ALASKA TEAMSTER-EMPLOYER

WELFARE TRUST

SUMMARY PLAN DESCRIPTION FOR ACTIVE & RETIRED PLAN PARTICIPANTS AND THEIR ELIGIBLE DEPENDENTS

Effective January 1, 2018

www.959trusts.com

ALASKA TEAMSTER-EMPLOYER WELFARE TRUST

520 East 34th Avenue, Suite 107
Anchorage, AK 99503-4116
(907) 751-9700 or (800) 478-4450

TO ALL PARTICIPANTS:

This Summary Plan Description Booklet has been prepared to give you basic information about the benefits available through the Alaska Teamster-Employer Welfare Trust. Summarized in this Booklet are the eligibility requirements that you must satisfy to qualify for benefits, the benefit plans themselves, and procedures for review and appeal of claims. This Booklet provides information about the administration of the program, and your rights under the law.

This Booklet contains descriptions of the Medical, Prescription Drug, Dental, and Time Loss benefits provided by the Trust. It also contains a description of a Vacation Plan that is available to some Eligible Employees. The Vision benefit provided by the Trust is described in a separate booklet and in this Plan. Life Insurance for active employees, medical and prescription drug benefits for Retired Participants covered by Medicare, and Accidental Death & Dismemberment benefits are fully insured and are described in a separate booklet and in this Plan. Covered benefits, coverage limits and exclusions, deductibles, copays, maximum benefits, claim submission requirements, and appeal rules and requirements for Retired Participants covered by Medicare (Medicare Retirees) are specified in a separate booklet provided by TEAMStar and not in this booklet.

The Board of Trustees has the right to amend, change or discontinue (1) the types and amounts of benefits under this Plan, and (2) the rules determining who is eligible for benefits, including those rules providing eligibility pursuant to the Dollars Bank or Lag Period, even if you have already accumulated Dollars Bank credit or satisfied the Lag Period. The Board of Trustees and its Administrative Committee are granted the sole and exclusive discretionary authority to administer and interpret the Plan and all administrative and trust documents, including: making all factual and equitable determinations and deciding coverage, eligibility, participation and the amount of benefits payable (if any), and the meaning and applicability of Plan provisions. Any such determinations shall be conclusive and binding on all parties having dealings with the Plan. The Trust Customer Service Office is the only party authorized by the Board of Trustees to answer questions about the Plan. No Trustee, Employer, Employer Associate or Labor Organization, nor their employees or representatives, have any authority in this regard.

The nature and amount of Plan benefits are always subject to the actual terms of the Plan as it exists at the time the product is dispensed or the services giving rise to the claim are provided, or, in the case of Vacation, Time Loss, Life Insurance or Accidental Death and Dismemberment benefits, the time that the event giving rise to the claim occurs. *Plan benefits are not guaranteed or lifetime benefits*.

We encourage you to read this Booklet carefully prior to obtaining medical care. If you have questions about Plan benefits, please contact the Trust Customer Service Office.

Important Note: Please give special attention to the cost containment features that have been designed by the Trustees to control costs without reducing the level of Medically Necessary care available to you. Also, the Board of Trustees has entered into Preferred Provider arrangements with health care providers that offer their services at discounted rates to Plan Participants. Contact the Trust Customer Service Office for more information.

Sincerely,

BOARD OF TRUSTEES

QUICK REFERENCE TABLE
WHERE TO CALL FOR INFORMATION

INFORMATION NEEDED	WHERE TO CALL

Eligibility Information
Enrollment Forms
Claims Information:
    Life Insurance and AD&D
    Vacation Plan
    Medical Plan
    Prescription Drug Benefit
    Dental Care Benefit
    Time Loss Benefit
	Trust Customer Service Office
	Alaska Teamster-Employer Welfare Trust
	520 E. 34th Avenue Suite 107
	Anchorage, AK 99503-4116
	(907) 751-9700 or (800) 478-4450
	Trust Email Address:
	benefits@959trusts.com
	Internet Website: www.959trusts.com
	
	Administrative Office
	BeneSys, Inc.
	1220 SW Morrison St., Suite 300
	Portland, OR 97205-2222
	(800) 714-3209

Prescription Drug Program Pharmaceutical Provider: Network Retail and Mail Order Pharmacy Program	**OptumRx** Customer Care Services (877) 839-8119 Member Website: www.OptumRx.com **Trust Customer Service Office** (907) 751-9700 or (800) 478-4450
Vision Care Benefit Information and Forms	**Vision Service Plan (VSP) Customer Service** (800) 877-7195 Internet Website: www.vsp.com Vision Service Plan Attn: VSP P.O. Box 385018 Birmingham, AL 35238-0518
Life Insurance Provider	**Symetra** If you have any questions, please contact the Trust Customer Service Office at (907) 751-9700 or (800) 478-4450.

Telemedicine	**Teladoc** (800) 835-2362 www.teladoc.com
Disease Management Program	**HealthCare Strategies** HealthReach Program (800) 582-1535 www.hcare.net
Surgery Benefit Manager An enhancement program to the standard medical plan which provides access to a wide range of educational tools and resources.	**BridgeHealth Medical** (888) 387-3909 **www.BridgeHealthMedical.com** To register: click on *Plan Member Login* • Web Access Code: SLWMB

FREQUENTLY ASKED QUESTIONS

Q. What documents will need to be provided if I am enrolling/dis-enrolling dependents?

A.

Event	Sample Documents	Plan Provision
Marriage	**Marriage Certificate**	**Must be submitted within 60 days following marriage.**
Gain Dependent: Birth/ Adoption	**Birth certificate or Certificate of Adoption**	**Must be submitted within 60 days following birth/ adoption.**
Spouse/Dependent gains coverage through employment	**Notification from new employer**	**Must be submitted within 60 days of newly becoming eligible under another health plan.**
Spouse/Dependent losses employment	**Notification from prior employer**	**Must be submitted within 60 days of loss of coverage.**

Q: I understood that my plan would not charge for a routine physical examination. However, the explanation of benefits I received shows that you applied part of the charges to my deductible and only paid a percentage of the balance.

A. This happens when your physician has indicated on the billing statement that your examination was for a specific symptom or complaint. The billing statement must reflect that the primary purpose for your visit was for preventive care. The Plan and Trust **cannot** change the physician's billing statement; you will need to contact your physician.

Q. What is the name of our insurance company?

A. Your medical and dental benefit coverage is provided through the Alaska Teamster-Employer Welfare Trust, which is a multi-employer employee benefit plan governed by a federal law called ERISA, the Employee Retirement Income Security Act. Medical and dental benefits (other than Retiree benefits obtained through TEAMStar) are not paid by an insurance company; they are paid directly by the Plan.

Q. The doctor's office needs my group number and identification number to file my claim.

A. The group and ID numbers for your medical, dental and prescription drug benefits are now on your ID card. Please refer to your medical/dental card for your medical and dental ID numbers.

Q: What does the limit to "Usual, Customary and Reasonable" charges mean?

A. The Plan will not pay charges above the "Usual, Customary and Reasonable" rate for medical services or supplies. A charge that does not meet *all three* of those requirements – by being "usual," "customary," *and* "reasonable" – will be adjusted by the Plan or eliminated. A charge is "usual" if it is no more than the charge that the medical provider most frequently makes to its patients for that service or supply. A charge is "customary" if it is equal to or less than the 85th percentile rate established for the geographic area by the Plan's third party service, which analyzes appropriate health care charges, and does not exceed Medicare's allowed amount for end-stage renal disease charges. A charge is "reasonable" if the service or supply is justified by the circumstances, and is not performed too frequently or at an unreasonable time.

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SUMMARY OF BENEFITS

LIFE INSURANCE AND AD&D BENEFITS – SEE SECTION 12

Insured

Please refer to the separate brochure describing your Life Insurance and AD&D benefits

• Eligible Employee Life Insurance	$25,000
• Eligible Employee AD&D	$25,000
• Eligible Employee Dependent Life Insurance	
Spouse	$2,000
Dependent Child	$2,000
• Retired Participant's Life Insurance	$5,000

MEDICAL PLAN BENEFIT – SEE SECTIONS 5.1 THROUGH 5.20

Benefit Funded by the Trust

- Annual/Lifetime Maximum Benefit – No Dollar Limit (Visit or Procedure Limits May Apply)

  Medicare Eligible Retired Participant – See TEAMStar Retiree Booklet

- Calendar Year Deductible

  For Eligible Employees and their Dependents

Per Participant	$1,000
Per Family	$3,000

  For Retired Participants and their Dependents

  Each Participant WITH Medicare See TEAMStar Retiree Booklet

- Annual Out-of-Pocket Limit (includes Calendar Year Deductible)

  For Eligible Employees and their Dependents

Per Participant - PPO	$3,800
Per Family	$7,600
Per Participant -non-PPO	$7,600
Per Family – non-PPO	$15,200
Per Participant for Prescriptions	$3,200
Per Family for Prescriptions	$6,000

For Retired Participant and their Dependents

Each Participant WITH Medicare See TEAMStar Retiree Booklet

	Preferred Providers *% of Covered Expenses*	**Non-Preferred Provider** *% of contract rates*
• Hospital Services (*inpatient & outpatient*)		
Hospitals ***in*** Alaska, ***within*** 75 miles of a Preferred Provider facility	80%	60% of rate negotiated with Preferred Provider; after additional $1,000 inpatient deductible
Hospitals ***in*** Alaska; ***not*** within 75 miles of a Preferred Provider facility	80%	60%
Hospitals ***outside*** of Alaska	80%	60%
Preadmission Testing	100%	100%
• Professional Services and Supplies		
Physician visits (home, office, or hospital visits)	80%	60%
Surgeon and assistant surgeon	80%	60%
Diagnostic x-rays, laboratory testing	80%	60%
Chiropractic office visits (up to 10 visits per year)	80%	60%
• Acupuncture (up to 10 visits per year)	80%	60%
• Naturopathic Services (some exclusions apply)	80%	60%
• Physical, occupational or massage therapy (up to a combined limit of 20 visits per year)	80%	60%
Speech therapy (up to 20 visits per year)	80%	60%
Cardiac rehabilitation	80%	60%
• Medical equipment and prosthetics	80%	60%
• Home Health Care Benefit	80%	60%

All Hospital confinements are subject to

***Precertification Review*.**

	% of Covered Expense
• Skilled Nursing Facility	80%; up to 100 days
• Hospice Care	80%

Surgeries performed at a non-Preferred Provider facility within 75 miles of a Preferred Provider facility may be payable at 60% of the rate negotiated with a Preferred Provider. In addition, certain Surgical procedures may be covered at 50% if performed on an inpatient basis. Also, expenses for non-emergency orthopedic surgery are covered only if provided through BridgeHealth or a Preferred Provider. No other non-emergency orthopedic surgery expenses are covered by this Plan.

Refer to the COVERED EXPENSES section of this Booklet.

• Teladoc Services	100%
• Preventive Health Care *(Refer to Section 5.13)*	
Routine Physical Examination	100%; subject to UCR and Schedule of Routine Examination Benefits.
Well Child Care	100%; subject to UCR and Schedule of Well Child Benefits
Immunizations	100%; subject to UCR and Schedule of Immunizations
• Services at the Coalition Health Center	No copay for the first visit each year. Subject to a $20 copay per visit thereafter Deductible waived
• Ambulance Service	70%; limited to 70% of preferred provider charges for non-Emergency air ambulance services
• Hearing Loss Benefit	70%; up to $800 *per hearing device, per ear* during any 3 consecutive years; not subject to deductible or out-of-pocket limitations

PRESCRIPTION DRUG BENEFIT – SEE SECTION 8

Benefit Funded by the Trust
A separate maximum out-of-pocket limit applies to prescription drugs: For Active Participants $3,200 per Individual, $6,000 per Family.

	Participating Retail Pharmacy** ***(34-Day Supply)***	**Preferred Participating Mail Order Pharmacy**	**Non-Participating Pharmacy*****
Generic Drugs	Participant co-payment is 20% of the total cost of the Drug.	Participant co-payment is the lesser of 20% of the cost of the drug or $20 for each prescription.	No reimbursement.
Preferred Brand-name Drugs* *Reimbursement Limitations apply, see below**	Participant co-payment is 35% of the total cost of the Drug.	Participant co-payment is the lesser of 35% of the cost of the drug or $50 for each prescription.	No reimbursement.
Non-Preferred Brand-name Drugs* *Reimbursement Limitations apply, see below**	Participant co-payment is 50% of the total cost of the Drug.	Participant co-payment is the lesser of 50% of the cost of the drug or $100 for each prescription.	No reimbursement.
Specialty Drugs(*) Must be filled at participating Specialty Drug mail order facility	Not applicable.	Participant co-payment is $100 for each Specialty prescription. 30 day supply.	No reimbursement

If filled through a participating retail pharmacy, the Plan also covers medications and supplements that are designated as "preventive care" under Health Care Reform and which the Plan is required by law to provide. For a list of the covered medications and supplements, see www.hhs.gov/. These items are covered at 100% in-network, but you must have a prescription from your doctor (even for the over-the-counter items). Also, not all items are covered for everybody - for example, there are age restrictions, and some items are limited to generic only. Contact the Pharmaceutical Provider for more information.

*** REIMBURSEMENT LIMITATIONS:***

If you or your Physician request that your prescription be filled with a brand-name Drug when a generic equivalent is available, you will be responsible for paying the full difference in price between the generic and brand-name Drug *in addition to* your brand-name Prescription Drug co-payment. The generic drug price is established by the Plan's Pharmaceutical Provider.

If you fail to use your prescription drug card at a participating pharmacy, there is no reimbursement.

***** OUT-OF-NETWORK:***

If no in-network pharmacy is located in the area, the copayment is 50% of the Drug cost per each prescription filled out-of-network.

DENTAL CARE BENEFIT – SEE SECTION 9

Benefit Funded by the Trust

The Plan provides Dental benefits only to Eligible Employees and their Dependents.

	% of Covered Expenses
Dental Calendar Year Deductible	$75 per Participant; waived for Diagnostic and Preventive and Orthodontics only
Dental Calendar Year Maximum Benefit	$2,000 per Participant (age 19 and older)
Class I – Diagnostic and Preventive	80%; $75 deductible waived

	% of Covered Expenses
Class II – Basic Dental	80%
Class III – Major Dental	50%
Orthodontics – Individuals under age 19	50%; up to $1,200 lifetime; $75 deductible waived

VISION CARE BENEFIT – *SEE SECTION 10*

Benefit Funded by the Trust

The Plan provides Vision benefits only to Eligible Employees and their Dependents.

Please refer to the separate brochure describing your vision benefits.

Benefit	Frequency	Copayment
Examination	12 months	$10
Lenses	12 months	$25 (lenses and frame)
Frames	24 months	

SECTION 1
ELIGIBILITY RULES FOR EMPLOYEES

1.1 INTRODUCTION TO PLAN LEVELS, DOLLARS BANK ACCOUNT, AND SELF-PAYMENT ACCOUNT

This Plan provides coverage at three Plan Levels: Employee-Only, Employee-Plus, and Family. The Employee-Only level covers only you, as the employee with employer contributions made on your behalf to the Plan. The Employee-Plus level covers either you and your eligible spouse, or you and your eligible children. The Family level covers you, your eligible spouse, and your eligible children.

The cost of each Plan Level is determined by the Trustees. When you begin having employer contributions made for your coverage under the Plan, you will have a choice about which Plan Level to select. If you do not make a selection when required, you will be enrolled in the Employee-Only Plan Level. Plan Level selections can only be changed at yearly Open Enrollment, for coverage effective January 1 of the following year, or when certain qualifying events have occurred in your family.

Employer contributions properly made to the Trust on your behalf are credited to your Dollars Bank account under the Plan. You first become eligible for the Plan based on a sufficient amount of employer contributions being made to the Plan and credited to your Dollars Bank account over a six-month period.

Once you are eligible for the Plan, continued payments for your coverage at your Plan Level are made month by month from your Dollars Bank. If your Dollars Bank reaches a certain level but does not have sufficient funds to pay for the next month of coverage at your Plan Level, you have the option of making self-payments (using approved payment methods) to maintain coverage. To make self-payments automatically, you can deposit up to the amount of the cost of one month of coverage at your Plan Level into a Self-Payment Account. With a Self-Payment Account, a deduction from your Self-Payment Account will automatically be made in the amount needed for you to maintain coverage at your Plan Level.

1.2 ELIGIBILITY FOR EMPLOYEES

An Employee becomes a Participant and is eligible as an Active Employee for Health and Welfare benefits described in this Booklet – medical, prescription drug, vision, and dental programs, time loss benefits, life insurance, dependent life insurance, and accidental death and dismemberment benefits – ***if*** the Employee:

- is an Employee of a Contributing Employer working pursuant to a Collective Bargaining Agreement or Written Agreement that requires contributions to the Trust on behalf of the Employee, and
- for a period of six consecutive Payroll Months or less, his Dollars Bank account is credited with employer contributions equal to at least the monthly cost of coverage at the highest Plan Level.

How an Employee Becomes Eligible for Coverage as an Active Employee

An Employee becomes eligible for coverage as an Active Employee on the first day of the calendar month after a period of six consecutive months or less in which his/her Dollars Bank account is credited with employer contributions equal to at least the monthly cost of coverage at the highest Plan Level.

An Active Employee who has met the initial eligibility requirements will be automatically enrolled in Employee-Only coverage. Enrollment of a spouse and/or children under the Employee-Plus or Family coverage levels requires a timely and properly-completed enrollment form. Otherwise, the Eligible Employee will remain enrolled in Employee-Only coverage until a change at the Plan's next Open Enrollment or

(if available) a change at Special Enrollment. Enrollment forms are available online and from the Trust Customer Service Office.

Continuation of Eligibility as an Active Employee

An Active Employee will continue to be eligible for benefits as an Active Employee in one of two ways.

First, an Active Employee's coverage will automatically be continued to the next month if, as of the 25th day of a month in which he has coverage as an Active Employee, his Dollars Bank account contains sufficient employer contributions to pay for the following month's coverage at his Plan Level. This payment from your Dollars Bank will be made automatically and is mandatory (except for certain members covered by the Uniformed Service Employment and Reemployment Rights Act).

Second, an Active Employee can continue coverage if, as of the 25th day of a month in which he has coverage as an Active Employee his Dollars Bank account contains ***at least $300 in properly-credited Employer contributions***, and ***no later than the 10th day of the following month*** he makes a self-payment of the difference between the amount in his Dollars Bank account and the monthly cost of coverage for his Plan Level. (Please contact the Trust Office for details regarding approved methods of payment.) Any amount in your Self-Payment Account as of the 25th of the month will be automatically applied toward the difference between the cost of coverage at your Plan Level and the amount in your Dollars Bank account at that date.

An Employee who does not qualify for continued eligibility as an Active Employee will be eligible to elect COBRA continuation coverage, as specified in Section 14. The continuation of eligibility rules in this section regarding Active Employees do not apply to Employees or their family members who are eligible based on COBRA continuation coverage.

1.3 DOLLARS BANK ACCOUNT FOR EMPLOYEES

Funds properly contributed to the Trust by an Employer pursuant to a Collective Bargaining Agreement or Written Agreement are credited to the Employee's Dollars Bank account. Funds in your Dollars Bank account are used solely to pay the monthly cost for coverage under the Plan at your Plan Level, and cannot be used for any other purpose.

In your Dollars Bank, you can accumulate and retain up to six times the monthly cost of the Plan Level in which you are enrolled. If you change Plan Levels, your maximum Dollars Bank amount will be adjusted at the time of that change.

If no contributions are properly made to your Dollars Bank for a period of 12 consecutive months and in those 12 months you do not have eligibility under the Plan as an Active Employee or under COBRA, your current Dollars Bank account will be permanently forfeited. However, if you provide proof to the Plan that during such a 12-month period without Dollars Bank contributions you have been on an approved military or disability leave and so have retained your employment status with a contributing Employer to the Trust, your Dollars Bank will not be forfeited so long as you retain your employment status with that employer.

Any Active Employee working under a Collective Bargaining Agreement when the Employees covered by that Collective Bargaining Agreement voluntarily terminate participation in the Trust forfeits all amounts remaining in his Dollars Bank at the end of the calendar month immediately following the month in which the Collective Bargaining Agreement providing for participation in the Trust is no longer in effect. Also, any service as an Employee of that Employer will not be considered in determining eligibility to become a Retired Participant.

1.4 SELF-PAYMENT ACCOUNT FOR EMPLOYEES

An eligible Active Employee may choose to deposit personal funds into a Self-Payment Account, for the purpose of automatically having funds available and automatically credited toward self-payments that may be needed to maintain Plan coverage at the employee's Plan Level. The maximum amount in a Self-Payment Account is the cost of one month of coverage at your Plan Level. If you provide funds to be deposited in your Self-Payment Account in excess of the one-month coverage cost maximum, the Trust will deposit the allowed amount into your Self-Payment Account and refund the excess to you.

If you have funds in a Self-Payment Account, and you are eligible to make a partial payment, and those funds are sufficient to allow you to continue coverage at your Plan Level, a deduction from your Self-Payment Account will automatically be made in the amount needed to maintain coverage at your Plan Level.

1.5 CERTIFICATE OF CREDITABLE COVERAGE FOR HEALTH BENEFITS

When your coverage ends, the Plan will give you a certificate of creditable coverage. You may also request a certificate of creditable coverage, and one will be provided to you. This certificate provides information your new plan may need.

1.6 INITIAL ENROLLMENT, OPEN ENROLLMENT, AND LATE ENROLLMENT RULES

Initial Enrollment and Requalification as an Active Employee

When you first have Employer contributions made to a Dollars Bank account containing no Employer contributions or when you first become eligible (or requalify) for Plan coverage based on Employer contributions, the Plan will notify you that you have the option to elect coverage at one of the Plan Levels -- Employee-Only, Employee-Plus, or Family, using an approved enrollment form provided by the Plan. This initial coverage election period will end 45 days after you first become eligible (or requalify) for Plan coverage. If you do not properly elect coverage on an approved enrollment form and provide all required documentation during the initial coverage election period, you will automatically have your coverage election set as Employee-Only.

Your coverage election can be changed at any time during the 45-day coverage election period, by providing a new properly-completed enrollment form and all required documentation. After the initial coverage election period ends, your initial coverage election can only be changed at the next annual Open Enrollment set by the Plan, or if you qualify for Special Enrollment because of one of the changes described below.

Open Enrollment

The Plan will set an Open Enrollment period each year during which you may change the Plan Level that you have selected. If you do not provide a properly-completed new election form during this Open Enrollment period, your previously-selected Plan Level (Employee-Only, Employee-Plus, or Family) will remain in effect and cannot be changed until the next Open Enrollment or Special Enrollment period that applies to you. Active Employees and COBRA participants will be allowed to make election changes during Open Enrollment.

Special Enrollment

Active Employees and COBRA participants may change the election of Plan Level coverage in any of the following Special Enrollment periods provided that a completed Special Enrollment form has been received by the Trust office and you agree to and make the required Self-Payment contributions in the first 60 days from the date in which the Qualifying Event occurred:

1. Within 60 days following marriage or divorce of the Employee.

2. Within 60 days of birth, adoption, or placement for adoption of a child who would qualify as an eligible Dependent of the Employee under the terms of the Plan at the Employee-Plus or Family coverage levels.

3. Within 60 days of the death of a spouse, child, or child placed with the Employee for adoption who is eligible for coverage under this Plan as a Dependent under the Employee-Plus or Family coverage levels.

4. Within 60 days of a loss of coverage to an Employee or, an Employee's Spouse, or an Employee's Dependent where that individual is not enrolled in this Plan but would be eligible for coverage under this Plan at one of the Plan Levels, and the loss of coverage is from another health insurance policy or program (including any COBRA Continuation Coverage, individual insurance, or a public program such as Medicaid), *if the other coverage terminated due to any of the following reasons:* (1) termination of employment or reduction in the number of hours of employment, or death, divorce or legal separation; (2) termination of employer contributions toward the other coverage; or (3) if the other coverage was COBRA coverage, the exhaustion of that coverage. COBRA coverage is "exhausted" if it ceases for any reason other than failure of the individual to pay premiums on a timely basis.

5. Within 60 days of an Employee's Spouse or Dependent newly becoming eligible or re-qualifying for coverage under another health insurance policy or program (including any COBRA Continuation Coverage, individual insurance, or a public program such as Medicaid).

If an Active Employee is not in an open enrollment or Special Enrollment period and is enrolled in Employee-Plus coverage but does not have any eligible Dependents, his or her Plan Level will be automatically changed to Employee-Only. If an Active Employee is not in an open enrollment or Special Enrollment period and is enrolled in Family coverage but either does not have any eligible children, or does not have an eligible Spouse, his or her Plan Level will be automatically changed to Employee-Plus.

1.7 TERMINATION OF ACTIVE ELIGIBILITY FOR EMPLOYEES

Eligibility of Employees and their Dependents will terminate on the earliest of any of the following dates, and may be continued if permitted under COBRA:

1. For Employees and their Dependents, the date that the Employee's Dollars Bank contributions and any self-payments are not sufficient to continue coverage;
2. The date the Employee or Dependent enters full-time service (more than 31 days) in the Uniformed Services of the United States, except as provided under the section of this Booklet entitled *Continued Coverage While in Uniformed Service*;
3. The date the Employee or Dependent enters the military service of any country other than the United States;
4. For all Participants, the date the Plan terminates.
5. For an Employee, as of the first day of the calendar year for which the Employee submits a waiver of coverage for himself or herself for that calendar year, in such form as approved by the Plan, and only to the extent that the form is duly signed by such Employee and no claims for such Employee have been submitted to the Plan for such calendar year. Once submitted and approved, such waiver of coverage shall be irrevocable for the calendar year involved, and shall automatically expire at the end of that calendar year.
6. For the Spouse of an Employee, as of the first day of the calendar year for which the Employee or Spouse submits a waiver of coverage for himself or herself for that calendar year, in such form as approved by the Plan, and only to the extent that the form is duly signed by such Spouse and no claims for such Spouse have been submitted to the Plan for such calendar year. Once submitted and approved, such waiver of coverage shall be irrevocable for the calendar year involved, and shall automatically expire at the end of that calendar year.

1.8 REINSTATEMENT OF ACTIVE ELIGIBILITY FOR EMPLOYEE

If an Employee's eligibility terminates due to insufficient Dollars Bank funds, non-payment of a self-payment required to continue coverage, or termination of coverage under COBRA or USERRA, coverage as an Active Employee may be reinstated in the following ways:

1. **Within 13 months after coverage ends,** the Employee is properly credited with sufficient funds in his Dollars Bank account, received over a period of six months or less, to pay for one month of coverage at his Plan Level. Eligibility is reinstated and coverage is provided on the first day of the calendar month following the month in which the Dollars Bank reaches the required level.
2. **If more than 13 months elapse after coverage ends,** the Employee again meets the initial eligibility requirements described above in Section 1.2.

1.9 CONTINUED COVERAGE WHILE IN UNIFORMED SERVICE

If an Eligible Employee performs service in the Uniformed Service of the United States, federal law provides certain rights to continued coverage under this Plan. An Eligible Employee may choose to continue coverage for up to a maximum of 24 months from the date that service commences (unless the Eligible Employee or Dependents have a right to a longer period of continued coverage as described in Section 14).

The term "Uniformed Service" means the Armed Forces (including the Coast Guard), the Army National Guard and the Air National Guard when engaged in active duty for training, inactive duty training, or full-time National Guard duty, the commissioned corps of the Public Health Service, and any other category of persons designated by the President in time of war or emergency. Voluntary and involuntary service are covered, as are various types of duty: active duty, active and inactive duty for training, National Guard duty under Federal statute, absence from employment for fitness-for-duty examination, and performance of funeral honor duty.

If an Employee (and his or her eligible Dependents) is eligible for benefits as of the date of entry into the Uniformed Service, and the Employee's absence is due to a Uniformed Service leave of **31 days or less**, coverage will be continued at no cost to the Employee. The Employee will be credited with Dollars Bank contributions necessary to keep coverage in effect as if the Employee had worked in covered employment with a Contributing Employer during the period of service.

