Alaska Pipe Trades Association – U.A. Local No. 375 Health and Security Trust Fund

Summary Plan Description

January 2022

KEY CONTACTS

If you have questions about these topics…	See Pages…	Contact…
Eligibility ▪ Active ▪ Self-Pay ▪ Retiree **Hour Bank Status** **Administrative** ▪ Benefit enrollment forms ▪ Family status changes ▪ Address changes	**6 - 21** **6- 7**	Welfare & Pension Administration Service, Inc. In Seattle: (206) 441-7574 Toll-free: (800) 732-1121, opt. 4
Health Care Plans ▪ Medical benefits ▪ Dental benefits ▪ Vision benefits	**22– 53**	**Welfare & Pension Administration Service, Inc.** In Seattle: (206) 441-7574, opt. 0 Toll-free: (800) 331-6158, opt. 0
Health Care Claims ▪ Submitting claims ▪ Checking on claim status ▪ Appealing a denied claim **Where to mail claims:** Dental, Member Paid and Medicare claims: Alaska Pipe Trades P.O. Box 34687 Seattle, WA 98124-1687 Medical and Vision claims: Aetna P.O. Box 981106 El Paso, TX 79998-1106	**58– 61**	**Administration Office** Welfare & Pension Administration Service, Inc. **Claims questions:** Toll-free: (800) 331-6158, opt. 0 In Seattle: (206) 441-7574, opt. 0
Inpatient and Outpatient Preauthorization	**27– 30**	**Comagine Health** (800) 783-8606 7 a.m.– 4 p.m. Alaska Standard Time
Prescription Drugs	**46**	**CVS Caremark** (866) 818-6911
Life & AD&D Insurance ▪ Benefits ▪ Filing claims **Where to mail claims:** Alaska Pipe Trades P.O. Box 34687 Seattle, WA 98124-1687	**54 – 55**	**Welfare & Pension Administration Service, Inc.** In Seattle: (206) 441-7574, opt. 4 Toll-free: (800) 732-1121, opt. 4
Supplemental Unemployment Benefit	**56**	**U.A. Local 375** (907) 479-6221

WELCOME!

Welcome to the Alaska Pipe Trades Association – U. A. Local No. 375 Health and Security Trust Fund ("Trust"). The Trust's Plan provides you and your family with excellent health care benefits.

The Trust serves families who are employed by or retired from employers who have labor contracts with the U. A. Local No. 375.

This Plan Booklet and Summary Plan Description provides you with information about your Medical, Dental, Vision and Life Insurance Plan.

Did You Know?

The United Association of Journeymen and Apprentices of the Plumbing and Pipe Fitting Industry of the United States and Canada, or "UA" as it is commonly known, is a multi-craft union whose members are engaged in the fabrication, installation, and servicing of piping systems.

There are approximately 326,000 highly skilled United Association members who belong to 321 individual local unions across North America.

Providing health care coverage that you can depend on is part of the United Association of Journeymen and Apprentices of the Plumbing and Pipe Fitting Industry's goal to better the working conditions for its members.

TAKE ACTION

This Plan Booklet provides information about your benefit options and helps you to make the choices that are the best decisions for you and your family. To make the most of your benefit enrollment opportunity:

- **Read this Plan Booklet to understand your choices and compare your options.**
- **If you have questions, request additional information.**
- **Keep this Plan Booklet on hand for future reference.**

AUTHORITY TO INTERPRET AND CHANGE THE PLAN

The Trust is governed by a Board of Trustees consisting of both UA and employer representatives. The Board of Trustees has the exclusive authority and discretion to interpret the Plan provisions, to determine eligibility for and entitlement to Plan benefits and to amend the Plan. Any interpretation or determination by the Trustees made in good faith, which is not contrary to law, is conclusive on all persons affected.

The Board of Trustees has delegated certain claims administration processes to the Administration Office and to the Plan network provider. In administering the Plan, the Administration Office or the network provider may utilize internal guidelines, medical protocols or third-party review organizations in determining whether or not specific services or supplies are covered under the terms of the Plan. Additionally, the Board of Trustees has delegated to the Local 375 Union Office the authority to provide information relating to the amount of benefits, eligibility and other Plan provisions.

The Administration Office and the Local 375 Union Office does not have the authority to change the provisions of the Plan. An interpretation of the Plan by the Administration Office or the Local 375 Union Office is subject to review by the Board of Trustees. No individual trustee, employer, employer association, labor organization, or any individual employed by an employer or labor organization, has any authority to interpret or change the Plan.

The Board of Trustees reserves the right, at its sole discretion, to make any changes it deems necessary to promote efficiency, economy and better service for the Participants and their covered dependents. The Trust has no obligation to furnish benefits beyond those described in the Plan. All Plan benefits, including retiree benefits, are provided to the extent that money is currently available to pay the cost of such benefits.

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ELIGIBILITY AND ENROLLMENT

Active Participants

Eligibility for active Participants who are covered by a collective bargaining agreement is determined on the basis of an hour bank system. To become eligible and to maintain eligibility, you must satisfy the hour bank eligibility requirements discussed below. You must also enroll in this Plan before your claims can be processed.

Hour Bank Eligibility Provisions

All hours reported by contributing employers are credited to the Participant's Hour Bank.

A new Participant will become covered beginning with the first day of the second calendar month following an accumulation of 540 hours in his or her Hour Bank.

KEY POINT

Initial Eligibility: A new Participant will become covered beginning with the first day of the second calendar month following an accumulation of 540 hours in his or her Hour Bank.

Continued Eligibility

Each month after satisfying the initial eligibility requirements, 135 hours will be deducted from a Participant's Hour Bank to maintain coverage under the Plan. A Participant will continue to be covered as long as there are at least 135 hours in the Participant's Hour Bank.

Lag Month

To provide sufficient time for receiving and processing employer reports, a lag month is used in determining the monthly eligibility. The work month is the month hours are actually worked, the reporting month or lag month is the following month in which the hours are reported to the Trust, and the eligibility month is the month you are eligible to receive benefits. For instance, if you worked sufficient hours in January, your hours will be reported to the Trust in February and you will be covered in March.

Work Month	Coverage Month		Work Month	Coverage Month
Jan.	March		July	Sept.
Feb.	April		Aug.	Oct.
March	May		Sept.	Nov.
April	June		Oct.	Dec.
May	July		Nov.	Jan.
June	Aug.		Dec.	Feb.

Hour Bank Maximum

The maximum number of hours which may be accumulated to a Participant's credit is 675. This means that you can accumulate hours for five months of coverage.

When Active Coverage Terminates

Coverage for active Participants terminates:

- The last day of the month when the Participant does not have sufficient hours to provide another month of coverage.
- On the date the Participant dies.
- On the date the Trust ceases to provide benefits.

- For associate Employees, on the last day of the month prior to the month for which contributions are not received.

If a Participant does not accumulate any hours in his or her Hour Bank for four consecutive months after losing eligibility, any remaining hours will be forfeited on the first day of the fifth month, unless the Participant is eligible for and elects the continuation coverage. If the hours are forfeited, the Participant must reestablish eligibility as a new Participant.

Reinstatement of Eligibility

To reestablish eligibility, a Participant must meet the initial eligibility requirements as set forth above.

Active Participants Not Covered under Hour Bank Eligibility Rules

Active Participants who are not subject to a collective bargaining agreement requiring contributions to this Trust (associate Participants) will have their eligibility determined on a month-to-month basis as determined by the Trustees.

In addition, these associate Participants are NOT eligible for Indefinite Self-Pay Plans or Retiree coverage.

Continuation Rights for Active Participants

Continuation coverage for active Participants who have lost eligibility may be continued in certain circumstances. See the section on page 11 regarding Continuation Coverage Plans.

Reciprocity Eligibility Provisions

To be eligible for coverage under this Agreement, you must meet the following requirements:

- You must be a member in good standing of Local 375, including dues paid up to date; and
- The other Health and Security Fund under which you are working must be participating under The United Association Health and Welfare Fund Reciprocal Agreement.

Under the Reciprocal Agreement, all contributions made on your behalf to another Fund for Health and Security benefits may be transferred back to this Fund.

KEY POINT

Under the "United Association Health and Welfare Fund Reciprocal Agreement," you may retain your Plan eligibility and benefits, even when you are working in another U.A. jurisdiction.

When received by the Home Fund, if the contribution rate in effect on this Fund is greater or lesser than that in effect on the other Fund, the money reciprocated on a monthly basis will be divided by the current Local 375 contribution rate to determine the reported hours.

The adjusted number of hours will be used to determine your eligibility for coverage, if any, in this Fund. These hours will be credited to your Hour Bank.

For example, if you were to work in a jurisdiction requiring contributions of $11.00 per hour, the hours submitted to the U. A. Local No. 375 Health and Security Trust Fund would be adjusted according to the current Local 375 contribution rate.

- Reciprocal Trust rate $11.00 per hour remits 180 hours X $11.00 = $1,980;
- $1,980 divided by Local 375 Trust $11.75 per hour = 168.5 hours reported;
- The resulting hours will be credited in your Hour Bank Account.

The traveling members will register for reciprocity at the same time they obtain their travel card from their Home Local Union. If you are contemplating employment outside of 375's jurisdiction, please contact the Local Union Office for additional information in advance of leaving Alaska.

Dependent Eligibility

Your eligible dependents include only your:

- Legal spouse
- Natural children, stepchildren, adopted children and children placed with you for adoption, foster children, children for whom you have legal custody who reside with you, the member, in a regular parent–child relationship:
  - From birth to age 26; or
  - Who attain age 26 while covered under this program and who, as of the date they would otherwise lose coverage, are disabled, the disability arose before the child reached age 26 and as a result of that disability the child is primarily dependent on the Participant or retiree for support. For this purpose, disability is defined a mental or physical condition that is expected to be permanent and continuous for the remainder of the child's life and results in the inability to engage in of self-sustaining employment, including one or more of the following: the inability to perform activities of daily living, the inability to engage in normal social functions, the inability to independently complete tasks. Disability does not include conditions that are temporary or where recovery would be expected through treatment.

    A Social Security Disability Award will be considered presumptive evidence of disability. Absent a Social Security Disability Award, the Plan will make a disability determination based on the individual's facts and circumstances. The Plan may consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment.

