid for a child named in a Qualified Medical Child Support Order
- Directly to a provider if a custodial parent or legal guardian has made an assignment to the provider for such benefits

Physical Examination and Autopsy

The Plan shall have the right and opportunity to have a covered person examined by a physician of its choice to determine the extent of any sickness or injury for which you have made a claim.

This right may be used as often as it is reasonable to do so. If a covered person dies, the Plan may require an autopsy where the law does not forbid it. Such an examination or autopsy shall be made at the Plan's expense.

HEALTH CLAIM PROCEDURES

Covered participants must follow the procedures outlined here to obtain health benefit payments under this Plan.

All claims and questions regarding health claims should be directed to the Trust Fund Administrator.

The Board of Trustees shall be ultimately and finally responsible for providing full and fair review of the decision on such claims in accordance with the following provisions and with the Employee Retirement Income Security Act of 1974, as amended ("ERISA").

Benefits under the Plan will be paid only if the Board of Trustees decides in its discretion that the covered participant is entitled to them. The responsibility to process claims in accordance with the Summary Plan Description may be delegated to the Trust Fund Administrator; provided, however, that the Trust Fund Administrator is not a fiduciary of the Plan and does not have the authority to make decisions involving the use of discretion.

Each covered participant claiming benefits under the Plan shall be responsible for supplying, at such times and in such manner as the Board of Trustees in its sole discretion may require, written proof that the expenses were incurred or that the benefit is covered under the Plan.

If the Board of Trustees in its sole discretion shall determine that the covered participant has not incurred a covered expense or that the benefit is not covered under the Plan, or if the covered participant shall fail to furnish such proof as is requested, no benefits shall be payable under the Plan.

The US Department of Labor (DOL) has established four types of claims:

- Pre-Service Non-Urgent Care
- Pre-Service Urgent Care
- Concurrent Care
- Post-Service

Pre-Service Non-Urgent Care Claims

A "pre-service claim" is a claim for a benefit under the Plan where the Plan conditions receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining medical care.

Since this Plan is an indemnity plan, the only "pre-service claims" are the few services that must have prior authorization, as outlined in the Summary Plan Description.

Pre-service claims are only claims to the extent that pre-certified services are reviewed and a determination is made regarding the medical necessity of the service or the appropriate level of care. Pre-service claim determinations do not address eligibility or Plan coverage for specific service items.

KEY POINT

If a participant needs medical care for a condition which could seriously jeopardize his/her life, there is no need to contact the Plan for prior authorization. The covered participant should obtain such care without delay.

Pre-Service Urgent Care Claims

A "pre-service urgent care claim" is any claim for medical care or treatment with respect to which the application of the time periods for making non-urgent care determinations could seriously jeopardize the life or health of the covered participant, or his/her ability to regain maximum function, or, in the opinion of a physician with knowledge of his/her medical condition, would subject the covered participant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

This Plan does not require prior authorization of pre-service urgent care as established by the DOL.

Further, if the Plan does not require the covered participant to obtain approval of a

medical service prior to getting treatment, then there is no "pre-service claim."

The covered participant simply follows the Plan's procedures with respect to any notice which may be required after receipt of treatment, and files the claim as a post-service claim.

Concurrent Claims

A "concurrent claim" arises when the Plan has approved an on-going course of treatment to be provided over a period of time or number of treatments, and either:

- The Plan determines that the course of treatment should be reduced or terminated
- The covered participant requests extension of the course of treatment beyond that which the Plan has approved

If the Plan does not require the covered participant to obtain approval of a medical service prior to getting treatment, then there is no need to contact the Health Trust Administrator to request an extension of a course of treatment.

The covered participant simply follows the Plan's procedures with respect to any notice which may be required after receipt of treatment, and files the claim as a post-service claim.

Post-Service Claims

A "post-service claim" is a claim for a benefit under the Plan after the services have been rendered.

KEY POINT

In no instance will the Plan pay claims submitted more than 12 months from the date of service relating to the claim.

When Health Claims Must Be Filed

Health claims must be filed with the Trust Fund Administrator within the timeframe set forth in the Notice, Proof, and Payment of Health Claims section of this booklet. Claims filed later than that date shall be denied. In no instance will the Plan pay claims submitted more than 12 months from the date of service relating to the claim.

Benefits are based upon the Plan's provisions at the time the charges were incurred. Charges are considered incurred when treatment or care is given or supplies are provided.

A pre-service claim (including a concurrent claim that also is a pre-service claim) is considered to be filed when the request for approval of treatment or services is made and received by the Trust Fund Administrator in accordance with the Plan's procedures.

However, a post-service claim is considered to be filed when the following information is received by the Trust Fund Administrator

- The date of service
- The name, address, telephone number and tax identification number of the provider of the services or supplies
- The place where the services were rendered
- The diagnosis and procedure codes
- The amount of charges
- The name of the Plan
- The name of the covered employee
- The name of the patient

Upon receipt of this information, the claim will be deemed to be filed with the Plan.

The Trust Fund Administrator will determine if enough information has been submitted to enable proper consideration of the claim. If not, more information may be requested, as provided herein.

This additional information must be received by the Trust Fund Administrator within 45 days from receipt by the covered participant of the request for additional information. Failure to do so may result in claims being declined or reduced.

Timing of Claim Decisions

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

Pre-Service Non-Urgent Care Claims

A pre-service health claim will generally be processed within 15 days of receipt. This period may be extended for up to 15 days if the Plan determines that an extension is necessary due to matters beyond the control of the Plan, and notifies the participant within the initial 15-day period of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision.

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

Concurrent Claims: Plan Notice of Reduction or Termination

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

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

Post-Service Claims

A post-service claim will generally be processed within 30 days of receipt. This period may be extended for up to 15 days if the Plan determines that an extension is necessary due to matters beyond the control of the Plan, and notifies the claimant within the initial 30-day period of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision. If an extension is necessary due to the participant's failure to submit the necessary information to process the claim, the notification of the extension will describe the necessary information, and the claimant will be provided at least 45 days from receipt of the notification to submit the additional information. The period for making a determination will be tolled from the date on which the notification of the extension is sent to the participant until the date on which the claimant responds to the request for additional information. If the participant fails to supply the necessary information within the 45 day period, the claim will be denied.

Urgent Care Health Claims

Urgent care claims may be filed, orally or in writing, by the participant or by the health care provider with knowledge of the participant's medical condition. A decision on an urgent care claim will generally be made within 72 hours after receipt of a claim that is complete when submitted. Participants will be notified within 24 hours if additional information is

required to process the claim, and will be provided at least 48 hours to submit the additional information. If additional information is required to process the claim, a determination will be made within 48 hours of the earlier of the Plan's receipt of the requested information, or the end of the period afforded the claimant to provide the additional information. A determination involving urgent care may be provided orally within the timeframes in this section, with a written notification furnished not later than 3 days after the oral notification.

INITIAL BENEFIT DETERMINATIONS

A Claim means a request for a Plan benefit, made by a Claimant (Plan Participant or by an authorized representative of the Plan Participant) that complies with the Plan's reasonable procedures for filing benefit claims. A Claim does not include an inquiry on a Claimant's eligibility for benefits, or a request by a Claimant or his/her physician for preauthorization of benefits for medical treatment.