If an Eligible Employee (and his or her eligible Dependents) is eligible for benefits as of the date of entry into the Uniformed Service of the United States, and the Employee's absence is due to a Uniformed Service leave of **31 days or more**, the Employee or eligible Dependent(s) may elect to continue coverage by: (1) using available Dollars Bank funds, or (2) self-payment under the provisions of the Uniformed Service Employment and Reemployment Rights Act of 1994 (USERRA). An Employee electing to continue coverage need not use his/her Dollars Bank and may always pay the required premium and preserve the Dollars Bank account, but if he/she chooses to use his/her Dollars Bank to pay USERRA premiums, the portion of the Dollars Bank that is used will not be recredited to the Employee upon reinstatement.

A premium for continuation coverage under USERRA will be in an amount established by the Trust. Such premium shall be payable in monthly installments. The maximum length of USERRA continuation coverage is the lesser of:

- 24 months beginning on the day that the Uniformed Service leave commences; or
- a period ending on the day after the Eligible Employee fails to return to employment within the time allowed by USERRA.

If health care expenses are incurred by the Employee or Dependents during a period of Uniformed Service leave, and those expenses are submitted to the Plan and benefits are paid by the Plan, the Employee will be deemed to have chosen continued coverage for the month(s) beginning when the Employee entered Uniformed

Service leave through the last month in which those health care expenses were incurred. In this case, available funds will be deducted from the Employee's Dollars Bank account to provide eligibility to the extent possible.

Reinstatement of Eligibility following Uniformed Service

If an Employee was eligible for benefits on the date of entry into the Uniformed Service and upon completion of service the Employee notifies the Employer of his or her intent to return to employment as specified in USERRA, the Employee's eligibility will pick up as it was the day before the Employee entered into Uniformed Service.

The Plan pays no benefits for conditions incurred or aggravated during performance of duties in the Uniformed Service.

If there is any conflict between these provisions and USERRA, the minimum requirements of USERRA shall govern.

1.10 FAMILY AND MEDICAL LEAVE ACT

The Family and Medical Leave Act (FMLA) generally provides that in certain situations an Eligible Employee is entitled to take up to 12 weeks of unpaid leave during any 12-month period, and that in such situations the Contributing Employer is required to continue coverage for the Employee.

In addition, FMLA provides for up to 26 weeks of caregiver leave for an employee to care for a covered family member who incurred a serious physical or mental illness in the line of duty in covered military service. The total FMLA leave for this military service member care, combined with other FMLA leave, cannot exceed 26 weeks.

FMLA leave also includes up to 12 weeks of "qualifying exigency" leave arising out of the following situations affecting a covered family member in military service: (1) certain short-notice deployments; (2) certain military events, programs, or ceremonies; (3) childcare and school activities; (4) financial or legal appointments; (5) counseling; (6) rest and recuperation; (7) certain post-deployment activities; and (8) other activities as agreed upon by the employee and employer.

Determination as to whether a leave of absence is an FMLA leave shall be made by the Contributing Employer, and is subject to review by the Board of Trustees. If requested, an Employee must submit proof acceptable to the Trust that the leave is in accordance with FMLA provisions.

An Eligible Employee is entitled to continue coverage under FMLA if he or she:

- is employed by a Contributing Employer with 50 or more total employees within 75 miles from the Employee's work site, or the Contributing Employer is a public agency; and
- has worked for his or her Contributing Employer for at least 12 months; and
- has worked at least 1,250 hours during the 12 month period preceding the start of the FMLA leave of absence; and
- is on a FMLA-qualified leave from employment with the Contributing Employer.

In the event that both a husband and wife are covered as Eligible Employees, the FMLA continued coverage may not exceed a combined total of 12 weeks if the FMLA leave is related to the birth or placement of a child or to caring for a parent with a serious health condition. If an Employee is on a FMLA leave on the day coverage is to begin, coverage will nonetheless begin.

If an Employee becomes eligible for both: (a) FMLA coverage due to the Employee's own disability, and (b) this Plan's 29-month *Extended Benefits for Total Disability,* continuation of eligibility will run concurrently

until the FMLA leave is exhausted, then the available balance of *Extended Benefits for Total Disability* will be applied. Continuation of eligibility under FMLA is concurrent with all other continuation options except for COBRA; an Employee is eligible to elect COBRA Continuation Coverage as of the day FMLA coverage ceases.

Continuation of coverage under FMLA ends on the earliest of:

- The day the Employee returns to work;
- The day the Employee notifies his or her Employer that he or she is not returning to work;
- The day coverage under the Plan would otherwise end (i.e., Plan maximum has been paid); or
- The day after coverage has been continued under FMLA for 12 weeks.

Employees should contact their Employer to find out more about Family and Medical Leave and the terms on which an Employee may be entitled to it.

If there is any conflict between these provisions and FMLA, the minimum FMLA provisions shall govern.

1.11 SPOUSES WITH DUAL EMPLOYER CONTRIBUTIONS TO THE PLAN

If spouses both become eligible as Active Employees, they will be allowed to make a joint election on a form approved by the Plan to waive one spouse's right to his or her Dollars Bank balance and all Employer contributions otherwise payable into the Dollars Bank account of that spouse, and instead direct all such Dollars Bank funds and Employer contributions into the Dollars Bank account of the other spouse.

Any such election will be effective as of the first day of the next month following the properly-completed election by both spouses, and at that time all Dollars Bank funds held by the waiving spouse shall be transferred to the Dollars Bank of the other spouse. Spouses making this election acknowledge and accept that:

- This election can only be changed during the annual open enrollment or if you divorce, and only on a prospective basis – that is, for new Dollars Bank contributions received after the change. Previously-transferred and received Dollars Bank contributions will only be transferred back to the other spouse at death of the originally-designated spouse upon death.
- The spouse whose Dollars Bank account is designated as the sole recipient of both spouses' Dollars Bank funds and contributions will have sole authority to elect Plan Levels for coverage, including but not limited to elections regarding the Plan coverage of the waiving spouse and any Dependent children.
- In the event of divorce, without regard to any agreements of the spouses or ex-spouses, or orders of the court or any other body, there will be no transfer of Dollars Bank contributions previously received and credited by the Trust from one spouse to the other spouse.

1.12 COMPOSITE RATE CONTRACTS

The Trustees may approve a Composite Rate Contract providing a fixed monthly contribution in an amount designed to provide Family coverage for covered employees. If the contributions are made on your behalf at the required rate under an approved Composite Rate Contract, your coverage for the following month will automatically be provided at the Family coverage level, without an election to choose another coverage level.

If your contributions under a Composite Rate Contract cease or are insufficient to provide coverage at the latest composite rate approved by the Trustees, your continued eligibility will be determined based on payment of the approved composite rate –either through employer contributions, or permitted self-payments together with employer contributions.

The automatic election of Family coverage under an approved Composite Rate Contract overrides the Plan Level election processes described above.

SECTION 2
ELIGIBILITY RULES FOR RETIRED PARTICIPANTS

2.1 ELIGIBILITY FOR RETIRED PARTICIPANTS

The Trust does not provide Vision, Accidental Death and Dismemberment, Time Loss, and Vacation Benefits to Retired Participants and their Dependents.

- Upon retirement under the Alaska Teamster-Employer Pension Trust, an individual is eligible for medical and prescription drug benefits , and life insurance to a limited extent, if the individual:
- is entitled to Medicare; and
- has been credited with at least 20,000 Covered Hours under the Welfare Trust since initial participation under the Plan; and
- has Covered Hours under the Welfare Trust in at least 12 months out of the last 48 before his or her retirement date under the Pension Trust (or, if not covered by the Pension Trust, 12 months out of the last 48 before his or her retirement from his or her Contributing Employer or Employers),or at least 50,000 Covered Hours under the Welfare Trust since Initial participation under the Plan; and
- has made the required timely self-payments; and
- has submitted a completed Retired Participant Welfare Trust enrollment form by 31 days after his or her retirement date under the Pension Trust, by 31 days after losing coverage under this Plan, or as provided in Section 2.3.

The Plan credits Eligible Employees with 173 Covered Hours for each month an Employer contributes to the Plan for work by the Employee under a Flat Rate Contract. This credit applies exclusively for purposes of determining eligibility for benefits as a Retired Participant.

Later, an individual can also enroll at age 65 if he or she has worked at least 40,000 Covered Hours under the Welfare Trust. **However, an Individual can enroll as a Retired Participant only once. For example, if a Retired Participant stops making the monthly self-payment for any reason other than an exception under "Working While Retired," the Participant and any Dependents cannot enroll in the Plan again.**

Effect of Termination of Participation in Trust

If an Eligible Employee was working under a Collective Bargaining Agreement when the Employees covered by that Collective Bargaining Agreement voluntarily terminated participation in the Trust, any service as an Employee of that Employer will not be treated as Covered Hours in determining eligibility to become a Retired Participant.

2.2 PAYMENTS FOR RETIRED PARTICIPANTS

Retired Participants make monthly self-payments to continue coverage after retirement. The amount of the monthly self-payment varies depending on the cost of benefits and other factors. The self-payment is due the 15th day of the month before coverage is provided. A Retired Participant can arrange to have monthly self-payments deducted from his or her Pension Trust check or authorize an automatic ACH withdrawal from a bank account. If you would like information on the current cost of monthly self-payments, contact the Trust Customer Service Office.

For Retirees, rates are based on an estimate of the average cost of benefits for that group as determined by the Trustees

If you would like information on the current cost of monthly self-payments, contact the Trust Customer Service Office.

2.3 WHEN COVERAGE MUST BEGIN

A Retired Participant must enroll for Health and Welfare Trust benefits before coverage will begin for the Participant and his or her Dependents. Enrollment forms are available from the Trust Customer Service Office. A Retired Participant must submit a properly completed enrollment form by 30 days after the Participant's retirement date under the Pension Trust, or by 30 days after losing coverage under this Plan, whichever is later. However, a Retired Participant who has not previously enrolled in this Plan may enroll by submitting a properly completed enrollment form by 30 days after ceasing work for a Contributing Employer if (1) the individual has been credited with at least 20,000 Covered Hours under the Welfare Trust since his or her retirement date under the Pension Trust, and (2) the individual has Covered Hours under the Welfare Trust in at least 12 months out of the last 48 months before ceasing work for a Contributing Employer.

Coverage for Retired Participants must begin when the Pension Trust pays the Participant his or her first pension check unless the Retired Participant has health coverage through the employment of the Retired Participant's spouse or has coverage under this Plan because of Dollars Bank or COBRA continuation. If a Retired Participant has coverage through his or her spouse's employment or has coverage under this Plan because of Dollars Bank or COBRA continuation, coverage for the Retired Participant will begin when that coverage ends, and the Retired Participant has timely made the required self-payment.

Retired Participants must enroll all eligible Dependents at the same time they enroll. Coverage for eligible Dependents begins on the same day the Retired Participant's coverage begins, or the date the Dependent is acquired, if later. If a spouse has other health plan coverage through his or her employment when the Retired Participant enrolls, the Retired Participant may enroll the spouse when the spouse subsequently loses coverage. The Retired Participant must enroll the spouse within 60 days of loss of coverage, and coverage must be effective the day after the spouse's prior coverage terminated. If a Retired Participant marries after enrollment, the new spouse must be enrolled within 60 days of the marriage.

The Surviving Spouse of a Retired Participant is also eligible for Health and Welfare benefits, provided the Surviving Spouse pays any required self-payments and was enrolled in the Plan on the date of the Retired Participant's death.

A Retired Participant must submit a properly completed enrollment form by 30 days after the Participant's retirement date under the Pension Trust, or by 30 days after losing coverage under this Plan, whichever is later.

2.4 WORKING WHILE RETIRED

1) If you are a Retired Participant who is working after retirement, neither you nor your Dependents are eligible to participate in this Plan if your employer provides health coverage, for which you are eligible, or if you become eligible for coverage as an active Employee under this Plan. If you were enrolled as a Retired Participant on or after January 1, 1996, and your eligibility ends due to active Employee coverage or other employer health care coverage, you may resume participation in this Plan when your employment ends. Retired Participants must immediately resume participation in this Plan and begin paying the required monthly self-payments the month following the month in which that active Employee coverage or other employer coverage ends.

2) If you are a Retired Participant who is working after retirement, you or your Dependents are not eligible to participate in this Plan if you are determined under the Pension Trust to be working more than 40 hours a month in "Suspendible Employment" that is not covered under a collective bargaining agreement or Written Agreement. Generally, Suspendible Employment is work in the same trade or craft in which you engaged as an Active Participant in the Pension Trust, in an industry covered by the Pension Trust, and in the geographic area covered by the Pension Trust. If you work in a supervisory or self-employed capacity in the same trade or craft in which you engaged as an Active Participant, you are considered to be working in your former trade or craft.

   There is an exception to the Suspendible Employment rules if you were a member of a collective bargaining unit on the first date employment in that unit became covered by the Pension Trust. In this case, so long as your employment wasn't Suspendible Employment before contributions to the Pension Trust for that employment began, your continued employment as a member of that unit is not Suspendible Employment.

   Please refer to the current Summary Plan Description for the Pension Trust or contact the Trust Customer Service Office if you would like further information regarding the Suspendible Employment rules or applicable exceptions.

   You and your Dependents may resume participation in this Plan when your employment in your former trade or craft ends, only if that employment was covered under a Collective Bargaining Agreement or Written Agreement, and only if you resume participation in the Plan immediately. Retired Participants must immediately resume participation in this Plan and begin paying the required self-payments for the month following the month in which their other coverage ends.

2.5 WHEN COVERAGE ENDS FOR RETIRED PARTICIPANTS AND THEIR DEPENDENTS

Eligibility of a Retired Participant will terminate on the earliest of any of the following dates:

1. on the last day of the month in which the Retired Participant no longer qualifies for coverage; or
2. the date the Retired Participant fails to make a required self-payment on time;
3. the date the Retired Participant enters the military service of any country;
4. the date the Plan terminates, or the Trustees eliminate the Retired Participant's coverage; or
5. the last day of the month that the Retired Participant has designated for cancellation of coverage, if the Retired Participant has provided written notice of cancellation of coverage to the Trust Customer Service Office on or before the cancellation date.

Subject to approval by the Board of Trustees, the Administrative Committee shall have the authority to adopt written policies providing an exemption from termination of a Retired Participant's coverage for failure to make a required self-payment on time.

SECTION 3
ELIGIBILITY RULES FOR DEPENDENTS

A Dependent of an eligible Active Employee becomes eligible for Plan benefits if eligible to be covered under the Plan Level selected by the Active Employee and properly enrolled with any required documentation, on a form approved by the Plan. A Dependent of an eligible Retired Employee becomes eligible when the Retired Employee becomes eligible, or the date the Dependent is acquired, if later. Retired Participants must enroll their existing Dependents at the same time they enroll, or such Dependents are forever ineligible for Plan Benefits. Retired Participants must enroll new Dependents within 60 days of marriage or the date the Dependent is acquired, or such Dependents are forever ineligible for Plan benefits. A Spouse of a Retired Participant, however, may be enrolled within 60 days of birth or adoption of a Dependent child.

Dependents are defined as:

1. The Spouse of an Eligible Employee or Retired Participant.
2. Children of an Eligible Employee or Retired Participant, if they are:
   (a) Genetic children under age 26, legally adopted children under age 26, and children under age 26 who have been placed in the Eligible Employee's or Retired Participant's home for adoption or foster care by that Employee or Retired Participant;

   (b) Stepchildren under age 26 who are the genetic or legally adopted children of the Eligible Employee's or Retired Participant's Spouse;

   (c) Grandchildren under age 26 provided the Eligible Employee or Retired Participant has permanent legal custody of the grandchild;

   (d) Children who, when they turned age 26, were and continue to be incapable of earning a living because of a mental or physical handicap (provided the child was so handicapped and eligible as Dependent at the time they reached such limiting age), and are dependent upon the Eligible Employee or Retired Participant for support. Evidence of the child's dependence and incapacity must be filed with the Plan within 31 days after attaining age 26, and periodically thereafter;

   (e) Children under the age of 26 who are otherwise eligible for coverage as described above, and who are required to be enrolled by a Qualified Medical Child Support Order (QMCSO).

3.1 TERMINATION OF ELIGIBILITY FOR DEPENDENTS

A Dependent's eligibility will terminate on the earlier of the following dates:

- The date he or she no longer qualifies as a Dependent (except that a Dependent Child of an Eligible Employee or Retired Participant who reaches age 26 shall remain eligible until the end of the month of his or her 26th birthday); or
- The date the Eligible Employee's or Retired Participant's coverage terminates; or
- The date the Plan terminates, or the Trustees eliminate the Dependent's coverage under the Plan.

3.2 QUALIFIED MEDICAL CHILD SUPPORT ORDERS

The Plan will enroll children of an Eligible Employee or Retired Participant, as directed by a Qualified Medical Child Support Order (QMCSO). A Qualified Medical Child Support Order is any judgment, decree or order issued by a court or by an administrative agency under applicable state law that has the force of state law which:

- provides the child of an Eligible Employee or Retired Participant with coverage under a health benefits plan, or
- enforces a state law relating to medical child support pursuant to Section 1908 of the Social Security Act, which provides in part that if the Eligible Employee or Retired Participant parent does not enroll the child, then the non-Employee or -Participant parent or State agency may enroll the child.

To be Qualified, a Medical Child Support Order must clearly specify:

- the name and last known mailing address of the Participant and the name and mailing address of each child covered by the Order,
- a description of the type of coverage to be provided by the Plan to each such child,
- the period to which the Order applies.

An appropriately completed National Medical Support Notice that satisfies the above requirements will be deemed a Qualified Medical Child Support Order.

A Medical Child Support Order will not qualify if it would require the Plan to provide any type or form of benefit or any option not otherwise provided under this Plan, except to the extent necessary to comply with Section 1908 of the Social Security Act.

Payment of benefits by the Plan under a Medical Child Support Order to reimburse expenses claimed by a child shall be made to the child or his custodial parent or legal guardian if so required by the Medical Child Support Order.

No Participant's child covered by a Qualified Medical Child Support Order will be denied enrollment on the grounds that the child is not claimed as a Dependent on the parent's Federal income tax return or does not reside with the parent.

When a Qualified Medical Child Support Order is Received

The Trustees have adopted a Qualified Medical Child Support Order Procedure, which is available upon request and without charge from the Trust Customer Service Office. If the Trust receives a proposed or final order, the Trust Customer Service Office will notify the Participant and each child named in the order. The order will then be reviewed to determine if it meets the definition of a "Qualified Medical Child Support Order." Within a reasonable time, the Participant and each child named in the order will be notified of the decision. A notice will also be sent to each attorney or other representative named in the order or accompanying correspondence.

If the order is not qualified, the notice will give the specific reason for the decision. The party(ies) filing the order will be given an opportunity to correct the order or appeal the decision through the *Claims Review Process* explained in this Booklet. **If the order is qualified**, the notice will give instructions for enrolling each child named in the order. A copy of the entire Qualified Medical Child Support Order must be received prior to enrollment, and Retired Participants must pre-pay the required contributions for the child(ren). Child(ren) enrolled pursuant to a Qualified Medical Child Support Order will be subject to all provisions applicable to Dependent coverage under the Plan.

SECTION 4
NOTIFICATION OF STATUS CHANGE REQUIREMENTS FOR PARTICIPANTS

4.1 NOTICES REGARDING COBRA QUALIFYING EVENTS

In the case of a divorce, death, a Dependent child ceasing to be a Dependent, or other "qualifying event" that causes or would cause a loss of Plan coverage, the Participant must notify the Administrative Office ***within 60 days*** of when the event occurs to preserve rights to elect continuing Plan coverage. Eligible Employees and Retired Participants are liable to repay Plan benefits paid on behalf of an individual who is no longer their Dependent.

This notice must be provided in writing to the Administrative Office (contact information in the Quick Reference Table at the front of this booklet). Your written notice should describe the qualifying event, the date of the qualifying event, the affected employee's name and any dependents' name(s) and addresses. If the qualifying event is divorce, you should include a certified copy of your divorce decree. If the qualifying event is a dependent's loss of eligibility for coverage as a Dependent, you should include a written explanation of the reason for the loss of Dependent status. You may send your written notice and supporting documentation by mail, hand delivery, or overnight courier. If you use the mail, your envelope must be postmarked by no later than the 60-day deadline specified above. If you hand deliver your notice and documentation, it must be received by an authorized individual at the address specified above by no later than the 60-day deadline. If you use an overnight courier (such as UPS), your notice must be delivered to the courier for shipment (as reflected on the delivery order) no later than the 60-day deadline specified above. Other types of notice, such as faxes, electronic notice (including email notice) and oral notice (including notice by telephone) are not acceptable. If your written notice and supporting documentation is not mailed, delivered by hand, or sent by overnight courier as specified above to the Administrative Office within the 60-day period, **you and/or your family members will lose the right to elect COBRA**.

4.2 NOTICES REGARDING DISABILITY DURING COBRA COVERAGE

In order to qualify for a possible extension of COBRA coverage following an Eligible Employee's termination of employment or reduction in hours based on a determination of disability by the Social Security Administration, you must notify the Administrative Office within 60 days after the latest of:

- the date of the Social Security Administration's disability determination,
- the date of the covered employee's termination of employment or reduction of hours, or
- the date on which the qualified beneficiary loses (or would lose) coverage as a result of his or her termination of employment or reduction of hours.

You must provide written notice of disability (including the nature of the disability) and a copy of the Social Security Administration determination of disability within the 60-day time period specified above to the Administrative Office (contact information in the Quick Reference Table at the front of this booklet). You must mail your written notice and supporting documentation, and your envelope must be postmarked by no later than the 60-day deadline specified above. You may also send your written notice and supporting documentation by overnight courier (such as UPS), and your delivery envelope must show a delivery order date within the 60-day deadline specified above. Other forms of notice, including hand delivery, fax, oral notice (including telephone notice) and electronic notice (including email notice) are not acceptable. If your written notice and Social Security Administration determination of disability are not mailed or sent by courier to the Administrative Office within the 60-day period specified above, **then there will be no disability extension of COBRA coverage**.

SECTION 5
MEDICAL PLAN BENEFIT

Your Medical Plan Benefit provides comprehensive coverage of Covered Expenses incurred for an Illness or Injury, and is subject to a deductible and coinsurance provision that applies to each Participant each calendar year. The Medical Plan benefit has been structured to provide an incentive to use Preferred Providers for hospital treatment, office visits, and supplies.

You should also know the limitations and exclusions of the Medical Plan Benefit. Some of these limitations and exclusions are described with the Plan benefits; others are described in Section 7, ***EXCLUSIONS AND GENERAL LIMITATIONS***.

PLEASE NOTE THAT COVERAGE FOR MEDICARE-ELIGIBLE RETIRED PARTICIPANTS AND THEIR SPOUSES AND DEPENDENTS IS DESCRIBED IN A SEPARATE TEAMSTAR BOOKLET, AND SECTIONS 5.1 THROUGH 5.20 DO NOT APPLY.

5.1 CALENDAR YEAR DEDUCTIBLE

The deductible is the amount of Covered Expense which must be incurred during each calendar year before Medical Plan Benefits are payable. Non-Covered Expenses may not be used to satisfy the deductible. Only Covered Expenses incurred after a Participant's effective date of coverage may be used to satisfy the calendar year deductible.

> **There is a separate deductible applied to each out-of-network hospital admission in addition to the calendar year deductible. Refer to the *PREFERRED PROVIDER PROGRAM* section of this Booklet for details.**

The calendar year deductible applies to all Covered Expenses unless specifically stated otherwise. Certain Covered Expenses such as preventive health care services (e.g. routine physical examination) or outpatient prescription drugs purchased under the Prescription Drug Benefit are not subject to the calendar year deductible.

For Eligible Employees and their Dependents

The amount of the deductible for each Eligible Employee is the first $1,000 of Covered Expenses incurred in a calendar year. To meet the family annual deductible of $3,000, three or more Participants in the same family must have paid a total of $3,000 for Covered Expenses incurred in one calendar year.

5.2 PERCENTAGE PAYABLE

After the deductible has been satisfied, the percentage payable for Covered Expenses will vary between 60% and 100%, depending on the particular service performed, if a Preferred Provider is utilized, if the Utilization Management Program procedures (described in Section 6) are followed, and if the Annual Out-of-Pocket Limit has been met.

5.3 ANNUAL OUT-OF-POCKET LIMIT

The Annual Out-of-Pocket Limit is the maximum amount of Covered Expenses each Participant pays each calendar year. Once Participants have reached their Annual Out-of-Pocket Limit, Covered Expenses during the remainder of that calendar year are payable at 100%. The calendar year deductible is included in the Annual Out-of-Pocket Limit.

The following expenses are <u>not</u> applied toward the Out-of-Pocket Limit:

- An expense reduced because it is in excess of the Usual, Reasonable and Customary charge;
- An expense for a non-covered service; or
- Any expenses under Prescription Drug, Hearing Loss, Vision Care, or Dental Care Benefits.

For Eligible Employees and their Dependents for Preferred Provider Expenses

The Annual Out-of-Pocket Limit for each Eligible Employee for Preferred Provider Expenses is $3,800 during a calendar year. The family Annual Out-of-Pocket Limit for Preferred Provider Expenses is $7,600 during a calendar year.

For Eligible Employees and their Dependents for Non-Preferred Provider Expenses

The Annual Out-of-Pocket Limit for each Eligible Employee for Non-Preferred Provider Expenses is $7,600 during a calendar year. The family Annual Out-of-Pocket Limit for Non-Preferred Provider Expenses is $15,200 during a calendar year.

5.4 PREFERRED PROVIDER PROGRAM

The Trust has entered into contracts with hospital facilities and a network of physicians and other medical providers to provide services and supplies to Participants at preferred rates, which reduce a Participant's out-of-pocket expenses and reduce the overall cost to the Plan. While contracts provide for preferred rates, they do not allow for discrimination with regard to provided services. The Preferred Provider program provides a nationwide network of medical providers. Services through that network are payable at 80% of Covered Expenses. Services outside that network are payable at 60% of Covered Expenses. To locate a Preferred Provider in your area, please go online to www.959trusts.com and click on "*Find Network Providers*" or contact the Trust Customer Service Office.

The hospital Preferred Provider Program applies to Hospital emergency room, inpatient Hospital services, outpatient Hospital services, surgical services including maternity care, and home health services.

Covered Expenses at a **<u>Preferred Provider</u>** hospital are payable at **80%**.

Covered Expenses for non-Emergency Services at a **<u>non-Preferred Provider</u>** hospital within 75 miles of a Preferred Provider Hospital are payable at **60%** of the rate negotiated with the Preferred Provider for the same service after the $1,000 deductible has been applied (see the shaded box below). Because the rates negotiated with a Preferred Provider are normally lower than the rates charged by a non-Preferred Provider, the Participant will normally pay more than 40% of the total charges billed by a non-Preferred Provider. If the service is not available from a Preferred Provider, or if the service is provided at a location more than 75 miles from a Preferred Provider, Covered Expenses at the non-Preferred Provider hospital are payable at 60% of the UCR charges.

Emergency Services provided at a non-Preferred Provider hospital are payable as follows: services at hospitals located within 75 miles from a Preferred Provider hospital are covered at 80% of the Preferred Provider rate for the same service; services at hospitals located more than 75 miles from a Preferred Provider hospital are covered at 80% of the greater of the Preferred Provider rate for the same service or the UCR charge; and services that are not available from a Preferred Provider are covered at 80% of the UCR charge. However, if Medicare would pay more for the service, the Plan will match the Medicare reimbursement rate.

There is a separate, additional $1,000 deductible applied to <u>each inpatient out-of-network hospital admission</u>, in addition to the calendar year deductible.

- **This out-of-network hospital deductible does not apply toward the Annual Out-of-Pocket Limit.**

- **This out-of-network hospital deductible may be waived in the event of an Emergency hospital admission**.

For **<u>outpatient services</u>** rendered at a non-Preferred Provider facility, the reimbursement will be 60%, after a 50% penalty reduction is applied. In addition, any co-insurance will not apply towards the patient's annual out-of-pocket limit.

<u>HOSPITALS IN ALASKA</u>

If a Participant goes to a hospital within 75 miles of a Preferred Provider hospital in Alaska that is not part of the Preferred Provider Program, the reimbursement rate will be 60% of the Preferred Provider rate. The additional $1,000 inpatient deductible will also apply to each scheduled non-Preferred Provider hospital admission, unless the service is not available from the Preferred Provider hospital in Alaska. Additional limits to Surgical Services are described below at Section 5.8.

<u>HOSPITALS OUTSIDE OF ALASKA</u>

If a Participant goes to an out-of-network hospital outside of Alaska, the reimbursement rate will be 60% and will apply to each hospital admission and outpatient procedure. Additional limits to Surgical Services are described below at Section 5.8.