Qualified Medical Child Support Order (QMCSO)

The Plan recognizes Qualified Medical Child Support Orders (QMCSO) and enrolls dependent children as directed by the Order. A Qualified Medical Child Support Order is any judgment, decree or order (including a domestic relations settlement Agreement) issued by a court or by an administrative agency under applicable state law which:

- Provides child support or health benefit coverage to a dependent child, 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 Participant does not enroll the dependent child, then the non-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,
- The name and mailing address of each dependent child covered by the order or the name and mailing address of the state official issuing the order,
- A description of the type of coverage to be provided by the Plan to each such dependent child,
- The period of coverage to which the order applies, and
- The name of each Plan to which the order applies.

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 or his custodial parent or legal guardian shall be made to the child or his custodial parent or legal guardian if so required by the Medical Child Support Order.

No dependent 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.

If a proposed or final order is received, the Administration Office will notify the Participant and each child named in the order. Each child named in the order may designate a representative to receive copies of notices with respect to the order. The order will then be reviewed to determine if it meets the definition of a "Qualified Medical Child Support Order."

A properly completed National Medical Support Notice issued by a state agency shall be deemed to be 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 or parties filing the order will be given an opportunity to correct the order or appeal the decision through the claims review procedures 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 and any required self-payments must be received prior to enrollment. Any child or children enrolled pursuant to an order will be subject to all provisions applicable to dependent coverage under the Plan.

TAKE ACTION

To enroll in benefits, complete the Health Trust's Benefits Enrollment Form. (On this form, you will also be able to designate a beneficiary for your Life Insurance coverage.)

Enrolling Your Dependents

If you have eligible dependents, it will be necessary to enroll your dependents and include your dependent information on the enrollment form. An enrollment form for your current dependents, , should be submitted within 90 days of your enrollment in order to avoid delay in processing claims.

Acquiring a New Dependent

If you acquire a new dependent while you have coverage, a new enrollment form must be completed and submitted along with the appropriate documentation. You should complete a new enrollment form within 90 days of your marriage, birth, adoption or placement for adoption and supply an appropriate marriage or birth certificate. Submit the new enrollment form to the Administration Office, even if the required documentation is not yet available. The Trust will not pay claims for a new dependent until all appropriate documentation has been submitted. In no event will the Trust pay claims more than 12 months after the incurred date, even if the appropriate documentation is submitted after 12 months.

If You Fail to Timely Enroll Your Dependents

If you fail to timely enroll your dependents your dependents will not be eligible to enroll until the next open enrollment period. The only exception to this is if the dependent or employee has a special enrollment event. Special enrollment events include marriage, birth, adoption or placement for adoption. In addition, spouses and dependents may have special enrollment rights if they did not enroll in the Plan due to the availability of other coverage through another group health plan or health insurer (including COBRA continuation coverage) and the availability of that other coverage is subsequently lost. In order for this special enrollment right to apply, the employee must indicate on the enrollment form that Plan coverage is declined due to other coverage and must show proof of other coverage when seeking special enrollment.

If a special enrollment opportunity is available, the employee must request special enrollment within 60 days of the marriage, birth, adoption, placement for adoption or loss of other coverage that triggered the special enrollment opportunity. In the case of marriage or loss of other coverage, enrollment will be effective no later than the first day of the first calendar month beginning after the date the completed request for enrollment is received by the Plan. In the case of birth, adoption or placement for adoption, enrollment will be effective not later than the date of such birth, adoption or placement for adoption.

When Dependent Coverage Begins

- Eligibility for your dependents will be effective:
  - On the date you become covered for your current dependents.
  - On the date of birth, adoption, placement for adoption, on date of foster child legal custody, on date of marriage for stepchildren. If enrollment is requested timely but not all the required documentation is received, claims will be pended for up to 12 months from the date of service until all required documentation has been received.
  - On the first day of the first calendar month beginning after the date the completed enrollment is received in the case of marriage.
- If your coverage has lapsed, your dependent's coverage will begin on the first day of the month when you again have coverage.
- A newborn child becomes covered as set forth above from birth providing your coverage has not lapsed. Claims will be pended for up to 12 months until all required documentation has been received by the Trust.

If Your Dependent is Eligible for Medical Coverage Through Another Employer

If your spouse is eligible for medical coverage through his or her employment with another employer, and does not enroll for that coverage, then your spouse will be disqualified from receiving medical and prescription drug coverage under this Plan. You will be required to submit an affidavit as proof that your spouse is not eligible for other medical coverage through his or her employer.

Your spouse will not be disqualified from receiving coverage under an Alaska Pipe Trades Association – U. A. Local No. 375 Health and Security Trust Fund, if your spouse is eligible for other medical coverage and enrolls in it.

If your spouse is eligible for other medical coverage and subsequently loses that other medical coverage, your spouse may enroll in the Plan provided the request for enrollment is submitted within 30 days of losing the other medical coverage.

When Dependent Coverage Terminates

Coverage for an individual dependent terminates:

- On the last day of the month the dependent ceases to meet the eligibility requirements for a dependent of the Participant.
- On the day the Participant is no longer covered.
- On the date the Trust ceases to provide benefits.

CONTINUATION COVERAGE PLANS

The Plan includes various continuation coverages to eligible active Participants and their dependents. The following is a list of the continuation provisions.

Disability Waiver of Eligibility

A Participant who ceases active work because of a Non-Occupational Illness or Injury and who fails to qualify for coverage in a particular month because of such disability shall continue to be covered for up to three consecutive months after eligibility ceases due to lack of hours in the Hour Bank. For this purpose, disability means the Participant is under the personal and regular care of a licensed provider for a Non-Occupational Injury or Illness that prevent the Participant from engaging in any occupation for compensation, profit, or gain.

The cost of coverage will be paid by the Trust. The three-month waiver of the cost of coverage shall also apply where a Participant has been maintaining coverage by self-payment and then becomes disabled. For this purpose, disabled means a sickness or injury that totally and continuously prevents you from working in any occupation for wage or profit, and which occurred while you are a covered participant and is expected to last for the rest of your life.

Proof of such disability must be received before the waiver of the cost of coverage becomes applicable.

After the three-month waiver period, you may elect to continue your health coverage to the extent other continuation rights may apply. This waiver provision runs concurrently with COBRA. If you elect COBRA after receiving a disability waiver, your combined coverage under COBRA and the disability waiver extension will not exceed 18 months.

The waiver shall apply to all benefits for you and your dependents.

You must apply for this waiver within 30 days following loss of eligibility. Forms may be obtained from the Administration Office or the Local 375 Union Office.

Waiver does not apply to Participants receiving unemployment compensation.

Family and Medical Leave

If you become eligible for a family or medical leave of absence in accordance with the Family and Medical Leave Act of 1993 (FMLA), including any amendments to such Act, your insurance coverage may be continued on the same basis as if you were an actively at work Employee for up to 12 weeks during the 12-month period, as defined by your employer, for any of the following reasons:

- To care for your child after the birth or placement of a child with you for adoption or foster care; so long as such leave is completed within 12 months after the birth or placement of the child.
- To care for your spouse, child, foster child, adopted child, stepchild, or parent who has a serious health condition.
- For your own serious health condition.

Participants who think they may be eligible for a FMLA leave should contact their Employer immediately. An Employer must provide documentation to the Trust to confirm eligibility for FMLA leave, and make arrangements to pay the required contributions to continue coverage.

Following FMLA, the Plan's Continuation of Coverage Options may be available.

COBRA Continuation Coverage

Under the circumstances described below, you, your lawful spouse and eligible dependents each have the independent right to elect to continue your health coverage beyond the time coverage would

ordinarily have ended pursuant to a Federal law known as COBRA (Consolidated Omnibus Budget Reconciliation Act).

Qualifying Events

You, as the participating Employee, have the right to elect continuation of your health coverage from the Trust if you would otherwise lose eligibility because of a reduction in hours of employment or termination of employment.

Your spouse and dependent children have the right to choose continuation of coverage if he or she would otherwise lose eligibility for any of the following reasons:

- The participating Employee's termination of employment or reduction in hours of employment, leaving fewer than 135 hours in the Employee's Hour Bank.
- Death of the participating Employee.
- Divorce from the participating Employee.
- The child no longer qualifying as an eligible dependent under the Plan.

COBRA Notification Responsibilities

The Trust offers continuation coverage only after it has been notified of a qualifying event.

Your employer is responsible for informing the Trust if your employment is terminated. The Administration Office will determine when the Employee's Hour Bank falls below 135 hours.

If you or your eligible dependents have a loss of coverage because of divorce, death, or a child losing dependent status you must notify the Administration Office in writing within 60 days of the date of the qualifying event. The notice must identify the individual who has experienced the qualifying event, the eligible Employee's name and the qualifying event that occurred. Failure to provide timely notice will result in your coverage ending as it normally would under the terms of the Plan. The Board of Trustees reserves the right to determine whether coverage has in fact been lost due to a qualifying event.

To help ensure you receive necessary notices, you should notify the Administration Office if your address or that of any family member changes. You should retain this notice and also keep a copy of any written notices you send the Trust.

Election of COBRA

Once the Administration Office has received proper notice that a qualifying event has occurred, it will notify you and each of your eligible family members of your rights to elect continuation coverage.

TAKE ACTION

A written election must be submitted to the Administration Office within 60 days from the date coverage would otherwise end or 60 days from the date the notification is received from the Trust, if later.

Unless otherwise stated on the election form, an election of COBRA coverage under the Trust by one family member covers all other eligible members of the same family. Notice must be sent to the Administration Office.

Failure to elect continuation within this 60-day period will cause eligibility to end as it normally would under the terms of the Plan.

Available Coverage

The continuation coverage offered is the same as the Trust coverage provided to other Participants. Your self-pay options are:

1. Medical and Prescription Drug only; or
2. Medical, Prescription Drug, Dental and Vision

You and/or your eligible dependents may elect either of the self-pay options. Life and AD&D benefits are not available under COBRA continuate coverage.

Adding New Dependents

COBRA is only available to individuals who were covered under the Plan at the time of the qualifying event.

If you elect COBRA and acquire a new dependent through marriage, birth, adoption, or placement for adoption, you may add the new dependent to your COBRA coverage by providing written notice to the Administration Office within 60 days of acquiring the new dependent.

The written notice must identify the Employee, the new dependent, the date the new dependent was acquired and be mailed to the Administration Office.