A Claimant may appoint an authorized representative to act on his/her behalf with respect to the Claim. Only those individuals who satisfy the Plan's requirements to be an authorized representative will be considered an authorized representative. A healthcare provider is not an authorized representative simply because of an assignment of benefits. Contact the Claims Administrator for information on the Plan's procedures for appointing an authorized representative.

Claims that are properly filed with the Claims Administrator will be processed in accordance with the following guidelines:

- Pre-Service Non-Urgent Health Claims. A pre-service health claim is a properly filed claim for medical or dental benefits that must be preauthorized to receive full benefits from the Plan. Pre-service claims are only claims to the extent that preauthorized services are reviewed and determined to be Medically Necessary for the appropriate level of care requested. Pre-service determinations do not address the Claimant's eligibility or Plan coverage for specific services or treatment. **Failing to obtain preauthorization for a pre-service claim will result in reduced or denied benefits.** Pre-service claims include, but are not limited to non-emergency admission to a Hospital, or a Skilled Nursing Facility, Home Health Care or Hospice Care. A pre-service claim will generally be processed within 15 days of receipt.

  This period may be extended for up to 15 days if the Plan determines an extension is necessary due to matters beyond the control of the Plan, and notifies the claimant within the initial 15-day period of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision. If an extension is necessary due to the claimant's failure to submit the information necessary to process the claim, the notification of the extension will be provided to the Claimant as soon as possible, but not later than 5 days after the receipt of the claim. The notice will describe the specific necessary information needed to process the claim, and the Claimant will be provided at least 45 days from receipt of the notification to submit the additional information. The period for making a determination will be tolled from the date on which the notification of the extension is sent to the Claimant until the date on which the Claimant responds to the request for additional information within the extension period described in the notice of not less than 45 days from the notice.

  If services that require preauthorization have been provided and the only issue is what payment, if any, will be made, the claim will be processed as a post-service claim.

- Post-Service Health Claims. A post-service health claim is any properly filed claim for medical, dental, vision, audio, or Prescription Drug benefits that is not a pre-service claim and does not involve urgent care, where the treatment or services have already been provided. A post-service claim will generally be processed within 30 days of receipt. This period may be extended for up to 15 days if the Plan determines an extension is necessary due to matters beyond the control of the Plan, and notifies the Claimant within the initial 30-day period of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision. If an extension is necessary due to the Claimant's failure to submit the information necessary to process the claim, the notification of the extension will describe the necessary information, and the Claimant will be provided at least 45 days from receipt of the notification to submit the additional information. The period for making a determination will be tolled from the date on which the notification of the extension is sent to the claimant until the date on which the Claimant responds to the request for additional information within the extension period described in the notice of not less than 45 days from the notice.
- Urgent Care Health Claims. Urgent care health claims are pre-service claims with respect to which the normal time frames for review of a claim could seriously jeopardize the life or health of the claimant, or expose the Claimant to severe pain that could not adequately be managed without the care or treatment that is the subject of the claim. Urgent care claims may be filed, orally or in writing, by the Claimant or by the health care provider with knowledge of the Claimant's medical condition. A decision on an urgent care will generally be made within 72 hours after receipt of a claim that is complete when submitted. Claimants will be notified within 72 hours if additional information is required to process the claim, and will be provided at least 48 hours to submit the additional information.

  If additional information is required to process the claim, a determination will be made within 48 hours of the earlier of the Plan's receipt of the requested information, or the end of the period afforded the Claimant to provide the additional information. A determination involving urgent care may be provided orally within the time frames in this section, with a written notification furnished not later than three days after the oral notification.

  It is important to remember that, if a participant needs emergency medical care for a condition which could seriously jeopardize his/her life, there is no need to contact the Plan for prior approval. The participant should obtain such care without delay. Further, if the Plan does not require the participant to obtain approval of a medical service prior to getting treatment, then there is no Pre-Service Claim. The participant simply follows the Plan's procedures with respect to any notice which may be required after receipt of treatment and files the claim as a Post-Service Claim.
- Concurrent Care Claims. Concurrent care claims are pre-service claims involving an ongoing course of treatment to be provided over a period of time or for a number of treatments. Except in the case of urgent care, a claim to extend a course of treatment beyond the period of time or number of treatments previously approved, will be treated as a new claim and processed within the timeframes appropriate to the type of claim. A

claim to extend a course of treatment that involves urgent care will be processed within 72 hours after receipt of the claim, provided the claim is made to the Plan at least 72 hours prior to the expiration of the prescribed period of time or number of treatments.

If the claim is not made at least 72 hours prior to the expiration of the prescribed period of time or number of treatments, the request will be treated as a claim involving urgent care. If the Plan reduces or terminates certification for a course of treatment before the end of the previously approved period or number of treatments, the Plan will notify the Claimant in advance of the reduction or termination to allow the Claimant to appeal and obtain a determination on review before the benefit is reduced or terminated.

Adverse Benefit Determinations

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

The written denial will give the following information:

1. Information to identify the claim, including, the date of service, the health care provider, the claim amount (if applicable).
2. The specific reasons for the denial;
3. Specific reference to pertinent Plan provision(s) on which the denial is based;
4. A description of any additional material or information necessary for the Claimant to perfect the claim and an explanation of why such material or information is necessary;
5. If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion, or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the determination and that a copy of the same will be provided free of charge to the Claimant upon request;
6. If the denial is based on medical necessity, or experimental or investigational treatment, or a similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Claimant's medical circumstances, or a statement that such an explanation will be provided free of charge upon request;
7. A statement that the participant is entitled to receive, upon request, and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the claimant's claim for benefits;
8. A description of the Plan's internal review and External Review Procedure and the applicable time limits.
9. The identity of any medical or vocational experts consulted in connection with a claim, even if the Plan did not rely upon their advice (or a statement that the identity of the expert will be provided upon request and free of charge).
10. The availability of, and contact information for, an applicable office of health insurance consumer assistance or ombudsman established by the Public Health Service Act Section 2793.

If the Claimant has questions about the denial of benefits, the Claimant should contact the Claims Administrator at the address and telephone number on the Notice of Determination.

An Adverse Benefit Determination also includes a rescission of coverage, which is a retroactive cancellation or discontinuance of coverage due to fraud

or intentional misrepresentation regarding eligibility or a claim for benefits (including failure to timely notify the plan that dependent has lost eligibility).

A rescission of coverage does not include a cancellation or discontinuance of coverage that takes effect prospectively, or is a retroactive cancellation of coverage due to the Participant's failure to timely pay a required premium.

REMEDIES AVAILABLE SHOULD A CLAIM BE DENIED

A Claimant may appeal an adverse benefit determination. The Plan offers a two-level internal review procedure to provide a Claimant with a full and fair review of an adverse benefit determination. If a Claimant completes the two levels of internal review and is dissatisfied with the determination on internal review, the Claimant may request an External Review in accordance with the procedures that follow under the title External Review Procedure.