5.5 HOSPITAL EMERGENCY ROOM

Benefits are extended for Hospital outpatient emergency room care **when required for Emergency treatment** of an Illness or Injury.

No benefits will be extended for emergency room care that is not related to an Emergency and/or could have been provided in a Physician's office, an outpatient clinic or urgent care center.

5.6 INPATIENT HOSPITAL SERVICES

All Hospital confinements are subject to Precertification Review by the Utilization Management Program. Precertification Review only certifies the Medical Necessity of proposed treatment; <u>it does not guarantee that a Participant is eligible for Plan benefits when services are received</u>. Call the Trust Customer Service Office for questions regarding eligibility and benefits.

If a Participant is admitted to a Hospital due to Illness or Injury, Benefits will be extended for:

1. Daily room and board charges up to the Hospital's charge for a semi-private room for each day of confinement. The Plan will cover a private room or intensive care unit if Medically Necessary.

2. Hospital charges for other ancillary services and supplies provided during confinement. Hospital ancillary services or supplies may include:

   - General nursing services (not private duty nursing)
   - Use of operating and cystoscopic rooms
   - Surgical and anesthetic supplies, splints, casts and dressings
   - Oxygen, drugs and medical equipment utilized during confinement
   - Laboratory and x-ray examinations, physiotherapy and/or hydrotherapy
   - Take-home medications dispensed by the Hospital pharmacy at the time of discharge

Pursuant to the Newborns' and Mothers' Health Protection Act, the Plan covers a hospital length of stay in connection with childbirth for the mother or newborn child for 48 hours following a vaginal delivery, and 96 hours following a cesarean section delivery. The mother's or newborn's attending provider, after consulting with the mother, may, however, discharge the mother or her newborn child earlier than 48 hours (or 96 hours if applicable). Preadmission review is only required for lengths of stay expected to exceed the 48-hour/96-hour limits.

5.7 OUTPATIENT HOSPITAL SERVICES

Covered Expenses for services provided by a Hospital on an outpatient basis include:

- Diagnostic laboratory examinations, chemotherapy, diagnostic x-rays, radium or radioactive isotope therapy;
- Outpatient hemodialysis, radiation therapy, and chemotherapy;
- Surgical procedure(s) performed in the outpatient department; and
- Medically Necessary Hospital services for the removal of impacted teeth or the removal of a dental root without extraction of an entire tooth. Covered Dental Expenses related to charges from a dentist or oral surgeon are paid under dental care benefits.

5.8 SURGICAL SERVICES

The Plan provides benefits for a surgical procedure performed at a Hospital (on an inpatient or outpatient basis), or at a freestanding Outpatient Surgical Center. Included are services rendered by an assistant surgeon and Physician anesthesiologist or Registered Nurse anesthetist for anesthesia in connection with a surgical procedure.

However, the Plan covers expenses for non-emergency orthopedic surgery expenses *only* if provided through BridgeHealth or a Preferred Provider. Other non-emergency orthopedic surgery expenses are not covered by this Plan, and do not count toward the Plan's out-of-pocket limits.

The surgical procedures listed below are usually performed on an outpatient basis as "same day surgery" (confinement of less than 15 consecutive hours). If any of these procedures are performed on an **OUTPATIENT** basis, Covered Expenses are payable at 80% if performed at a PPO facility.

If a Participant goes to an outpatient facility that is not part of the Preferred Provider network and is within a 75-mile radius of a Preferred Provider facility, the reimbursement rate will be 60%, after a 50% penalty reduction is applied. For example, if a non-Preferred Provider outpatient charge is $500, the Plan will consider only $250 of those charges ($500 less 50% = $250). In this example, the Plan will pay $150 ($250 x 60% = $150) and the Participant will pay the $350 balance. If the service is for non-emergency orthopedic surgery performed by a non-Preferred Provider, $0 (zero) will be paid by the Plan.

If any of the procedures listed below are performed on an <u>INPATIENT</u> basis, the Plan pays 50% of Covered Expenses, unless it can be demonstrated that special risk factors exist which make surgery on an inpatient basis Medically Necessary.

AUDITORY SYSTEM

Treatment of closed or open nasal fracture

Myringotomy or tympanotomy

INTEGUMENTARY SYSTEM

Excision of lesion or skin biopsy

Excision of nail and nail matrix

Wound repair and skin abrasion

Breast biopsy, any technique

Artery or vein ligation, simple

NERVOUS SYSTEM

Excision, benign tumor; subcutaneous

Carpal tunnel

ENDOSCOPY

Upper GI endoscopy

Bronchoscopy

Small bowel biopsy

Procto/proctosigmoid

Colonoscopy

Hemorrhoidectomy, simple

REPRODUCTION

Vasectomy

Tubal Ligation

Abortion

DIGESTIVE SYSTEM

Liver biopsy (needle)

Repair inguinal hernia (under age 5)

MUSCULOSKELETAL SYSTEM

Reconstruction of nail bed

Tenotomy or arthrotomy

Arthroscopy, knee

Hammertoes and bunions

Fractures, simple

RESPIRATORY SYSTEM

Excision, nasal polyps

Nasal injections

URINARY SYSTEM

Variocele repair

Circumcision

Urethral dilation

Meatotomy

Urethrocystography or cystourethroscopy

Covered Expenses for surgical or radiotherapy procedures include:

1. Benefits payable for surgical procedures include the operation, local infiltration, metacarpal/digital block or topical anesthesia when used, and normal uncomplicated follow-up care.
2. Services rendered for surgery or radiotherapy by a primary operating surgeon or assisting surgeon. Benefits for a second Physician or Surgeon on the same case at the same time are payable when attendance is warranted by a need for supplementary skills.

3. When regional or general anesthesia (not including local infiltration anesthesia) is provided by the primary operating or assisting Physician, the amount payable is determined by the "basic" value for anesthesia without added value for time.
4. If an incidental procedure (i.e., incidental appendectomy, lysis of adhesions, excision of previous scar, puncture of ovarian cyst) is performed through the same incision, the benefit will be based on the major procedure only.
5. When multiple or bilateral surgical procedures, which add significant time or complexity, are performed during the same operative session, Covered Expenses will not exceed 100% (full value) for the major procedure, plus 50% for successive non-incidental procedure(s).
6. The services of an assistant surgeon are reimbursed up to 25% of the maximum amount payable for the primary surgeon.
7. Covered Expenses incurred for acquisition of an organ for transplant (live or cadaveric donor), except that expenses for acquisition of an organ from an eligible Plan Participant for purposes of transplantation into another person who is not an eligible Plan Participant are not Covered Expenses under this Plan.
8. Benefits for preoperative care, surgical procedures, and postoperative care will be based on "Surgery Guidelines" as outlined in the *Physician's Current Procedural Terminology (CPT)* published by the American Medical Association, and as updated from time to time.
9. Breast reconstruction in connection with a mastectomy. This covers reconstruction of the breast on which the mastectomy was performed, surgery and reconstruction on the other breast to produce a symmetrical appearance, and prostheses and treatment of physical complications at all stages of a mastectomy, including lymphedemas.

5.9 SKILLED NURSING FACILITY OR EXTENDED CARE FACILITY

Benefits are extended for Covered Expenses incurred during inpatient care at a Skilled Nursing Facility or Extended Care Facility, when the Participant's Illness or Injury would otherwise require a Hospital stay. This benefit is limited to 100 days per confinement. The Plan provides no benefits for Custodial Care.

5.10 PREADMISSION TESTING

The Plan will extend benefits for pre-admission laboratory and x-ray testing performed in a Hospital's outpatient department within the 7-day period preceding scheduled admission to that Hospital for medical treatment or a surgical procedure. These Covered Expenses are reimbursed at 100%.

5.11 TRANSPORTATION AND EXPENSES FOR MEDICALLY NECESSARY TREATMENT

Air Transportation for Parent of a Dependent Child

This benefit will pay **for round-trip coach class air transportation for one parent of a minor Dependent child to allow the child to obtain Medically Necessary treatment that is not available locally**. This provision does not apply to travel for diagnostic testing. While the Dependent child is confined in the Hospital or receiving outpatient treatment, the parent who accompanies the child will be eligible for reimbursement of reasonable expenses for meals, lodging and local ground transportation. The Plan also pays reasonable expenses for meals, lodging and local ground transportation for the Dependent child if he or she is receiving outpatient treatment. The maximum combined reimbursement for the parent and the Dependent child is $75 per day. Original written receipts must be submitted to the Administrative Office in order to obtain reimbursement.

Air Transportation for Emergency Treatment

The Emergency Treatment Air Transportation benefit is available for all Participants. This benefit will pay for up to $500 for coach class air transportation to the nearest medical facility where Medically Necessary Emergency treatment can be given, when such treatment is not available without air transportation. This provision does not apply to travel for diagnostic testing.

Air Ambulance Transportation Services

For air ambulance services, the Plan's preferred providers are Guardian and LifeFlight Air Ambulance Services in Alaska only, and must be utilized by calling 1(800) 478-9111. If the Plan's preferred provider for air ambulance services is not utilized, the reimbursement rate will not exceed the Plan's preferred provider's retail rate.

Travel and Lodging and Waiver of Deductible and Co-Insurance for Certain Pre-Approved Medically Necessary Surgeries through BridgeHealth

The Plan has contracted with BridgeHealth Medical (BridgeHealth) to allow Participants and Dependents, when pre-approved by BridgeHealth and the Trust, to obtain certain medically necessary surgical treatments from approved BridgeHealth providers outside Alaska. When medically necessary and approved by BridgeHealth and the Trust in advance and in writing, the Trust will provide the following benefits for the patient and a medically-necessary companion:

- *Transportation and Lodging - Round-trip air transportation and lodging for the patient and a medically-necessary companion are paid in full by the Trust when using a pre-approved BridgeHealth provider located more than 100 miles from his or her home. To be covered, any and all travel arrangements must be scheduled, reserved and specifically approved in advance and in writing by both BridgeHealth and the Trust.*

- *Waiver of Deductible and Co-Insurance for Approved Treatments - Because of the cost of savings to the Trust for approved BridgeHealth treatments, the deductible is waived and charges for the BridgeHealth provider are paid at 100% for BridgeHealth treatments approved in writing in advance by BridgeHealth and the Trust.*

- *Incidental Expenses - Incidental expenses of up to $50 per day during travel to obtain treatment at an approved BridgeHealth provider will be paid by the Trust.*

Any medical services not performed by an approved BridgeHealth provider or not approved in advance in writing by BridgeHealth and the Trust, including pre- and post-surgery care, are subject to the usual deductibles, coverage limits, and other terms of the Plan. Orthopedic surgeries that are not performed by an approved BridgeHealth provider or a Preferred Provider of this Plan are not covered at all by this Plan, unless provided in an emergency. A portion of the lodging and incidental expense benefits provided through the BridgeHealth program may be subject to income tax.

5.12 HOSPICE CARE

Hospice care provides medical and supportive care to terminally ill patients during the last months of life, and also provides support for the patient's family. Hospice care is provided by a licensed facility or organization either on an inpatient basis at a Hospice facility or on an outpatient basis at home. Covered Expenses include the following items:

- professional services of a Registered Nurse, licensed practical or vocational nurse, or a home health aide.
- physical, occupational, speech, respiratory or rehabilitation therapy.
- laboratory services, medical supplies, and oxygen prescribed by a Physician.
- Medical Social Services furnished to a terminally ill Participant and his or her immediate family. "Medical Social Services" means those counseling services furnished by a psychiatrist, psychologist, or staff member of a licensed social services agency.
- Bereavement counseling by a licensed social worker or licensed pastoral counselor to assist the family unit during the bereavement period in coping with the death of the terminally ill Participant.

5.13 PREVENTIVE HEALTH CARE

Preventive care is covered 100% (subject to UCR limits), with no copayment or deductible. Preventive care means those services and supplies designed as "preventive care" under the Health Care Reform law, and which the Plan is required by law to provide.

Covered preventive care may be different depending on your age, gender and circumstances. Here are some examples of common services that (depending on your age, gender and circumstances) are covered preventive care:

- Routine physical exams
- Cholesterol screenings
- Mammograms
- Pap smears
- Colonoscopies
- Obesity screening
- Blood pressure screening
- Type 2 Diabetes screening
- Immunizations (as recommended by the Centers for Disease Control and Prevention)
- Newborn Hearing exam
- Pediatric oral and vision screening
- Tobacco cessation programs

The schedules of preventive care services are available at **www.hhs.gov/healthcare/prevention** and **www.cdc.gov/vaccines/schedules/index.html**, or from the Trust Office. Be sure to check the schedules before you access services because some services are not covered for all ages, and some have coverage limits. Also note that the Plan may use reasonable medical management techniques, such as location for service or test frequency, to determine covered preventive care.

When both preventive care and diagnostic or therapeutic services occur at the same visit, you generally pay the cost share for the diagnostic or therapeutic services but not for the preventive care.

Preventive care drugs and supplements are covered under the Prescription Drug Benefit, and only if prescribed.

5.14 PROFESSIONAL SERVICES AND SUPPLIES

Covered Expenses for professional services and supplies include:

1. Services rendered by a Physician for medical treatment of an Illness or Injury. "Medical treatment" means services rendered by or in the presence of a Physician or through an online or telephone consultation with a Teladoc Physician. Benefits are provided for office, home, and Hospital visits.
2. Office visit services performed by a chiropractor, up to a maximum of 10 office visits per calendar year.
3. Acupuncture up to a maximum of 10 visits per calendar year, and Medically Necessary naturopathic services.
4. Services of a Registered Nurse (R.N.), provided the services rendered are not custodial in nature and cannot be performed by a less qualified professional.
5. Physical therapy, occupational therapy, massage therapy or cardiac rehabilitation services, when prescribed by and under the direction of a Physician. Benefits for rehabilitation services are limited to one visit per day, and do not include services which are primarily educational, sports-related, or preventive in nature (i.e., physical conditioning or exercise). Physical therapy, massage therapy and occupational therapy are limited to 20 visits per calendar year except for physical or occupational therapy that is Medically Necessary to treat a spinal injury.
6. Speech therapy when Medically Necessary to restore speech (the ability to express thoughts, speak words, form sentences) lost as a result of Illness or Injury. Speech therapy must be: (a) prescribed by and under the direction of a Physician, and (b) expected to result in significant improvement of speech function. Speech therapy prescribed for a speech delay (e.g. resulting from a congenital condition) or for a learning disability is not a Covered Expense. Speech Therapy is limited to 20 visits per calendar year.
7. Diagnostic x-rays, radium or radioactive isotope therapy performed by a Physician or Radiologist, or diagnostic laboratory examinations performed by a Physician or pathologist. Benefits may also be payable for certain diagnostic tests under ***PREVENTIVE HEALTH CARE and PREADMISSION TESTING***.
8. Medically Necessary **professional ambulance service** to transport a Participant to or from the nearest medical facility where appropriate treatment can be given. A **licensed air ambulance is considered a Covered Expense** if it is determined that the location and nature of the Illness or Injury make a licensed **air ambulance** Medically Necessary. The Plan will not consider payment of charges in excess of those retail rates charged by its preferred provider for air ambulance services. The Plan's preferred providers for these services in Alaska are Guardian or LifeFlight Air Ambulance.
9. Administration of oxygen; casts, splints, and surgical dressings.
10. Purchase or rental, up to the purchase price, of prosthetic devices, durable medical equipment and supplies. Covered Expenses are defined as:
    - Prosthetic devices and braces (including surgically implanted devices and corrective appliances), excluding replacements or repairs; or
    - Equipment and those supplies which are:
        - ordered by a Physician, and
        - usable only by the Patient, and
        - of no further use when medical need ends, and
        - not primarily for the comfort or hygiene of the Participant, and
        - not for environmental control, and
        - not for exercise, and
        - manufactured specifically for medical use, and

• approved as Medically Necessary treatment, as determined by the Fund, and
• not for prevention purposes.

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. A device used specifically as a safety item or to affect performance primarily in sports-related activities is not a Covered Expense. Non-durable medical supplies including (but not limited to) elastic stockings, ace bandages, gauze and like products are not Covered Expenses.

11. Services of a Physician (MD) or dentist (DDS or DMD) for treatment of accidental Injury to sound natural teeth *if treatment is performed within six months of the date of the Injury.* "Sound natural teeth" means natural teeth (not teeth that have been restored with crowns, fixed or removable prosthodontics) that are free of active or chronic clinical decay, that have at least 50% bony support, that are functional in the dental arch, and that have not been excessively weakened by previous dental procedures. Services to alter vertical dimension or to restore occlusion are not Covered Expenses.
12. Services of a Physician or oral surgeon (DMD) for Covered Expenses for treatment of temporomandibular joint (TMJ) dysfunction. Related surgical services require pre-certification for medical necessity.
    - The Plan will provide benefits for two appliances over a Participant's lifetime.
    - Covered Dental Expenses related to charges from a dentist (DDS or DMD) or oral surgeon are paid under the dental care benefits.
13. Syringes and diabetic supplies, including lancets, strips and swabs which are obtained without a prescription but are necessary for the use of a prescription drug.

5.15 HEARING LOSS BENEFIT

The Hearing Loss benefit provides for a hearing aid device. Covered Expenses include ear mold(s), initial set of batteries, cords and other necessary equipment, warranty, follow-up consultation, and repair of a hearing aid device. Hearing examinations and evaluations are covered under the Plan's medical benefits.

The maximum benefit payable is 70% of Covered Expenses, up to $800 *per ear for hearing aid devices*, during any period of three consecutive years. The calendar year deductible does not apply to this benefit, and any expense you incur over the Plan's paid benefit amount is not applied to the Annual Out-of-Pocket Limit.

No hearing loss benefit is extended for more than one hearing aid device for each ear; or for replacement of a hearing aid device more often than once during any period of three consecutive years.

5.16 HOME HEALTH CARE BENEFIT

The Plan will extend a benefit for Medically Necessary home health care, including home I.V. therapy services, rendered by a Licensed Home Health Care Agency, for care which would have been covered under the Plan if services were performed in a Hospital or Skilled Nursing Facility.

Covered Expenses are reimbursed at 80% if provided by a Preferred Provider. If services are provided by a non-Preferred Provider in the Anchorage area, Covered Expenses are reimbursed at 60% of the rate negotiated with the Preferred Provider. If services are provided by a non-Preferred Provider outside the Anchorage area, Covered Expenses are reimbursed at 60%. Covered Expenses are also subject to the calendar year deductible.

5.17 TREATMENT FOR MENTAL ILLNESS/SUBSTANCE ABUSE

Benefits are extended for the treatment of Mental Illness, and alcohol, drug, or chemical dependency, on the same basis as for treatment of any other condition.

5.18 MEDICARE PART B REIMBURSEMENT

If a Participant or Dependent is diagnosed with end-stage renal disease (ESRD) and is eligible for and obtains a Medicare Part B Supplemental policy upon or after qualifying for Medicare coverage due to ESRD, the Plan will reimburse the cost of that Medicare Part B Supplemental policy. Requests for such reimbursement must be submitted to the Plan pursuant to policies and procedures approved by the Administrative Office. Members with ESRD are required to provide the Administrative Office with proof of the effective date of Medicare coverage.

5.19 HEALTHREACH DISEASE MANAGEMENT PROGRAMS

The Plan has partnered with HealthCare Strategies, Inc. (HCS) to provide their HealthReach program. HCS has developed a unique and comprehensive approach to disease management. HealthReach provides ongoing education, support, and mentoring to employees and their covered dependents that live with challenging medical conditions, like diabetes, heart disease, cancer, and others.

HealthReach Coaching: If you are selected to participate in the coaching program, a registered Nurse Care Manager will contact you by phone and mail to provide assistance with possible gaps in care, managing current health conditions, and support to reach personal goals. Your HealthReach Care Manager will provide you with confidential and personalized information to help you understand your options, work collaboratively with your doctors, and improve the care you receive.

Pharmacy Review: HCS will identify members who have medicines that are potentially duplicative – or might be harmful when taken together with other prescriptions. Your primary care physician will then be notified to help improve coordination of care among all doctors prescribing your medications.

Additional Charges for Not Participating in Disease Management: Plan members and dependents who are identified for HealthReach Coaching and choose not to participate will be subject to a penalty, reducing the amount of Plan benefits payable. Eligible individuals who, as certified by the disease management/chronic condition management vendor, choose not to participate in the Plan's disease management program will have future medical claims (excluding preventive services required to be paid at 100%) penalized at a 10% reduction in the maximum percentage payable by the Plan. (For example, a charge normally paid 80% by the Plan will be paid 70% by the Plan; a charge normally paid 60% by the Plan will be paid at 50%; etc.) If you or a family member are subject to this reduction, the amount of this reduction will **not apply** to your or your family's out-of-pocket maximum. The 10% penalty will be removed beginning with the first of the month following the time that the individual begins actively participating in the disease management program, as certified by the disease management vendor.

Please note all communications between members and HealthReach remain **completely private and confidential**.

5.20 HEALTH REIMBURSEMENT ARRANGEMENT (HRA)

The Plan has established a Health Reimbursement Arrangement ("HRA") to give Participants additional flexibility to meet their families' health care needs. Under the Health Reimbursement Arrangement, Eligible Employees and Retired Participants can have accounts ("HRA Accounts") maintained by the Plan that can be used to fund certain health expenses.

HRA Contributions

The Plan's Health Reimbursement Arrangement is funded by Contributing Employers that contribute an extra amount to this Plan under the terms of their collective bargaining agreements or Written Agreements, designated as contributions for the HRA accounts of covered employees ("HRA Contributions").

HRA Account Eligibility
An Employee is eligible to have HRA Contributions made on his or her behalf deposited into an HRA Account if the contributions have been properly made and he or she is currently eligible for medical benefits under this Plan. A person who has had HRA Contributions made on his or her behalf but who is not currently eligible for medical benefits under the Plan will have those HRA Contributions held by the Plan until the time that he or she becomes eligible for medical benefits under the Plan.

An HRA Account is limited to a maximum of $2,500 at any given time.

If you are a Participant and have had funds deposited into an HRA Account, you will remain eligible to use the HRA account for eligible HRA expenses for as long as there is still money in your HRA account. Funds in the HRA Account remain in the HRA Account if unused.

If you have an HRA Account as an Active Employee and terminate coverage, retire, or transition to Retiree coverage, the HRA Account will remain in place as long as you maintain a balance in the Account.

If you die with an HRA Account balance and have a Spouse or Dependent(s) covered by the Plan, their eligible HRA expenses may continue to be paid out of your HRA Account for expenses incurred while they remain covered by the Plan.

Eligible HRA Expenses
A Participant's HRA account may be used to reimburse any qualified medical, prescription drug, dental, or vision expenses under Internal Revenue Code Section 213(d) ("Qualified Medical Expenses") for the Participant and his or her dependents covered by the Plan, including deductibles and copayments for Plan coverage as well as Qualified Medical Expenses not otherwise covered by the Plan. It may also be used to make self-payments or COBRA payments to maintain coverage under this Plan for the Participant and his or her dependents covered by the Plan. Any payments from the HRA Account will be limited to the balance of the Account, with no further payments made when the HRA Account is at a zero balance.

You must notify the Administrative Office if you wish to use your HRA Account to make any payment or partial payment of COBRA premiums or self-payments for Active or Retiree coverage.

Time Limits for Payments from Your HRA Account
In order to be payable, claims for reimbursement of Eligible HRA Expenses, like all other covered Plan expenses under Section 15.14, must be submitted within one year of the date the expense was incurred. In addition, the HRA Account may only be used to cover expenses incurred on or after January 1, 2016, and after the date your HRA Account was established.

Expenses for Spouses and Dependents No Longer Covered by the Plan
If your Spouse or Dependent terminates coverage under the Plan for any reason (including divorce of a Spouse), the HRA Account can only be used to reimburse expenses for that person incurred before the loss of coverage.

How to Use the HRA Account
Once your HRA Account has been established, you will receive a debit card that can be used for payment of certain expenses payable under the HRA. You can use the debit card to pay for copayments, deductibles, and for other out-of-pocket medical or prescription drug expenses for you and your Dependents covered under the Plan. By using your debit card for a medical or prescription drug co-payment, deductible, or other out-of-pocket medical or prescription drug expenses, you are certifying that the copayment, deductible, or other medical care expense was incurred for you or a Dependent covered under the Plan and that it is Qualified Medical Expense as defined in Section 213(d) of the Internal Revenue Code.

For dental and vision claims as well as medical and Prescription Drug claims for which you do not use your debit card, you must complete a claim form to receive reimbursement. When you submit a claim for reimbursement, you will be asked to include written statements and/or bills from an independent third party describing the service or product, the amount of the expense, and the date of the service or sale. Depending on the circumstances, this could include an invoice, prescription, an affidavit, and/or other documentation required by the Administrative Office. Cash register receipts alone are not an acceptable form of proof to allow reimbursement from an HRA Account. (Further details about required documentation are on the claim form.)

The Administrative Office may also provide options for submitting HRA reimbursement claims electronically.

HRA Account Amounts and Charges

Your HRA Account is the amount of HRA Contributions actually and properly made on your behalf, less reimbursements paid out of the account, and less administrative charges or other expenses incurred. The Plan will assess an administrative charge of $4.50 per month to maintain your HRA Account, payable from your HRA Account balance.

Opt-Out

You may permanently opt out of participation in the HRA at any time, in which case your HRA Account will be closed and no further HRA reimbursements will be available to you. This will not affect HRA Contributions made on your behalf, which may still be made to the Plan but will no longer be credited to your HRA Account. Notify the Administrative Office if you'd like to opt out.

SECTION 6
UTILIZATION MANAGEMENT PROGRAMS

The Plan pays benefits only for Medically Necessary Services. The following procedures are designed to assist the Plan in determining Medical Necessity before you receive health care services.

Purpose of the Utilization Management Programs

Your Plan is designed to provide Participants with financial protection from significant health care expenses. The development of new medical technology/procedures and the ever increasing cost of providing health care present a challenge to maintaining a high level of benefits. To enable the Plan to provide coverage in a cost-effective way, the Plan has adopted Utilization Management Programs designed to help control increasing health care costs by not paying benefits for services that are not Medically Necessary. By doing this, the Plan is better able to continue to maintain its level of benefits.

If you follow procedures of the Utilization Management Programs, you may avoid some out-of-pocket costs. **If you don't follow these procedures, the Plan provides reduced benefits, and you will be responsible for paying more out of your own pocket.**

6.1 ELEMENTS OF THE UTILIZATION MANAGEMENT PROGRAMS

1. **Precertification Review:** Review of Plan benefit coverage of proposed health care services before the services are provided (except in the case of emergency hospital admissions, where review must be sought within 72 hours after admission);
2. **Concurrent (Continued Stay) Review:** Ongoing assessment of the Plan benefit coverage of health care services as they are being provided, especially (but not limited to) inpatient confinement in a Hospital or specialized facility;
3. **Retrospective Review:** Review of health care services after they have been provided;
4. **Case Management:** A process whereby the Participant, the family, Physician and/or other providers, and the Trust work together under the guidance of the Plan's independent Utilization Management Organization to coordinate Plan benefit coverage of a quality, timely and cost-effective treatment plan. Case Management services may be particularly helpful for Participants who require complex, high-technology medical services and who may therefore benefit from professional assistance to guide them through Plan benefit coverage.

6.2 ADMINISTRATION OF THE UTILIZATION MANAGEMENT PROGRAMS

The Plan's utilization management program is administered by a Utilization Management Organization. The health care professionals at the Utilization Management Organization focus their review on the necessity and appropriateness of Hospital stays and the necessity, appropriateness and cost-effectiveness of proposed medical or surgical services.

The Utilization Management Organization determines if a course of care or treatment is Medically Necessary.

***The Utilization Management Organization certifies the Medical Necessity of proposed treatment. The Utilization Management Organization does not guarantee that a Participant is eligible for Plan benefits when services are received. Call the Trust Customer Service Office for questions regarding eligibility*.**

6.3 RESTRICTIONS AND LIMITATIONS OF THE UTILIZATION MANAGEMENT PROGRAMS

- The fact that your Physician recommends surgery, hospitalization, or confinement in a specialized facility, or that your Physician or another provider proposes or provides other services/supplies doesn't necessarily mean that the recommended services/supplies will be determined Medically Necessary.
- The Utilization Management Programs are not intended to diagnose or treat medical conditions, validate eligibility for coverage, or guarantee payment of Plan benefits. Certification of Medical Necessity does not necessarily mean that an individual is eligible for Plan benefits or that Plan benefits will be payable. For example, benefits would not be payable if your eligibility for coverage ended before the services were rendered, if the services were not covered by the Plan, or the maximum benefit had already been paid.
- All treatment decisions rest with you and your Physician. You should follow whatever course of treatment you and your Physician believe to be the most appropriate. Benefits payable by the Plan may, however, be affected by the Utilization Management Programs.
- The Plan and the Utilization Management Organization are not responsible for either the quality of health care services actually provided, or for the results if the Participant chooses not to receive health care services that the Utilization Management Organization determined to be not Medically Necessary.