Children acquired through birth, adoption, or placement for adoption are entitled to extend their continuation coverage if a second qualifying event occurs.

Continuous Coverage Required

Your coverage under COBRA must be continuous from the date your coverage would have otherwise ended if COBRA was not elected.

Monthly Self-Payments Required

You must pay the entire cost of the continuation coverage.

The Trust uses a composite rate, which means that you pay the same monthly rate if you are covering one person or an entire family. The cost for the coverage available through the Trust is set annually.

COBRA self-payments are due on the first of each month for that month's coverage and must be sent to the Administration Office. The only exception is that the self-payment for the period preceding the initial election of coverage may be made up to 45 days after the date of election.

Your initial payment must cover all months for which you want coverage and be retroactive to when your coverage ended. If your initial payment is not received or postmarked within 45 days of when you elected coverage, your right to continuation coverage will be lost.

KEY POINT

Coverage will be terminated if payment is not received by the Administration Office within 30 days of the due date. Checks that are received and do not clear the bank due to insufficient funds are considered non-payment.

Length of Continuation Coverage

COBRA continuation coverage may last for up to 18 months following loss of coverage as a result of a termination of employment or reduction in hours.

For all other qualifying events (death of Employee, divorce or legal separation from Employee, or a child no longer qualifying as a dependent under the Plan) continuation coverage may last for up to 36 months. However, continuation coverage will end on the last day of the month if any one of the following occurs before the maximum available continuation period:

- A required self-payment is not paid to the Administration Office on a timely basis for the next monthly coverage period.
- You or your eligible dependent becomes covered under any other group health plan after the date of your COBRA election. You are required to notify the Administration Office when you become eligible under another group health plan.
- You or your eligible dependent provides written notice that you wish to terminate your coverage.
- You or your eligible dependent becomes entitled to Medicare benefits after the date of your COBRA election.

- The date the Trust or Plan terminates or the date your employer no longer participates in the Trust or Plan unless your employer or its successor does not offer another health plan for any classification of its Employees that formerly participated in the Trust.

KEY POINT

In no event will continuation of coverage extend beyond 36 months.

Length of Continuation Coverage—Disabled Participants

If you, your spouse, or any dependent covered by the Trust is determined by the Social Security Administration to be disabled within the first 60 days of continuation coverage, the entire family of the disabled individual can receive an additional 11 months of continuation coverage for up to a maximum of 29 months.

If you are eligible for an extension of coverage as a result of you or a dependent being disabled, the cost of the coverage will be 150% of the COBRA self-payment rate for the additional 11 months of coverage provided as a result of your disability.

To obtain the additional months of coverage, you must notify the Administration Office in writing within 60 days of receipt of your Social Security Disability Determination or prior to the end of your initial 18-month period of continuation coverage.

If the disabled individual is subsequently found to not be disabled, you must notify the Administration Office in writing within 30 days of this determination.

Continuation coverage will end on the earlier of 29 months from the loss of coverage, or the month that begins more than 30 days after the final determination has been made that the disabled individual is no longer disabled.

Length of Continuation Coverage—Second Qualifying Event

Eligible dependents who are entitled to continuation coverage as the result of the Employee's termination of employment or reduction of hours can extend their coverage up to a total of 36 months if a second qualifying event occurs during the initial 18 months of continuation coverage. Possible second qualifying events are:

- The Employee's death.
- A divorce from the Employee.
- A child losing dependent status.
- The Employee becoming eligible for Medicare during the initial 18 months of continuation coverage.

If an eligible dependent wants extended coverage as a result of a second qualifying event, he or she must notify the Administration Office in writing within 60 days of the second qualifying event.

Failure to give such timely written notice of a second qualifying event will cause the individual's coverage to end as it normally would under the terms of the Plan.

KEY POINT

If you are entitled to Medicare or other group coverage at the time you elect COBRA, you can be eligible for both.

Relationship Between COBRA and Medicare or Other Health Coverage

Your COBRA coverage will terminate if you become entitled to Medicare or other group health coverage after your COBRA election.

If you have coverage based on COBRA and you are entitled to Medicare based on age or disability and no longer have current employment status, Medicare will pay first and the Trust will pay secondary and coordinate with Medicare. **This Plan does not provide benefits for amounts that would have been reimbursed by Medicare Parts A or B.**

Current employment status means you are still at work or have received short-term disability benefits for less than six months.

If you have Medicare coverage based on end stage renal disease and have Trust coverage (based on COBRA or otherwise), the Trust will pay primary during the 30-month coordination period provided for by statute.

If you have other group health coverage, your other group coverage will pay primary and the Trust's COBRA continuation coverage will be secondary.

KEY POINT

In considering whether to elect continuation coverage, please be aware that a failure to continue your group health coverage can affect your rights under Federal law.

Effect of Not Electing Continuation Coverage

If you do not elect continuation coverage you should be aware that Federal law gives you special enrollment rights. You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a spouse's plan) within 30 days after your group health coverage from the Trust ends because of your qualifying event. You will also have the same special 30-day enrollment right at the end of the maximum continuation coverage period available to you.

Health Insurance Marketplace

Instead of enrolling in COBRA, there may be other more affordable coverage options available through the Health Insurance Marketplace. Participants or dependents who enroll in coverage through the Marketplace may qualify for lower monthly premiums and lower out-of-pocket costs than under COBRA.

The Marketplace offers "one-stop shopping" to find and compare private health insurance options. In the Marketplace, you could be eligible for a new kind of tax credit that lowers your monthly premiums right away, and you can see what your premium, deductibles, and out-of-pocket costs will be before you make a decision to enroll. Through the Marketplace you'll also learn if you qualify for free or low-cost coverage from Medicaid or the Children's Health Insurance Program (CHIP). You can access the Marketplace for your state at www.HealthCare.gov. Being eligible for COBRA does not limit your eligibility for coverage for a tax credit through the Marketplace. Additionally, you may qualify for a special enrollment opportunity for another group health plan for which you are eligible (such as a spouse's plan), even if the plan generally does not accept late enrollees, if you request enrollment within 30 days.

Participants or dependents who elect COBRA can switch to a Marketplace plan during the Marketplace open enrollment. Participants and dependents may also be able to end COBRA early and switch to a Marketplace plan if there is an event that gives rise to a special enrollment period, such as marriage or birth of a child. However, if COBRA is terminated early without an event that gives rise to a special enrollment, then Marketplace coverage is not available until the next Marketplace open enrollment period.

Once COBRA is exhausted and expires, special enrollment is also available through the Marketplace, even if the open enrollment ended. If a Marketplace plan is selected instead of COBRA then COBRA may not thereafter be elected unless there is a new COBRA qualifying event.

For information about health insurance options available through the Health Insurance Marketplace, and to locate an assister in a particular geographic area who can provide information about the different options, visit www.HealthCare.gov.

Uniformed Services Employment and Reemployment Rights

If you leave employment with a contributing employer for military service, you have the following options:

- You may elect to run-out your Hour Bank. When your Hour Bank has less than the cost of one month of eligibility, you may elect to extend coverage by making self-payments for USERRA continuation coverage.
- You may elect to freeze your Hour Bank until you return from military service. If you freeze your Hour Bank, you still have the option of electing to self-pay for USERRA continuation coverage.

Notice of Military Service

You are responsible for notifying the Administration Office that you are entering military service. If you want to freeze your Hour Bank, you must notify the Administration Office within 60 days of beginning military service or your Hour Bank will continue to run-out.

If you want to run-out your Hour Bank, and then elect USERRA continuation coverage, you must notify the Administration Office of your military service within 60 days of termination of your Hour Bank coverage. If you fail to notify the Administration Office within the 60-day time period, you will not be entitled to elect USERRA continuation coverage.

Election of USERRA Continuation Coverage

After timely notification to the Administration Office of military service, you will be sent an election form to affirmatively elect to freeze your Hour Bank and/or elect USERRA continuation coverage. Your completed election form must be sent to the Administration Office, and postmarked or received within 60 days from the later of the date coverage would otherwise end, or 60 days from the date the notification is furnished. If you do not return your election forms by the due date, you will not be allowed to freeze your Hour Bank or elect USERRA continuation coverage.

Length of USERRA Continuation Coverage

If you provide timely notice and properly elect to freeze your Hour Bank, it will be frozen the first of the month following the month in which you begin military service.

If you properly elect to freeze your Hour Bank and elect USERRA continuation coverage, the USERRA continuation coverage will begin on the first day of the month following the month in which you begin military service, provided the required self-payments are made.

If you decide to run-out your Hour Bank before commencing USERRA continuation coverage, USERRA continuation coverage will begin the first of the month following depletion of your Hour Bank, provided the required self-payments are made.

USERRA continuation coverage will end on the first of the dates indicated below:

- 24 months following the month your Hour Bank terminates or is frozen because of your entry into military service;
- The last day of the month in which you fail to return to employment or apply for a position of reemployment within the time required by USERRA;
- The last day of the month for which a timely self-payment is not received or postmarked.

Available Coverage

You may elect to self-pay for USERRA continuation coverage for yourself, yourself and your dependents, or only your dependents.

You and/or your eligible dependents may elect either of the self-pay options.

Once you elect a coverage option, that election cannot be changed for the duration of USERRA continuation coverage. Benefits are the same as those provided to similarly situated active Participants. If the Trust changes its Plan benefits, USERRA continuation coverage will also change.

Monthly Self-Payments Required

If your military leave is for 31 days or more, a monthly self-payment is required for USERRA continuation coverage. The Administration Office will notify you of the self-payment amount when it

sends you the election forms. The rate for USERRA coverage is the same as the COBRA continuation coverage rate.

The initial payment for USERRA coverage is due within 45 days from the date the Administration Office receives a completed election form. The first payment must cover all months for which coverage is sought through the month in which the first payment is made. Eligibility will not commence, nor will claims be processed until the initial payment has been made, at which time eligibility will be retroactive to the date your Hour Bank coverage ended (or was frozen).

After the initial payment, monthly payments are due on the first of each month for that month's coverage. USERRA continuation coverage terminates if a monthly payment is not postmarked or received by the Administration Office within 30 days from the beginning of the month to be covered.

USERRA continuation coverage must be continuous and must immediately follow the date your Hour Bank coverage ended (or was frozen).