In cases where coverage has been rescinded or a claim for benefits is denied, in whole or in part, and you believe the claim has been wrongfully denied, you may appeal the denial and review pertinent documents. The claims procedures of this Plan provide you with a reasonable opportunity for a full and fair review of a claim and adverse benefit determination. More specifically, the Plan provides:

1. 180 days following the notification of an adverse benefit determination within which to appeal the determination;
2. The opportunity to submit written comments, documents, records, and other information relating to the claim for benefits;
3. A review that does not afford deference to the previous adverse benefit determination and that is conducted by an appropriate named fiduciary of the Plan, who shall be neither the individual who made the adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual;
4. A review that takes into account all comments, documents, records and other information submitted by you relating to the claim, without regard to whether such information was submitted or considered in any prior benefit determination;
5. In deciding an appeal of any adverse benefit determination that is based in whole or in part upon a medical judgment, the Plan fiduciary shall consult with a health care professional who has appropriate training and expertise in the field of medicine involved in the medical judgment, who is neither an individual who was consulted in connection with the adverse benefit determination that is the subject of the appeal, nor the subordinate of any such individual;
6. For the identification of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a claim, even if the Plan did not rely upon their advice; and
7. The Claimant will be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits in possession of the Administrative Office or the Claims Administrator; any internal rule, guidelines, protocol, or other similar criterion relied upon in making the adverse benefit determination; and any explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Claimant's medical circumstances.

Level 1 – Internal Review

When a claim has been denied or partially denied, the Claimant may seek an appeal under these Internal Review procedures.

The Claimant must follow steps in this appeal process in the order and time designated or the Claimant will lose the right to further review of the claim denial.

The first level of review will be performed by the Claims Administrator on the Plan's behalf. The appeal must be filed in writing within 180 days following the date on the written notice of an adverse benefit determination.

To file an appeal in writing, the appeal must be addressed as follows:

Zenith American Solutions
111 West Cataldo, Suite 220
Spokane, WA 99201-3201

Phone: 855-229-0720 (toll-free)
Fax: 509-328-8623
E-mail: www.zenith-american.com

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

1. The name of the Claimant;
2. The Claimant's social security number or alternative Plan identification number (if applicable);
3. All facts or theories supporting the claim for benefits;
4. A statement in clear and concise terms of the reason or reasons for the disagreement with the handling of the claim; and
5. Any material or information that the Claimant has which indicates that he/she is entitled to benefits under the terms of the Plan.

TAKE ACTION

If you want to appeal a denied Medical, Dental or Vision claim, you must submit your request within 180 days of receiving the denied claim.

Timing and Notification of Benefit Determination on Appeal

The Administrative Office shall notify the Claimant of the Plan's benefit determination on review within the following time frames:

- Urgent Care Claims – within a reasonable period of time appropriate to the medical circumstances, but not later than 72 hours after receipt of the claim.
- Pre-Service Non-Urgent Care Claims – within a reasonable period of time appropriate to the medical circumstances, but not later than 30 days after receipt of the appeal.
- Concurrent Claims – the response will be made in the appropriate time period based on the type of claim (Pre-service Non-Urgent or Post Service).
- Post-Service Claims – within a reasonable period of time, but not later than 30 days after receipt of the appeal.

The period of time within which the Plan's determination is required to be made shall begin at the time the Level 1 Internal Review is filed, as determined by the post-mark (or if hand delivered or delivered electronically, the date of receipt by the Administrative Office), regardless of whether all information necessary to make a determination accompanies the filing.

Manner and Content of Notification of Adverse Benefit Determination on First Level Appeal

The Administrative Office shall provide the Claimant, in writing or electronically, of the Plan's adverse benefit determination on review, setting forth the same information as described in the section above entitled Adverse Benefit Determinations above.

Level 2 – Internal Review

The Level 2 Internal Review will be done by the Board of Trustees, as Plan Administrator. The Claimant shall have the right to request a hearing before the Board of Trustees, by submitting the request in writing to the Claims Administrator at the address noted on the notice of the Level 1 Review

determination, within sixty (60) calendar days of the date of the notice.

The Claimant may present his/her testimony and argument to the Trustees.

The Claimant may be represented by an attorney or other authorized representative. The Board of Trustees may afford the Claimant or his/her authorized representative the opportunity to appear in person or telephonically at the hearing. The Board of Trustees will review the information initially received and any additional information provided by the Claimant, regardless of whether such information was submitted by the Claimant or considered in the Level 1 Internal Review. The Board of Trustees will not afford deference to the initial adverse benefit determination. When deciding an appeal that is based in whole or in part on a medical judgment, the Trustees will consult with a health care professional who has the appropriate training and experience in the field of medicine involved in the medical judgment. Any medical or vocational expert whose advice was obtained on behalf of the Plan in connection with the adverse benefit determination will be identified to the Claimant. Any health care professional engaged for the purpose of a consultation on a claim will not be an individual who was consulted in connection with the initial adverse benefit determination that is the subject of the appeal, nor the subordinate of any such individual.

The Trustees will review a properly filed appeal of a post-service claim at the next regularly scheduled Board of Trustee meeting following receipt of the properly submitted second level appeal, provided the second level appeal is received at least twenty (20) calendar days prior to such regularly scheduled Board of Trustee meeting. If the second level appeal is received within 20 calendar days of the next regularly scheduled Board of Trustee meeting, it will be set for hearing at the next following meeting.

If the claim involves the reduction or termination of a previously approved claim for Concurrent Care or Non-Urgent Pre-Service care, the Trustees will review the second level appeal within 15 days of receipt of the properly filed second level appeal regardless of the date of the next regularly scheduled Board of Trustees meeting. The Trustees will review a properly filed second level appeal of an Urgent Care claim within 72 hours after receipt of the appeal regardless of the date of the next regularly scheduled Board of Trustee meeting. In such cases, such appeal hearing may be conducted via teleconference or email poll. All necessary information on a claim for Concurrent Care, Non-Urgent Pre-Service care, or Urgent Care may be transmitted between the Plan and the claimant by telephone, facsimile, or other available expeditious method. The Trustees may delegate the decision on an expedited appeal to a Committee of not less than three Trustees or to the Trust Claims Administrator upon prior approval of a quorum of the Board of Trustees. Such decision on a Concurrent Care, Non-Urgent Pre-Service care, or Urgent Care second level appeal will be provided to the appellant telephonically by the Administrator following the meeting, with a written decision to follow as soon as practical, but not more than five (5) days following such decision.

The Board of Trustees will issue a decision on a Post-Service Level 2 Internal Review as soon as practical but not more than thirty (30) business days after the Level 2 Internal Review hearing.

The Claimant cannot proceed to an External Review (as described more fully below) unless the Claimant timely files for, and timely completed the Level 1 and Level 2 Internal Review process.

External Review Procedure

The Plan has an external review procedure that provides for a review conducted by a qualified Independent Review Organization (IRO). The Claimant may request a review by an IRO within 4 months after the date of the notice of the

Plan's adverse decision regarding the Level 2 Internal Review. If there is no corresponding day 4 months after the date of the notice on the Level 2 Internal Review appeal determination notice, then the request must be filed by the 1st day of the fifth month following the date of the notice. As with the original appeal, the Claimant's request for external review must be in writing and include all of the items set forth in 1-5 of the section above entitled Level 1 – Internal Review. The Plan is entitled to charge a fee of $25 to initiate an External Review, which must be paid when the Claimant submits the Request for External Review Form to initiate the process.