6.4 PRECERTIFICATION REVIEW

Certain health care services such as hospitalization, outpatient surgery and certain other outpatient services, require precertification.

- **If you use an Aetna network provider**, your provider is responsible for obtaining necessary precertification for you. Because precertification is the provider's responsibility, if your provider fails to pre-certify required services, the provider's reimbursement will be limited and the provider cannot pass those costs on to you.
- **If you use a non-preferred provider**, your provider may pre-certify for certain services on your behalf. If the provider fails to pre-certify those services, Aetna will review the medical necessity of those services when the claim is filed. If the service is not medically necessary or is otherwise not payable by this Plan and is not approved, no benefits will be paid. If the service is medically necessary and otherwise payable by this Plan, benefits will be paid according to the Plan's limitations.

Precertification Review is a procedure administered by the Utilization Management Organization to assure that the admission and length of stay in a Hospital or specialized facility, surgery or other health care services are Medically Necessary. The Utilization Management Organization determines if recommended confinements, surgery or other health care services meet or exceed accepted standards of care.

If additional information is needed, the Utilization Management Organization will advise the caller. The Utilization Management Organization will review the information provided, and will let you, your Physician and the Hospital (or other provider), and the Administrative Office know whether or not the proposed services have been certified as Medically Necessary. The Utilization Management Organization will respond to your Physician or other provider by telephone shortly after the Utilization Management Organization receives the request and any required medical records and/or information, and the determination will then be confirmed in writing.

6.5 REQUEST FOR REVIEW OF DENIAL OF BENEFITS BASED ON PRECERTIFICATION REVIEW

Regular Request for Review

If the Utilization Management Organization determines that the proposed service is not Medically Necessary, you and/or your Physician may submit a written request for review accompanied by any additional information to support the need for the proposed service. The request for review should be sent to the Utilization Management Organization. You can expect that the Utilization Management Organization will respond in writing within 30 days after receiving the request and any required medical records and/or information.

Expedited Request for Review

If the Utilization Management Organization determines that the proposed service is not Medically Necessary, the treating Physician may telephone the Utilization Management Organization to request an expedited review with the medical director or a Physician designated by the Utilization Management Organization to provide the necessary review. The Utilization Management Organization will usually respond to your Physician by telephone within 24 working hours, and later confirm the determination in writing to you, your Physician, and the Administrative Office.

Independent Review of a Denial of Precertification

If the Utilization Management Organization confirms the initial determination that the proposed service is not Medically Necessary, you and/or your Physician may submit a written request for an independent medical review of the denial of precertification. Call the Trust Customer Service Office for information regarding this independent review. The independent medical reviewer will consider all information presented by your Physician and the Utilization Management Organization. You can expect a written response regarding this review from the Trust within 60 days after your request for such a review is received.

This independent medical review is not required and you may request review by the Administrative Committee at any time within 180 days after a denial of precertification, whether or not you may have requested an independent medical review.

6.6 CONCURRENT (CONTINUED STAY) REVIEW

When you are receiving medical services in a Hospital or specialized facility, the Utilization Management Organization may contact you to assure that continuation of medical services is Medically Necessary.

Concurrent Review may include such services as:

- coordinating Home Health Care or the provision of Durable Medical Equipment;
- determining the Medical Necessity of continued medical services; and/or
- advising you of the various options covered under this Plan for your medical care.

The Plan pays no benefits for charges related to days of confinement in a Hospital or specialized facility that have not been determined to be Medically Necessary.

6.7 REQUEST FOR REVIEW OF A DENIAL OF BENEFITS BASED ON CONCURRENT REVIEW

If the Utilization Management Organization determines continued services are not Medically Necessary, you and/or your Physician will be notified and you will have the opportunity to request review of the determination. The obligation to request review rests entirely with you. The review procedures for concurrent review are the same as those for precertification review; see Section 6.5.

6.8 RETROSPECTIVE REVIEW

All claims for services or supplies may be subject to retrospective review to determine if they were Medically Necessary. **If it is determined that the services or supplies were not Medically Necessary, no benefits will be provided by the Plan for those services or supplies. The review procedures from a denial of benefits based on Retrospective Review are the same as those for Precertification Review; see Section 6.5.**

6.9 CASE MANAGEMENT

Case Management is administered by the Utilization Management Organization. The Utilization Management Organization's medical professionals work with the patient, family, care-givers, Health Care Providers, and the Administrative Office to coordinate Plan coverage of a treatment program. Case Management services are particularly helpful when the patient needs complex, costly, and/or high-technology services.

Case Management may authorize coverage of specific care that would not otherwise be a covered benefit under the Plan if it appears that such alternate care will offer a cost-effective result without a sacrifice to the quality of your care. Case Management, the patient and the attending provider must all agree to the alternate care. The decision to provide alternate care will be made by Case Management in its sole discretion on a case by case basis pursuant to this section. Such a decision shall not be construed to alter or change other provisions of the Plan, nor shall it be construed as a waiver of the right to otherwise administer the Plan in strict accordance with its terms.

Working with the Case Manager

You can request Case Management services by calling the Utilization Management Organization. In most cases, the Utilization Management Organization will initiate Case Management services automatically. The Utilization Management Organization's Case Manager will work directly with you to review proposed treatment plans and to assist in coordinating services and obtaining discounts as needed. From time to time, the Case Manager may confer with your Physician and may contact you or your family to assist in making plans for the Plan to cover continued health care services, and to assist you in obtaining information to facilitate coverage of those services.

You, your family, or your Physician may call the Case Manager at any time to ask questions, make suggestions, or offer information.

SECTION 7
EXCLUSIONS AND GENERAL LIMITATIONS

In addition to any exclusions and limitations described elsewhere in this Booklet, the following Exclusions and General Limitations are applicable to all benefits provided under this Plan. These exclusions shall not be interpreted to violate 26 U.S. Code Section 9802, 29 U.S. Code Section 1182, or 42 U.S. Code Section 300gg-2.

No Plan Benefits are extended for any of the following:

1. Any service rendered or supplies furnished prior to a Participant's date of eligibility or after a Participant's eligibility for coverage terminates (including treatment for an Illness or Injury arising prior to the termination of eligibility). An expense is considered incurred on the date the Participant receives the service for which the charge is made. For more information, refer to the ***ELIGIBILITY RULES*** section of this Booklet.

2. Care, treatment or services for which there is no legal obligation of the Participant to pay, or for which no charge is made in the absence of eligibility for Plan benefits, unless otherwise required by law.

3. Amounts in excess of the calendar year maximum benefit amounts.

4. Care, treatment or services that are furnished under any governmental institution or agency, except to the extent that such services are reimbursable to an agency of the federal government for a non-military service related Illness or Injury, or must be reimbursed under the Indian Health Care Act, 25 USC § 1621e(a) and (c).

5. Services for which payment may be obtained from any local, state or federal government agency, except to the extent prohibited by law.

6. Expenses incurred for which benefits are provided under any other group insurance policy, other medical benefits or service plan, union welfare plan or employee benefit plan, or to the extent payment is required pursuant to any collective bargaining agreement or other contract. Refer to the Coordination of Benefits section of this Plan regarding coordination with health plans and insurance policies.

7. Expenses due to or as a result of: (1) war, act of war, armed invasion or aggression (declared or undeclared) or service in the armed forces of any country, or (2) non-therapeutic release of nuclear energy, or (3) a Participant committing or attempting to commit a felony, or engaging in the commission of an intentional criminal act.

8. Any charge for services furnished by any provider not meeting the definition of Physician or Health Care Provider, or charges for services by a Relative of the Participant or a member of the Participant's household.

9. Expenses relating to any condition for which coverage is available, if proper claim were made, from Workers' Compensation, occupational disease or injury law or similar legislation. The Plan covers no expenses for any condition arising out of or received or aggravated in the course of engaging in any activity for wage or profit. This exclusion does not apply, however, to the extent that the condition is received or aggravated in the course of self-employment, if all of the following conditions are met: (a) the self-employment is conducted at the participant or beneficiary's home; (b) the self-employment earns the participant or beneficiary no more than $5,000 per year; and (c) the condition is not covered under any Worker's Compensation, occupational disease or injury law or similar legislation.

10. Any expense incurred for: (1) services that are not Medically Necessary, (2) Experimental and/or Investigational treatment, (3) fees in excess of Usual, Customary and Reasonable charges, (4) fees from

PPO providers in excess of Preferred Provider rates, or (5) any services or supplies not considered legal in the U.S.

11. Expenses for treatment of infertility or for conception, including but not limited to, artificial insemination, in- vitro fertilization, ovum transplants, embryo transfers, the cost of donor semen, surrogate parenting, reversal of voluntarily surgically induced sterilization procedures, and other infertility-related services.

12. Services and associated expenses for cosmetic procedures, including but not limited to pharmacological regimens, nutritional procedures or treatments, non-Medically Necessary plastic and/or reconstructive surgery, and insertion or removal of breast implants. Cosmetic procedures are those that may improve physical appearance but do not correct or materially improve a physiological function and are not Medically Necessary. However, this Plan will cover surgery related to mastectomy as required by federal law.

    Covered Expenses include cosmetic surgery that is Medically Necessary for prompt repair of damage caused by Injury sustained before or while the Participant is covered by the Plan. "Prompt repair" means that surgery is performed before the end of the calendar year following the year in which the Injury occurred, except in situations where repair must be postponed for Medically Necessary reasons.

13. Charges for gastric bypasses, gastric balloons, stomach stapling, jejunal bypasses, "lap band" surgery, and services of a similar nature. In addition, the Plan excludes charges for all services and associated expenses for obesity or weight control treatment, even if you have other medical conditions related to or caused by obesity or the need for weight control, except for obesity screening and counseling as a preventive care service. Obesity includes morbid or gross obesity.

14. Custodial Care, domiciliary care, respite care, private duty nursing, rest cures, or care in a home for the aged or institution of a similar nature, except as specifically provided under the Hospice Care Benefit.

15. Charges for personal convenience items such as telephone, television, guest meals, or similar services and supplies while confined in a Hospital or Skilled Nursing Facility or while receiving outpatient care.

16. Charges for telephone consultations, cancelled or broken appointments, completion of forms or reports, or expenses for cyber medicine providers, other than consultations provided through Teladoc.

17. Hospital emergency room care that is not related to an Emergency and/or could have been provided in a Physician's office, an outpatient clinic or urgent care center.

18. Expenses for any surgical procedures which alter the refractive character of the eye, or any complications as a result of those surgical procedures. Routine eye examinations, glasses or contact lenses, or vision therapy including orthoptics, except as specifically provided under Vision Care Benefits.

19. Nutritional or dietary supplements or substitutes; non-prescription medications or supplements; and electrolyte supplements; except that the Plan will provide benefits for a fiber supplement where the patient suffers from a diagnosed condition of elevated cholesterol, and a Physician specifically recommends the fiber supplement as an alternative to prescription drug treatment for elevated cholesterol.

20. Services and associated expenses for personal blood storage.

21. Expenses for replacement or repair of prosthetic devices or durable medical equipment, unless Medically Necessary due to the Participant's medical condition.

22. Services and associated expenses for or which are incidental to sexual reassignment, inter-sex (trans-sexual) operations, procedures designed to alter physical characteristics to those of the opposite sex, or any resulting medical complications.

23. Services and associated expenses for: (1) weight reduction programs, (2) nutritional counseling, except diabetic nutrition training and healthy diet counseling, (3) megavitamin therapy, (4) baldness or hair removal, (5) hypnotism, (6) biofeedback, (7) stress management, (8) pain control, (9) physical exercise or physical conditioning programs, (10) educational services or treatment for a learning disability, and/or (11) any goal-oriented behavior modification therapy.

24. Appliances or equipment primarily for convenience or environmental control, such as air conditioners, humidifiers and dehumidifiers, air filters, whirlpools, Jacuzzi or hot tub devices, or exercise equipment. Expenses incurred for modifications to your home, property, or vehicles.

25. Any maternity-related expenses for Dependent children, beyond initial Pregnancy diagnosis.

26. Salabrasion, chemosurgery or other such skin abrasion procedures associated with the removal of scars, tattoos, actinic changes and/or performed as a treatment for acne.

27. Services and associated expenses related to care or treatment for sexual deviations and disorders, attention deficit and other conduct and impulse disorders with or without hyperactivity (except Prescription Drugs and Physician Visits are not excluded), autism, developmental disabilities, vocational disabilities, dyslexia, learning disorders, and mental retardation or other organic-based disorders.

28. Examinations or testing when such services relate to or are performed: (1) in order to obtain insurance, (2) for travel, marriage or adoption, (3) for judicial or administrative proceedings or orders, (4) for purposes of medical research, or (5) to obtain or maintain a license or official document of any type. Notwithstanding this exclusion, the Plan will provide benefits for ICC, DOT, and FAA physicals pursuant to the Preventive Health Care provision. The Plan will also provide benefits for TB diagnostic screening provided it is not for foreign travel.

29. Mental health and/or substance abuse treatment for any of the following: relationship, family, marriage, custody, adoption, academic or other counseling or treatment. In addition, involuntary commitments, police detentions, court ordered therapy, mental health and/or substance abuse treatments required as a condition of employment and other similar arrangements are not covered unless also Medically Necessary.

30. Any service not specifically listed in this Plan as a Covered Expense, including but not limited to injectibles. All injectibles and specialty prescription medications must be obtained through the Plan's prescription benefit manager's specialty pharmacy.

31. Any service related to treatment of injuries or illnesses caused by the performance of any service or procedure for which no benefits are extended under the Plan, including, but not limited to, exclusions 11, 12, 13, 18, 22, 25, 26, and 27.

32. Naturopathic services or supplies consisting of: (1) herbal supplements, (2) essential oils, (3) over the counter remedies, and (4) any experimental remedies and/or practices.

33. Services and associated expenses for non-emergency orthopedic surgery, except if provided through BridgeHealth or a Preferred Provider.

SECTION 8
PRESCRIPTION DRUG BENEFIT PROVIDED BY THE TRUST FOR ELIGIBLE EMPLOYEES, RETIRED PARTICIPANTS AND DEPENDENTS

The Prescription Drug Benefit program is designed to make your purchase of prescription medication convenient and affordable. The Plan provides a Retail (walk-in) Pharmacy Program with a network of participating pharmacies, and a Mail Order Pharmacy Program for your Prescription Drug needs. The retail and mail order programs are administered by the Pharmaceutical Provider. Your Prescription Drug Benefit is also described in separate brochures that provide detailed information on how to use each program. These brochures are available from the Trust Customer Service Office and the Administrative Office. In case of ambiguity between those brochures and the Plan, the terms of the brochures shall govern.

PLEASE NOTE THAT COVERAGE FOR MEDICARE-ELIGIBLE RETIRED PARTICIPANTS AND THEIR SPOUSES AND DEPENDENTS IS DESCRIBED IN A SEPARATE TEAMSTAR BOOKLET, AND SECTIONS 8.1 THROUGH 8.6 DO NOT APPLY.

8.1 DEFINITIONS

A **"Prescription Drug"** or **"Drug"** means a Medically Necessary take-home medication or article (including insulin, syringes, diabetic testing supplies, glucose monitoring equipment and self-administered injectables) that may be lawfully dispensed as provided under the federal Food, Drug, and Cosmetic Act (FDA), upon the written prescription of a Physician licensed by law to administer it, and dispensed by a licensed pharmacy.

A brand-name Prescription Drug is sold under a trademark name or created by the manufacturer who may hold a patent on the Drug. There is not always a generic version for every brand-name drug. In order to achieve maximum savings to both you and the Plan, the Pharmacy Program includes a special list of brand-name drugs called "Preferred" drugs. These drugs are selected by the Pharmacy Program Manager to be on the list primarily based on drug effectiveness and then cost. The prescription drug benefit requires different copayment amounts for a **"Preferred Brand-Name Drug"** and a **"Non-Preferred Brand-Name Drug."** You may still have your prescription filled with a Non-Preferred Brand-Name Drug; however, your copayment will be significantly higher.

A **generic** Prescription Drug is chemically the same (has the same active ingredients) as the brand-name Drug, and are usually referred to by their common chemical names. Generic Drugs can be produced and sold after the patent has expired on a brand-name Drug. Generic Drugs must meet the same FDA standards as their brand-name counterparts.

A **“copayment”** is the charge you pay for each prescription as part of the cost sharing arrangement with the Plan. You are responsible for the copayment at the time your prescription is filled.

- PARTICIPATING RETAIL PHARMACY (34-Day Supply): At a participating retail pharmacy, your copayment is 20% for a generic Drug, 35% for a preferred brand-name Drug and 50% for a non-preferred brand-name Drug.
- MAIL ORDER PHARMACY: If using the preferred mail order pharmacy program, your copayment for a 90-day supply of maintenance medication is $20 for a generic Drug, $50 for a preferred brand-name Drug and $100 for a non-preferred brand-name Drug.

If you don’t use your prescription drug card or you use a non-participating pharmacy when you could have used a network pharmacy you pay 100%.

Certain Prescription Drugs require review or “prior authorization” before they may be obtained through the Plan’s Prescription Drug Benefit. If your pharmacist tells you that a medication your Physician has prescribed requires prior authorization, ask your pharmacist or Physician to call the Pharmaceutical Provider (see the Quick Reference Table at the front of this booklet).

Important Note: If your dependents have other health coverage that includes prescription drugs benefits, they must use that program if it is their primary coverage. Dependents with primary drug coverage provided through their employer plan or other trust plan **may not use** the Alaska Teamster Employer Welfare Trust Prescription Drug Program described below. In addition, copayments or any out of pocket expenses not paid by the primary plan are not covered by the Trust.

8.2 PARTICIPATING PHARMACY NETWORK

Prescription Drugs received from a participating pharmacy or an approved out-of-network pharmacy are paid at a higher level than those received from a non-participating pharmacy. A participating pharmacy is a retail pharmacy that has contracted to provide Prescription Drugs at a discounted rate to Participants covered under the Plan. You may obtain a current listing of participating pharmacies and approved out-of-network pharmacies from the Trust Customer Service Office.

It is important to present your ID card to the pharmacy. If you use a participating pharmacy and you don’t present your ID card, you will not receive the discounted rate for your Prescription Drug and you must pay 100% of the cost of the medication to the pharmacy. Use your ID card to receive the maximum benefit.

8.3 RETAIL PHARMACY PROGRAM

The Retail Pharmacy program is designed to meet your short-term (a 34-day supply or less) prescription drug needs. When your prescription is filled at a participating pharmacy, you will have to pay only your copayment to the pharmacy. You will not have to file a claim form and wait for reimbursement, as the retail pharmacy will bill the Plan directly for the remainder of the cost of your prescription. If you do not have a list of participating pharmacies (or a list of approved out-of-network pharmacies), contact the Trust Customer Service Office.

After receiving a short-term prescription from your Physician, go to any participating pharmacy and present your pharmacy ID card to the pharmacist who will check your eligibility for coverage from a list supplied by the Plan. You may receive up to a 34-day supply of medication per prescription through the Retail Pharmacy Program. You must have taken at least 75% of your prescription before a refill will be covered by the Plan.

If filled through a participating retail pharmacy, the Plan also covers medications and supplements that are designated as “preventive care” under Health Care Reform and which the Plan is required by law to provide. For a list of the covered medications and supplements, see **www.hhs.gov/healthcare/prevention**. These items

are covered at 100% in-network, but you must have a prescription from your doctor (even for the over-the-counter items). Also, not all items are covered for everybody - for example, there are age restrictions, and some items are limited to generic only. Contact the Pharmaceutical Provider for more information.

8.4 MAIL ORDER PHARMACY PROGRAM

If you need to take maintenance medications on an ongoing basis, you may obtain up to a 90-day supply through the Preferred Participating Mail Order Pharmacy program for direct delivery to your home. Maintenance medications are Drugs prescribed for more than 34 days or taken on a regular or long-term basis. Pre-addressed prescription order forms and envelopes are available from the Trust Customer Service Office, the Administrative Office or the pharmacy benefit manager's website; please refer to the Quick Reference Table in the front of this booklet.

How to Use the Mail Order Pharmacy Program

Ask your doctor to prescribe maintenance medications for up to a 90-day supply, plus refills. Complete the prescription order form and mail it with your prescription to the mail order program using the special pre-addressed envelope. For the protection of each Participant, a "patient health profile" questionnaire must be completed and mailed with the first order. The Mail Order Pharmacy Program will use this health history when reviewing your prescriptions for safety and appropriateness. The Mail Order Pharmacy Program will process your order and send your medications to your home via the U.S. postal service. A new order form and envelope will be returned to you with each prescription delivery.

If you need a prescription immediately, *ask your Physician for 2 prescriptions.* The first prescription should be for up to a 34-day supply and should be taken to a retail participating pharmacy to be filled. The second prescription should be sent to the Mail Order Pharmacy Program in the envelope provided for that purpose.

When your prescription is filled you will receive a notice showing the number of times it may be refilled. It will also show your prescription number. In addition, there will be a pre-addressed reply envelope enclosed. Simply fill out the information on the reverse side of the reply envelope, enclose the refill notice, seal, stamp and mail. Your prescription will be refilled and mailed back to you.

PRESCRIPTION DRUG COPAYMENTS

	Participating Retail Pharmacy* ***(34-Day Supply)***	**Preferred Participating Mail Order Pharmacy**	**Non-Participating Pharmacy****
Generic Drugs	Participant copayment is 20% of the total cost of the Drug.	Participant co-payment is the lesser of 20% of the cost of the drug or $20 for each prescription.	No Reimbursement
Preferred Brand-name Drugs* *Reimbursement Limitations apply, see below**	Participant copayment is 35% of the total cost of the Drug.	Participant co-payment is the lesser of 35% of the cost of the drug or $50 for each prescription.	No Reimbursement
Non-Preferred Brand-name Drugs* *Reimbursement Limitations apply, see below**	Participant copayment is 50% of the total cost of the Drug.	Participant co-payment is the lesser of 50% of the cost of the drug or $100 for each prescription.	No Reimbursement
Specialty Drugs(*) Must be filled by participating Specialty Drug mail order facility	Not applicable.	Participant co-payment is $100 for each Specialty prescription. 30 day supply.	No reimbursement

If filled through a participating retail pharmacy, the Plan also covers medications and supplements that are designated as “preventive care” under Health Care Reform and which the Plan is required by law to provide. For a list of the covered medications and supplements, see www.hhs.gov/healthcare/prevention. These items are covered at 100% in-network, but you must have a prescription from your doctor (even for the over-the-counter items). Also, not all items are covered for everybody - for example, there are age restrictions, and some items are limited to generic only. Contact the Pharmaceutical Provider for more information.

REIMBURSEMENT LIMITATIONS:

If you or your Physician request that your prescription be filled with a brand-name Drug when a generic equivalent is available, you will be responsible for paying the full difference in price between the generic and brand-name Drug *in addition to* your brand-name Prescription Drug copayment. The generic price is established by the Plan's Pharmaceutical Provider.

*****OUT OF NETWORK PRESCRIPTIONS:***

If no network pharmacy is located in the area, the co-payment is 50% of the Drug cost per each prescription filled out-of-network.

Specialty medications are generally used in treating unique disease conditions and are typically injectable or that otherwise require special handling considerations. Members that require these specialty medications may receive express delivery to their home or office from the Pharmacy Program Manager's Mail Order facility and also receive clinical support by pharmacists and other educational material to help maximize treatment success. A list of examples of specialty medications can be obtained by visiting the web site. Specialty medications have a minimum copay of $100 for each 30-day prescription, and a 90-day prescription (with a copay of up to $300) may only be obtained if the participant or beneficiary has been prescribed that specialty medication continuously for at least six months.

8.5 PRESCRIPTION DRUGS THAT ARE NOT COVERED

1. Drugs prescribed for cosmetic purposes only;
2. Drugs available without a prescription, except insulin, diabetic supplies and preventive care items;
3. Pharmaceuticals requiring a prescription that:
    - Have not been approved by the U.S. Food and Drug Administration (FDA); or
    - Are not approved by the FDA for the condition, dose, route and frequency for which they are prescribed (i.e. are used "off-label");
4. Prescription Drugs when there is an equivalent available without a prescription;
5. Nicotine gum, Anorexiants (appetite suppressants) and anti-obesity medications, or Nystatin oral powder;
6. Drugs for treatment of infertility;
7. Medical supplies and equipment where coverage is provided under the Medical Plan Benefit (except syringes and needles for administration of insulin, and other self-administered injectables), and alcohol swabs;
8. Drugs that were not prescribed by a provider acting within the scope of their license;
9. Experimental and/or Investigational or unproven Drugs or therapies, or medications with no FDA indications;
10. Drugs furnished to you by the local, state or federal government and any Drug to the extent payment or benefits are provided from the local, state or federal government, whether or not the payment or benefits are received, except as otherwise provided by law;

11. Prescription vitamins, except prenatal vitamins, vitamins used for indications other than nutritional supplementation, and preventive care items;

12. Any replacement of a Prescription Drug resulting from loss or theft.

8.6 PRESCRIPTION DRUGS THAT ARE LIMITED

1. Progesterone products, including compounded forms.

2. Pharmaceuticals prescribed for treatment of sexual dysfunction that are in excess of the quantity level limits or Utilization Management recommendations established by the Plan's pharmacy benefits manager. Pharmaceuticals prescribed for treatment of sexual dysfunction are available under the Plan's Retail Pharmacy Program ONLY; they are NOT available under the Plan's Mail Order Pharmacy Program.

3. Products for smoking cessation received from a Participating Retail Pharmacy are limited to a 34-day supply. Smoking cessation products received from a Participating Mail Order Pharmacy are limited to a 90-day supply. Smoking cessation products available without a prescription are not covered by the Plan.

SECTION 9
DENTAL CARE BENEFIT FOR ELIGIBLE EMPLOYEES AND THEIR DEPENDENTS

9.1 COVERED DENTAL EXPENSES

An active Participant or dependent of an active Participant may go to any licensed dentist. Covered Dental Expenses are deemed to be incurred on the date dental care is received. Covered Dental Expenses are services that meet all of the following requirements:

1. Services are rendered by a licensed dentist, licensed dental hygienist working under the supervision of a dentist, or Physician, whose charges are Usual, Customary and Reasonable as determined by the Plan.
2. Services demonstrate Dental Necessity for treatment of a Participant's dental condition. "Dental Necessity" means that a service or supply meets all of the following conditions:
   - The treatment is appropriate given the symptoms, and is consistent with the diagnosis. "Appropriate" means that the type, level, length of service, and setting are needed to provide safe and adequate care;
   - It is rendered in accordance with generally accepted practice and professionally recognized standards;
   - It is not treatment that is regarded as Experimental and/or Investigational, educational, or unproven;
   - It is specifically allowed by the licensing statutes which apply to the provider who renders the service; and
   - It is not primarily for the convenience of the Participant, the Participant's dentist, or another provider.
3. Services are not specifically excluded from coverage.

9.2 CALENDAR YEAR DEDUCTIBLE AND MAXIMUM BENEFIT PAYABLE

The deductible is the amount of Covered Dental Expenses which must be incurred during each calendar year before dental care benefits are payable. The deductible for each Participant is the first $75 of Covered Dental Expenses incurred per calendar year. **The deductible does not apply to Orthodontic services as well as diagnostic and preventive services.**

- Dental care benefits (Class I, Class II, and Class III) are limited to a maximum benefit payable of **$2,000** per Participant or beneficiary, for ages 19 and older, during each calendar year. For those eligible who are under age 19, the $2,000 maximum does not apply. Any dental treatment is subject to exclusion from Plan benefits if determined not to satisfy the Plan's UCR and/or dental necessity requirements.
- Orthodontia benefits are available only through age 18 (under the age of 19), and are limited to a lifetime maximum benefit payable of **$1,200** per Dependent child.