Reinstatement of Eligibility Following Military Service

If you properly elected to freeze your Hour Bank when you entered military service, the balance in your Hour Bank will be carried over until you are discharged from military service. Your Hour Bank eligibility will be reinstated the first of the month in which you are discharged. Following reinstatement, Hour Bank eligibility will terminate the last day of any month in which your Hour Bank has less than the cost of one full month of coverage at the current Hour Bank deduction rate. You are responsible for notifying the Administration Office of your discharge from military service.

If you return to employment with a contributing employer immediately following military service and within the time period required by USERRA, your Hour Bank eligibility will be reinstated on the first day of the second month after your Hour Bank has the minimum required for a month of coverage. Pending reinstatement of Hour Bank eligibility, you may make self-payments for coverage. If you elected to freeze your Hour Bank when you entered military service and you return to employment within the time period required by USERRA, you may make self-payments if you fail to work sufficient hours to reinstate Hour Bank eligibility before the previously frozen Hour Bank runs out.

To request self-pay continuation coverage after leaving military service, you must notify the Administration Office within 30 days following your return to employment. After timely notification, the Administration Office will provide an election form. Your completed election form must be sent to the Administration Office and postmarked or received within 60 days from the date it was mailed to you. The initial payment to continue coverage must be included with the completed election form and cover all months through which the first payment is made. The self-payment rate is the same as the COBRA continuation rate.

The coverage provided will be that stated under USERRA continuation coverage.

The self-pay coverage must be continuous and must commence the later of the first of the month in which you return to employment within the time specified by USERRA or the first of the month following the termination of your previously frozen Hour Bank eligibility. The reinstated coverage terminates on the earliest of your receipt of 18 consecutive months of reinstated coverage, reinstatement of your Hour Bank eligibility based upon your hours worked, or the last day of the month for which a timely self-payment is not received or postmarked. Self-pay coverage runs concurrently with any COBRA coverage that you and your dependents may be entitled to receive.

If you are on the out-of-work list at the local union, it is considered a return to employment with a contributing Employer for purposes of making self-payments for coverage.

Regardless of whether you want to make self-payments for coverage, you should contact the Administration Office if you return to employment within the time required by USERRA, so that your Hour Bank may be credited with any hours that remained in your account when you left for military service, and eligibility can be reinstated without satisfying the rules for initial eligibility.

Relationship of USERRA Continuation Coverage to COBRA

You may have the right to elect COBRA continuation coverage in lieu of USERRA continuation coverage. The length of USERRA continuation coverage may be different from that of COBRA continuation coverage. If you have questions regarding election or duration of COBRA continuation coverage, please see page 11 or contact the Administration Office.

RETIREE AND MEDICARE PARTICIPANTS

The Board of Trustees is providing this program of Retiree Health and Welfare Benefits to the extent that monies are currently available, and may be available in the future, to pay the cost of such a program. The Board of Trustees retains full and exclusive authority, at its discretion, to determine the extent to which monies are available for the program. This program is not guaranteed to continue indefinitely and may be terminated or modified at any time by the Board of Trustees.

Eligible Retiree Coverage

You are eligible for the Trust's Retiree Plan if:

You have attained age 62, you are receiving a Normal or Late Retirement Benefit from the Alaska Plumbing and Pipefitting Industry Pension Plan and you had active Hour Bank coverage in the Plan immediately preceding your retirement effective date.

Or

You are totally Medicare Social Security disabled, you are receiving a Disability Retirement Benefit from the Alaska Plumbing and Pipefitting Industry Pension Plan and you had active Hour Bank coverage in the Plan immediately preceding your retirement effective date.

Or

You are under age 62 and you satisfy the following conditions:

1) You have a minimum of 25,000 hours reported to this Plan as an active Participant;
2) You had contributions reported to this Plan for hours work in at least 24 of the 36 months immediately preceding your application to participate in the Retiree plan (for employees who return to active employment, months for which a retiree self-pay contribution is made will count toward the 24 month requirement);
3) You are eligible for and receiving a normal, early or disability pension from Alaska Plumbing and Pipefitting Industry Pension (you will be considered to be receiving a pension during any month your pension is suspended due to your return to active employment);
4) You apply for retiree coverage within 30 days of your retirement effective date; and
5) You are not eligible for Medicare.

Participants who elected to self-pay prior to April 28, 2011 under the "Four-Year Indefinite Self Pay" rule, may continue to self-pay even if they are not retired and do not satisfy the conditions set forth above.

Once you elect retire coverage, you must remain continuously covered in this Plan as a retiree, active employee due to receipt of employer contributions, or COBRA participant. If you enroll as a Retiree and then cease contributing to the Plan and do not reinstate your coverage as an active employee, you will lose the future ability to re-enroll in the Trust's Retiree Plan. If you lose active coverage, you cannot delay enrollment as a Retiree Plan except as otherwise provided in this Plan. If you return to work and reestablish coverage as an active employee, you may stop making your Retiree premium payments upon commencement of active eligibility; however, when you lose active coverage, you cannot delay reenrollment in the Retiree Plan except as otherwise provided in this Plan Booklet.

A delayed application for enrollment or re-enrollment Retiree Plan will only be accepted if you:

- You had four or more years of continuous Hour Bank coverage but then lost your coverage due to a disability verified by a medical doctor; and
- You attempted to return to work but were unable to reestablish Hour Bank coverage within six months from your loss of coverage; and
- You were unable to reestablish your Hour Bank coverage due to your disability.

Enrollment

A Retiree will be eligible on the first of the month following your date of retirement provided you have been an Hour Bank Participant covered for welfare benefits immediately preceding your retirement date, except as otherwise provided above.

Death of the Retiree Survivor Coverage

If you were covered at the time of death, your surviving spouse or child(ren) may self-pay for coverage after your death. The Local Union Office must be notified within 60 days after the Retiree's death of the intent to self-pay for coverage.

Such self-pay coverage may be continued by the widow(er) or child(ren) until:

- The widow(er) or child(ren) becomes covered by another employer-sponsored health plan.
- The survivor dies.
- The survivor attains age 65 and becomes eligible for Medicare.
- 36 months has elapsed.

Cost of Retiree Coverage

If you are eligible for and elect the Retire Plan you will be required to contribute to the cost of the Plan. You may continue under the plan as long as your contributions are paid.

Retiree Coverage Options

These coverage options are offered as retiree self-pay plans:

- Retiree Medical and prescription drugs.
- Retiree medical, prescription drugs, dental and vision.

Eligibility for Medicare

All Participants, including Retirees and dependents, regardless of age, who are otherwise eligible and entitled to participate in the Federal Medicare program for benefits, are required to enroll and participate in both Parts A and B of the Medicare program.

- Part A of Medicare covers general Hospital expenses.
- Part B covers doctors or medical expenses.

You are required to notify the Administration Office within 60 days of becoming eligible for Medicare. If you or your dependent fails to enroll in Medicare, benefits will be paid as if you were enrolled in Medicare. As a result, it is important for you and your dependents to enroll in Medicare on a timely basis. You should contact your local Social Security Office regarding enrollment in Medicare before your or your Covered Dependent's 65th birthday or if you are disabled.

If, while eligible under this Plan, you or your dependent becomes entitled to Medicare because of end-stage renal disease (ESRD), this Plan generally 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 individual receives a kidney transplant. Then, starting with the 31st month after the start of Medicare coverage, Medicare pays first and this Plan pays second.

If you are eligible for Medicare and fail to enroll, Plan benefits will be reduced as though you were enrolled in both Parts A and B of Medicare.

This means benefits would be paid on the assumption that you are enrolled in both Parts A and B of Medicare; and if you have, in fact, not enrolled, you could incur significant uncovered out-of-pocket expenses.

Medicare Example:

	WITH Medicare Part B	WITHOUT Medicare Part B
Medical Charges	$1,000	$1,000
Medicare Pays	$800	$0
Health Plan Pays	$200	$200
Patient Pays	$0	$800

Health Care Providers Who Opt Out of Medicare

You should also confirm that your doctor accepts Medicare payments and has not opted out.

If you are Medicare eligible, you will be reimbursed by the Plan as if you have signed up under Medicare Parts A and B and have been paid by Medicare.

SUMMARY OF HEALTH CARE BENEFITS	ACTIVE EMPLOYEES/DEPENDENTS	RETIREES/DEPENDENTS
Annual Deductible Per calendar year	$400 per individual $1,200 per family	
Medical Out of Pocket Limit	$3,000 per individual $9,000 per family	
PRIMARY CARE		
Routine Medical Care Health Care Provider office visits, etc.	80% of Allowed Amount	
Preventive Care	100% of Allowed Amount	
X-ray/Labs	80% of Allowed Amount	
Air Transportation Benefits	80% of Allowed Amount	
HOSPITAL CARE		
Inpatient Services ▪ **All days in a Hospital must be preauthorized** before any non-emergency admission ▪ **Emergency admission must be certified within 48 hours** of the admission except maternity (48 hours or less for routine deliveries / 96 hours for caesarean sections) **Preadmission testing is required** for tests and X-rays that should be done on an outpatient basis	80% of Allowed Amount	
Inpatient Surgery ▪ **A second surgical opinion is required** for certain types of non-emergency surgeries ▪ All days in a Hospital must be preauthorized	80% of Allowed Amount	
Second Surgical Opinion	100% of Allowed Amount	
Outpatient Surgery Certain outpatient procedures require preauthorization	100% of Allowed Amount	
Preoperative/Preadmission Testing	100% of Allowed Amount	

SUMMARY OF HEALTH CARE BENEFITS	ACTIVE EMPLOYEES/DEPENDENTS	RETIREES/DEPENDENTS
Organ Transplants	80% of Allowed Amount	
Birthing Center Expenses	100% of Allowed Amount	
ALTERNATIVE CARE		
Naturopaths Up to 18 visits per individual per calendar year combined with Chiropractic Care and acupuncture treatment.	80% of Allowed Amount	
Chiropractic Care Up to 18 visits per individual per calendar year combined with Naturopaths and acupuncture treatment.	80% of Allowed Amount	
ALTERNATIVES TO HOSPITALIZATION		
Skilled Nursing Care Up to 100 days per calendar year Preauthorization required for inpatient treatment	100% of Allowed Amount	
Hospice Care Up to 30 days per calendar year Preauthorization required for inpatient treatment	80% of Allowed Amount; $3,000 outpatient maximum	
Home Health Care Up to 100 visits per calendar year Preauthorization required for inpatient treatment	100% of Allowed Amount	
BEHAVIORAL HEALTH		
Mental Health Treatment Inpatient or outpatient Preauthorization required for inpatient treatment	80% of Allowed Amount	
Substance Abuse Treatment Inpatient or outpatient Preauthorization required for inpatient treatment	80% of Allowed Amount	
PRESCRIPTION DRUG BENEFITS		
Prescription Drug Out of Pocket Limit	$4,500 per individual $5,600 per family	