For an adverse benefit determination to eligible for external review, the Claimant must complete the required forms to process an External Review. The Claimant may obtain the appropriate forms and information on the filing process by contacting the Claims Administrator.

Preliminary Review

Within 6 business days following the date of receipt of the external review request, the Claimant will be provided a written notice stating whether the request is eligible for external review and if additional information is necessary to process the request. If the request is determined to be ineligible, the notice will include the reasons for ineligibility and provide contact information for the appropriate State or federal oversight agency. If additional information is required to process the external review request, the notice will describe the information needed and you may submit the additional information within the 4 month filing period or within 48 hours of receipt of the notification, whichever is later.

Timing of Notice from the IRO

The IRO will notify you in writing of your rights to submit information to the IRO and the applicable time period and procedure for submitting such information. The IRO will provide written notice of the final external review decision within 45 days after the IRO receives the request for external review. The notice will contain the reasons and rationale for the decision, including any applicable evidence-based standards used, and references to the evidence or documentation considered in reaching the decision.

Decision of IRO Final

The decision of the IRO is binding upon you and the Plan, except to the extent other remedies may be available under applicable law. Before filing a lawsuit against the Plan, you must exhaust all available levels of review as described in this section, unless an exception under applicable law applies. A legal action to obtain benefits must be commenced within one (1) year of the date of the Notice of Determination on the final level of internal or external review, whichever is applicable.

Appointment of Authorized Representative

A covered participant is permitted to appoint an authorized representative to act on his/her behalf with respect to a benefit claim or appeal of a denial.

An assignment of benefits by a covered participant to a provider will not constitute appointment of that provider as an authorized representative.

To appoint such a representative, the covered participant must complete a form, which can be obtained from the Trust Fund Administrator.

In the event a covered participant designates an authorized representative, all future communications from the Plan will be with the representative, rather than the covered participant, unless the covered participant directs the Board of Trustees, in writing, to the contrary.

YOUR RIGHTS

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

Disclosures and Certification

The Trust's privacy practices are administered in accordance with regulations adopted by the Department of Health and Human Services (45 CFR Section 164). The Board of Trustees for the Trust has adopted the following provisions:

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

Request, Use and Disclosure of PHI

The Trustees are permitted to receive PHI from the Plan and to use and/or disclose PHI only to the extent necessary to perform the following administrative duties:

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

Disclosure of PHI to Trustees

With respect to PHI disclosed to the Trustees, the Trustees agree to the following:

- The Trustees will not use or disclose any PHI received from the Plan, except as permitted in this section or required by law
- The Trustees will ensure that any of their subcontractors or agents to whom they may provide PHI that was received from the Plan, agree to written contractual provisions that impose at least the same obligations to protect PHI as are imposed upon the Trustees
- The Trustees will not use or disclose PHI for employment related actions and decision or in connection with any other benefit or employee benefit plan of the Trustees

- The Trustees will report to the Plan any known impermissible or improper use of disclosure of PHI not authorized by this Plan Summary of which they become aware
- The Trustees will make their internal practices, books, and records relating to the use and disclosure of PHI received from the Plan available to the Department of Health and Human Services (DHHS) or its designee for the purpose of determining the Plan's compliance with HIPAA

When the PHI is no longer needed for the purpose for which disclosure was made, the Trustees must, if feasible, return to the Plan or destroy all PHI that the Trustees received from or on behalf of the Plan. This includes all copies in any form, including any compilations derived from the PHI. If return or destruction is not feasible, the Trustees agree to restrict and limit further uses and disclosures to the purposes that make the return or destruction infeasible.

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

Trustee Certification as to Participant's Rights

The Board of Trustees also certifies it will observe the following with regard to Plan participants and their PHI:

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

Adequate Separation

The Trustees represent that adequate separation exists between the Plan and the Trustees so the PHI will be used only for Plan administration. The Trustees certify that they have no employees, or other persons under their control, that will have access to PHI, except the Trust's in-house administrator who is subject to the HIPAA Privacy and Security Rules and manages PHI accordingly.

Effective Mechanism for Resolving Issues of Noncompliance

The Trustees certify that any individual or entity who suspects an improper use and/or disclosure of PHI may report that occurrence to the Plan Privacy Official.

EMPLOYEE RETIREMENT INCOME SECURITY ACT (ERISA)

Statement of ERISA Rights

As a participant in the Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974. ERISA provides that all Plan participants shall be entitled to:

- Examine, without charge, at the Trust Fund Administrator's office and at other locations, such as worksites and union halls, all Plan documents, including insurance contracts, collective bargaining agreements and copies of all documents filed by the Plan with the U.S. Department of Labor, such as detailed annual reports and Plan descriptions
- Obtain copies of all Plan documents and other Plan information upon written request to the Trust Fund Administrator; the administrator may make a reasonable charge for the copies

- Receive a summary of the Plan's annual financial report; the Trust Fund Administrator is required by law to furnish each participant with a copy of this summary financial report

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit Plan.

The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. The claim fiduciary shall have the discretion to determine eligibility for benefits and to construe the terms of the Plan.

KEY POINT

The Employee Retirement Income Security Act (ERISA) is a federal law that regulates the majority of private pension and welfare group benefit plans in the United States.

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 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 your rights. For instance, if you request materials from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Trust Fund Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Trust Fund Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court.

If you have a claim for benefits which is denied or ignored, in whole or in part, you may request a hearing before the Board of Trustees in accordance with the Claim and Appeal provisions of the Plan. If you are dissatisfied with the determination of the Trustees following such hearing, you may file suit in a state or Federal court. In addition, if you disagree with the Plan decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in Federal court.

If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

If you have any questions about your Plan, you should contact the Trust Fund Administrator. If you have any questions about this statement or about your rights under ERISA, you should contact the nearest office of the Pension and Welfare Benefits Administration, U.S. Department of Labor, listed in your telephone directory, or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210.

Amendment and Termination of the Plan

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

- Terminate or amend the Plan
- Alter or postpone the method of

payment of any benefit

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

The Trust may be terminated in writing by mutual agreement of the Trustees in conjunction with the Mechanical Contractors Association and United Association Local 262 at any time, subject to all of the requirements and procedures for Plan termination under ERISA and all applicable regulations.

Upon voluntary termination of the Trust, all the assets remaining in the Trust after payment of all expenses shall be used for the continuance of benefits provided in the Plan until such assets are exhausted. If such termination occurs as the result of a merger, all assets remaining in the Trust Fund after payment of final expenses must be transferred to the Trust Fund with which the merger has been negotiated.

THE FAMILY AND MEDICAL LEAVE ACT (FMLA)

A federal law, known as the Family and Medical Leave Act (FMLA), may apply to a family and medical leave when you work for an employer with 50 or more employees within a 75-mile radius.

To be eligible, 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 if your employer has enough employees to be covered under the FMLA, the law requires your employer to continue any medical, dental, and vision benefits, with payment of premium, for you and your covered dependents for up to 12 weeks during a 12-month period while you are on family or medical 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

KEY POINT

The Family Medical Leave Act (FMLA) is a federal law requiring that employers of 50 or more (and public employers of any size) allow employees to take leave to care for ill family members and to return to substantially similar employment conditions following the leave.

You should 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 obligations under the FMLA.