9.3 PERCENTAGES PAYABLE

The following percentages are payable for Covered Dental Expenses that are Usual, Customary and Reasonable:

Class I – Diagnostic and Preventive Services:	80%
Class II – Basic Dental Services:	80%
Class III – Major Dental Services:	50%
Orthodontic Services:	50%

9.4 PRE-TREATMENT ESTIMATES

A **"treatment plan"** is a dentist's written report explaining proposed treatment. Whenever you expect that your expenses for a treatment plan will be more than $500, a pre-treatment estimate is recommended. The pre-treatment estimate will tell you the total charges for a treatment plan and what part of those charges will be covered by the Plan. This way, before you begin treatment, you will know how much you will have to pay. Claims not submitted for a pre-treatment estimate are subject to retrospective review by the Plan's dental consultant(s).

For a pre-treatment estimate, send the treatment plan to the Administrative Office.

9.5 COVERED DENTAL SERVICES

Class I – Diagnostic and Preventive Dental Services:

- Oral examination, limited to two during any calendar year, or Emergency examinations as necessary
- Consultations by a dentist or Physician other than the practitioner providing treatment
- Dental x-rays – One complete mouth x-ray or panoramic x-ray during any period of 3 consecutive years. Benefits are limited to one complete mouth x-ray or one panoramic x-ray, but not both
- Supplementary bitewing x-rays, limited to once every calendar year unless special need is shown
- Intraoral periapical x-rays as needed
- One fluoride treatment per calendar year, limited to Dependent children through age 13 (under 14 years of age)
- Prophylaxis (teeth cleaning), up to twice each calendar year
- Topical application of sealants on permanent teeth, limited to once per tooth per lifetime for Dependent children through age 13 (under 14 years of age)
- Space maintainers, limited to Dependent children through age 13 (under 14 years of age)
- Diagnostic cultures, tests and laboratory examinations

Class II – Basic Dental Services: *(subject to the calendar year deductible)*

- Restorations (amalgam, silicate, acrylic, synthetic porcelain and composite filling restoration [for anterior teeth only] for decayed or broken teeth)
- Composite filling restoration for posterior teeth are covered at the Usual, Customary, and Reasonable charge for amalgam filling restoration
- Endodontic treatment (root canal therapy, pulp capping)
- Treatment of periodontal disease (maintenance procedures such as scaling and root planning following periodontal surgical services) *Note: This benefit is limited to one treatment within any three-month period.*
- Extractions and other oral surgical procedures
- General anesthesia as necessary for endodontic, periodontics, and oral surgical procedures
- Stainless steel crowns, limited to Dependent children through age 13 (under 14 years of age)
- Temporary crowns only in the case of emergency for a fractured tooth
- Repair to existing prosthetic appliances, limited to once per calendar year
- Reline or rebase of partial or complete dentures, limited to once per calendar year beginning six months after delivery of a new denture

Class III – Major Dental Services: (subject to the calendar year deductible)

- Inlay/Onlay restorations. Replacement is not covered within 5 years of initial restoration.
- Crowns, including build-up, post and core. Replacement is not covered within 5 years of initial crown -placement.
- Complete or partial dentures, to include the six-month post-delivery care. Replacement is not covered within 5 years of initial denture placement. If the Trust provides benefits for placement of temporary dentures, the benefit otherwise payable for permanent dentures placed within 5 years of the placement of the temporary dentures will be reduced by any benefits paid for the temporary dentures.
- Fixed prosthodontics (bridgework). Replacement is not covered within 5 years of initial placement of bridge-work.
- Occlusal adjustments and night guard's replacement every two years.

For Class III Dental Services, benefits are paid on the preparation date, not the seat date.

Orthodontic Services: (the deductible is waived for Orthodontic services)

The Orthodontia Benefit is available only through age 18 (under the age of 19). Benefits are payable at 50%, limited to a lifetime maximum benefit payable of **$1,200** per covered individual.

The Orthodontia Benefit provides coverage for non-surgical services to correct malocclusion (alignment of the teeth and/or jaws) that significantly interferes with their function. Necessary services related to an active course of Orthodontia treatment include diagnosis, initial installation of orthodontic appliances and adjustment of the appliances. Repair or replacement of Orthodontic appliances are not covered.

Benefits for Orthodontic services will cease as of the last day of the month:

- In which treatment ceases for any reason, or
- In which eligibility for coverage terminates, whether or not the course of treatment has been completed.

9.6 ALTERNATE BENEFIT PROVISION

In many cases, there is more than one method of satisfactory treatment or material that may be utilized to correct a dental condition. Under the provisions of this Plan, Covered Dental Expenses are limited to those services or supplies which are customarily employed in dental treatment, and which are recognized by the dental profession to be appropriate according to broadly accepted national standards of practice. The Plan takes into account the overall dental condition of the Participant.

You may choose a more costly custom or precision dental procedure. However, if you do, you will be responsible for paying the difference between the charges for the more elaborate procedure and the Dental Care Benefit paid by the Plan. **All treatment decisions rest with you and your dentist.**

Some examples of how the Alternate Benefit Provision may be applied:

- If a tooth can be satisfactorily restored with a resin, amalgam, or silicate filling, this is the covered expense. You may apply this covered expense toward a more elaborate or precision restoration that you and your dentist choose.
- If a standard partial denture will satisfactorily restore a case, the Plan permits you to apply the covered expense for that procedure toward a more complicated custom or precision case that you and your dentist may choose.
- Implants are held to the allowable "partial bridge" coverage.

9.7 EXCLUSIONS AND LIMITATIONS

In addition to non-covered services outlined under the Exclusions and General Limitations section of this Booklet, this Plan will not extend any Dental Care Benefit for:

1. Services that are eligible under any other Benefit provided by this Trust;
2. Services for which no charge would have been made in the absence of this coverage;
3. Any portion of charges that are determined by the Plan to exceed Usual, Customary and Reasonable charges;
4. Services excluded under the General Exclusions, see Section 7.
5. Services incurred prior to a Participant's date of eligibility; any Prosthetic devices or crowns (and the fitting thereof) which were ordered before the Participant became eligible;
6. Services incurred after a Participant's eligibility for coverage terminates (including treatment for conditions arising prior to the termination of coverage);
7. Any otherwise eligible expense that exceeds the annual maximum benefit for Dental Care Benefits or the lifetime maximum benefit for Orthodontic care;
8. Replacement of a misplaced, lost or stolen Prosthodontic device (bridgework, complete or partial denture); duplicate or spare dentures;

9. Repair or replacement of a lost or broken Orthodontic appliance; any Orthodontic services provided on or after the individual's 19th birthday;

10. Services, appliances, or restorations necessary to alter vertical dimension or restore the occlusion; or ridge augmentation to maintain occlusion;

11. Services (other than for replacement of structure loss from caries) to replace or stabilize tooth structure lost by attrition/erosion or abrasion;

12. Services for the personalization or characterization of a Prosthetic device or restoration;

13. Charges made for completion of forms, duplication of dental records, or charges made for cancelled, failed or broken appointments;

14. Charges made for analgesia, sedation, hypnosis and/or related services provided for apprehension or anxiety, unless pre-approved by the Plan;

15. Replacement of any existing Prosthodontic device (bridgework, complete or partial denture), crown, or inlay/onlay more often than once during any five-year period, and then only if the existing device, crown, or inlay/onlay is unserviceable. The five-year period is measured from the date that appliances were last installed;

16. Special programs including oral hygiene and dietary instructions; or charges for infection control procedures;

17. Services for the diagnosis or treatment of temporomandibular joint (TMJ) dysfunction, and any other craniomandibular disorder or other conditions of the joint linking the jawbone and skull, including ridge augmentation;

18. Orthognathic surgical procedures or services in connection with orthognathic surgery;

19. Charges made for sealants or topical application of fluoride, except as Class I – Diagnostic and Preventive Dental Services payable for Dependent children.

These exclusions shall not be interpreted to violate 26 U.S. Code Section 9802, 29 U.S. Code Section 1182, or 42 U.S. Code Section 300gg-2, but only if those Sections apply.

SECTION 10
VISION CARE BENEFIT PROVIDED BY THE TRUST FOR ELIGIBLE EMPLOYEES AND THEIR ELIGIBLE DEPENDENTS

The Vision Care Benefit is available to Eligible Employees and their Dependents. It is not available to Retired Participants or their Dependents.

The Vision Care Benefit is described in detail in a separate brochure. For a copy of this brochure, call the Trust Customer Service Office.

The Review Procedure beginning at Section 15.16 applies to vision benefits.

SECTION 11
TIME LOSS BENEFIT PROVIDED BY THE TRUST FOR ELIGIBLE EMPLOYEES

The Time Loss Benefit is only available to Eligible Employees. Retired Participants and Dependents are not eligible for the Time Loss Benefit.

Time Loss Benefits provide coverage to help protect an Eligible Employee against loss of income if the Employee is Totally Disabled because of an Illness or Injury. **Time Loss Benefits are payable up to $100 per week for each week of Total Disability; up to a maximum of 26 weeks.** For partial weeks, the benefit amount for each day is determined by dividing the weekly benefit by seven.

"Total Disability" or **"Totally Disabled"** means that as a result of an Injury or Illness, an Eligible Employee is absent from work and unable to engage in the duties of his/her customary occupation, and is performing no work of any kind for wage or profit.

Time Loss Benefits begin:

- with the first day of a Total Disability resulting from an Injury; or
- with the eighth day of Total Disability resulting from an Illness.

To qualify for Time Loss Benefits, an Active Participant must be regularly seen, treated, and certified Totally Disabled by a Physician. *Time Loss Benefits are subject to federal taxation, including FICA.*

Successive Periods of Total Disability

Time Loss Benefits will continue for up to a maximum of 26 weeks as long as an Eligible Employee remains Totally Disabled. A new period of disability will begin if:

- an Eligible Employee returns to full-time work for at least 30 calendar days, then becomes Totally Disabled again from the **same cause**; or
- an Eligible Employee returns to full-time work for at least one day, then becomes Totally Disabled again from a **different cause**.

Termination of Eligibility

If eligibility terminates after Total Disability is established and benefits are determined payable, benefits will continue until: (1) the Participant is no longer Totally Disabled, or (2) the maximum benefit has been paid.

EXCLUSIONS No Time Loss Benefit will be extended for any disabilities that are:

- related to any condition for which coverage is available, if proper claim were made, by Workers' Compensation, occupational disease or injury law or similar legislation. The Plan covers no expenses for any condition arising out of or received or aggravated in the course of engaging in any activity for wage or profit;
- caused by war or any act of war (declared or undeclared); as a result of participation in a riot; or
- resulting from the commission of a crime; or
- as a result of attempted suicide or intentionally self-inflicted Injury, while sane or insane.

SECTION 12
LIFE INSURANCE AND ACCIDENTAL DEATH & DISMEMBERMENT BENEFITS

Life Insurance and Accidental Death & Dismemberment Benefits are insured by the Plan's Life Insurance Provider, except for life insurance benefits for Retired Participants which are provided directly by the Trust. Insured benefits are also subject to insurance policy limitations, which are on file in the Trust Customer Service Office. In the event of any ambiguity or difference between that policy and this Summary Plan Description, the policy shall control.

12.1 LIFE INSURANCE BENEFICIARY DESIGNATION

Your beneficiary may be any person or persons you name on your beneficiary designation form, and you may change your beneficiary designation at any time by submitting a new beneficiary designation form (the consent of a beneficiary is not required). If you designate more than one beneficiary, benefits will be paid equally to your beneficiaries unless you specify otherwise in your beneficiary designation. The share of a beneficiary who does not live to receive payment will pass equally to those remaining beneficiaries who survive you unless you specify otherwise in your beneficiary designation. Your beneficiary will be the person(s) named in your most recent beneficiary designation on file with the Trust Customer Service Office. However, if your spouse is named as a beneficiary and you are subsequently divorced from that spouse, the beneficiary designation of that former spouse will be considered void. Following a divorce, you may re-designate a former spouse as the beneficiary by providing a new designation form.

If you fail to name a beneficiary or if no beneficiary lives to receive payment, benefits will be paid to the surviving person(s) in the first of the following classes: your

1. surviving legal spouse;
2. surviving children, naturally born or legally adopted, in equal shares;
3. surviving parents, in equal shares;
4. surviving brothers and sisters, in equal shares; or
5. estate

To obtain life insurance benefits, your survivor(s) or designated beneficiary or beneficiaries, as appropriate, must submit a certified death certificate.

12.2 REVIEW OF LIFE INSURANCE AND ACCIDENTAL DEATH & DISMEMBERMENT CLAIMS

The Review Procedure beginning at Section 15.16 applies to Life Insurance and Accidental Death & Dismemberment benefits.

SECTION 13
VACATION PLAN BENEFIT

The Vacation Plan provides cash payments to Eligible Employees whose Collective Bargaining Agreement or Written Agreement requires contributions for Vacation Benefits. These benefits are automatically paid out 4 times each year in lieu of holidays and vacation.

Eligibility for Vacation Benefits

If you are working for an Employer covered by a Collective Bargaining Agreement or Written Agreement that requires contributions for Vacation Benefits, then you are eligible for Vacation Benefits. Vacation Benefits are payable so long as the Welfare Trust holds Vacation Plan funds contributed on your behalf.

If you die before receiving all Vacation Plan funds held for you, then the remaining funds will be paid to your first survivor according to the following list:

- your spouse
- your estate

When Benefits are Payable

Benefits are automatically sent to your address on file with the Plan, as of the beginning of each quarter, February 1, May 1, August 1, and November 1. There may be a delay of up to 10 business days from the time the Welfare Trust receives a contribution to when it credits the contribution to you.

Benefit Amount

The amount you will receive is exactly equal to the amount that your Employer contributes to the Welfare Trust for you. Please note that before depositing Vacation Plan funds with the Welfare Trust; your Employer must pay your employment and income withholding taxes. Only those amounts actually contributed to the Welfare Trust by your Employer and credited to you are included in the benefits paid each quarter. Any investment earnings will be used to pay for administrative expenses involved in maintaining the Plan.

Election to Direct Vacation Plan Contributions to Make Self-Payments for Health Coverage

You may elect, on a prospective basis on a form approved by the Administrative Office, to have monthly contributions paid on your behalf for this Vacation Plan Benefit paid instead as monthly self-payments for your continued health plan coverage under Section 1. Any such payments that are in excess of the amount needed to continue your coverage in a month will be retained in your Self-Payment Account (unless you have reached the maximum Self-Payment Account limit, in which case such funds will be retained instead as part of this Vacation Plan Benefit). Vacation Plan contributions paid as self-payments, or remitted to your Self-Payment Account, do not count toward your benefit amount for Vacation Plan benefits.

An election to direct contributions for this Vacation Plan Benefit to be paid as self-payments under Section 1 can be terminated at any time, on a prospective basis, on a form approved by the Administrative Office.

SECTION 14
CONTINUING COVERAGE

14.1 COVERAGE IN THE EVENT OF A STRIKE, LOCKOUT OR LABOR DISPUTE

If an Eligible Employee is not working due to a strike, lockout or labor dispute, the Employee may continue eligibility by using credit from his/her Dollars Bank account. Such an Eligible Employee may also be eligible to continue eligibility under COBRA provisions explained in the *COBRA Continuation Coverage* section of this Booklet.

14.2 COBRA CONTINUATION COVERAGE

Under the Consolidated Omnibus Budget Reconciliation Act (known as COBRA), a Participant may continue the Plan's health benefits past the date coverage would normally end under certain circumstances called "Qualifying Events." In order to receive COBRA, a Participant must file a timely application following the Qualifying Event and make monthly self-payments directly to the Administrative Office. This summarizes Participants' COBRA rights and obligations.

14.3 QUALIFIED BENEFICIARY

A Participant continuing coverage under COBRA is known as a "Qualified Beneficiary." A Qualified Beneficiary is defined as any Participant who on the day before a Qualifying Event was covered under this Plan by virtue of being on that day either an Eligible Employee, a Retired Participant, the Spouse of an Eligible Employee or Retired Participant, or a Dependent child of an Eligible Employee or Retired Participant.

If during the period of COBRA coverage you have a newborn child or have a child placed with you for adoption, that Dependent Child may be enrolled for coverage for the balance of the period of COBRA coverage on the same terms available to Qualified Beneficiaries. You must notify the Administrative Office and enroll the child no later than 30 days after the birth or placement for adoption. A child born or placed for adoption while you are on COBRA coverage will have all the same COBRA rights as your Dependents who were covered by the Plan before the Qualifying Event that resulted in your loss of coverage.

14.4 QUALIFYING EVENTS

If eligibility for health benefits terminates due to either of the Qualifying Events shown below, an Eligible Employee and his or her Dependents may elect COBRA for a maximum of **18 months** following the date your coverage is lost:

- Your layoff or reduction in work hours (including reduction due to strike, lockout, or labor dispute); or
- Termination of your employment for any reason other than gross misconduct.

If Social Security determines that you or one of your eligible Dependents are totally disabled at any time before or during the first 60 days of COBRA coverage, the disabled person and family may extend COBRA coverage an additional 11 months beyond the original 18, to a maximum of 29 months (or if earlier, the first of the month that is 30 days after Social Security determines the individual is no longer disabled.) In order to qualify for this disability COBRA extension, you must report the Social Security disability determination to the Administrative Office before the initial 18 months of COBRA expires and within 60 days after the date of the Social Security determination.

The Spouse and eligible Dependent children of an Eligible Employee or Retired Participant may elect COBRA for a maximum of **36 months** from the date of loss of coverage due to any of the following Qualifying Events:

- Death of the Eligible Employee or Retired Participant;
- Divorce from the Eligible Employee or Retired Participant;
- Dependent child ceases to meet the Plan's definition of "Dependent."

In most circumstances, withdrawal of your Employer from the Plan is not a Qualifying Event.

Second Qualifying Event

If a second Qualifying Event occurs during the first 18 months of COBRA coverage, COBRA may be extended for Dependent Qualified Beneficiaries for up to 36 months from the date of loss of coverage due to the first Qualifying Event. The first Qualifying Event must be, and the second Qualifying Event cannot be, termination of employment or reduction in hours.

If an Eligible Employee experiences a Qualifying Event because of a termination of employment or reduction in hours after they became entitled to Medicare, their Dependents will be allowed to continue COBRA coverage until the later of:

- 18 months from the date of loss of coverage due to the Qualifying Event, or
- 36 months from the date the Eligible Employee became entitled to Medicare.

14.5 HOW TO ELECT COBRA CONTINUATION COVERAGE

In order to preserve your rights under COBRA, you must meet certain notification, election and payment deadline requirements.

Once the Administrative Office is notified of a Qualifying Event, it will send you information concerning your continuation options, including the necessary COBRA election forms. It is your responsibility to inform the Administrative Office of a death, divorce or of a child losing eligible Dependent status under the Plan. **If the Administrative Office is not notified within 60 days of a death or divorce or of a child losing eligible Dependent status, you and your Dependents will lose the right to elect COBRA. You must elect COBRA to be effective the day following your last day of regular coverage under the Plan. So there can be no gap in Plan coverage.**

You will have 60 days from the later of the date of the loss of coverage due to the Qualifying Event or the date the COBRA notice was mailed to you in which to send your COBRA election to the Administrative Office. You or your Spouse may make the election for all Qualified Beneficiaries in your family. If you do not make your election within this 60-day period, you will forfeit all rights to COBRA.

Your Dependents will be given the opportunity to elect coverage independently from you, **within this same 60-day period**, if they were covered under the Plan at the time of the Qualifying Event. Qualified Beneficiaries may elect COBRA even if they are covered by another group health plan or Medicare at the time of the Qualifying Event.

THE ADMINISTRATIVE OFFICE WILL NOTIFY YOU OF THE COST OF COBRA WHEN IT NOTIFIES YOU OF YOUR RIGHT TO THIS COVERAGE. TO REINSTATE YOUR PLAN COVERAGE, YOU MUST SUBMIT YOUR FIRST PAYMENT WITHIN 45 DAYS OF THE DATE YOU MAIL YOUR ELECTION FORM TO THE ADMINISTRATIVE OFFICE, OR YOUR PLAN COVERAGE WILL REMAIN CANCELLED. IF YOU WAIT UNTIL THE END OF THE ELECTION PERIOD, PAYMENT FOR THE FIRST OF EACH MONTH PASSED SINCE THE DATE COVERAGE TERMINATED MUST BE INCLUDED WITH THE FIRST PAYMENT. THE ADMINISTRATIVE OFFICE MUST RECEIVE YOUR CHECK OR MONEY ORDER ON OR BEFORE THE FIRST DAY OF EACH MONTH FOR WHICH COVERAGE IS ELECTED. YOU HAVE A 30-DAY GRACE PERIOD TO SEND IN YOUR COBRA PAYMENT FROM THIS DUE DATE.

14.6 TYPE OF BENEFITS

The Life Insurance Benefit, Accidental Death and Dismemberment (AD&D) Benefit, Time Loss Benefits and Vacation Benefit cannot be continued under COBRA Continuation Coverage.

All Participants electing COBRA continuation shall have coverage under the Medical Plan and the Prescription Drug Plan. Coverage under the Vision Plan and/or the Dental Plan is extended to Participants who were enrolled in these benefits at the time of a Qualifying Event.

If the coverage provided by the Plan is changed in any respect for Participants, those changes will apply at the same time and in the same manner for everyone whose coverage is continued under COBRA.

14.7 TERMINATION OF COBRA CONTINUATION COVERAGE

Coverage under COBRA will terminate **earlier than the stated maximum continuation period** under any one of the following circumstances:

- Failure to make the monthly payment on time (you will be allowed a 30-day grace period after the premium due date);
- The date the Qualified Beneficiary becomes, after the date of his or her election, covered under any other group health plan that does not contain any exclusion or limitation for a pre-existing condition of that Qualified Beneficiary;
- The date the Qualified Beneficiary becomes, after the date of his or her election, entitled to Medicare benefits;
- The first of the month that is 30 days after the date of a determination by Social Security that an individual on extended disability coverage is no longer disabled. This applies only to the 19th through 29th month of disability extended coverage;
- The date the Trust no longer provides group health coverage;
- The date your former Employer stops maintaining the Plan and starts maintaining another group health plan for Employees.

14.8 COBRA QUICK REFERENCE CHART

The following chart summarizes the circumstances under which health benefits can be continued, and the maximum duration of COBRA:

Qualifying Event	Qualified Beneficiary	Maximum Continuation Period
(1) Loss of benefits caused by reduction in Eligible Employee's hours	Employee and Dependents	18 months after loss of benefits*
(2) Loss of benefits caused by termination of Eligible Employee's employment except for gross misconduct	Employee and Dependents	18 months after loss of benefits*
(3) Loss of benefits caused by death of Eligible Employee or Retired Participant	Dependents	36 months after Qualifying Event
(4) Loss of benefits caused by divorce of Eligible Employee or Retired Participant	Dependents	36 months after Qualifying Event
(5) Loss of benefits caused by child losing dependent child status under Plan	Dependent child	36 months after Qualifying Event
(6) Entitlement to Medicare within 18 months before a Qualifying Event described in (1) or (2).	Dependents	Later of: (1) 36 mo. from Medicare entitlement, or (2) 18 months from date of loss of coverage due to original Qualifying Event

* If a Qualified Beneficiary is disabled at any time before or during the first 60 days of COBRA coverage, COBRA coverage may continue for up to 29 months.

If a second Qualifying Event occurs within 18 months of a Qualifying Event described in (1) or (2), COBRA coverage may be extended for up to a maximum of 36 months from the date of the first Qualifying Event.

If there is any conflict between these provisions and COBRA, the minimum requirements of COBRA shall govern.

SECTION 15
PAYMENT OF CLAIMS

15.1 ENROLLMENT PROCEDURE

It is important that the Trust Customer Service Office has a completed enrollment form for all Participants in its files. It is necessary that Active Employees, COBRA beneficiaries and Retired Participants complete an enrollment form before any claims can be processed. Retired Participants who are Medicare Eligible must complete such enrollment forms as required by TEAMStar in addition to any forms required by the Trust to enroll. If a Participant has not completed an enrollment form or if an additional enrollment form is needed, the Participant may obtain one from the Trust Customer Service Office. **The enrollment form is the means by which Active Employees, Retired Participants, and COBRA beneficiaries designate Dependents, as well as the beneficiary of Life Insurance and Accidental Death & Dismemberment benefits.**

It is important that you notify the Trust Customer Service Office as soon as possible if:

1. You change your home address.
2. You wish to change your beneficiary.
3. There is any change in your family status, *i.e.*, marriage, birth of a child, adoption, death, divorce, etc. If you do not provide timely notice of these events you and/or your family's rights to Plan coverage, benefits, and/or benefit options may be lost.

Active Employees, COBRA beneficiaries, and Retired Participants must also submit a marriage certificate in order to enroll a spouse. Additional documentation, such as a birth certificate, will be required to enroll other Dependents. The Trust Customer Service Office can provide the appropriate form needed to enroll new eligible family members or to remove those no longer eligible.

IMPORTANT: Active Employees, Retired Participants, and COBRA beneficiaries are held liable for benefit payments based on any incorrect information about family members, such as failing to notify the Trust Customer Service Office in case of divorce, if a child is no longer a Dependent, or if an adoption is rescinded. In addition, the person failing to provide the required information is liable for other costs incurred by the Plan as a result of the incorrect information. These costs include, but are not limited to, attorney's fees, administrative costs, and reasonable interest. See the complete Subrogation and Reimbursement Procedure, below.

15.2 SUBROGATION AND REIMBURSEMENT

The Plan and the Welfare Trust have the right to pursue a Participant's legal claims or rights against another party, or any insurance company, when Plan benefits are or will be paid or provided to the Participant and the condition for which the benefits are paid either was caused by another party or is covered by insurance or workers' compensation.

This would occur, for example, if a Participant is injured in an accident that is caused by another party. If the Plan covers benefits for the treatment of the Participant's injuries arising from the accident, the Plan and the Welfare Trust have the right to pursue the Participant's legal claims against the other party and any insurance company, including the Participant's. By accepting Plan benefits the Participant subrogates the Plan to all of the Participant's rights against any other party or under any insurance coverage or workers' compensation with respect to a condition for which the Plan provided benefits.

In addition, by accepting Plan benefits the Participant agrees that if he or she recovers damages, (including fees and costs) or insurance proceeds by settlement, verdict or otherwise for a condition, the Plan and the Welfare Trust have the right to be reimbursed by the Participant, his legal representatives, estate, heirs, guardian, and

dependents, the value of any benefits paid or to be paid or provided by the Plan and/or Welfare Trust in relation to such condition. These rights of reimbursement apply whether or not such payment is for covered Plan benefits, and disregarding equitable, state and common law doctrines such as unjust enrichment, common fund and the make-whole doctrine.

The following are:

- **the Plan and Welfare Trust's rules regarding its rights to pursue claims of Participants and to receive reimbursement; and**
- **the obligations of Participants who accept benefits for the treatment of conditions that are caused by other parties.**

Subrogation applies whenever: (1) another person, entity, workers' compensation program, or insurance carrier is or may be considered liable for damage or to pay proceeds or benefits with respect to a Participant's condition; and (2) the Plan has provided or paid or is responsible in the future to provide or pay for benefits or medical services in relation to such condition. By accepting benefits under the Plan, the Participant agrees that, to the extent of the value of any such benefits or medical services paid or to be provided by the Plan, the Plan is subrogated to all rights against any party or insurance company who: (1) is or may be liable for the Participant's condition or is or may have an obligation to pay insurance proceeds or workers' compensation in relation to the Participant's condition; or (2) is or may be liable or have an obligation for payment for medical treatment of such condition.

By accepting benefits under the Plan:

- The Participant agrees that the Plan and Welfare Trust may assert the Plan's subrogation rights independently of the Participant, his or her legal representatives, estate, heirs, dependents, or guardian ("related parties").
- The Participant and related parties agree, and are obligated to cooperate with the Plan and its agents in order to pursue and protect the Plan's and Welfare Trust's subrogation rights. Among other things, the Participant and related parties shall provide the Plan or its agents any relevant information requested by them and shall sign and deliver any documents the Plan or its agent's request.
- The Participant and related parties agree that the Plan's and Welfare Trust's rights of subrogation shall be considered as a first priority claim and lien against any other person or entity to be paid before any other claims are paid from any fund or recovery related to a condition, including claims by the Participant for general damages.
- The Participant and related parties agree that he or she will not release any party from liability for the payment of medical expenses without first obtaining the written consent of the Plan or its agents.
- The Participant and related parties agree that, if he or she enters into litigation or settlement negotiations regarding obligations of or claims against other parties, he or she will notify the Plan or its agents and will not prejudice, in any way, the Plan's subrogation rights.
- The Participant and related parties agree that the Plan or its agents may take any lawful action to pursue and protect the Plan's subrogation rights.
- The Participant and related parties agree that the cost of legal representation of the Plan in matters related to subrogation shall be borne solely by the Plan and that the cost of legal representation of the Participant shall be borne solely by the Participant, subject to the Procedures and Guidelines Regarding Subrogation/Reimbursement, available from the Trust Customer Service Office.