SUMMARY OF HEALTH CARE BENEFITS	ACTIVE EMPLOYEES/DEPENDENTS	RETIREES/DEPENDENTS
RETAIL CARD PLAN **Network Pharmacy** ▪ Deductible does not apply ▪ Limited to a 30-day initial (starter dose) supply and up to a 60-day supply on refills	**Generic** – Plan pays 90%, subject to $5 minimum copay per prescription (not to exceed actual cost) **Brand when a generic is not available** – Plan pays 80%, subject to $100 maximum copay per prescription **Brand when a generic is available** – Plan pays 70%, subject to $100 maximum copay per prescription	
Non-Network Pharmacy Full payment at time of purchase is required; you must submit a claim form to request reimbursement	**All Drugs** - Plan pays 70%, subject to $100 maximum copay per prescription	
MAIL ORDER PLAN ▪ Deductible does not apply ▪ Limited to a 90-day supply	**Generic** – Plan pays 90%, subject to $15 minimum copay per prescription (not to exceed actual cost) **Brand when a generic is not available** – Plan pays 80%, subject to $300 maximum copay per prescription **Brand when a generic is available** – Plan pays 70%, subject to $300 maximum copay per prescription	
DENTAL BENEFITS		
Annual Deductible Per calendar year	$25 per individual $75 per family	Dental available only to retirees if elected.
Calendar Year Maximum	$2,000 per individual (no maximum under age 18)	Dental available only to retirees if elected.
Preventive Care Exams, prophylaxis, X-rays	80% of Allowed Amount	Dental available only to retirees if elected.
Restorative Care Fillings, extractions, root canals	80% of Allowed Amount	Dental available only to retirees if elected.
Major Care Crowns, bridges, dentures	80% of Allowed Amount	Dental available only to retirees if elected.

SUMMARY OF HEALTH CARE BENEFITS	ACTIVE EMPLOYEES/DEPENDENTS	RETIREES/DEPENDENTS
VISION BENEFITS		
First-Year Maximum	The maximum benefit during the first 12 months of eligibility is $100 for each family member.	Vision available only to retirees if elected.
Eye Examination One per calendar year	90% of Allowed Amount up to scheduled maximum allowance	Vision available only to retirees if elected.
Contact lenses (in lieu of eyeglass lenses, there is not coverage for both)	90% of Allowed Amount up to scheduled maximum allowance	Vision available only to retirees if elected.
Prescription Eyeglass Lenses	90% of Allowed Amount up to scheduled maximum allowance	Vision available only to retirees if elected.
Frames for Prescription Lenses	Up to $115 per two consecutive calendars years	Vision available only to retirees if elected.

MEDICAL BENEFITS

Your involvement is important. While your Plan continues to provide substantial coverage to protect you and your dependents against the high cost of health care, the Plan must be used properly if it is to be entirely successful.

Annual Deductible

The annual deductible is the amount of covered services you must pay each calendar year before the Plan begins to provide benefits (unless noted otherwise). The same expense may be used to satisfy both the individual or family deductible for Preferred Providers and Non-Preferred Providers. The annual deductible is $400 per individual and $1,200 per family.

Any Covered Medical Expenses applied toward the deductible during the last three months of a calendar year may be carried over to reduce the deductible for the next calendar year. If two or more covered members of one family are injured in the same accident, only one deductible is required for expenses relating to the accident which occur in the year of the accident.

How Benefits Are Paid

After payment of your deductible (if applicable) Plan benefits are based on the **Percentage Payable** of the **Allowable Amount**.

The Percentage Payable is the percentage the Plan pays for covered services. The Plan pays most covered medical services (unless stated otherwise or not listed in this Summary Plan Description) at 80% of the Allowed Amount. You pay the remaining percentage until you reach the out-of-pocket limit.

The Allowed Amount for a Preferred Provider is the Preferred Provider's discount amount. For non-Preferred Provider's the Allowed Amount is the Usual, Customary and Reasonable (UCR) rate (not the billed amount). See the Definitions section for the definition of Usual, Customary and Reasonable.

When you receive services or supplies from a Non-Preferred Provider, the billed amount may exceed the UCR charge. Keep in mind that the Plan only pays a percentage of the UCR charge. For Non-Preferred Providers you may be responsible for 100% of any amount exceeding the UCR charge, which is referred to as balanced billing. For certain services, such as emergency services, inpatient treatment at a Preferred Provider facility or air ambulance, federal law prohibits the provider from balance billing you. If you are balanced billed by one of these providers, you should contact Local 375 or the Administration Office.

Preferred Provider Organization

The Trust has contracted to utilize the Aetna PPO network. If you use a provider in this network, your out-of-pocket costs and the costs to the Trust will be reduced as these providers have agreed to discounted rates. Visit their website at www.aetna.com/docfind to find participating providers and to verify that your doctor and care facility are part of the Aetna PPO network. The Aetna PPO network that you belong to is called "Aetna Choice® POS II (Open Access)."

Example : Non-PPO Office Visit

Billed Amount	$50
Allowed Amount	**$45**
Plan pays **80% of Allowed Amount**	$36
You pay **20% of Allowed Amount**	**$9**
For Non-Preferred Provider You pay **any amount over Allowed Amount**	**$5**
Total You Pay	$14

*In this example, the annual deductible has already been satisfied.

KEY POINT

Any charge in excess of the usual, customary and reasonable (UCR) charge allowed as determined by the Administration Office may be your responsibility.

Out-of-Pocket Limit

Out-of-pocket expenses are costs you pay for covered services, such as coinsurance or deductible amounts (unless specifically stated otherwise). The most that you pay in out-of-pocket expenses per year is called the out-of-pocket limit. Once the out-of-pocket limit has been reached, the Plan will pay 100% of most covered expenses for the rest of the calendar year (100% of PPO allowance or 100% of UCR for non-PPO charges), up to the benefit maximum allowable. The out-of-pocket limit is $3,000 per individual and $9,000 per family.

Individual Benefit Management

The Board of Trustees may work with the Plan's case management organization to provide Individual Benefits Management in certain healthcare treatment situations. Individual Benefits Management provides alternative benefits outside of the express terms of the Plan, when it is determined to be in the best interest of the Plan and Plan participants. Individual Benefits Management is subject to approval by the Board of Trustees. Individual Benefits Management shall not recommend a particular treatment. The final decision for your treatment is between you and your provider.

For Individual Benefits Management to be provided, the employee, or person legally qualified and authorized to act for the employee, will be required to sign a written consent that sets forth terms under which the Individual Benefits Management will be provided. The decision to offer Individual Benefits Management is made on an individual basis and is subject to the terms set forth in the written consent. Any Individual Benefits Management shall not be construed to alter or change all other provisions of the Plan, nor shall it be construed as a waiver of the Board of Trustees' right to administer the Plan in strict accordance of its terms in other situations. Individual Benefits Management will not be used to cover anyone who has simply exhausted their benefits or would otherwise not be eligible for coverage. The Board of Trustees may cease to allow the Individual Benefits Management at any time at the Board of Trustees' sole discretion, by sending written notice to the impacted participant or beneficiary.

Preauthorization Requirements

The Plan covers charges that are medically necessary for the care and treatment of a Non-Occupational Illness or Injury. The Trust contracts with Comagine Health to provide case management and utilization review services. The preadmission program requires you or your doctor to contact Comagine Health prior to any non-emergency inpatient admission and requires certification prior to certain outpatient surgery. **If you do not comply with the preauthorization requirement, benefits will be reduced to 50% of all covered charges related to that inpatient admission or outpatient surgery.**

Comagine Health can be contacted toll-free at (800) 783-8606, Monday through Friday, from 7 a.m. – 4 p.m., Alaska Standard Time.

Be sure to have on hand:

1. Name, WPAS ID number (as shown on ID card) or the social security number of the eligible Plan Participant;
2. Name of patient;
3. Name and phone number of your doctor;
4. Name of the Hospital; and
5. The planned surgical or diagnostic procedure.

If you call after normal business hours, you will receive a recorded message instructing you to leave your name and phone number. Your call will be returned the next business day.

Preauthorization Quick Guide	Call Comagine Health, (800) 783-8606 Monday through Friday, 7 a.m.– 4 p.m., Alaska Standard Time	
Event	**Requirement**	**Penalty**
Non-Emergency (Elective) Admission and Medical Air Transportation	Call at least one week prior to Hospitalization or transportation	Without preauthorization, approved benefits reduced to 50% for all allowed charges
Emergency or After Hours Admissions	Call within 48 hours of admission (72 hours on weekends or holidays)	Without preauthorization, benefits reduced to 50% for all related charges
Continued Stay Review	Comagine Health calls your provider within 24 hours prior to scheduled discharge date	No coverage for Hospital Room and Board Charges beyond preauthorized length of stay
Same Day Surgery and Preadmission Testing	Inpatient surgery must be approved by Comagine Health; certain preadmission tests may be done on an outpatient basis	Without preauthorization, no coverage for Hospital Room and Board Charges for days Hospitalized solely for testing purposes
Outpatient Surgery	The following outpatient surgeries or Hospitalizations must be approved by Comagine Health: ▪ Abdominoplasty, panniculectomy, and lipectomy abdomen ▪ Back surgery, including discectomy, laminectomy, and spinal fusion ▪ Breast surgery, including breast reconstruction and mammoplasty (both unilateral and bilateral) ▪ Hysterectomy, including abdominal, vaginal, and unspecified hysterectomy ▪ All nasal surgery ▪ Orthognathic surgery ▪ Uvulopalatopharyngoplasty (UPPP); a procedure to eliminate snoring ▪ Knee surgery ▪ Bunionectomy and/or hammertoe ▪ Varicose vein surgery	If outpatient surgery or Hospitalization occurs without preauthorization, benefits will be reduced to 50% for all related charges
Second Surgical Opinion	Comagine Health may require a second opinion for certain types of surgeries	If a second opinion is required and you do not obtain one, your benefits are reduced to 50%

Non-Emergency (Elective) Admission

Your request must be reviewed and authorized by Comagine Health prior to any inpatient admission in order to obtain the full maximum benefit from the Health Plan. We recommend that you contact Comagine Health at least one week prior to an elective admission. **If you do not comply with the preauthorization requirement, benefits will be reduced to 50% of all covered charges related to that inpatient admission.**

Emergency Admission

Emergency admission must be reviewed within 48 hours of the admission (within 72 hours on weekends or holidays) with the exception of the Newborns' and Mothers' Health Protection Act. This procedure may also be used for urgent "after hours" admissions when Comagine Health cannot be contacted. **If you do not comply with the preauthorization requirement, benefits will be reduced to 50% of all covered charges related to that inpatient admission.**

Continued Stay Review

If your Hospital stay must be extended beyond the days initially authorized, Comagine Health will obtain clinical data from your provider to process an extension of stay authorization. Comagine Health will contact your provider 24 hours prior to the scheduled discharge date to confirm discharge and/or authorize days for your confinement.