THE UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT (USERRA)

Employment and Reemployment Rights

If your health coverage ends because of your service in the uniformed services, you may continue coverage for yourself and your dependents until the earlier of:

- The end of the period during which you are eligible to apply for re-employment in accordance with the Uniformed Services Employment and Reemployment Rights Act (USERRA)
- 18 consecutive months after your coverage ended

The term "health coverage," as used here, means any medical, dental, or vision coverage provided under this Plan. The

provisions of health coverage are subject to revision as a result of any Plan modification.

KEY POINT

The Uniformed Services Employment and Reemployment Rights Act (USERRA) provides reemployment protection and other benefits for veterans and employees who perform military service.

You may be required to pay all or part of the premiums in order to continue coverage for yourself and your dependents. Your employer will provide you with information as to rate and procedures for payment.

The continuation of coverage rights under USERRA for you and your dependents will run concurrently with any other continuation provisions contained in the Plan. The continuation under USERRA will end at midnight on the earliest date shown below:

- The date your former employer ceases to provide any group health Plan to any employee
- The date any required premium is due and unpaid
- The date a covered person again becomes covered under the Plan
- The date your coverage has been continued for the period of time allowed (or for any longer period provided in the Plan)
- The date the Plan terminates

The employer's leave of absence policy will determine your right to participate in any group life or other coverage. After re-employment, credit will be given, if applicable, for the period of such service, if required to determine your benefit amounts, eligibility or costs.

GENERAL PROVISIONS

These General Provisions apply to all coverages under the Plan.

No Vested Right to Benefits

The Plan will not pay a benefit for charges incurred for services or supplies furnished to a person following termination of that person's coverage under the Plan, except as may be provided below.

Benefits will not be paid in excess of any maximums stated in the Summary Plan Description during the entire period of the person's coverage under the Plan, whether or not the period of coverage is interrupted.

Benefits may be modified by the Trustees at any time while the Plan is in force. If benefits are modified, the revised benefits (including any reduction in or elimination of benefits) apply to charges incurred for services or supplies on or after the effective date of the modification, except as may be specified in the Summary Plan Description.

There is no vested right to receive the benefits of the Plan.

The Board of Trustees shall administer this Plan in accordance with its terms and establish its policies, interpretations, practices, and procedures. It is the express intent of this Plan that the Board of Trustees shall have maximum legal discretionary authority to construe and interpret the terms and provisions of the Plan, to make determinations regarding issues which relate to eligibility for benefits, to decide disputes which may arise relative to a Plan member's rights, and to decide questions of Plan interpretation and those of fact relating to the Plan. The decisions of the Board of Trustees will be final and binding on all interested parties.

The Board of Trustees has the discretionary authority to decide whether a charge is Usual and Reasonable. Benefits under this Plan shall be paid only if the Board of Trustees determines that the benefit is payable under the terms of the Plan.

Alternative Course of Treatment

The Plan will pay for the least expensive procedure that will produce a result that meets professionally recognized standards, as defined in the General Definitions section.

If a covered person chooses a more expensive procedure, the Plan will pay only for the least expensive course of treatment as allowed by law.

Duplicate Benefits Exclusion

Benefits will not be paid more than once under the Plan for any charge.

Medical Conversion Privilege

There is no conversion coverage available for medical, dental or vision coverage under the Plan

The General Health Limitations apply to all health coverage other than life insurance under the Plan, except as stated in each section.

Assignment

You may assign the benefits to be paid under the Plan for a medical, dental, or vision care charge. No other assignment of the Plan or any rights or benefits under the Plan will have any force or effect unless and until the Plan consents to it in writing.

Anti-alienation and Anti-assignment
The Trust, and benefits payable in accordance with the Plan, shall not be subject in any manner to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance or charge by any covered person, provided that the Trustees may recognize an assignment of benefits from a covered person authorizing direct payment of benefits due under the terms of the Plan to a physician, medical facility, or other person or institution that has treated, cared for, or provided services or goods to the Claimant; and shall recognize a Qualified Medical Child Support Order (QMCSO). Further, no covered person shall at any time, either during the time in which they are covered by the Plan, or following their termination from coverage under the Plan, in any manner, have any right to assign their right to sue to recover benefits under the Plan, to enforce rights due under the Plan to an appeal an adverse benefit determination, or to any other causes of action which they may have against the Plan or its fiduciaries.

Incorrect Reporting

The facts shall be used to determine to what extent, if at all, a covered person is or was covered under the Plan when:

- Any information that pertains to the covered person is found to have been reported incorrectly
- The error affects the existence or amount of the coverage

In this event, a fair adjustment in premiums or in the amount of coverage, or both, shall be made.

Clerical Errors

Clerical errors, as defined below, shall be corrected and the Plan coverage (benefits or eligibility) shall be determined using correct information.

Clerical error is any error which:

- Relates to the transmittal and/or communication of Plan-related information
- Is perfunctory or ministerial in nature
- Is made by clerical-staff personnel (i.e., with limited or no authority over formal decisions)
- Involves claims processing, recordkeeping or underwriting functions
- Is made by the Plan Sponsor, Trust Fund Administrator, Plan Supervisor or any Party of Interest to the Plan
- Does not involve errors of judgment or involve the advance knowledge of how such error could unfairly be an advantage or disadvantage to any party thereto
- Does not, except for the error, expand or contract coverage
- Does not involve misconduct, misrepresentation, negligence, incompetence or significantly poor administration of either the coder or assumer as measured by industry standards
- Is promptly reported and rectified

Exemptions

To the full extent the law permits, all rights and benefits that accrue under the Plan shall be exempt from execution, attachment, or other legal process for the debts or liabilities of any covered person or beneficiary.

Workers' Compensation

The Plan is not in lieu of and does not affect any requirement for coverage by workers' compensation insurance.

Statements Not Warranties

All statements made by the Trust Fund Administrator or by a covered employee will, in the absence of fraud, be deemed representations and not warranties. No statement made by the Trust Fund Administrator or by the employee to obtain coverage will be used to avoid or reduce the coverage unless it is made in writing and is signed by the Trust Fund Administrator or the employee and a copy

is sent to the Trust Fund Administrator, the employee, or his beneficiary.

COORDINATION OF BENEFITS

The Coordination of Benefits provisions apply:

- To each covered person
- To any coverage for Medical, Dental, or Vision care under the Plan

They do not apply to any Life or AD&D Insurance under the Plan.

KEY POINT

Coordination of Benefits (COB) is a term to describe the process by which benefits paid under multiple health plans are coordinated to determine in what order benefits are paid and how much each plan should pay.

Effect on Benefits

When a covered person is entitled to medical, dental, or vision care benefits or services under more than one plan, the rules shown in the Order of Benefit Determination section below will be used to decide which plan is the principal plan. If the Plan:

- Is the principal plan among all of the plans that cover the covered person, then its benefits will be determined without taking into account the benefits or services of any other plan.
- Is not the principal plan, then its benefits may be reduced. They will be reduced so that all of the benefits and services provided by all of the plans during each claim determination period
- will not be more than 100% of the allowable expenses incurred by the covered person. The benefits provided by a plan include those that would have been provided if a claim had been duly made.

The benefits of the Plan will never be greater than the sum of the benefits that would have been paid if there were no other plan covering the covered person.