By accepting benefits for a minor, a guardian or Participant consents to these terms on behalf of the minor whether or not the minor is a Participant. These subrogation terms apply equally to all Participants.

Reimbursement applies whenever: (1) a Participant recovers damages or insurance proceeds by settlement, verdict or otherwise for or in relation to a condition; and (2) the Plan and/or Welfare Trust has paid or provided or is responsible in the future to pay or provide benefits in relation to such condition. Reimbursement also applies if a Participant has paid an improper self-payment amount, or the Plan has overpaid benefits.

By accepting benefits under the Plan:

- The Participant and related parties agree, on behalf of himself or herself that the Plan and/or Welfare Trust shall be reimbursed promptly by the Participant and or related parties, from any settlement, verdict, insurance and workers' compensation proceeds or other recovery, the value of the benefits paid or provided by the Plan or for which the Plan is responsible in the future to pay or provide to or on behalf of the Participant and related parties in connection to such condition.
- The Participant and related parties agree that the Plan or Welfare Trust, at their option, may collect amounts from the proceeds of any settlement, verdict, judgment, insurance and workers' compensation coverage or other recovery by the Participant or related parties, regardless of whether or not the Participant and such related parties have been fully compensated.
- The Plan has a first priority lien, to the extent of the Plan and/or Welfare Trust's claim for reimbursement against the proceeds of any such settlement, verdict, insurance and workers' compensation proceeds or other recoveries or amounts received by or on behalf of the Participant or such legal representatives, and other related parties.
- The Participant and related parties assign to the Plan and Welfare Trust any benefits the Participant and related parties may have or be entitled to under any automobile policy or any other coverage, to the extent of the Plan's claim for reimbursement.
- The Participant and related parties agree to sign and deliver, at the request of the Plan or its agents, any documents that are needed to protect such lien or effect such assignment of benefits.
- The Participant and related parties agree to cooperate with the Plan and its agents; to sign and deliver such documents as the Plan or its agents request; to provide any requested information; and to take such actions as the Plan or its agents request, all to protect the right of reimbursement of the Plan and/or Welfare Trust and to assist the Plan and/or Welfare Trust in making a full recovery of the value of the benefits paid or provided or for which the Plan is liable in the future to pay or provide.
- The Participant and related parties agree to take no action that would prejudice the Plan's and/or Welfare Trust's rights of reimbursement.
- The Participant and related parties agree that the Plan and Welfare Trust shall be responsible only for those legal fees and expenses to which they agree in writing.
- The Participant and related parties agree to hold any proceeds of any settlement, verdict, judgment, insurance coverage or other recovery in trust for the benefit of the Plan and Welfare Trust and that the Plan and Welfare Trust shall be entitled to recover from the Participant reasonable attorney's fees incurred in collecting such proceeds from the Participant.
- By accepting benefits for a minor, a guardian, or Participant consents to these terms on behalf of the minor whether or not the minor is a Participant. The reimbursement terms apply equally to all Participants.

- If the Plan and Welfare Trust's right to reimbursement exceeds 1/3 of the total recovery, including any and all attorney's fees and expenses payments, the Trustees may, in their sole and exclusive discretion, compromise the Plan's and Welfare Trust's right to reimbursement. Such compromise shall be considered on a case–by–case basis subject to any policies adopted by the Trustees.
- All amounts recovered by the Participant or any individual in the Participant's family or who is a dependent of the Participant in connection with the condition of the Participant shall be regarded as a recovery by the Participant, regardless of how the recovery is characterized. Likewise, the characterization by the parties or the Court of the amounts paid to the Participant shall not be binding on the Plan or Welfare Trust.
- If the Plan has overpaid benefits or the Participant has paid an improper self-payment amount, the Plan is entitled to recover overpaid amounts from Participants, persons or organizations to whom such amount was paid, or others whose acts caused amounts to be overpaid. The right of recovery includes costs and attorney's fees.

15.3 COORDINATION OF BENEFITS (COB) AND DUPLICATE COVERAGE

How Duplicate Coverage Occurs

This section describes the circumstances when a Participant or Dependent may be entitled to benefits under this Plan and may also be entitled to recover all or part of their expenses from some other source. This section also describes the rules that apply when this happens, commonly referred to as "Coordination of Benefits." All references to "Participants" regarding the Plan's "Coordination of Benefits" refer equally to all persons covered by the Plan including Dependents.

There are several circumstances that may result in a Participant being reimbursed for expenses not only from this plan but also from another source. This can occur if, for example:

1. A Participant is also covered by another group health care plan, or any group or individual insurance policy; or
2. Both husband and wife or parent and child are covered under Alaska Teamster-Employer Welfare Trust; or
3. A Participant is also covered by Medicare or some other government program, such as Medicaid, TRICARE, or a program of the U.S. Department of Veterans Affairs, coverage provided by a federal, state or local governmental agency, or coverage required by federal, state or local laws, such as (but not limited to) motor vehicle no-fault coverage for medical expenses or loss of earnings that is required by law; or
4. A third party is responsible for the condition that occasioned medical need under any group or other insurance policy or arrangement. In this instance, refer also to the Subrogation and Reimbursement section of this Booklet for further information.

15.4 WHEN AND HOW COORDINATION OF BENEFITS (COB) APPLIES

For the purposes of Coordination of Benefits, the word "plan" refers to any group or nongroup health care policy, HMO, contract or plan, whether insured or self-insured, that provides benefits payable on account of expenses incurred by the Participant or that provides services to the Participant.

Many families that have more than one family member working are covered by more than one health care plan.

Advise the Administrative Office if you have other insurance. If you don't notify the Administrative Office of other insurance, they will be unable to coordinate benefits; this could result in loss of benefits or an

overpayment on your claim that you must repay to the Trust. If the other coverage terminates, please notify the Administrative Office and provide them with the date of termination.

Coordination of Benefits generally operates so that one of the plans (called the primary plan) will pay its benefits first, without considering whether the other plan may cover some expenses. The other plan, (called the secondary plan) may then pay additional benefits. In no event will the combined benefits of the primary and secondary plans exceed 100% of the allowable Expenses incurred. Sometimes, the combined benefits that are paid will be less than total allowable Expenses.

Which Plan Pays First – Order of Benefit Determination Rules

Group plans determine the sequence in which they pay benefits, or which plan pays first, by applying uniform "order of benefit determination" rules in a specific sequence. This Plan uses the order of benefit determination rules established by the National Association of Insurance Commissioners (NAIC) and which are commonly used by insured and self-insured plans.

Any group plan that does not use these same rules always pays its benefits first. If the first rule does not establish a sequence or order of benefits, the next rule is applied, and so on, until an order of benefits is established. The rules are:

Rule 1: Employee/Dependent

The plan that covers a person as an employee, member or subscriber (that is, other than as a dependent) pays first (is the "primary plan"). The plan that covers that same person as a dependent pays second (is the "secondary plan").

Rule 2: Dependent Child Covered Under More Than One Plan

The plan that covers the parent whose Birthday falls earlier in the calendar year pays first; and the plan that covers the parent whose Birthday falls later in the calendar year pays second, if:

- the parents are married or are living together; or
- a court decree awards joint custody without specifying that one parent has the responsibility to provide health care coverage for the child or states that both parents are jointly responsible to provide coverage.

If the above "Birthday Rule" applies and both parents have the same Birthday, the plan that has covered one of the parents for a longer period of time pays first, and the other plan pays second.

If the specific terms of a court decree state that one parent is responsible for the child's health care expenses or health care coverage, and the plan of that parent has actual knowledge of the terms of that court decree, that plan pays first. If the parent with financial responsibility has no coverage for the child's health care services or expenses, but that parent's current spouse does, the plan of the spouse of the parent with financial responsibility pays first.

If the parents are not married or are separated (whether or not they ever were married), or are divorced, and there is no court decree allocating responsibility for the child's health care services or expenses, the order of benefits is:

- The plan of the custodial parent pays first;
- The plan of the spouse of the custodial parent pays second;

- The plan of the non-custodial parent pays third; and then
- The plan of the spouse of the non-custodial parent pays last.

The word "Birthday" refers only to the month and day in a calendar year; not the year in which the person was born.

For a dependent child covered under more than one plan of individuals who are not the parents of the child, the order of benefits should be determined above as if the individuals were the parents.

The term "custodial parent" refers to the parent awarded custody by a court decree or, in the absence of a court decree, the parent with who the child resides more than one-half of the time, excluding any temporary visitation.

Rule 3: Active/Laid-Off or Retired Employee. *This rule applies only when the two plans cover the same individual as the employee (for example, when a person who has coverage as a laid-off or retired employee also has coverage as an active employee of a new employer).*

The plan that covers either as an active employee (that is, an employee who is neither laid-off nor retired), or as that active employee's dependent, pays first; and the plan that covers the same person as a laid-off or retired employee, or as that laid-off or retired employee's dependent, pays second.

If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.

This rule does not apply if Rule 1 above applies.

Rule 4: Continuation Coverage. *This rule applies when an individual is covered under COBRA (or continuation coverage under the state equivalent of COBRA if COBRA does not apply) under one plan and as an active employee under another.*

If a person whose coverage is provided under a right of continuation under federal or state law is also covered under another plan, the plan that covers the person as an employee, retiree, member or subscriber (or as that person's dependent) pays first, and the plan providing continuation coverage to that same person pays second.

If the other plan does not have this rule, and if, as a result the plans do not agree on the order of benefits, this rule is ignored.

This rule does not apply if Rule 1 above applies.

Rule 5: Longer/Shorter Length of Coverage

If none of the four previous rules determines the order of benefits, the plan that covered the person for the longer period of time pays first; and the plan that covered the person for the shorter period of time pays second. In the case of two or more plans offered in succession by the same entity or organization, the plans are treated as one if the person was eligible for coverage under the second plan within 24 hours after the first plan ended.

The start of a new plan does not include a change:

- in the amount or scope of a plan's benefits;
- in the entity that pays, provides or administers the plan; or

- from one type of plan to another (such as from a single employer plan to a multiple employer plan).

The length of time a person was first covered under a plan is measured from the date the person was first covered under that plan. If that date is not readily available, the date the person first became a member of the group will be used to determine the length of time that person was covered under the plan presently in force.

Rule 6: When No Rule Determines the Primary Plan.

It is extremely rare when the order of benefit determination rules do not establish an order of benefits, but it does occur. This is the final fallback rule that applies when all other rules fail to establish an order of benefits. If none of the previous rules determines which plan pays first, each plan will pay an equal share of the expenses incurred by the Participant. However, this plan will not pay more than it would have paid if it would have been the primary plan.

15.5 HOW MUCH THIS PLAN PAYS WHEN IT IS SECONDARY PAYOR

1. When this Plan is secondary, and benefits are eligible expenses under the primary plan and this Plan, the Trust Plan will pay the difference between the Allowable Charges and payments actually made by the primary plan(s). **In no event, however, will this Plan pay more than 30% of Allowable Expenses when paying secondary benefits.**

2. When this Plan is secondary, and benefits are not an eligible expense under the primary plan, but are an eligible expense under this Plan, the Trust Plan will pay benefits as if it were the primary payor in accordance with the standard deductible, co-insurance and plan maximum provisions described in this SPD.

3. When this Plan is secondary, and benefits are an eligible expense under the primary plan, but **ARE NOT** eligible expenses under this Plan, **NO TRUST BENEFITS WILL BE PAYABLE.** To the extent that payment by this Plan as secondary payor would result in total payments greater than the maximum "usual, customary, and reasonable" allowable fee under this Plan, no benefits will be payable.

"Allowable Expense" means a health care service or expense, including deductibles, coinsurance or copayments, and without reduction for any applicable deductible, that is covered in full or in part by any of the plans covering the Participant, except as provided below or where a statue applicable to this Plan requires a different definition. This means that an expense or service (or any portion of an expense or service) that is not covered by any of the plans is not an Allowable Expense. The following are examples of expenses or services that are not Allowable Expenses:

- The difference between the cost of a semi-private room in a Hospital or other facility and a private room, unless the patient's stay in a private Hospital room is Medically Necessary.

- If the coordinating plans determine benefits on the basis of usual, customary and/or reasonable charges, any amount in excess of the lowest usual, customary and/or reasonable charge.

- If the coordinating plans provide benefits or services on the basis of negotiated fees, any amount in excess of the lowest of the negotiated fees.

- If one coordinating plan determines benefits on the basis of usual, customary and/or reasonable charges and the other coordinating plan provides benefits or services on the basis of negotiated fees, any amount in excess of the lesser of the two plans' fees.

- Out-patient prescription drug charges.

- Any expense that a provider by law or in accordance with a contractual agreement is prohibited from charging the Participant.

When benefits are reduced by a primary plan because a Participant did not comply with the primary plan's provisions, such as provisions related to Utilization Management and/or similar provisions in other plans, the amount of those reductions will not be considered an Allowable Expense of this Plan when it pays second.

15.6 ADMINISTRATION OF COB

To administer COB, the Plan reserves the right to:

- exchange information with other plans involved in paying claims;
- require that you, your physician, or your Health Care Provider furnish any necessary information;
- reimburse any plan that made payments this Plan should have made; or
- recover any overpayment.

If this Plan should have paid benefits that were paid by any other plan, this Plan may pay the party that made the other payments in the amount this Plan determines to be proper under this provision. Any amounts so paid will be considered to be benefits under this Plan, and this Plan will be fully discharged from any liability it may have to the extent of such payment.

To obtain all the benefits available to you, you should file a claim under each plan that covers the person for the expenses that were incurred. However, any person who claims benefits under this Plan must provide all the information the Plan needs to apply COB.

If this Plan is secondary, and if the coordinating primary plan provides benefits in the form of services, this Plan will consider the reasonable cash value of each service to be both the Allowable Expense and the benefits paid by the primary plan.

If this Plan is secondary, and if the coordinating primary plan does not cover health care services because they were obtained "out-of-network," benefits for services covered by this Plan will be payable by this Plan only to the extent they would have been payable if this Plan were the primary plan.

If this Plan determines that it is the secondary payor, and if the coordinating plan determines that it is also secondary because:

- it provides by its terms that it is always secondary or excess to any other coverage; or
- it does not use the same order of benefit determination rules as this Plan;

and if this Plan advances an amount equal to the benefits it would have paid had it been the primary plan, this Plan will be subrogated to all rights the Participant may have against the other plan, and the Participant shall execute any documents required or requested by this Plan to pursue any claims against the other plan for reimbursement of the amount advanced by this Plan.

15.7 COB WITH MEDICAID, TRICARE, OR VETERANS AFFAIRS FACILITY SERVICES

Under federal law, Medicaid or TRICARE are always secondary plans. If a Participant is covered by both this Plan and Medicaid or TRICARE, this Plan pays first and Medicaid or TRICARE pays second.

If a Participant receives services in a U.S. Department of Veterans Affairs Hospital or facility on account of a *military service-related condition,* benefits are not payable by this Plan.

If a Participant receives services in a U.S. Department of Veterans Affairs Hospital or facility on account of any Illness or Injury that is ***not*** *a military service-related condition,* benefits are payable by this Plan to the extent those services are Covered Expenses.

15.8 COB WITH MOTOR VEHICLE NO-FAULT COVERAGE REQUIRED BY LAW

If a Participant is eligible for benefits under both this Plan and any motor vehicle no-fault coverage that is required by law, the motor vehicle no-fault coverage pays first, and this Plan pays second.

15.9 COB WITH OTHER COVERAGE PROVIDED BY STATE OR FEDERAL LAW

If the Participant is eligible for benefits under both this Plan and any other coverage provided by any other state or federal law, the coverage provided by any other state or federal law pays first and this Plan pays second, unless otherwise required by law.

15.10 COORDINATION WITH MEDICARE

Medicare is a health insurance program for people 65 years of age or older, certain younger people with disabilities, and people with end-stage renal disease (ESRD). The original Medicare plan has two parts: Part A (hospital insurance) and Part B (medical insurance). As Medicare now offers new health plan choices besides the original Medicare plan, be sure to contact your local Social Security Administration Office for information about Medicare.

Medicare Part A helps pay for care in hospitals and skilled nursing facilities, and for home health and hospice care. Part A coverage is paid for through payroll taxes during your working career. Medicare Part B helps pay for physician's services, outpatient hospital care and some other medical services that Part A doesn't cover, such as outpatient diagnostic laboratory and x-ray services, preventive care, or services of therapists. For Part B coverage, you must pay the Part B premium; this monthly premium is deducted from your Social Security checks.

You need to enroll for both Medicare Part A and Medicare Part B to receive the maximum available benefits under this Plan. If a Participant does not enroll in and utilize Medicare Parts A & B when eligible, benefits payable under this Plan will still be reduced by the amount Medicare would have paid under Medicare Parts A & B.

Using Providers Who Accept Medicare Assignment

A provider who accepts Medicare assignment agrees that the total charge to you will not be more than the Medicare allowed charge. Providers who don't accept Medicare assignment are allowed to charge a Medicare beneficiary up to 15% over Medicare's approved payment amount. To make the best use of benefits available under this Plan, use the services of a provider who accepts Medicare assignment.

Medicare Participants May Retain or Cancel Coverage Under This Plan.

If a Participant becomes covered by Medicare, whether because of end-stage renal disease (ESRD), disability or age, the Participant may either retain or cancel coverage under this Plan.

- If a Participant is covered by this Plan and by Medicare, and retains coverage under this Plan, and the Participant is not a Retired Participant, this Plan will continue to provide the same benefits. This Plan pays first and Medicare pays second. Refer to ***Rule 1*** under WHICH PLAN PAYS FIRST.

- If the Eligible Employee or Retired Participant cancels coverage under this Plan, coverage of the Eligible Employee's or Retired Participant's Dependents will also terminate, but the Dependents will be entitled to elect COBRA Continuation Coverage.

15.11 COORDINATION WITH MEDICARE COVERAGE – WHO PAYS FIRST

Coverage Under The Plan and Medicare When You or Your Eligible Dependent is Age 65 or Older

If you are an **Eligible Employee and you or your Dependent** are entitled to Medicare as a result of being age 65 or older, coordination with Medicare rules will occur under the rules and procedures specified in your TEAMStar Booklet.

Coverage Under The Plan and Medicare When You are Totally Disabled

If you become Totally Disabled and entitled to Medicare because of your disability, you will no longer be considered actively employed. As a result, once you become entitled to Medicare because of your disability, Medicare pays first and this Plan pays second. If your Dependent becomes entitled to Medicare because of a disability, whether Medicare or the Plan pays first will depend on your current employment status. If you are an Eligible Employee, the Plan will pay first and Medicare will pay second. If you are a Retired Participant or your family's coverage under the Plan is not based on your current employment (as in the case of certain "COBRA" benefits), then once your Dependent becomes entitled to Medicare, Medicare will pay first and the Plan will pay second.

Coverage Under The Plan and Medicare When You Have End-Stage Renal Disease

If you or your Dependent are eligible for Medicare benefits based on disability status, and if you are a Retired Participant or your family's coverage is not based on your current employment status, Medicare benefits will be paid first and Plan benefits second as discussed above. If you or your Dependent then develop end-stage renal disease and become eligible for Medicare benefits on that additional basis, Medicare will continue to pay benefits first and the Plan will continue to pay second. Otherwise, if you or your Dependent become entitled to Medicare because of end-stage renal disease (ESRD), this Plan pays first and Medicare pays second for 30 months starting the **earlier** of:

- the month in which Medicare ESRD coverage begins; or
- the first month in which the Participant receives a kidney transplant.

Then, starting with the 31st month after the start of Medicare coverage, Medicare will pay first and the Plan will pay second.

15.12 HOW MUCH THE PLAN PAYS WHEN IT IS SECONDARY TO MEDICARE

Covered Expenses must first be submitted to Medicare.

It is important to remember that the Plan will not pay more than our "normal benefit payable," which is the amount the Plan would have paid in the absence of Medicare coverage. If the Plan's "normal benefit payable" and the benefit paid by Medicare are the same amounts, or if the benefit paid by Medicare is more than the Plan's "normal benefit payable," the Plan will not pay any additional benefits. The combination of the Plan's "normal benefit payable" and the benefit paid by Medicare will never exceed what the Plan would have paid in the absence of Medicare coverage. For additional details, see the TEAMStar Retiree Booklet.

15.13 HOW TO FILE YOUR CLAIMS

If you have any covered Dependents or a spouse, a current enrollment form is necessary to file a claim for Plan benefits and to coordinate benefits if you have additional insurance coverage. A current enrollment form is also required if there is a change in your status or the status of your dependents.

For Life Insurance, AD&D benefits, the Vacation Plan, and Time Loss benefits, mail your claim to the Trust Customer Service Office. (Contact information in the Quick Reference Table at the front of this booklet).

For Medical, Prescription Drug, and Dental benefits, mail your claim to the Administrative Office. (Contact information in the Quick Reference Table at the front of this booklet). For Medicare Retiree claims, submit the claim following the procedures in your TEAMStar booklet.

For Vision benefits mail your claim to the Vision Care Benefit organization. (Contact information in the Quick Reference Table at the front of this booklet):

Be sure your bills are itemized. In many cases, the provider of services will submit the claim directly. The following information must be indicated on the submitted bills or your Physician's standard claim form:

- Eligible Employee's or Retired Participant's name
- Eligible Employee's or Retired Participant's social security number
- Patient's name and relationship to Eligible Employee or Retired Participant
- Physician's or supplier's name, address, telephone number and Tax identification number
- Diagnosis (condition treated) and the service procedure code
- If treatment is related to Injury, date and place of Injury, including details (i.e., auto accident, fall, etc.)
- Date each service was performed, and the cost for each service

15.14 TIME LIMIT FOR FILING CLAIMS

All claims for reimbursement through the Trust's Medical or Dental Benefits must be submitted within one year of the date Covered Expenses were incurred. Claims must show the applicable procedure codes adapted from: (1) the Current Physician Terminology (CPT) Uniform Codes on Medical Procedures; (2) the American Dental Association (ADA) recommended Uniform Codes on Dental Procedures and Nomenclature, and (3) the actual charges to the Participant for all medical and dental services or procedures.

15.15 PAYMENT OF BENEFITS

After the Administrative Office processes your claim, it will send the Participant an *Explanation of Benefits* which gives information about the status of the claim and any deductibles applied.

Any Participant may request that benefits be paid to a provider of covered health services or supplies, or to any other agency that may have provided or paid for any benefits covered by the Plan.

In the event the Trust determines that the Participant is incompetent or incapable and no guardian has been appointed, or in the event the Participant has not provided the Trust with an address at which he can be located for payment, the Trust may, during the lifetime of the Participant, pay any benefit otherwise payable to the Participant to any other person or institution determined by the Trust to have rendered health services to the Participant or to be equitably entitled to payment. In the case of the death of a Participant, before all benefits payable under the Plan have been paid, the Trust may pay any such benefit to any person or institution

determined by the Trust to be entitled by the terms of the Plan or otherwise equitably entitled to payment. The remainder of such benefit shall be paid to the Participant's estate.

15.16 CLAIMS REVIEW PROCESS

A claim for benefits under the Plan arises only if you have filed a written request for a benefit determination with the Administrative Office. The following sets forth the Plan's timelines for deciding your claim, and your appeal rights if your claim for benefits is denied. Please note that what follows are separate claim procedure rules that apply depending on whether your claim is for medical benefits, disability benefits, or non-medical welfare benefits. Moreover, if your claim is for medical benefits, different claim procedures apply based on whether your claim is for prior approval of a benefit before the service or treatment is obtained, or is after service or treatment. In addition, the Plan Administrator may, outside of the timelines set forth herein, reconsider an initial claim or appeal determination at any time if facts that were not within the control of the Plan Administrator become known subsequent to the initial determination.

15.16.1 MEDICAL BENEFIT CLAIM DETERMINATIONS AND APPEALS

The following procedures apply to any claim for medical benefits (including dental, vision and prescription drug).

Initial denial decisions and appeal decisions on review will be provided in a culturally and linguistically appropriate manner in a non-English language upon request, but only if you live in a county where 10 percent or more of the population is literate only in the same non-English language as determined by the applicable federal guidelines.

If the above percentage standard is met, the following three conditions will apply to claimants in such counties: oral language services such as a telephone hotline in the applicable non-English language will be available to answer questions and assist in filing claims and appeals; the Administrative Office will provide upon request a notice in the applicable non-English language; and will include the English version of all notices a statement in the applicable non-English language indicating how to access the language services.

The Plan ensures that claims and appeals are adjudicated in a manner designed to ensure the independence and impartiality of persons, including medical experts or review organizations involved in making decisions, and no hiring or retention decisions will be based upon the likelihood that the person will support a denial of benefits.

If the Administrative Office fails to adhere to all the requirements of the claims review process, you may be deemed to have exhausted the internal claims and appeal process and may submit a request for external review if applicable. A deemed exhaustion, however, does not occur if violations of the claims review process are *de minimis* violations that do not cause, and are not likely to cause, prejudice or harm to you so long as the violations were for good cause or due to matters beyond the control of the Plan and occurred in the context of an ongoing good faith exchange of information between you and the Administrative Office. You may request a written explanation of the violation, which must be provided within 10 days, including the bases for asserting that the violation should not cause the internal claims and appeals process to be deemed exhausted. In case there is a deemed exhaustion, you may also be entitled to remedies under Section 502 of ERISA by filing a case in court. Unless otherwise specified herein, you are required to exhaust the internal claim and appeal process before filing a request for external review or filing a lawsuit.

15.16.1.2 Timing of Initial Determination – Medical Benefit Claims After Service or Treatment

If your claim for a benefit does not require pre-approval in advance of receiving medical care, written notice of a denial will generally be provided to you within a reasonable period of time, but no later than 30 days after receipt of your claim by the Plan. If matters beyond the control of the Plan so require, one 15-day extension of

time for processing the claim beyond the initial 30 days may be taken. A written notice of the extension will be furnished to you before the end of the initial 30-day period. An extension notice will explain the reasons for the extension and the expected date of a decision.

If an extension is required because you have not provided the information necessary to decide your claim, the notice of extension will specifically describe the required information, and the time period for processing your claim will not run from the date of such notice until the earlier of 1) the date the Plan receives your response to a request for additional information or 2) the date set by the Plan for your requested response (at least 45 days from the date of the request).

15.16.1.3 Timing of Determination – Concurrent Care Medical Decision

- 15.16.1.3.1 Reduction or termination of ongoing course of treatment

If the Plan has previously approved an ongoing course of treatment to be provided over a period of time or a number of treatments, notice of any later decision to reduce or terminate the ongoing course of treatment (other than by Plan amendment or termination) shall be treated as an adverse benefit determination that you can appeal. Such notice will be provided to you sufficiently in advance of the reduction or termination to allow you to appeal and receive a determination on appeal before the treatment is reduced or terminated, so that generally your benefits for an ongoing course of treatment would continue pending an appeal.

- 15.16.1.3.2 Extension of ongoing course of treatment involving urgent care

If your request that the Plan extend an ongoing course of treatment beyond the previously approved period of time or number of treatments involves urgent care, you will be notified of the decision by the Plan within 24 hours after its receipt of the request, provided the request is received at least 24 hours prior to the expiration of the pre-approved period of time or number of treatments.