Preoperative Outpatient Testing Benefits

This Plan covers charges made by a Health Care Provider, Hospital, outpatient surgery center, or licensed diagnostic laboratory facility for preoperative testing prior to scheduled surgery at 100% of usual, customary and reasonable charges, but only if:

- The tests are related to the scheduled surgery;
- The tests are done within the seven days prior to the scheduled surgery;
- You or your dependent undergoes the scheduled surgery in the Hospital or outpatient surgery center. This does not apply if the tests show that the surgery should not be done because of your or your dependent's physical condition;
- The charge for the surgery is a Covered Medical Expense;
- The tests are done while not inpatient in a Hospital;
- The test results appear in your or your dependent's medical record, kept by the Hospital or surgery center where the surgery is to be done; and
- The tests are not repeated in, or by, the Hospital or the facility where the surgery is performed.

If you or your family member cancels the scheduled surgery, the benefit for this testing is paid at the Plan's regular benefit level shown in the "Summary of Benefits."

Same-Day Surgery and Preadmission Testing

If you and your Physician agree that surgery is necessary and inpatient surgery has been approved by Comagine Health, your Physician will then arrange for you to be admitted to the Hospital.

Confinement as an inpatient prior to the scheduled day of non-emergency surgery is not normally medically necessary.

Room and Board Charges Second Surgical Opinions

For certain types of non-emergency inpatient surgeries, Comagine Health may recommend a second opinion be required in order to receive full Plan benefits.

The Plan pays 100% of the Allowed Amount for the second opinion. If the second surgical opinion does not agree with the first, you may obtain a third opinion. The cost of the third opinion will also be paid at 100%.

Remember, by getting a second opinion, you will be better informed about your condition and what the proposed surgery is meant to do. The second opinion also lets you know more about the risks of surgery or if there are any non-surgical treatment methods.

KEY POINT

If a second surgical opinion is not received prior to the surgery, and Comagine Health recommended a second opinion be completed, all benefits for all covered charges related to that surgery will be reduced to 50%.

The choice whether to have the surgery is still yours. If you choose to have the surgery, you do so knowing you have made the most informed decision possible.

The Plan covers charges for a second surgical opinion for any surgery which:

- Is recommended by the first provider who proposed to perform the surgery;
- Is non-emergency in nature, meaning the provider feels the procedure can be postponed without undue risk to you, or your dependents; and
- Is covered by this Plan.

To be covered, the surgical opinions must both:

- Be performed by a Physician who is certified by the American Board of Surgery or other appropriate specialty board; and
- Take place before the date the proposed surgery is scheduled to be done.

Charges for a second surgical opinion are not covered if the provider who renders the opinion subsequently performs the surgical procedure that is the subject of the opinion.

The Plan pays benefits at the rate of 50% of the Allowed Amount after the deductible if Comagine Health recommends a second surgical opinion that is not obtained before surgery.

SPECIFIC COVERED MEDICAL EXPENSES

The Plan covers medical charges for the following services and supplies for treating a Non-Occupational Injury or Illness. Only Non-Occupational Injuries and Non-Occupational Illnesses are covered.

KEY POINT

Your coverage is good worldwide. For example, if you are traveling and become Hospitalized in a licensed general Hospital outside of Alaska, you will be entitled to your full benefits, provided the services received would have been covered expenses if rendered in the U.S.

Preventive Care

The Plan covers certain preventive care in full (not be subject to the calendar year deductible or coinsurance). To protect yourself from balance billing, it is recommended that you seek covered services from an Aetna POS II participating provider. Preventive care covered at 100% includes routine physical exams, immunizations, pap tests, mammograms and laboratory tests and other services described in the following sources:

- Evidence-based tests or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force. These recommendations include blood pressure and cholesterol screening, diabetes screening for individuals with hypertension, various cancer and sexually transmitted infection screenings, and counseling in defined medically appropriate areas.
- For infants, children, and adolescents, such other evidence informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration.
- A limited number of over-the-counter pharmaceuticals when prescribed by your provider and purchased through the Plan's pharmacy network, including:
  - aspirin (325 mg and 81 mg) for cardiovascular disease for men and women
  - folic acid (0.4 mg and 0.8 mg) supplements for women
  - smoking cessation products when prescribed by a Physician
- With respect to women, such additional preventive care and screenings not described above as provided for in comprehensive guidelines supported by the Health Resources and Services Administration.

Preventive care is limited to Medically Necessary and appropriate services. Where the recommended preventive care comes with recommendations regarding coverage or frequency, these will be followed. If no guidance on coverage or frequency is given, the Plan may adopt or utilize reasonable medical management techniques to determine the coverage and frequency limit. Unless otherwise agreed to by the Board of Trustees, any additions to the above list of preventive care will be effective on the first day of the Plan year beginning 12 months after the new preventive service is listed.

Additional Screening and Preventive Benefits

The Plan covers medically necessary preventive care in addition to the preventive care described above. Benefits for preventive that is not described above, is subject to the deductible. Benefits for these services are payable at 90% of PPO allowance or UCR and subject to the same conditions and limitations as any other covered procedure.

Primary Care

These services include medically necessary care and treatment and performance of surgical operations, payable whether these fees are for treatment received in the Hospital, at home or in the doctor's office, or elsewhere.

- Health Care Providers acting within the scope of their license.
- Outpatient surgery
- The cost and administration of anesthesia
- X-ray, CT scans, MRIs and other imagery
- Radiation therapy, X-ray treatments and examinations (other than dental X-rays not necessitated by an injury), microscopic tests, or any laboratory tests or analysis made for diagnostic or treatment purposes.
- Blood plasma or whole blood.

Telemedicine

The Plan covers medically necessary audio and/or visual visits where the patient is not physically seen but which are appropriately billed and comply with applicable state and federal law. Telemedicine visits are subject to the Plan's normal copay and coinsurance requirements for office visits.

In addition to being able to see your regular provider, you may also see a Teladoc provider with no copays or coinsurance. Teladoc provides access to a national network of board-certified doctors and pediatricians in the U.S. who are available on-demand 24 hours a day, 7 days a week, 365 days a year to diagnose, treat and prescribe medication (when necessary) for many simple and routine medical issues via telephone, mobile app or online video consultations. This includes treatments for the flu, eye infections, bronchitis, sinusitis and much more. Teladoc does not replace existing primary care relationships, but supplements them as a convenient, affordable alternative for medical care.

Durable Medical Equipment

The Plan covers medically necessary durable medical equipment that is:

- Ordered by a Physician.
- Of no further use when medical need ends.
- Usable only by the patient.
- Not primarily for the comfort of hygiene of the patient.
- Not for exercise.
- Manufactured solely for medical use, including diabetic education.
- Approved as effective and usual and customary treatment of the condition (as determined by the Plan).
- Not for prevention purposes or useable only for certain activities such as running, swimming or relaxation.

Durable medical equipment includes, but is not limited to:

- Casts, splints, trusses, crutches, and medical type braces.
- Oxygen and rental to purchase price of the equipment needed for the administration of oxygen.
- Artificial limbs or eyes.
- Wheelchair and Hospital bed.

Any accrual of rental charges that exceed the reasonable purchase price of the equipment are not a Covered Medical Expense. Batteries and/or equipment maintenance charges are not covered.

Medical Transportation Benefits

The Plan covers professional local ground and air ambulance service for emergency medical transportation to treat and emergency medical condition. This benefit is limited to transportation to the nearest Hospital equipped to treat the condition.

The Plan also covers non-emergency transportation by a licensed air ambulance and/or round-trip coach within Alaska or from Alaska to another state, for:

- A covered Participant or dependent.
- A parent accompanying a child.
- An adult accompanying a totally disabled adult.

Such air transportation must be preauthorized and must be recommended by a Physician because the necessary treatment is not available locally or elsewhere in the State of Alaska or treatment at the destination can be provided for a lower cost, after deducting for the cost of the air transportation.

Dental Benefits and the Medical Plan

Dental services for the treatment of a dental injury to sound natural teeth (including the initial replacement of the injured teeth and any necessary dental X-rays), provided the expense is incurred within one year after the injury. Dental injury means an accidental injury to sound natural teeth that is the direct result of a sudden, unexpected and unintended external force, such as a blow or fall, which requires treatment. It must be independent of sickness or any other causes. It does not include tooth breakage while biting or chewing. Sound natural teeth are teeth that: are whole or properly restored, are without impairment or periodontal disease, are not in need of the treatment provided for reasons other than dental injury.

Dental treatment necessitated by degenerative medical conditions, such as cancer, will be considered a Covered Medical Expense under this Plan.

The Plan also pays benefits for covered general anesthesia expenses in a Hospital or ambulatory surgical center for treatment of a dental condition, including any related facility charges, in the same manner and subject to the same conditions and limitations as any other covered service. Benefits are payable only if the Covered Person: 1) is under the age of seven, or physically or developmentally disabled, with a dental condition that cannot be safely and effectively treated in a dental office; 2) has a medical condition that, as determined by a Health Care Provider, would place the Covered Person at undue risk if the procedure were performed in the dental office. Please refer to the Dental Benefits section of this Summary Plan Description for routine dentistry benefit coverage.

The medical Plan does not pay benefits for extraction of teeth or other dental work or surgery for any reason that involves any tooth or tooth structure, alveolar process, abscess or periodontal disease, or disease of the gingival tissue, except for emergency treatment of dental pain when a dentist is not available.