The term "plan" means a plan that provides medical, dental, or vision care benefits or services by or through any:

- Group coverage
- Group practice or prepayment coverage
- Group service plan
- Method of coverage for persons in any other group
- Coverage that is required or provided by law.

The term "plan" shall also include "no-fault" motor vehicle insurance where the law does not forbid it.

With respect to any two plans that cover a covered person on whose expenses a claim is based, the "principal plan" is the plan under which benefits will be determined first.

The term "allowable expense" means any necessary, reasonable, and customary item of expense that is, at least in part, a covered expense under one or more of the plans that cover the covered person. When a plan provides a service, the service will be deemed to be both an allowable expense and a benefit paid.

The term "claim determination period" means a calendar year.

An "anti-duplication provision" is a provision that reserves to a plan the right to consider the benefits or services of other plans in determining its benefits.

Medicare and Other Statutory Plans

If a covered person is eligible for Medicare, Medicare will be the principal plan except:

- When the law requires this Plan to be the principal plan
- When, to fulfill an employer's obligation under the law

Any other plan that is required or provided by law, including a "no-fault" plan, will be the principal plan unless the law forbids such plan to be the principal plan.

KEY POINT

When Medicare is the principal plan, Medicare benefits, both Parts A and B, will be taken into account in determining any benefits to be paid under the Plan, whether or not the covered person has enrolled in both Part A and Part B of Medicare.

Plans Without Anti-Duplication Provisions

When one of any two plans does not include an anti-duplication provision, then that plan will be the principal plan. If any part of a plan is not subject to an anti-duplication provision, then that part will be deemed to be a separate plan and will be the principal plan.

Plans With Anti-Duplication Provisions

These rules will be used to decide which of any two plans is the principal plan when both contain an anti-duplication provision. The first rule listed that describes one, but not both, of the plans will identify the principal plan.

- The plan that covers the covered person other than as a dependent.
- The plan that covers the covered person as a dependent of the parent whose birthday occurs earlier in a calendar year (the Birthday Rule). If both parents have the same birthday, the plan that has covered the parent for the longer period of time. The rule of the other plan will be used in place of this rule when: (a) the rule of the other plan is not based on the birthday of the parent; and (b) the result of using this rule is that the plans do not agree on which plan is the principal plan.
- The plan that covers the covered person through present employment instead of a plan that covers the covered person through prior employment. (Through prior employment means as a laid off or retired employee or as a dependent of a laid off or retired employee.) This rule will not be used when: (a) the other plan does not include a similar rule; and (b) the result of using this rule is that the plans do not agree on which plan is the principal plan.
- The plan that has covered the covered person for the longer period of time.

Exception to the Birthday Rule

If the covered person is a dependent child of parents who are divorced or separated, then the following rules will be used in place of the Birthday Rule:

- The plan of the parent who has been assigned the financial duty for the child's health care by a court decree
- The plan of the parent who has custody of the child
- The plan of the stepparent who is married to the parent with custody of the child
- The plan of the parent who does not have custody of the child.

Right to Information, Payment, and Recovery of Payment

To meet the intent of the Coordination of Benefits provisions or an anti-duplication provision of any other plan:

- The Trust Fund Administrator, in a way allowed by law, may give or get any information that is needed to decide the benefits that are payable. A covered person must declare coverage under any other plans and give to the Trust Fund Administrator the information that is needed to meet the intent of this provision.
- The Trust Fund Administrator shall have the right to pay to any organization the amount that organization has paid that should have been paid by this Plan. An amount so paid will be deemed to be a benefit paid under the Plan. To the extent of the payment, this Plan will have no more liability under the Plan.

If this Plan has paid more than it should

have paid to meet the intent of this provision, it may recover the excess amount from one or more of the following, as the Trust Fund Administrator may decide:

- Any person to, or for, or with respect to whom the payment was made
- Any other insurance company
- Any other organization

Plan members who are eligible for secondary coverage by any other health plan are encouraged to obtain such coverage.

Failure to obtain secondary coverage may result in the Plan member incurring costs, which are not covered by the Plan and which would otherwise be covered by the secondary coverage. The Plan will not pay for any costs which would have been payable by such secondary coverage, except to the extent that such costs are payable in any event by the Plan.

RIGHT OF RECOVERY/SUBROGATION

Conditional Benefit Payments

The Plan excludes benefits for any injury, or sickness caused by the act or omission of another person or entity (known as a "third party"), where an opportunity for recovery exists from the third party and/or under an automobile (including underinsured or uninsured motorist policies), homeowners, commercial premises, renter's, medical malpractice, or other insurance or liability policy.

If a covered participant has the potential right of recovery for which a third party or insurer may have the legal responsibility, the Plan, as a convenience to the covered participant, may advance benefits pending the resolution of the claim upon the following conditions:

- The covered participant, by accepting or claiming benefits, agrees that the Plan is entitled to reimbursement from any judgment, settlement, disputed claim settlement, or other recovery, up to the full amount of all benefits provided by the Plan, but not to exceed the amount of the recovery, except that the Plan will deduct reasonable attorney's fees and costs on a pro-rated basis from the reimbursement amount, if the covered participant complies with the terms of the Plan and agreement to reimburse.
- Prior to advancing benefits, the Plan will require that the covered participant (and the covered participant's attorney or legal representative) complete, sign and return a Subrogation Agreement, provided by the Trust Fund Administrator. The Subrogation Agreement constitutes an enforceable contract in which the covered participant agrees that as a condition of the Plan paying eligible claims resulting from the actions of the liable third party, the participant agrees to repay the Plan the full value of the claims paid to treat the injury, illness or accident injury or condition, on a first-dollar basis, from any recovery, settlement or judgment received from the liable third party and/or their insurer. The Subrogation Agreement also creates an assignment of any recovery, settlement or judgment in favor of the Plan up to the amount of the benefits paid by the Plan, and a constructive lien against any recovery, settlement or judgment made by a third party.
- The Plan will require that the covered participant and/or their attorney or legal representative provide documentation to the Plan, which describes the circumstances of the injury or sickness, and that the covered participant do whatever is necessary to secure the Plan's right to reimbursement.
- A covered participant must do nothing after payment of benefits by the Plan to prejudice the Plan's right to reimbursement.

- When a recovery is obtained from a liable third party or insurer, whether by direct payment, settlement, judgment, or any other way, an amount sufficient to satisfy the Plan's reimbursement amount must be paid by the covered participant or their attorney or other legal representative into an escrow or trust account and held there until the Plan's claim is resolved by mutual agreement, arbitration or a court order. If the funds necessary to satisfy the Plan's reimbursement amount are not placed into an escrow or trust account, the covered participant or person named to hold the funds will be personally liable for any loss the Plan suffers as a result.
- If the Plan is forced to bring legal action to enforce the terms of the Plan's provisions, the Plan shall be entitled to its reasonable attorney's fees, costs of collection and court costs.

The Plan may deny coverage or seek reimbursement from providers if there is a reasonable basis to determine that this provision or any agreement to reimburse the Plan is not enforceable, or if there is a reasonable basis to believe that the parties involved will not honor the terms of this provision or any agreement to reimburse the Plan. Pursuant to this exclusion, the Plan may continue to exclude expenses incurred after a judgment or settlement of the claim, if such expenses are related to the third party recovery. In addition, the Plan may offset future benefits, including those of family members, by denying such payments until it is reimbursed for the benefits provided that are related to the third party recovery.