15.16.1.4 Contents of Initial Denial – Medical Benefit Claims

If your claim is denied, in whole or in part, you will be notified in writing by the Plan. The written notice will include the following:

- the specific reason or reasons for the denial;
- references to the specific Plan provisions on which the denial is based;
- a description of any additional material or information necessary in order for you to perfect the claim, and an explanation of why such material or information is needed;
- an explanation of the Plan's review procedure for denied claims, including the applicable time limits for submitting your claim for review (claims involving urgent care will have a description of expedited appeal procedures);
- a statement of your right to bring a civil action under Section 502(a) of ERISA if your claim is denied on appeal;
- a copy of any internal rule, guideline, protocol or other similar criterion that was relied upon in deciding your claim for benefits, or a statement that such was relied upon and a copy will be provided free of charge upon request;
- if the decision was based on a medical necessity or experimental treatment or other similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying Plan terms to your medical circumstances, or a statement that an explanation will be provided free of charge upon request;

- information sufficient to identify the claim involved, including the date of service, the health care provider, the claim amount (if applicable), and a statement describing the availability, upon request, of the diagnosis code and treatment code and their corresponding meanings;
- the specific reason or reasons for the denial including, to the extent applicable, the denial code and its corresponding meaning and a description of the Plan's standard, if any, that was used in denying the claim
- an explanation of the Plan's review procedure, including both internal appeal and external review processes, and information regarding how to initiate an appeal; and
- the availability of, and contact information for, any applicable office of health insurance consumer ombudsman established under the Public Health Services Act Section 2793 to assist individuals with the internal and external claims and appeals process.

15.16.1.5 Appeal Procedure for Denied Claim

If you wish to appeal a denial of a claim, you or your authorized representative must file a written appeal with the Plan Administrator within 180 days after receiving notice of denial, unless your claim concerns the reduction or termination of a previously approved ongoing course of treatment. In that case, you must file a written appeal within a shorter time period that permits the Plan Administrator to issue an appeal decision before the treatment is reduced or terminated. A denial of a claim includes a denial in whole or in part, and for purposes of appeal rights, includes a rescission of coverage whether or not the rescission has an adverse impact on any particular benefit at that time. You or your authorized representative may submit a written statement, documents, records, and other information. You may also, free of charge upon request, have reasonable access to and copies of Relevant Documents. The review will consider all statements, documents, and other information submitted by you or your authorized representative, whether or not such information was submitted or considered under the initial denial decision. Claim determinations are made in accordance with Plan documents and, where appropriate, Plan provisions are applied consistently to similarly situated claimants. In addition:

- the appeal decision will not defer to the initial decision denying your claim and will be made by a plan fiduciary who is not a person who made the initial decision, nor a subordinate of such person;
- if the initial denial decision was based in whole or in part on a medical judgment, the plan fiduciary will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment;
- any health care professional engaged for such consultation will not be a person consulted in the initial decision, nor a subordinate of any such person;
- any medical or vocational expert whose advice was obtained in connection with the decision to deny your claim will be identified upon request, whether or not the advice was relied upon;
- if your claim involves urgent care, your request for an appeal may be submitted orally or in writing, and all necessary information, including the appeal decision, is to be transmitted between the Plan and you by telephone, facsimile, or other similarly expeditious method;
- you will be provided, free of charge, any new or additional evidence considered, relied upon, or generated by the Plan or at the direction of the Plan in connection with the claim, and such information will be provided as soon as possible and sufficiently in advance of the date of the final internal appeal decision is required to be issued to provide a reasonable opportunity for you to respond prior to that date; and
- if a final internal appeal decision is based on new or additional rationale, you will be provided, free of charge, with the rationale as soon as possible and sufficiently in advance of the date on which the final internal appeal decision is required to be issued to provide a reasonable opportunity for you to respond prior to that date.

The Administrative Committee of the Board of Trustees reviews appeals of denied claims and makes final determinations. The Administrative Committee has full discretionary authority, including power to administer, construe and interpret the terms and provisions of the Plan, SPD and Trust Agreement and to determine eligibility for benefits under the Plan.

15.16.1.7 Timing of Appeal Decision – Medical Benefit Claims After Service or Treatment

Your appeal generally will be addressed at the next regularly scheduled quarterly meeting of the Administrative Committee after an appeal is received. If, however, your appeal is received within 30 days prior to such a meeting, it will be considered by the second regularly scheduled quarterly meeting after it is received. In addition, if special circumstances require an extension of time for processing your appeal, a decision will be rendered no later than the third regularly scheduled quarterly meeting after your appeal is received. Written notice of any extension of time will be sent before it commences explaining the reason for the extension and the expected date of the appeal determination. Notice of the appeal decision will be provided not later than five days after the decision is made.

If an extension is required because you have not provided the information necessary to decide your claim, the time period for processing your claim will not run from the date of notice of an extension until the earlier of 1) the date the Plan receives your response to a request for additional information or 2) the date set by the Plan for your requested response (at least 45 days from the date of the request).

15.16.1.8 Hearing on Appeal

Within a reasonable time after receipt of the request for review, you will be notified of the date, time and place of the appeal hearing by regular mail addressed to your address as shown on the request for review. You may request to be present at the hearing before the Administrative Committee. You may be represented at the hearing by an attorney or any other representative of your choosing. The proceedings at the hearing may be recorded by a method determined by the Committee. In conducting the hearing, the Committee shall not be bound by the usual common law or statutory rules of evidence. Copies will be made of all statements, documents, and records that you or your authorized representative introduces at the hearing and all other Relevant Documents. This information will be attached to the record of the hearing, and made a part thereof.

15.16.1.9 Contents of Appeal Decision – Medical Benefit Claims

If you appeal a denied claim, the decision on review will be in writing and will include the following information:

- the specific reason or reasons for the decision;
- reference to the specific Plan provisions on which the decision is based;
- a statement of your right to receive, upon request free of charge, reasonable access to and copies of all Relevant Documents;
- a statement of your right to bring a civil action under Section 502(a) of ERISA;
- a copy of any internal rule, guideline, protocol or other similar criterion that was relied upon in deciding your claim for benefits on review, or a statement that such was relied upon and that a copy will be provided free of charge upon request;
- if the decision on review was based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying plan terms to your medical circumstances, or a statement that an explanation will be provided free of charge upon request;
- the following statement: "You and your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U. S. Department of Labor Office and your State insurance regulatory agency;"

- information sufficient to identify the claim involved, including the date of service, the health care provider, the claim amount (if applicable), and a statement describing the availability, upon request; of the diagnosis code and treatment code and their corresponding meanings;
- the specific reason or reasons for the decision including, to the extent applicable, the denial code and its corresponding meaning and a description of the Plan's standard, if any, that was used in denying the claim that includes a discussion of the decision;
- an explanation of the Plan's available external review process for denied claim, including information regarding how to initiate the external review and the applicable time limits; and
- the availability of, and contact information for, any applicable office of health insurance consumer ombudsman established under the Public Health Services Act Section 2793 to assist individuals with the internal and external claims and appeals process.

15.16.1.10 Relevant Documents

Relevant Document means any document, record or other information that:

- was relied upon in making a decision to deny benefits;
- was submitted, considered, or generated in the course of making the decision to deny benefits, whether or not it was relied upon in making the decision to deny benefits;
- demonstrates compliance with any administrative processes and safeguards designed to confirm that the benefit determination was in accord with the plan and that plan provisions, where appropriate, have been applied consistently regarding similarly situated individuals; or
- constitutes a statement of policy or guidance with respect to the plan concerning a denied treatment option or benefit for the claimant's diagnosis, without regard to whether such advice or statement was relied upon in making the decision to deny benefits.

15.16.1.11 Voluntary External Review for Medical Claims

If your claim for medical benefits has been denied under the Plan's internal appeal process (or you are deemed to have exhausted the internal appeal process), you may have the option to file a voluntary appeal for external review by an independent review organization. You may submit a request for external review of a medical claim denial only if the denial involves: 1) medical judgment (including but not limited to requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit; or a determination that treatment is experimental or investigational), as determined by the external reviewer; or 2) a rescission of coverage, regardless whether the rescission has any effect on a benefit at that time. Denial determinations on the basis that you failed to meet enrollment or eligibility requirements under the Plan are not subject to review by the external review process.

The request must be filed with the Administrative Office within four months after the date of receipt of the denial decision. If there is no corresponding date four months after the date of receipt of the denial decision, the request must be filed by the first day of the fifth month following the receipt of the denial decision. If the last filing date falls on a weekend or Federal holiday, the filing date is extended to the next week that is not a weekend or Federal holiday.

Within five business days following the date of receipt of the external review request, the Administrative Office will complete a preliminary review of the request to determine whether:

- the claim was covered under the Plan at the time the health care item or service was requested or, in the case of retrospective review, was covered under the Plan at the time the health care item or service was provided;

- the denial decision does not relate to the claimant's failure to meet enrollment and eligibility requirements under the terms of the Plan;
- you have exhausted the Plan's internal review process unless you are not required to exhaust the internal appeals process under the applicable final regulations; and
- you have provided all the information and forms required to process an external review.

Within one business day after completing the preliminary review, the Administrative Office shall issue a written notice to you as to whether your claim is eligible for external review. If your request is complete but not eligible, the notice will include the reasons for its ineligibility and contact information for the Employee Benefits Security Administration, toll-free number 866-444-EBSA (3272), at the Department of Labor. If the request is not complete, the notice will describe the information or materials needed to make the request complete. You will be allowed to perfect the request for external review within the four-month filing period or within the 48-hour period following receipt of the notice. Whichever is later.

If your request for external review is complete and eligible, it will be assigned to an independent review organization ("IRO") that has been accredited by URAC or a similar nationally-recognized accrediting organization to conduct the external review. The Administrative Office has contracted with IROs and uses unbiased methods for selecting the IRO for your claim.

The assigned IRO will utilize legal experts where appropriate to make coverage determinations under the Plan. It will provide you a written notice of your request's eligibility and acceptance for external review which will include a statement that you may submit, within ten business days after receipt of the notice, additional information that the IRO must consider when conducting its review. The IRO is not required to, but may consider, information submitted after ten business days. Within five business days after assignment of the IRO, the Plan shall provide the IRO the documents and information considered in making the denial decision. If the Plan fails to timely provide the documents and information, the IRO may terminate the external review and make a decision to reverse the denial decision. The IRO shall notify you and the Plan of its decision within one business day after it is made. The IRO shall forward information submitted by you to the Plan within one business day. Upon receipt of the information, the Administrative Office may reconsider its denial decision and if it decides to reverse its decision, notify you and the IRO within one business day after making such a decision. The IRO shall terminate its external review upon receipt of such notice.

The IRO will review your claim de novo and not be bound by any decisions or conclusions reached during the Plan's internal claim and appeal process. In addition to the documents and information provided, the IRO to the extent such information is available and the IRO considers them appropriate, will consider the following in its decision:

- your medical records;
- the attending health care professional's recommendation;
- reports from appropriate health care professionals and documents submitted by the Plan, you and your treating provider;
- the terms of the Plan;
- appropriate practice guidelines, which must include applicable evidence-based standards and may include other practice guidelines developed by the Federal government, national or professional medical societies, boards, and associations;
- applicable clinical review criteria developed and used by the Plan, unless the criteria are inconsistent with terms of the Plan or applicable law; and

- the opinion of the IRO's clinical reviewer after considering documents and information to the extent they are available and the clinical reviewer considers them appropriate.

The IRO shall provide written notice of the final external review decision to you and the Plan within 45 days after the IRO receives the request for external review. The IRO's decision shall include the following:

- a general description of the reason for the request for external review, including information sufficient to identify the claim (including the dates of service, health care provider, claim amount if applicable, the diagnosis and treatment codes and their corresponding meanings, and the reason for the previous denial);
- the date the IRO received the assignment to conduct the external review and the date of the IRO decision;
- references to the evidence or documentation, including the specific coverage provisions and evidence-based standards, considered in reaching its decision;
- a discussion of the principal reasons for its decision, including the rationale for its decision and any evidence-based standards that were relied on in making its decision;
- a statement that the determination is binding except to the extent that other remedies may be available under State or Federal law to you or the Plan;
- a statement that judicial review may be available to you; and
- current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman established under the Public Health Services Act Section 2793.

After a final external review decision, the IRO shall maintain records of the claim and notices for six years. Such records are available for examination by you, the Plan or applicable governmental oversight agencies upon request, except where such disclosures would violate applicable privacy laws.

Upon receipt of a final external review decision reversing a denial decision, the Plan shall immediately provide coverage or payment for the claim.

15.16.1.12 Expedited External Review Process for Denied Claims

If your claim is eligible for the external review process, you may request an expedited external review if:

- an initial denial involves a medical condition for which the timeframe for completing an expedited internal appeal would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function, and you have filed a request for an expedited internal appeal; or
- a final internal appeal decision involves a medical condition where the timelines for completion of a standard external review would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function, or the appeal decision concerns an admission, availability of care, continued stay, or health care item or service for which you have received emergency services but have not been discharged from a facility.

Immediately upon receipt of a request for expedited external review, the Administrative Office shall determine whether the request meets the reviewability standards set for preliminary reviews under the Standard External Review Process discussed above. The Administrative Office shall immediately send you a notice that complies with the requirements for standard external reviews as to whether your request for an expedited external review is eligible.

If your request for an expedited external review is complete and eligible, it will be assigned to an IRO. The Administrative Office shall provide all necessary documents and information considered in making its denial decision to the IRO electronically or by telephone or facsimile or other available expeditious method. The IRO, to the extent information or documents are available and the IRO considers them appropriate, shall consider the documents and information described above for standard external reviews. The IRO shall review

the claim de novo and is not bound by any decision or conclusions reached during the Plan's internal claims and appeal process.

The IRO shall provide a notice of its final expedited external review decision in accordance with the requirements for standard external review decisions as expeditiously as your medical condition or circumstances require, but no later than 72 hours after the IRO receives the request for an expedited external review. If the notice is not in writing, within 48 hours of the notice, the IRO shall provide written confirmation of the decision to you and the Plan.

15.16.2 DISABILITY BENEFIT CLAIM DETERMINATIONS AND APPEALS

The following procedures apply to any claim for benefits under the Plan that requires a finding of disability.

15.16.2.1 Timing of Initial Denial – Disability Benefit Claims

If your claim is a disability claim, a written denial notice will be provided to you within a reasonable period of time, but not later than 45 days after receipt of your claim by the Plan. If matters beyond the control of the Plan require an extension of the time for processing your disability claim, the initial period may be extended for up to 30 days. Written notice of an extension will be sent before the end of the initial 45-day period. In addition, another 30-day extension of time for processing your claim due to matters beyond the control of the Plan may be taken. Written notice of such second extension will be sent before the end of the first 30-day extension period. The extensions shall not exceed a period of 60 days from the end of the initial 45-day period.

An extension notice will explain the reasons for the extension, the expected date of a decision, the standards for a benefit entitlement, any unresolved issues that prevent a decision on your claim, and any additional information needed to resolve those issues. If an extension is required because you have not provided the information necessary to decide your claim, the time period for processing your claim will not run from the date of notice of an extension until the earlier of 1) the date the Plan receives your response to a request for additional information or 2) the date set by the Plan for your requested response (at least 45 days from the date of the request).

15.16.2.2 Contents of Initial Denial – Disability Benefit Claims

If your claim for a benefit is denied, you will be notified in writing. The written notice will include the following:

- the specific reason or reasons for the denial;
- references to the specific Plan provisions on which the denial is based;
- a description of any additional material or information necessary in order for you to perfect the claim, and an explanation of why such material or information is needed;
- an explanation of the Plan's review procedure for denied claims, including the applicable time limits for submitting your claim for review;
- a statement of your right to bring a civil action under Section 502(a) of ERISA, if your claim is denied on appeal;
- any internal rule, guideline, protocol or other similar criterion that was relied upon in deciding your claim for benefits, or a statement that such was relied upon and a copy will be provided free of charge upon request; and
- if the decision was based on a medical necessity or experimental treatment or other similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying Plan terms to your medical circumstances, or a statement that an explanation will be provided free of charge upon request.

15.16.2.3 Appeal Procedure for Denied Claim

If you wish to appeal a denial of a claim for disability benefits, you or your authorized representative must file a written appeal with the Plan Administrator within 180 days after receipt of written notice of the denial. You or your authorized representative may submit a written statement, documents, records, and other information. You may also, free of charge upon request, have reasonable access to and copies of Relevant Documents. The review will consider all statements, documents, and other information submitted by you or your authorized representative, whether or not such information was submitted or considered under the initial denial decision. Claim determinations are made in accordance with Plan documents and, where appropriate, Plan provisions are applied consistently to similarly situated claimants.

In addition, the following procedures apply:

- the appeal decision will not defer to the initial decision denying your disability claim and will be made by Plan trustees who are not persons who made the initial decision, nor subordinates of such person;
- if the initial denial decision was based in whole or in part on a medical judgment, the Administrative Committee will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment;
- any health care professional engaged for such consultation will not be a person consulted in the initial decision, nor a subordinate of any such person; and
- any medical or vocational expert whose advice was obtained in connection with the decision to deny your disability claim will be identified upon request, whether or not the advice was relied upon.

The Administrative Committee of the Board of Trustees reviews appeals of denied claims and makes final determinations. The Administrative Committee has full discretionary authority, including power to administer, construe and interpret the terms and provisions of the Plan, SPD and Trust Agreement and to determine eligibility for benefits under the Plan.

15.16.2.4 Timing of Appeal Decision – Disability Benefit Claims

Your appeal generally will be addressed at the next regularly scheduled quarterly meeting of the Administrative Committee after an appeal is received. If, however, your appeal is received within 30 days prior to such a meeting, it will be considered by the second regularly scheduled quarterly meeting after it is received. In addition, if special circumstances require an extension of time for processing your appeal, a decision will be rendered no later than the third regularly scheduled quarterly meeting after your appeal is received. Written notice of any extension of time will be sent before it commences explaining the reason for the extension and the expected date of the appeal determination. Notice of the appeal decision will be provided not later than five days after the decision is made.

If an extension is required because you have not provided the information necessary to decide your claim, the time period for processing your claim will not run from the date of notice of an extension until the earlier of 1) the date the Plan receives your response to a request for additional information or 2) the date set by the Plan for your requested response (at least 45 days from the date of the request).

15.16.2.5 Hearing on Appeal

Within a reasonable time after receipt of the request for review, you will be notified of the date, time and place of the appeal hearing by regular mail addressed to your address as shown on the request for review. You may request to be present at the hearing before the Administrative Committee. You may be represented at the hearing by an attorney or any other representative of your choosing. The proceedings at the hearing may be recorded by a method determined by the Committee. In conducting the hearing, the Committee shall not be bound by the usual common law or statutory rules of evidence. Copies will be made of all statements, documents, and records that you or your authorized representative introduces at the hearing and all other Relevant Documents. This information will be attached to the record of the hearing, and made a part thereof.

15.16.2.6 Contents of Appeal Decision – Disability Benefit Claims
If you appeal a denied claim, the decision on review will be in writing and will include the following information:

- the specific reason or reasons for the decision;
- reference to the specific Plan provisions on which the decision is based;
- a statement of your right to receive, upon request free of charge, reasonable access to and copies of Relevant Documents; and
- a statement of your right to bring a civil action under Section 502(a) of ERISA;
- any internal rule, guideline, protocol or other similar criterion that was relied upon in deciding your claim for benefits on review, or a statement that such was relied upon and a copy will be provided free of charge upon request;
- if the decision on review was based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying Plan terms to your medical circumstances, or a statement that an explanation will be provided free of charge upon request; and
- the following statement: "You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency."

15.16.2.7 Relevant Documents
Relevant Document means any document, record or other information that:

- was relied upon in making a decision to deny benefits;
- was submitted, considered, or generated in the course of making the decision to deny benefits, whether or not it was relied upon in making the decision to deny benefits;
- demonstrates compliance with any administrative processes and safeguards designed to confirm that the benefit determination was in accord with the Plan and that Plan provisions, where appropriate, have been applied consistently regarding similarly situated individuals; or
- constitutes a statement of policy or guidance to the Plan concerning a denied treatment option or benefit for your diagnosis, whether or not it was relied upon in making the decision to deny benefits.

15.16.3 NON-MEDICAL WELFARE BENEFIT CLAIM DETERMINATIONS AND APPEALS

The following procedures apply to any claim for non-medical benefits under the Plan (including Life Insurance and Accidental Death & Dismemberment Benefits, and Vacation Plan Benefits).

15.16.3.1 Timing of Initial Denial – Non-Medical Welfare Benefit Claims
If your claim is for benefits other than disability benefits, a written denial notice will generally be provided to you within 90 days after the date your claim is received by the Plan. However, if special circumstances require an extension of time for processing the claim beyond the initial 90-day period, written notice of the extension will be furnished to you before the end of the initial 90-day period. An extension of time will not exceed a period of 90 days from the end of the initial 90-day period. An extension notice will explain the reasons for the extension and the expected date of a decision.

15.16.3.2 Contents of Initial Denial – Non-Medical Welfare Benefit Claims
If your claim for a benefit is denied, you will be notified in writing. The written notice will include the following:

- the specific reason or reasons for the denial;
- references to the specific Plan provisions on which the denial is based;
- a description of any additional material or information necessary in order for you to perfect the claim, and an explanation of why such material or information is needed;

- an explanation of the Plan's review procedure for denied claims, including the applicable time limits for submitting your claim for review; and
- a statement of your right to bring a civil action under Section 502(a) of ERISA, if your claim is denied on appeal.

15.16.3.3 Appeal Procedure for Denied Claim

If you wish to appeal a denial of a claim for benefits other than disability benefits, you or your authorized representative must file a written appeal with the Plan Administrator within 60 days after receipt of written notice of the denial. You or your authorized representative may submit a written statement, documents, records, and other information. You may also, free of charge upon request, have reasonable access to and copies of Relevant Documents. The review will consider all statements, documents, and other information submitted by you or your authorized representative, whether or not such information was submitted or considered under the initial denial decision. Claim determinations are made in accordance with Plan documents and, where appropriate, Plan provisions are applied consistently to similarly situated claimants.

The Administrative Committee of the Board of Trustees reviews appeals of denied claims and makes final determinations. The Administrative Committee has full discretionary authority, including power to construe and interpret the terms and provisions of the Plan, SPD and Trust Agreement and to determine eligibility for benefits under the Plan.

15.16.3.4 Timing of Appeal Decision – Non-Medical Welfare Benefit Claims

Your appeal generally will be addressed at the next regularly scheduled quarterly meeting of the Administrative Committee after an appeal is received. If, however, your appeal is received within 30 days prior to such a meeting, it will be considered by the second regularly scheduled quarterly meeting after it is received. In addition, if special circumstances require an extension of time for processing your appeal, a decision will be rendered no later than the third regularly scheduled quarterly meeting after your appeal is received. Written notice of any extension of time will be sent before it commences explaining the reason for the extension and the expected date of the appeal determination. Notice of the appeal decision will be provided not later than five days after the decision is made.

If an extension is required because you have not provided the information necessary to decide your claim, the time period for processing your claim will not run from the date of notice of an extension until the earlier of 1) the date the Plan receives your response to a request for additional information or 2) the date set by the Plan for your requested response (at least 45 days from the date of the request).

15.16.3.5 Hearing on Appeal

Within a reasonable time after receipt of the request for review, you will be notified of the date, time and place of the appeal hearing by regular mail addressed to your address as shown on the request for review. You may request to be present at the hearing before the Administrative Committee. You may be represented at the hearing by an attorney or any other representative of your choosing. The proceedings at the hearing may be recorded by a method determined by the Committee. In conducting the hearing, the Committee shall not be bound by the usual common law or statutory rules of evidence. Copies will be made of all statements, documents, and records that you or your authorized representative introduces at the hearing and all other Relevant Documents. This information will be attached to the record of the hearing, and made a part thereof.

15.16.3.6 Contents of Appeal Decision – Non-Medical Welfare Benefit Claims

If you appeal a denied claim, the decision on review will be in writing and will include the following information:

- the specific reason or reasons for the decision;
- reference to the specific Plan provisions on which the decision is based;
- a statement of your right to receive, upon request free of charge, reasonable access to and copies of Relevant Documents; and

- a statement of your right to bring a civil action under Section 502(a) of ERISA.

15.16.3.7 Relevant Documents
Relevant Document means any document, record or other information that:

- was relied upon in making a decision to deny benefits;
- was submitted, considered, or generated in the course of making the decision to deny benefits, whether or not it was relied upon in making the decision to deny benefits; or
- demonstrates compliance with any administrative processes and safeguards designed to confirm that the benefit determination was in accord with the Plan and that Plan provisions, where appropriate, have been applied consistently regarding similarly situated individuals.

15.17 ASSIGNMENT OF CLAIMS PROHIBITED

Health benefits and other rights related to the Plan or Welfare Trust may not be sold, transferred, pledged, or assigned, and any attempt to do so will be void. The payment of benefits directly to a health care provider, if any, is done as a convenience to you and your covered dependents and does not constitute an assignment of health benefits or any other rights to the Plan or Welfare Trust.

SECTION 16
IMPORTANT PROVISIONS AND INFORMATION REGARDING YOUR PLAN BENEFITS

16.1 AUTHORITY TO MAKE CHANGES.

The Board of Trustees of the Alaska Teamster-Employer Welfare Trust has the right in its sole discretion to amend, modify, revoke or terminate the Plan, in whole or in part, at any time. ***Benefits provided under this Plan are not vested.*** The Board of Trustees' authority includes the right, in its sole discretion, to:

(a) terminate or amend either the amount or condition with respect to any benefit even though such termination or amendment affects claims which have already accrued; and/or

(b) alter or postpone the method of payment of any benefit; and/or

(c) amend, terminate or rescind any provision of the Plan; and/or

(d) merge the Plan with other plans, including the transfer of assets.

Except as delegated pursuant to this section, the authority to make changes to the Plan rests solely with the Board of Trustees. Any amendment, modification, revocation or termination of the Plan is made by a resolution adopted by the Board of Trustees, or by resolution adopted by a committee of the Board of Trustees which has been delegated authority to act on behalf of the Board of Trustees. No individual Trustee, Union representative, or Employer representative is authorized to interpret this Plan on behalf of the Board of Trustees, or to act as an agent of the Board of Trustees.

Upon termination, the Trustees may allocate remaining funds to pay expenses and administrative costs, and distribute assets so as to carry out the Trust's purpose. No Trust funds may revert to the Union, an Employer, an Employee or Plan Participant.

The Trustees may require that information be submitted as reasonably necessary to determine the Plan's compliance with any nondiscrimination requirements of the Internal Revenue Code or any other law or regulation, and may require additional employer contributions as reasonably necessary to ensure compliance with any such statutes.

16.2 ADMINISTRATION AND OPERATION OF PLAN

The Board of Trustees of the Plan is the named fiduciary with the authority to control and manage the operation and administration of the Plan. The Board shall make such rules, interpretations and computations and take such other actions to administer the Plan as the Board, in its sole discretion, may deem appropriate. The rules, interpretation, computations and actions of the Board shall be binding and conclusive on all persons. The Board of Trustees, and/or persons appointed by the Board of Trustees, shall have full discretionary authority to determine eligibility for benefits and to construe terms of the Plan, benefits payable, and any rules adopted by the Board of Trustees.

The Trustees may allow new groups of Employees to participate in this Plan. The admission of new groups, however, shall be allowed only after the Trustees are satisfied that the admission of such groups will not be detrimental to the Plan or Trust. Moreover, the Trustees shall accept as Contributions only payments made in accordance with a Collective Bargaining Agreement or Written Agreement that is not detrimental to the Plan or Trust. The Trustees are authorized to reject any agreement or practice, or Contributions that are determined to be pursuant to an agreement or practice, that is detrimental to the Plan or Trust and no Participant or Beneficiary right will be created by such rejected agreement, practice or Contributions. The determination of

whether an agreement or practice, or the admission of a new group, is detrimental to the Plan or Trust shall be made by the Trustees in their sole discretion, and may include but not be limited to adverse actuarial, financial or selectivity considerations.

Under no circumstances is the Trust liable for the negligence, wrongful acts or omissions of any doctor, dentist, laboratory or other person or organization performing services or supplying materials in connection with benefits under this Plan.

1. **Plan Name:** Alaska Teamster-Employer Welfare Plan
2. The **Plan Administrator** and **Plan Sponsor** is The Board of Trustees. Their address is:

   Board of Trustees
   Alaska Teamster-Employer Welfare Trust
   520 East 34th Avenue, Suite 107
   Anchorage, Alaska 99503-4116
   (907) 751-9700

3. The **Trust Customer Service Office** will provide any Plan participant or beneficiary, upon written request, information as to whether a particular Employer is contributing to this Trust and, if so, that Employer's address.
4. **Internal Revenue Service Plan identification number:**

   The Employer Identification Number (EIN) issued to the Board of Trustees is 91-6034674.

5. **Type of Plan:**

   The Plan provides all Participants with medical and prescription drug benefits. The Plan provides some, but not all, Participants with life insurance, accidental death and dismemberment insurance, vision, dental, time loss, and vacation benefits. All benefits are paid directly from the Trust, except that the Trust pays insurance premiums to provide life insurance and accidental death and dismemberment insurance.