Hospital Care

Hospital Expenses

The Plan covers medically necessary charges for daily room and board in other than a private room. For private room accommodations, only charges for room and board up to the average Semi-Private Room Rate of the Hospital in which you are confined are considered covered medical expenses.

Intensive Care Unit

Coverage will be provided for charges including daily room and board expenses. Intensive Care Unit means a section, ward or wing within a Hospital which is operated exclusively for critically ill patients and provides special supplies, equipment, and constant observation care by Registered Nurses (R.N.), or other highly trained Hospital personnel; excluding any Hospital facility maintained for the purpose of providing normal post-operative recovery treatment or service.

The Plan limits all inpatient admissions to 100 calendar days. This includes Hospital admissions for observation or routine treatment and shall include all services and supplies provided by and billed for by the Hospital and Hospital personnel.

Qualified Organ(s)/Tissue Transplant Services

Coverage will be provided for the following transplants, subject to the conditions and limitations specified below or in other sections of the Plan:

- Heart
- Lung, single or bilateral
- Heart/lung combined
- Kidney
- Pancreas
- Kidney/pancreas combined
- Liver
- Cornea
- Bone marrow
- Peripheral blood stem cell

Benefits for all transplants must be authorized in writing by Comagine in advance (see the "Preauthorization Requirements" section, page 27). Approval will be based on medical necessity, the patient's medical condition, the qualifications of the providers, appropriate medical indications for the transplant, and the availability of appropriate, non-experimental medical procedures for the condition.

If a transplant is not successful, only one re-transplant will be covered, subject to the same conditions and limitations applicable to the original transplant. If you or your eligible dependent is the recipient of a donated human organ, the donor's medical expenses (including compatibility testing of donors and potential donors) will be covered.

Repair of an organ (e.g., joint or valve replacement) is not considered a transplant.

Transplant benefits are subject to all Plan conditions and limitations, and no benefits will be provided for the following:

- Nonhuman, artificial, or mechanical transplants.
- Services or supplies related to experimental or investigational treatment.
- Services or supplies for the donor when the donor benefits are available through other group coverage.
- Expenses for that portion of treatment funded by governmental or private entities as part of an approved clinical trial.
- Lodging, food, or transportation costs, unless otherwise specifically provided under this Plan.

Donor and procurement services and costs incurred outside the United States or your dependent's own human organ or tissue unless otherwise specifically provided under this Plan.

Maternity Benefits

This Plan covers charges for pregnancy, childbirth, miscarriage, or abortion, on the same basis as any other medical expense, for you or your spouse. If coverage under the Plan ends for any reason, benefits continue to be payable only if the person is totally disabled.

Midwives

No coverage is provided under this Plan for services of midwives unless working for or in conjunction with a birthing center.

Birthing Center Benefits

This Plan covers charges made by a birthing center in its own behalf for services and supplies furnished by the center to you, or your spouse, in connection with a pregnancy covered by the Plan. Charges by the center are covered by the Plan, at 100% of the Allowed Amount for:

- Prenatal care.
- Delivery and post-delivery care rendered within 24 hours after the delivery.

The Plan does not cover maternity benefits, including delivery or birth, for your dependent children, except for certain prenatal preventive benefits.

Rehabilitative Therapy

Outpatient Rehabilitative Therapy. Benefits are provided for outpatient rehabilitative therapy (physical, occupational and speech therapy) to the extent that the therapy will significantly restore and improve a lost function(s) following a severe Illness, Injury or surgery. No benefits will be provided for care that is custodial in nature, or when no significant clinical improvement is expected as a result of the therapy.

The services must be provided under the referral and direction of the attending Physician and administered by a licensed Health Care Provider acting within the scope of their license. The Covered Person must continue under the care of the attending Physician during the time the therapy is being provided. Benefits are subject to the following provisions:

- Benefits are limited to a maximum of 40 treatments each calendar year.
- Treatment must be provided by a licensed physical, occupational or speech therapist.
- Treatment must begin within one year of the date of the onset of the condition being treated.
- Treatment must be ordered by a Physician and a written treatment program may be required by the Administration Office. (A treatment program will be required after the 25th visit.)

Inpatient Rehabilitative Therapy. Benefits are provided for inpatient Rehabilitative Facility care when Medically Necessary to restore and improve function previously normal but lost due to Illness or Injury. Benefits are subject to the following provisions:

- Confinement must occur within one year from the date of onset of the condition.
- Confinement must be authorized by a Physician and a written treatment plan must be submitted to the Administration Office by the Physician prior to admittance.
- Benefits are limited to 100 days per calendar year combined with all Hospital Care inpatient admissions.
- Preauthorization is required for inpatient facility services.

Habilitative Therapy

Benefits are provided for habilitative care services when Medically Necessary to treat mental health disorders identified in the current International Classification of Diseases (ICD) and the Diagnostic and Statistical Manual of Mental Disorders (DSM) and physical or structural birth defect (congenital anomaly). To be covered, services must be prescribed and documented to either improve function or maintain function where significant deterioration in function would result without therapy. Function means the ability to execute skills required for activities of daily living which would be normal and expected based on the age of the patient. The patient must be under the care of a Physician during the time the habilitative services are being provided, and all services must be provided by a Health Care Provider acting within the legal scope of their license. A formal treatment plan may be required upon request and will be required after the 25th visit. Periodic re-evaluations will also be required.

Covered Services under this benefit include:

- Neurological and psychological testing, evaluations and assessments.

- Speech, occupational and physical therapy when provided as part of a formal written treatment plan.
- Neurodevelopmental therapy when provided as part of a formal written treatment plan.
- Applied Behavior Analysis (ABA) therapy for individuals diagnosed with Autism Spectrum Disorder (ASD) when the following conditions are met:
  - A documented comprehensive individual treatment plan is developed based on a functional analysis completed within 6 months of the beginning of treatment;
  - Routine evaluation of data on a regular basis and documentation of demonstrable progress against targeted goals at least once every six months; and
  - The ABA services are provided by, or are under the supervision of, a program manager who is a Board Certified Behavior Analyst (BCBA) or a Physician or Health Care Provider whose legal scope of license includes behavior analysis; and
  - Psychotherapy, which may include ABA services.

Skilled Nursing

The Plan covers Skilled Nursing Facility charges at 100% of the eligible PPO allowance or Usual, Customary and Reasonable charges for up to 100 days.

The Plan recognizes Skilled Nursing Facility charges for certain services and supplies which are provided to a patient who is recovering from a covered disease or injury.

A Physician must recommend and approve confinement in a Skilled Nursing Facility. Also, the patient must be under a Physician's continuing care.

When Admission Begins

Admission in the Skilled Nursing Facility must begin within 14 days after a Hospital stay.

The person must be confined as a registered bed patient on the certification of a Physician that such Skilled Nursing Facility confinement is necessary.

Confinement must be for the same injury or disease that required Hospital treatment. Also, the prior Hospital confinement must begin while you or your dependents are covered under this Plan.

All periods of Skilled Nursing Facility confinement during any disability will be considered one confinement.

Covered Expenses

- Room and board—including charges for services such as general nursing care made in connection with occupying a room. If a private room is occupied, coverage will be limited to the standard Semi-Private Room Rate.
- Use of special treatment rooms; X-ray and laboratory examinations; physical, occupational, or speech therapy; oxygen and gas therapy and other medical services customarily provided to patients.
- Drugs, biologicals, solutions, dressings and casts. No other supplies are covered.

Facility Requirements

The term ”Skilled Nursing Facility” means only an institution which meets fully all of the following requirements:

- It is regularly engaged in providing skilled nursing care for sick or injured persons with 24 hours a day supervision of a Physician or a Health Care Provider.
- It has available, at all times, the services of a Physician who is a staff member of a general Hospital.

- It has on duty, 24 hours a day, a graduate Registered Nurse, Licensed Vocational Nurse, or Licensed Practical Nurse and has a graduate Registered Nurse on duty at least eight (8) hours per day.
- It maintains a daily medical record for each patient.
- It complies with all licensing and other legal requirements.
- It is not, other than incidentally, a place for rest, a place for Custodial Care, a place for the aged, a place for drug addicts, a place for alcoholics, a hotel, or similar institution.

Expenses Not Covered

The Plan's skilled nursing benefit does not include benefits for Custodial Care. Physician services and private duty or special nursing services provided by the Skilled Nursing Facility also are not part of the skilled nursing benefit.

Home Health Care

The Plan covers home health care at 100% of eligible Usual, Customary and Reasonable charges for up to 100 visits per calendar year.

Requirements

A home health care plan must be outlined in writing by a Physician.

Also, the Physician must certify that the treatment is necessary and the patient would have to remain Hospitalized for treatment if there was no health care at home.

Home health care must begin following the end of a Hospital or extended care facility stay, must be for the same or a related condition and must be precertified and approved by Comagine Health.

Covered Expenses

Covered expenses include the following charges made by a home health care agency:

- Physical, occupational, or speech therapy.
- Medical supplies, prescribed drugs, and laboratory services which would be covered if the patient was in the Hospital.
- Part-time (less than eight hours) or intermittent care by a Registered Nurse (R.N.), or a Licensed Practical Nurse (L.P.N.) if an R.N. is not available.
- Part-time (less than eight hours) or intermittent patient care by a home health aide.

Covered home health care expenses must be made by an organization or agency which meets the requirements for participation as a home health care agency under a Medicare plan.

Expenses Not Covered

- Supplies and services not included in the provider's home health care plan, or not provided through a home health care agency.
- Services of a person who ordinarily lives in the patient's home, or who is a family member.
- Custodial Care.
- Transportation.
- Services of a social worker.

Hospice Care

Hospice care benefits cover charges for services rendered to a terminally ill patient as part of a hospice care program. A terminally ill patient is a person who has received, from a Physician, a medical prognosis of six months or less to live.

In a hospice program, the terminally ill patient receives health care benefits at home or an inpatient facility. Care focuses on controlling pain and other symptoms associated with terminal illness while also helping the family, as well as the patient, acknowledge the approach of death.

Benefits for this coverage are provided at 80% for 30 days inpatient and up to $3,000 outpatient while covered under this Plan. The Plan limits all inpatient admissions to 100 calendar days.