The Plan reserves its right to bring a breach of contract action in state court to enforce the Plan's right to reimbursement under the provisions of this Plan and to assert a constructive trust in federal court under ERISA 502(a)(3) to recover the funds received by the covered participant from a third party in accordance with this Plan provision. Venue for any enforcement action of this Plan provision will be in the Superior Courts of the State of Alaska or the U.S. District Court for the State of Alaska.

TRUST FUND PLAN INFORMATION

Plan Name and Plan Sponsor

The Plan is known as the Alaska Pipe Trades U.A. Local 367 Health and Security Trust Fund Plan.

The Plan is maintained by the Plan Sponsor whose name and address are:

> The Trustees of the Alaska Pipe Trades U.A. Local 367
> Health and Security Trust Fund
> 610 West 54th Avenue
> Anchorage, Alaska 99518-1137

Plan Identification Numbers

The employer identification number is: EIN 92-0035263

The Plan number is: PN 501

A complete list of the employers and employer organizations sponsoring the Plan may be obtained upon written request to the Trust Fund Administrator and is available for examination at the Trust Fund Administrator's office.

Plan Effective Date

The Plan Effective Date is: April 1, 2003. (Prior to April 1, 2003 the Plan was insured under Pacific Life and Annuity from January 1, 2000.)

Type of Welfare Plan and Funding Organization

This welfare Plan is a Medical, Dental Vision, Life and AD&D Plan.

The Life and AD&D is fully insured through a policy of insurance underwritten by Symetra Life Insurance Company.

The Medical, Dental and Vision coverages are self-insured by the Alaska Pipe Trades U.A. Local 367 Health and Security Trust. The Trust purchases excess loss insurance to limit the Trust's liability for large claims on any individual and for all claims under the Plan during a Plan Year. Excess Loss Insurance is underwritten by Symetra Life Insurance Company.

Symetra Life Insurance Company's principal executive office is located at:

> Symetra Life Insurance Company
> 5069 – 154th Place N.E.
> Redmond, Washington 98052

Trust Fund Administrator

The Trust Fund Administrator is Zenith American Solutions, whose address and phone numbers are:

> Zenith American Solutions
> 111 West Cataldo, Suite 220
> Spokane, Washington 99201-3201
> P.O. Box 5434
> Spokane, Washington 99205-0434
> (855) 229-0720

Agent for Service

Each member of the Board of Trustees is designated as Agent for Service of legal process on behalf of the Trust Fund.

The addresses at which the process may be served are set forth in this section.

Service of legal process also may be made upon the Trust Fund Administrator.

Source of Plan Contributions

The contributions necessary to finance the Plan are made by the employer and employees. The contributions are calculated actuarially.

The contributions are received and held in trust by the Trustees who pay the claims and costs of administration.

Date Fiscal Year Ends

The fiscal year for this Plan ends, each year, on December 31.

Claims Procedure

Claim / Enrollment forms may be obtained from the Trust Fund Administrator's office.

Collective Bargaining Agreements

This Plan is maintained pursuant to one or more collective bargaining agreements. A copy of any such agreement may be obtained upon written request to the Trust Fund Administrator and is available for examination at the Trust Fund Administrator's office.

Board of Trustees of the Plan

The names, titles, and business addresses of the Trustees of the Plan are as follows:

Employer Trustees

Jim Rafter
P.O. Box 222325
Anchorage, AK 99522

William C. Goodale
P.O. Box 5503
Ketchikan, AK 99901

Kevin Carey
6305 Libra Place
Anchorage, AK 99518

Brian Miller
LONG Building Technologies, Inc.
5660 B Street
Anchorage, AK 99518

Union Trustees

Aaron Plikat
UA Local 367
610 W. 54th Ave
Anchorage, AK 99503

Adrian "Pete" Nolfi
234 West 12th Avenue
Anchorage, AK 99501

Craig Hately
UA Local 367
610 W. 54th Avenue
Anchorage, AK 99503

Gene Bay
P.O. Box 32102
Juneau, AK 99803

DEFINITIONS

Terms that are used only within one section of the Summary Plan Description are defined in that section.

Accident. The term "accident" means an event that: (a) caused a physical injury; (b) was caused by a sudden, violent, and external force; (c) was not expected and could not have been reasonably foreseen; and (d) could not have been avoided.

Allied Health Professional. The term "allied health professional" means only a person shown in the list of Allied Health Professionals below, but only if:

- The person is licensed and practices within the scope of the license; and
- The requirements shown in the list of Allied Health Professionals are met.

List of Allied Health Professionals:

- A dentist.
- A psychologist.
- A physical therapist.
- A speech therapist, but only if the patient is referred to the speech therapist by a physician.
- An occupational therapist.
- A chiropractor.
- A podiatrist.
- An optometrist.
- An optician.
- A physician assistant or nurse assistant.
- A certified registered nurse anesthetist.
- A nurse midwife.
- A certified direct-entry midwife.
- A clinical or certified social worker.
- An advance nurse practitioner.
- A psychological associate.
- A naturopath.
- An osteopath.
- A marital and family therapist.
- A certified acupuncturist.

Approved Clinical Trial. An "*Approved Clinical Trial*" is defined as a Phase I, II, III, or IV clinical trial for the prevention, detection, or treatment of cancer or other life-threatening condition or disease (or other condition described in ACA such as federally funded trials, trials conducted under an investigational new drug application reviewed by the U.S. Food and Drug Administration [FDA] or drug trials exempt from having an investigational new drug application). A *life-threatening condition* is any disease from which the likelihood of death is probable, unless the course of the disease is interrupted.

Benefit Maximum. A "benefit maximum" is a maximum amount of benefits that will be paid by the Plan for a specified type of covered charge incurred during a given period of time. The charges to which a benefit maximum applies are not considered covered charges after the benefit maximum has been reached.

Calendar Month and Calendar Year. A "calendar month" is one of the 12 named months of a calendar year. A "calendar year" is a period that starts on January 1 and ends on December 31 of each year.

Covered Dental Service. The term "covered dental service" means only a service that: (a) is essential for the necessary care of the patient's teeth and supporting tissue; (b) is performed by a dentist or dental hygienist; (c) has a reasonably favorable prognosis; (d) is generally accepted professional practice and meets professionally recognized standards; and (e) is the least expensive procedure that will produce a result that meets professionally recognized standards. A temporary dental service will be deemed an integral part of the final dental service rather than a separate covered dental service.

Covered Participant or Covered Person. The term "covered participant" or

"covered person" means an eligible employee who is a member of U.A. Local 262 Plumbers and Steamfitters, participants under a Special Agreement, employees of an employer who is signatory to an agreement requiring contributions to the Alaska Pipe Trades Local 367 Health & Security Trust on their behalf who has worked the required number of hours for eligibility or a qualified dependent.

Custodial Care. The term "custodial care" means care that consists of services and supplies that are given mainly to help a person to meet the activities of daily living, whether or not the person is disabled, and that are not rendered mainly for their therapeutic value in the treatment of an injury or disease. Custodial care includes, but is not limited to, care such as: (1) care mainly to provide room and board; (2) preparation of special diets; (3) supervision of the administration of medications that can normally be self-administered; and (4) personal care such as helping the person to walk, get in or out of bed, bathe, dress, eat, or use the toilet.