6. **Name and address of the person designated as agent for the service of legal process:**

   Ms. Dennie Castillo
   Alaska Teamster-Employer Welfare Trust
   520 East 34th Avenue, Suite 107
   Anchorage, Alaska 99503-4116

   Service of legal process may also be made upon any Member of the Board of Trustees or on the Plan Administrator.

7. Names and addresses of Trustees:

Employer Trustees	Union Trustees
Marion Davis Horizon Lines, Inc. 1711 Tidewater Rd. Anchorage, AK 99501	Rick Boyles Teamsters Local 959 520 E. 34th Avenue Anchorage, AK 99503
Scott DePaepe United Parcel Service 6200 Lockheed Drive Anchorage, AK 99502	Derek Musto Teamsters Local 959 520 East 34th Avenue Anchorage, AK 99503
Frank Monfrey United Freight & Transport Inc. 1701 E. 1st Avenue Anchorage, AK 99501	Eileen Whitmer Teamsters Local 959 751 Old Richardson Highway Fairbanks, AK 99501
Todd Henderson Brice, Inc. PO Box 70668 Fairbanks, AK 99707	Barbara Huff-Tuckness Teamsters Local 959 520 E 34th Avenue Anchorage, AK 99503

8. All contributions to the Plan are made by Contributing Employers in accordance with Collective Bargaining Agreements in force with Teamsters Local No. 959, or by Employers signatory to a written agreement between the Trust and the Employer.

9. **The date of the end of the Plan Year:**

   The Plan Year ends each June 30.

10. The Trust pays insurance premiums for the following benefits:

    Life Insurance

    Accidental Death & Dismemberment Insurance

    The Trust pays all other benefits from Trust assets, and purchases stop-loss insurance to protect against large claims. The stop loss carrier does not guarantee Plan benefits.

16.3 RECIPROCITY AND TRANSFER OF ASSETS AND LIABILITIES

(a) If the Trustees enter into reciprocity agreements with other employee benefit plans and trusts in which assets are transferred to the Plan and Trust on behalf of an employee whose employer is contributing into the transferor plan and trust, the employee will be credited with the hours of service and contributions applicable to his employment with that contributing employer for purposes of determining participation, eligibility and benefits in the Plan, but only pursuant to the terms of the Plan.

(b) If employer contributions on behalf of an employee into the Plan and Trust are to be transferred pursuant to a reciprocity agreement to another plan and trust, that employee, as to such transferable contributions, shall not be credited in any way with hours of service or contributions under the terms of the Plan and Trust for any purpose, including but not limited to calculating participation, eligibility and benefits. Nothing in the foregoing, however, is intended to impair the right of the Plan and Trust to enforce delinquent contributions from a contributing employer whose contributions are to be transferred pursuant to a reciprocity agreement.

(c) The calculation of all credits recognized under the terms of a reciprocity agreement shall be made solely pursuant to the terms of the Plan.

SECTION 17
PROTECTION OF PRIVACY AND SECURITY

17.1 USES AND DISCLOSURE OF SUMMARY HEALTH INFORMATION

The Plan may disclose Summary Health Information to the Board of Trustees, provided the Board of Trustees requests the Summary Health Information for the purpose of modifying, amending, or terminating the Plan.

17.2 PERMITTED AND REQUIRED USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION FOR PLAN ADMINISTRATION PURPOSES

Unless otherwise permitted by law, and subject to the conditions of disclosure described in Section 17.3 and obtaining written certification pursuant to Section 17.4, the Plan may disclose Protected Health Information and Electronic Protected Health Information to the Board of Trustees, provided the Board of Trustees uses or discloses such Protected Health Information and Electronic Protected Health Information only for Plan administration purposes. “Plan administration purposes” means administration functions performed by the Board of Trustees on behalf of the Plan, such as quality assurance, claims appeals, auditing and monitoring. Plan administration functions do not include functions performed by the Board of Trustees in connection with any other benefit or benefit plan of the Board of Trustees, and they do not include any employment-related functions.

Notwithstanding the provisions of this Plan to the contrary, in no event shall the Board of Trustees be permitted to use or disclose Protected Health Information or Electronic Protected Health Information in a manner that is inconsistent with 45 CFR § 164.504(f).

17.3 CONDITIONS OF DISCLOSURE FOR PLAN ADMINISTRATION PURPOSES

With respect to any Protected Health Information disclosed to it by the Plan (other than Summary Health Information and information disclosed pursuant to a signed authorization that complies with the requirements of 45 CFR 164.508, which are not subject to these restrictions), the Board of Trustees shall:

1. Not use or further disclose the Protected Health Information other than as permitted or required by the Plan or as required by law;
2. Ensure that any agents, including a subcontractor, to whom it provides Protected Health Information received from the Plan agree to the same restrictions and conditions that apply to the Board of Trustees with respect to such information;
3. Not use or disclose the Protected Health Information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Board of Trustees;
4. Report to the Plan any use or disclosure of the information that is inconsistent with the uses or disclosures provided for of which it becomes aware;
5. Make available Protected Health Information of an individual to that individual, as required by 45 CFR § 164.524;
6. Make available Protected Health Information for amendment and incorporate any amendments to Protected Health Information in accordance with 45 CFR § 164.526;
7. Make available the information required to provide an accounting of disclosures as required by 45 CFR § 164.528;

8. Make its internal practices, books, and records relating to the use and disclosure of Protected Health Information received from the Plan available to the Secretary of Health and Human Services for purposes of determining compliance by the Plan with the HIPAA privacy regulations;
9. If feasible, return or destroy all Protected Health Information received from the Plan that the Board of Trustees still maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible; and
10. Ensure that the adequate separation required by 45 CFR § 164.504(f)(2)(iii) relating to the Plan and Board of Trustees is established.

Further, with respect to any Electronic Protected Health Information (other than Summary Health Information and information disclosed pursuant to a signed authorization that complies with the requirements of 45 CFR 164.508, which are not subject to these restrictions) that it creates, receives, maintains, or transmits on behalf of the Plan, the Board of Trustees shall:

1. Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the Electronic Protected Health Information that it creates, receives, maintains, or transmits on behalf of the Plan;
2. Ensure that the adequate separation required by 45 CFR § 164.504(f)(2)(iii) relating to the Plan and Board of Trustees is supported by reasonable and appropriate security measures;
3. Ensure that any agents, including a subcontractor, to whom it provides Electronic Protected Health Information agree to implement reasonable and appropriate security measures to protect the information; and
4. Report to the Plan any Security Incident of which it becomes aware.

17.4 CERTIFICATION OF BOARD OF TRUSTEES

The Plan shall disclose Protected Health Information and Electronic Protected Health Information to the Board of Trustees on the receipt of a certification by the Board of Trustees that the Plan document has been properly amended to incorporate the provisions of 45 CFR § 164.504(f)(ii), and that the Board of Trustees agrees to the conditions of disclosure set forth in Section 17.3.

17.5 PERSONNEL WITH ACCESS TO PROTECTED HEALTH INFORMATION

The Board of Trustees and Business Associates of the Plan shall be given access to Protected Health Information. The Board of Trustees shall only have access to and use Protected Health Information to the extent necessary to perform plan administration functions for the Plan. In the event that any member of the Board of Trustees does not comply with these requirements, that Trustee is subject to review under Article II, Section 8 of the Trust Agreement, for non-compliance.

SECTION 18
GENERAL PLAN DEFINITIONS

"Administrative Office" means the entity identified at in the Quick Reference Table at the front of this booklet.

An **"Ambulatory Surgical Center"** or **"Outpatient Surgical Center"** is a specialized facility established primarily for the purpose of performing surgical procedures, and which fully meets one of the following two tests:

1. It is licensed as an Ambulatory Surgical Center under the laws of the jurisdiction in which it is located; or
2. Where licensing is not required, it meets all of the following requirements:
   - it is operated under the supervision of a licensed Physician who is devoting full time to supervision and permits a surgical procedure to be performed only by a duly qualified Physician who is privileged to perform the procedure in at least one Hospital.
   - it requires in all cases, except those requiring only local infiltration anesthetics, that a licensed anesthesiologist administer the anesthetic or supervise the anesthetist who administers the anesthetic, and that the anesthesiologist or anesthetist remain present throughout the surgical procedure.
   - it provides at least one operating room and at least one post-anesthesia recovery room, and has trained personnel and necessary equipment to handle emergency situations.
   - it is equipped to perform diagnostic x-ray and laboratory examinations or has an arrangement to obtain these services, and has immediate access to a blood bank or blood supplies.
   - it maintains an adequate written medical record for each patient.
   - it provides full-time services of one or more registered nurses (RN) for patient care in the operating rooms and in the post-anesthesia recovery rooms.

An Ambulatory Surgical Center that is part of a Hospital will be considered an Ambulatory Surgical Center for the purposes of this Plan.

"Annual Out-of-Pocket Limit" is the maximum amount of Covered Expenses each Participant pays each calendar year. Once a Participant has reached their Annual Out-of-Pocket Limit, Covered Expenses during the remainder of that calendar year are payable at 100%. The calendar year deductible is included in the Annual Out-of-Pocket Limit.

"Collective Bargaining Agreement" means the labor agreement between Teamster Local 959 and a Contributing Employer, which provides for contributions to this Trust in accordance with the provisions of the Trust Agreement.

"Contributing Employer" or **"Employer"** means a business entity that is required by a Collective Bargaining Agreement with the Union to make payments into this Trust. A Contributing Employer shall also include a business entity whose participation is permissible under applicable laws (including the Union on behalf of its own employees) and which contributes to the Trust pursuant to a Written Agreement with Trust. The Board of Trustees may require an Employer to sign a Written Agreement or Collective Bargaining Agreement acceptable to it before crediting Covered Hours of an Employer's Employees.

"Covered Expenses" mean the charges or expenses incurred by an eligible Participant while coverage is in force which are:

- made for care and treatment of an Illness or Injury as defined in the Plan; and

- Medically Necessary; and
- Usual, Customary and Reasonable; and
- covered under provisions of the Plan, or which are not expressly excluded.

"Covered Hour" means:

- an hour of work for which a Collective Bargaining Agreement or written agreement between the Trust and Employer obligates the Employer to contribute to the Trust on behalf of the Employee; or
- a unit that a Collective Bargaining Agreement states the Plan will credit to an Employee.

See also the special crediting rule under Flat Rate Contracts that applies exclusively for purposes of determining Retired Participant Status at Section 2.1.

"Custodial Care" means care or services provided family members for personal hygiene or to perform activities of daily living. People who are trained or licensed medical or nursing personnel can provide Custodial Care. Some examples of Custodial Care are training or helping patients get in and out of bed, as well as help with bathing, dressing, feeding, or eating, use of the toilet, ambulating, or taking drugs or medicines that can be self-administered. These services are Custodial Care regardless of where the care is given or who recommends, provides, or directs the care.

"Dependent" is an individual who has satisfied the eligibility rules described at **Eligibility Rules for Dependents of Active and Retired Participants**.

"Drug" or **"Prescription Drug"** is a Medically Necessary drug dispensed by a licensed pharmacist.

"Electronic Protected Health Information" means Protected Health Information that is transmitted or maintained in electronic media.

"Eligible Employee" is an Employee who has satisfied the eligibility rules of the Plan. An individual cannot be an Eligible Employee and a Retired Participant at the same time.

The term **"Emergency"** means an unforeseen Injury or acute Illness for which medical attention cannot be delayed without serious risk to the Participant's or Dependent's health, including situations where application of the normal time periods for deciding a claim 1) could seriously jeopardize life or health or ability to regain maximum function, or 2) in the opinion of a physician with knowledge of the medical condition, would subject the Participant or Dependent to severe pain that cannot adequately be managed without the care or treatment being sought.

The term "**Emergency Services"** is as defined under the Health Care Reform law, but generally means services at a hospital's emergency department for an emergency medical condition, and any further services that are necessary to stabilize the patient.

"Employee" means an individual on behalf of whom an Employer is obligated to contribute to the Trust pursuant to a Collective Bargaining Agreement or written agreement between the Trust and the Employer.

"Employer" – Please refer to the definition of **"Contributing Employer**."

"Experimental and/or Investigational." The Plan or its designee has the discretion and authority to determine if a service or supply is or should be classified as **"Experimental and/or Investigational."** A service or supply will be deemed to be Experimental and/or Investigational if, in the opinion of the Plan or its designee, **(based on the information and resources available at the time the service was performed or at the time the supply was provided, or the service or supply was considered for precertification under the Plan's**

Utilization Management Program), any of the following conditions were present with respect to one or more essential provisions of the service or supply:

1. The service or supply is described as an alternative to more conventional therapies in written documents by the health care provider that performs the service or prescribes the supply;
2. The prescribed service or supply may be given only with approval of an Institutional review Board as defined by federal law;
3. There is an absence of authoritative medical or scientific literature on the subject, or that literature indicates that the service or supply is Experimental and/or Investigational or that more research is needed;
4. Food and Drug Administration (FDA) has not approved marketing of the service or supply or has it under consideration;
5. The service or supply is available only through clinical trials sponsored by the FDA, the National Cancer Institute or the National Institutes of Health.

"Flat Rate Contract" means a Collective Bargaining Agreement or Written Agreement that obligates an Employer to contribute a specified monthly amount to the Plan and does not base the amount of such contribution on the number of Covered Hours an Employee works. A Collective Bargaining Agreement that obligates an Employer to contribute a specified monthly amount to the Plan if an Employee works a minimum number of Covered Hours is a Flat Rate Contract.

"Health Care Provider" means only a person shown on the list below, if that person is: (1) licensed under the laws of the state or jurisdiction where services are rendered; (2) practicing within the scope of their license, and (3) not a Relative to the Participant.

- A dentist (DDS or DMD).
- A podiatrist (DPM).
- A psychologist (PhD), or licensed clinical social worker (LCSW).
- A registered nurse (RN), licensed practical nurse (LPN), licensed vocational nurse (LVN), registered nurse practitioner (RNP), psychiatric mental health nurse, or certified midwife.
- A certified registered nurse anesthetist (CRNA), registered nurse anesthetist (RNA), or nurse anesthetist (NA) authorized to administer anesthesia in collaboration with a Physician.
- An optometrist (OD).
- A registered physical therapist (RPT), occupational therapist (OT), or speech therapist (CST).
- A chiropractor (DC).
- A Pharmacist (RPh or PharmD).
- A certified audiologist (MS, ccc-a or MA, ccc-a).
- A physician assistant (PA).
- A certified mental health or substance abuse counselor or social worker, including a *Licensed Professional Counselor (LPC) or a Licensed Psychological Associate (LPA),* who has a master's degree and is licensed/legally authorized to practice or provide services.
- Massage Therapist

The following is a partial listing of providers that are *not recognized by the Plan:*

- Christian Science Practitioner
- Non-certified midwife
- Homeopath

"Hospice" or **"Hospice Agency"** shall mean a facility or organization which administers a program of palliative and supportive health care services providing physical, psychological, social and spiritual care during the final stages of terminal illness and during bereavement. The facility or organization must be certified by the National Hospice Organization, be approved by Medicare, and be licensed under the laws of the jurisdiction in which it is located. A Hospice that is a part of a Hospital will be considered a Hospice for the purposes of this Plan.

"Hospital" means a public or private facility or institution licensed and operating according to law, that:

- is accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO);
- is approved by Medicare as a Hospital; and
- provides care and treatment by Physicians and Nurses on a 24-hour basis for Illness or Injury through the medical, surgical and diagnostic facilities on its premises.

For purposes of benefits provided for mental health treatment, an institution that lacks permanent facilities for surgery or where the patient is normally expected to remain at the facility, or under the direct supervision of facility staff, 24 hours a day, will be considered a Hospital and an institution that is primarily a place for care of persons with mental health conditions will be considered a Hospital, provided that such institutions meet all other requirements applied to Hospitals

Any portion of a Hospital used as an ambulatory surgical facility, birthing center, convalescent or extended care facility, hospice, skilled nursing facility, sub acute care facility, or other residential treatment facility or place for rest, custodial care or the aged will not be regarded as a Hospital for purposes of benefits provided by this Plan.

"Illness" means a bodily disorder, infection, or disease and all related symptoms and recurrent conditions resulting from the same cause. An Illness identified in the current version of the Diagnostic and Statistical Manual of Mental Disorders (DSM) is considered to be a Mental Illness for the purposes of this Plan. If there are multiple diagnoses, only the treatment for the Illness identified under the DSM code is considered Mental Illness treatment. Illness does not include an illness incurred or aggravated while performing a job-related task, engaging in any activity for wage or profit, or for which compensation could be available if application were made under a workers' compensation or occupational injury law or similar legislation.

"Injury" means physical harm sustained as the direct result of an accident, affected solely through external means, and all related symptoms and recurrent conditions resulting from the same accident. Injury does not include an injury incurred or aggravated while performing a job-related task, engaging in any activity for wage or profit, or for which compensation could be available if application were made under a workers' compensation or occupational disease or injury law or similar legislation.

"Lag Month Eligibility Period (*or*) Lag Period" means the period of time after which an Employee satisfies the Plan's eligibility requirements, and before coverage begins. See Section 1.1.

A **"Licensed Home Health Care Agency"** shall meet all of the following requirements:

- it must primarily provide skilled nursing services and other therapeutic services under the supervision of Physicians and Registered Nurses;

- it must operate according to policies established by a professional group, including Physicians and Registered Nurses, which governs the services provided;
- it must maintain written clinical records on all patients; and
- it must be licensed by the jurisdiction where it is located, operate according to the laws of that jurisdiction which pertain to agencies providing Home Health Care, and be certified as a Home Health Care Agency by Medicare.

"Life Insurance Provider" means the insurer, identified in the Quick Reference Table at the front of this booklet that provides benefits described at Section 12.

Services and supplies are **"Medically Necessary"** or provided due to **"Medical Necessity"** if such service or supply is determined by the Plan to be:

1. appropriate and necessary for the symptoms, diagnosis or treatment of an Illness, Injury or condition; and
2. not Experimental and/or Investigational; and
3. not primarily for the convenience of the Participant, the Participant's Physician or another provider; and
4. not primarily for research or data accumulation; and
5. within the standards of generally accepted medical practice and professionally recognized standards within the organized medical community in which services are provided; and
6. the most appropriate supply or level of service which can safely be provided. When applied to hospitalization, Medically Necessary means that the symptoms or condition cannot safely and adequately be treated on an outpatient basis.
7. Medical Necessity shall also encompasses dental necessity with respect to the Plan's dental benefits.

The fact that a Physician or other Health Care Provider may prescribe, order, recommend or approve a service or supply does not mean that such a service or supply will be considered to be Medically Necessary for the coverage provided by this Plan.

"Medicare" means the insurance program established by Title XVIII, United States Social Security Act of 1965, as originally enacted and as subsequently amended.

A **"Mental Illness"** is an Illness defined within the mental disorders section of the current edition of the International Classification of Diseases (ICD-9-CM) manual or is identified in the current edition of the Diagnostic and Statistical manual of Mental Disorders (DSM), including a psychological and/or physiological dependence on or addiction to alcohol or psychiatric drugs or medications, regardless of any underlying physical or organic cause.

The term **"Open Enrollment"** shall mean the annual period specified by the Trustees in which you may elect to change your Plan Level of benefits.

"Participant" shall mean any person eligible for benefits under the Plan, whether as an Eligible Employee, Retired Participant, or Dependent.

The terms **"Physician," "Surgeon"** or **"Doctor"** mean a licensed Doctor of Medicine (M.D.) or Doctor of Osteopathy (D.O.), licensed to practice in the state in which services are rendered and practicing within the scope of their license. For a list of additional recognized providers, refer to **Health Care Providers**.

"Payroll Month" means the four or six week payroll period ending in a calendar month that is ordinarily used by your Employer to report employees' hours of work during a month to the Plan. For an Employer reporting

hours of work on the basis of the bimonthly or monthly periods, the "Payroll Month" is the same as a calendar month.

"Pension Trust" means the Alaska Teamster-Employer Pension Trust.

"Pharmaceutical Provider" means the Prescription Drug Benefit administrator for the Plan, identified in the Quick Reference Table at the front of this booklet.

"Plan Level" means a type of coverage available under the Plan, as further described in Section 1. The cost of each Plan Level is determined by the Trustees. When beginning participation in the Plan, you have a choice about which Plan Level to select – or a Plan Level will be chosen for you. Plan Level selections can only be changed at yearly Open Enrollment, for coverage effective January 1 of the following year, or when certain qualifying events changes have occurred in your family.

"Plan" shall mean this document titled the *Alaska Teamster-Employer Welfare Trust Summary Plan Description* as adopted and thereafter amended by the Board of Trustees.

The term **"Preferred Provider Organization"** or **"PPO"** means a Hospital, Physician or other health professional, pharmacy, or other facility that has a contract for negotiated rates in effect with the Plan.

"Preferred Provider Plan" means a program whereby specific providers contract with the Plan to provide Medically Necessary services or supplies to Participants payable on a negotiated rate basis, approved by the Trustees and amended from time to time.

The term **"Pregnancy"** includes prenatal and postnatal care, childbirth, early termination of pregnancy, and complications of pregnancy for an Eligible Employee, Retired Participant, or Dependent Spouse, only. Pregnancy-related expenses are not provided for Dependent Children. Pregnancy will be covered as if it were an Illness.

The term **"Complications of Pregnancy"** means all physical effects suffered which have been directly caused by the pregnancy, but which would not be considered from a medical viewpoint the effects of a normal pregnancy. Complications of Pregnancy shall include, but are not limited to, conditions such as acute nephritis, nephrosis, cardiac compensation, missed abortion, ectopic pregnancy which terminated, caesarian section, spontaneous terminations of pregnancy which occur during a period of gestation in which a viable birth is not possible, and similarly medically diagnosed conditions. Complications of Pregnancy shall not include false labor, Physician prescribed rest during the period of pregnancy, morning sickness and similar conditions not constituting a classifiably distinct Complication of Pregnancy.

"Protected Health Information" means information that is created or received by the Plan that identifies a living or deceased participant or beneficiary, or for which there is a reasonable basis to believe the information can be used to identify the participant or beneficiary, and which relates to: the past, present, or future physical or mental health or condition of a participant or beneficiary; the provision of health care to a participant or beneficiary; or the past, present or future payment for the provision of health care to a participant or beneficiary.

"Relative" means the Participant's spouse, parents, children, siblings, or anyone residing in the same household as the Participant.

"Retired Participant" means an individual who has satisfied the eligibility and enrollment provisions at ***Eligibility Rules for Retired Participants***.

"Security Incident" has the same meaning as in 45 CFR § 164.304.

“Skilled Nursing Facility” or **“Extended Care Facility”** means an institution primarily engaged in providing patients with (i) skilled nursing care and related services, or (ii) services for the rehabilitation of injured, disabled or sick persons, and which meets all of the following requirements:

- it is accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) or Commission on Accreditation of Rehabilitation Facilities (CARF) as a Skilled Nursing Facility or is recognized by Medicare as a Skilled Nursing Facility; and
- it is regularly engaged in providing room and board and skilled nursing care for sick and injured persons under 24 hour-a-day supervision of a Physician or a Registered Nurse;
- it has available at all times a Physician who is a staff member of a Hospital;
- it has on duty 24 hours a day a Registered Nurse, licensed vocational nurse, or skilled practical nurse, and has on duty at least eight hours a day a Registered Nurse;
- it maintains a daily medical record for each patient who is under the care of a Physician;
- it is not (other than incidentally) a home for maternity care, rest, domiciliary care, or care of people who are aged, alcoholic, blind, deaf, drug addicts, or suffering from mental health conditions or tuberculosis; and
- it is not a hotel or similar facility.

“Spouse” means the person to whom an Eligible Employee or Retired Participant is legally married, as determined by applicable state law.

“Substance Abuse Facility” means a facility for treatment of abuse of alcohol or drugs which:

- is accredited by the Bureau of Alcohol and Drug Abuse in the Rehabilitation Division of the Department of Human Resources or a Hospital which is licensed by the Health Division of the Department of Human Resources (or analogous governmental entity that certifies Substance Abuse Facilities); and
- is accredited by the Joint Commission on Accreditation of Healthcare Organizations, providing a program for the treatment of substance abuse as part of its accredited activities.

For purposes of inpatient treatment for other than detoxification, Substance Abuse Facility means:

- a facility having either of the above accreditations; or
- a facility accredited by the Commission on Accreditation of Rehabilitation Facilities; or
- a Hospital.

“Summary Health Information” means information that (a) summarizes the claims history, claims expenses or type of claims experienced by individuals provided health benefits under the Plan; and (b) from which the information described at 42 CFR § 164.514(b)(2)(i) has been deleted, except that the geographic information described in 42 CFR § 164.514(b)(2)(i)(B) need only be aggregated to the level of a five-digit zip code.

“Summary Plan Description,” “Plan,” or this **“Booklet”** describes this document.

“Surviving Spouse” means the individual to whom an Eligible Employee or Retired Participant was legally married on the date of the Eligible Employee or Retired Participant’s death.

For Time Loss Benefits and for Extended Benefits for Total Disability, **"Total Disability"** or **"Totally Disabled"** means that as a result of an Injury or Illness, an Eligible Employee is absent from work and unable to engage in the duties of his/her customary occupation, and is performing no work of any kind for wage or profit.

The term **"Trust Agreement"** or **"Trust"** or **"Welfare Trust"** means the Trust Agreement establishing the Alaska Teamster-Employer Welfare Trust, and any modification, amendment, extension or renewal thereof.

"Trust Customer Service Office" means the Alaska Teamsters-Employer Welfare Trust.

"Trustees" shall mean any person(s) designated as Trustees pursuant to the terms of the Trust Agreement, and the successor of such persons from time to time in office. The term **"Board of Trustees"** and **"Board"** means the Board of Trustees established by the Trust Agreement.

An **"Urgent Care Facility"** is a public or private Hospital-based or free-standing facility, licensed as an Urgent Care Facility, that primarily provides minor Emergency and episodic medical care, in which one or more Physicians and Nurses are in attendance at all times when the facility is open, and that includes a life support system and an arrangement to provide x-ray and laboratory services.

"Usual, Customary and Reasonable" or **"UCR"** means the charge for a service or supply furnished by a covered provider, which meets the following criteria as determined by the Plan:

A charge is considered "usual" if it is the charge the provider most frequently makes to the majority of his or her patients for a given service or supply. A charge is considered "customary" when it is within the range of appropriate charges in the geographic area as determined by a third party service selected by the Plan to determine appropriate medical charges. A charge is within the range of appropriate charges if it is equal to or less than the 85th percentile rate established for the geographic area by the Plan's third party service and no more than the amount determined by the Plan's third party service as the then-current Medicare allowed charge for end-stage renal disease charges. With regard to end-stage renal disease charges, however, the Plan may pay charges up to the amount determined by the Plan's third-party service to be no more than 125% of the then-current Medicare allowed charges. A charge is considered "reasonable" when the service or supply is within reasonable utilization limits, and is justifiable considering the circumstances involved.

"Utilization Management" is a managed care procedure to determine the Medical Necessity, appropriateness, location and cost-effectiveness of health care services. This review procedure can occur before, during or after services are rendered, and may include (but is not limited to):

- Precertification/Preauthorization Review for hospitalizations, surgery, diagnostic procedures, home health and IV therapy services, hospice care and rehabilitation services; and
- Medical Case Management.

"Utilization Management Organization" means the organization, identified in the Quick Reference Table at the front of this booklet that performs Utilization Management for the Plan.

"Written Agreement" means an agreement between an Employer and the Trust requiring employer contributions to the Trust on behalf of its employees.

STATEMENT OF RIGHTS UNDER EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974

As a Participant in this Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 ("ERISA"). ERISA provides that all Plan Participants shall be entitled to:

Receive Information About Your Plan and Benefits

- Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated Summary Plan Description. The Administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each Participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

- Continue health care coverage for yourself, spouse, or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this Summary Plan Description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.
- Reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health Plan if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

Prudent Action by Plan Fiduciaries

- In addition to creating rights for Plan Participants, ERISA imposes duties upon the people who are responsible for the operation of the Plan. The people who operate the Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan Participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

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

- Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the 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 complied with the Plan's required administrative appeals procedures. In addition, if you disagree with the Plan's 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.

Assistance with Your Questions

- If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Office of Participant Assistance, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.