Deductible. A "deductible" is an amount of covered charges that must be incurred by a covered person before benefits will be paid by the Plan. No benefits will be paid for the charges applied toward a deductible.

Dental Hygienist. The term "dental hygienist" means only a person: (a) who has been trained in an accredited school; (b) who is licensed by the state in which he is practicing the art of dental prophylaxis; and (c) who is practicing under the direction and supervision of a dentist.

Dentist. The term "dentist" means only a person who: (a) is licensed to practice dentistry; and (b) is acting within the scope of the license. The term "dentist" shall include a physician who provides dental services within the scope of the physician's license.

Durable Medical Equipment. The term "durable medical equipment" means equipment that: (1) is designed for repeated use; (2) is mainly and customarily used for medical purposes; and (3) is not generally of use to a person in the absence of a disease or injury. Durable medical equipment includes, but is not limited to, such items as: hospital bed; wheelchair; iron lung; traction apparatus; intermittent positive pressure breathing machine; brace; crutch.

The items in the list that follows are examples of some, but not all, of the types of equipment that are **not** considered to be durable medical equipment: air conditioner; air purifier; heat lamp; heating pad; bed board; gravity traction device; exercise bicycle; weight lifting equipment; specially equipped van.

Employees Coverage and Dependents Coverage. The terms "employees coverage" and "dependents coverage" refer to the coverage provided under the Plan for: (a) eligible employees; and (b) dependents; respectively.

Evidence of Insurability. The term "evidence of insurability" means a statement or proof of a person's medical history upon which acceptance for Employee Life Insurance and Employee AD&D Insurance will be made. The statement or proof: (a) must be in a form that is satisfactory to Symetra; and (b) must be furnished at no cost to Symetra.

Group Life and AD&D Policy. The "group policy" is the policy of group health coverage issued to the policyholder by Symetra.

Health Trust Administrator. The Health Trust Administrator processes employee and dependent eligibility and enrollment for active and COBRA coverage and adjudicates medical, dental and vision claims.

Inpatient and Outpatient. The terms "inpatient" and "outpatient" refer either to the setting in which medical care is given or to a person who is receiving care in that setting.

When the terms describe the setting in which medical care is given:

- "Inpatient" means that the care is furnished to a person while the person is confined in a facility as a registered bed patient; and
- "Outpatient" means that the care is furnished to a person while the person is not so confined.

When the terms refer to a person who is receiving medical care:

- "Inpatient" means a person who is confined in a facility as a registered bed patient; and
- "Outpatient" means a person who is not so confined.

Insurance Class. The term "insurance class" for Life and AD&D means a category of employees who are eligible for the same insurance benefits under the group policy. An insurance class must be established by the Policyholder and approved by Symetra.

Intensive Care Unit. The term "intensive care unit" means only a separate, clearly designated service section that is part of an acute care hospital and that meets all of the tests listed below:

- It is solely for treatment of patients who are in a critical condition.
- It provides constant special nursing care and observation not available in the other sections of the hospital.
- It contains special life-saving equipment that is ready for immediate use.
- It contains at least two beds for critically ill patients.
- It has, at all times, at least one registered nurse who is in constant attendance.
- It meets the standards set for an intensive care unit by the Joint Commission on Accreditation of Hospitals.

The term "intensive care unit" shall include a burn unit or a cardiac care unit that meets all of the above tests. The term shall not include a unit for intensive alcoholism or psychiatric treatment.

Medical Coverage. The term "medical coverage" means only the comprehensive medical coverage provided under the Plan. It does not include any dental coverage, vision care coverage, or outpatient prescription drug coverage.

Nurse. The term "nurse" means only a person who is a registered nurse (R.N.), a licensed vocational nurse (L.V.N.), or a licensed practical nurse (L.P.N.).

Orthodontia Treatment. The term "orthodontia treatment" means the movement of the teeth through the bone by means of an active appliance to correct a malocclusion of the mouth.

Participating Employer. A "participating employer" is a covered employer that is required to contribute to the Alaska Pipe Trades U.A. Local 367 Health and Security Trust Fund in order to provide health coverage for its employees under the terms of a collective bargaining agreement or special agreement.

Percentage Payable. A "percentage payable" is a factor by which an amount of covered charges is multiplied to calculate a benefit under the Plan.

Physician. The term "physician" means only a person who is licensed and practices within the scope of the license as a doctor of medicine (M.D.) or as a doctor of osteopathy (D.O.).

Placement for Adoption. The term "placement for adoption" means the date the adoptive parent assumes and retains a legal obligation for total or partial support in anticipation of the adoption.

Plan. The term "Plan" means the Plan of benefits described in the Plan Document / Summary Plan Description issued by the Trustees of the Alaska Pipe Trades U.A. Local 367 Health and Security Trust Fund.

Pregnancy. The term "pregnancy" means any pregnancy, a complication thereof, or the termination of a pregnancy.

Program of Dental Treatment. The term "program of treatment" means all treatment that is done or is to be done in the oral cavity at one or more sessions as the result of the initial diagnosis. The program shall include the treatment for any complications that arise during the program.

Professionally Recognized Standards. The term "professionally recognized standards" means the prevailing standards of proven and effective medical practice recognized within the organized medical community. The Plan's determination of compliance with such standards includes consideration of:

- Pertinent professional literature, which may include the published determinations of agencies such as: the Food and Drug Administration (FDA); the National Institutes of Health (NIH); the Centers for Disease Control (CDC); the American Medical Association (AMA); the American Dental Association (ADA); and their affiliates and successors; other national and state medical associations and specialty societies; professional review groups; and similar groups.
- The determination of independent medical specialists when requested.

Qualified Medical Child Support Order. The term "qualified medical child support order" means any court order issued to provide health benefit coverage for a dependent child of an employee and which meets specified criteria as determined by the Trust Fund Administrator.

Sound Natural Tooth. The term "sound natural tooth" means a tooth that: (a) is organic and formed by the natural development of the body (not manufactured); (b) has not been extensively restored; and (c) has not become extensively decayed or involved in periodontal disease.

Specialty Drugs. The term "*specialty drugs*" means drugs that have one or more of the following characteristics:

- Therapy of chronic or complex disease;
- Specialized patient training and coordination of care (services, supplies or devices) required prior to therapy initiation and/or during therapy;
- Unique patient compliance and safety monitoring requirements;
- Unique requirements for handling, shipping and storage; or
- Potential for significant waste due to the high cost of the drug

Spouse. The term "spouse" means a legally married wife or husband but does not include domestic partners, or a legally separated spouse.

Surrogacy. The role of a woman who is compensated to bear a child by an individual. Surrogacy includes being a gestational carrier.

Treatment Plan (Dental). The term "treatment plan" means the attending dentist's report of a recommended program of treatment. The report must:

- Itemize the proposed procedures
- List the charge for each procedure
- Be accompanied by any appropriate diagnostic materials as may be required

Usual Charge and Customary Charge. With respect to any one service or supply:

- "Usual charge" means the minimum of the average charge that is accepted as payment in full by the provider of the service or supply; and
- "Customary charge" means the average charge for the service or supply in the geographic area concerned, as determined by the Trust Fund Administrator.