Requirements

A hospice care program must be established by the patient's provider and be outlined in writing. Also, it must:

- Be reviewed periodically or as requested by the Administration Office, by the patient's attending provider, and by the hospice care agency personnel.
- Provide palliative care to patients and supportive care to patients and their families.
- Include an assessment of the patient's needs and a description of the care to be rendered to meet those needs.

Facility Inpatient Benefits

These are inpatient charges made by a hospice care facility, Hospital, or Skilled Nursing Facility for room and board, but not more than the facility's most common semi-private charge, and other services and supplies for:

- Pain control.
- Other acute and chronic symptom management, which are covered in accordance with the "Summary of Health Care Benefits" and are payable on the same basis as a Hospital confinement for any other disease.

Other Hospice Care Benefits

The Plan provides benefits for charges of a hospice care agency for such services as:

- Part-time or intermittent nursing care by an R.N. or L.P.N. up to eight hours a day.
- Medical supplies, drugs and medicines prescribed by a provider.
- Medical social services under the direction of a provider.
- The Plan provides benefits for charges of a home health care agency for such services as:
- Part-time or intermittent home health aide services up to eight hours a day.
- Physical or occupational therapists for therapy.
- Physicians for consultation or case management services.

Hospice Care Agency

This agency or organization must:

- hospice care program and provide or otherwise arrange for services to meet those needs Have hospice care available 24 hours a day.
- Be licensed or certified as such by the state in which it is located.
- Provide skilled nursing services.
- Provide medical social services.
- Provide psychological and dietary counseling.
- Provide bereavement counseling for the immediate family.
- Establish policies governing the provision of hospice care.
- Evaluate the patient's medical and social needs.
- Develop a hospice care program and provide or otherwise arrange for services to meet those needs.

Expenses Not Covered

- Bereavement counseling, pastoral counseling, financial or legal counseling, such as estate planning or drafting of a will and funeral arrangements.
- Homemaker or caretaker services (services not solely related to care of the patient), such as sitter or companion services for the patient or other family members, transportation, housecleaning and house maintenance.
- Respite care. (This is care furnished by any provider or facility during a period of time when the family or usual caretaker cannot, or chooses not to, attend to your or your dependent's needs for any reason.)

Alternative Care

The Plan provides coverage for medically necessary naturopathic care, chiropractic treatment, and acupuncture treatment by licensed providers acting within the scope of their license. Alternative care benefits are limited to 18 visits per calendar year. Vitamins, supplements and non-FDA approved medicines are not covered.

Behavioral Health

The Plan cover medically necessary expenses incurred for the treatment of mental health conditions and substance abuse. Benefits and limits for the treatment of mental health and substance abuse conditions shall be no more restrictive than the benefits and limitation that apply to the treatment of similar medical conditions under the Plan. The Plan limits all inpatient admissions to 100 calendar days.

Clinical Trials

The Plan provides coverage for items and services furnished in connection with an approved clinical trial that would otherwise be covered by the Plan for a participant who is not participating in a clinical trial. For clinical trials, the Plan will not cover:

- The investigational item, device, or service itself.
- Items and services solely for data collection that are not directly used in the clinical management of the patient, or
- Services which are clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

An approved clinical trial is a phase I, II, III, or IV federally-funded clinical trial or drug trial that is conducted 1) under an investigational new drug application reviewed by the FDA or is a drug trial which is exempt from an investigational new drug application; and in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition.

Gene and Cellular Therapy

The Plan covers Medically Necessary Gene and Cellular Therapy services from a designated facility/provider. Coverage is provided subject to the Plan's annual deductible, copays, coinsurance and annual coinsurance and out-of-pocket maximums. Gene and Cellular Therapy services and treatment must be pre-certified to be covered. Your provider should call Aetna at the number printed on the back of your ID card to pre-certify these services. Aetna designates facilities/providers for Gene and Cellular Therapy services. Services must be provided by a designated facility/provider in order to be covered by the Plan. Coverage is subject to all other plan limitations and exclusions.

Gene and Cellular Therapy — includes gene and cellular based therapy techniques that modify and/or use a person's genes or cells to treat or cure disease. Gene and Cellular Therapy, as defined by the Plan, includes Medically Necessary gene and cellular based therapies provided by an approved Physician, Hospital or other Health Care Provider, including, but not limited to:

- Cellular immunotherapies;
- Genetically modified oncolytic viral therapy;
- Other types of cells and tissues from and for use by the same person (autologous) and cells and tissues from one person for use by another person (allogenic) for certain therapeutic conditions;
- All human gene therapy that seeks to change the function of a gene or alter the biologic properties of living cells for therapeutic use. Examples include therapies using:
  - Luxturna® (Voretigene neparvovec)
  - Zolgensma® (Onasemnogene abeparvovec-xioi)
  - Spinraza® (Nusinersen)
- Products derived from gene editing technologies, including CRISPR-Cas9;
- Oligonucleotide-based therapies. Examples include:
  - Antisense. An example is Spinraza (Nusinersen)
  - siRNA
  - mRNA
  - microRNA therapies

PLAN EXCLUSIONS

Medical benefits are not payable for the following expenses:

Expenses incurred in connection with any **accidental bodily injury or sickness arising out of or in the course of employment or self-employment**, which is or would be compensable under any Worker's Compensation or Occupational Disease Act or Law had a claim been filed. These expenses are the result of an occupational injury or disease. Only expenses as a result of a Non-Occupational Injury or disease are covered under this Plan.

Expenses which are **not certified by the attending provider to be necessary**, or any charges made by a Hospital unless the Hospitalization is recommended and approved by a provider.

Charges for any services, treatments, or supplies which **exceed the Usual, Customary and Reasonable charge**, as defined on page 79.

Expenses incurred in connection with **cosmetic surgery,** except:

- That which is necessary for the reconstruction of a breast after a mastectomy, including all stages of any reconstructive breast reduction performed on the non-diseased breast to make it equal in size with the reconstructed diseased breast.
- Repair of congenital defects of a newborn child.

Expenses for an **eye examination** for the purpose of prescribing corrective lenses or for the fitting of glasses or for eye glasses or contact lenses.

Expenses incurred for **vision training or orthoptics.**

Expenses for **refractive eye surgery**.

Expenses for the fitting or cost of **hearing aids**.

While covered under this Plan, expenses incurred as a result of an accidental bodily injury or sickness **caused by war**, or by an act of war, declared or undeclared, or by participating in a riot, or as a result of the commission of a felony by the injured Participant, spouse, or dependent.

Expenses incurred **while confined in a U.S. Government Hospital** or any other Hospital operated by a government unit, unless a charge is made that you, or your dependent, is legally required to pay without regard to the existence of coverage.

Expenses you or your dependent **would not be required to pay** in the absence of coverage.

Expenses incurred for charges made by a **midwife**.

Expenses incurred for surgical treatment of **TMJ (Temporal Mandibular Joint Disorder).** TMJ **nonsurgical lifetime limit** is $1,000.

Dental treatment, except as otherwise provided.

Any loss, expense, or charge which results from **appetite control or eating disorders**, or any treatment of **obesity** (including surgery to treat morbid obesity), except: Documented cases of a mental health condition, bulimia or anorexia that meet standard diagnostic criteria as determined by the Administration Office or present significant symptomatic medical problems.

Any expenses incurred with treatment of **behavioral problems**, attention deficit disorder, or those expenses associated with marriage or family counseling, except as specifically provided.

Any expenses associated with the treatment of **infertility**.

Expenses incurred for **vitamins** or vitamin, herbal, or mineral supplements.

Any expenses for **jaw surgery** or treatment of malocclusion.

Expenses incurred for **massage therapy**.

Expenses for treatment of **sexual dysfunctions**, including any drugs, supplies, or devices.

Any services or supplies received in connection with a Participant or dependent acting as a **Surrogate Mother**, regardless of whether a Participant or dependent is a biological parent. This exclusion applies to services or supplies related to the Surrogate Mother becoming pregnant, pregnancy and delivery charges. Additionally, a child of a Surrogate Mother shall not be considered a dependent if the child is not the biological child of a Participant or adult dependent or if the Surrogate Mother has entered into a contract or has an understanding prior to becoming pregnant that she will relinquish the child following its birth. The Plan also does not cover services or supplies provided to an individual not covered by the Plan who acts as a Surrogate Mother for a Participant or dependent. "Surrogate Mother" is defined as a woman who becomes pregnant through artificial or assisted methods for the purpose of carrying the fetus to term for a third party.

Any treatment of any individual while the individual is on **active duty in the U. S. Armed Forces**, subject to the individual's right to continue coverage under USERRA.

Any expense or charge for **injuries or illness caused by the act or omission of another person** (known as a third-party) for which there is a potential opportunity to recover from a third-party, a third-party or first-party insurer or any liability policy. Benefits may be advanced by the Plan pursuant to the Plan's reimbursement provisions.

Services where a patient is **not physically seen** by a provider or other covered provider, except as provided for through the Plan's telemedicine program or other medically necessary provider audio and/or visual visits where the patient is not physically seen but which are appropriately billed and comply with applicable state and federal law.

Any expenses or charges incurred for **automated lab or automated imagery work**.

Any services or expenses that result from **Experimental or Investigational treatment**.

Any claims that are not submitted or completed (including submission of supporting documentation that has been requested) **within one year from the date(s) of service**.

Expenses for services or supplies that are **limited or excluded under the specific benefit**.

Expenses for services or supplies which are **not provided or billed in accordance with generally accepted professional standards** and/or medical practice, including up-coding, unbundling, duplication, excessive or improperly coded billing charges.

Expenses for services or supplies **billed or charged in breach of or contrary to the Health Care Provider's PPO network agreement** or in breach of or contrary to Health Care Provider guidance or policies established by the PPO network.

TRAVEL BENEFITS FOR MEDICALLY NECESSARY TREATMENT AND BRIDGEHEALTH

As health care costs continue to increase, the Board of Trustees have noticed that there are many medical procedures that can cost considerably less (with comparable or better quality) when done outside the State of Alaska. Accordingly, the Plan offers participating employees and their dependents reimbursement for certain travel expenses incurred while traveling away from home if the travel is from Alaska to the lower 48 continental United States and the travel is primarily for inpatient medical care or outpatient surgeries.

Eligibility – To be eligible for travel reimbursement, the employee or dependent that has incurred the travel expense must be eligible for health benefits and a current Plan member at the time the travel expenses were incurred, when the medical treatment is provided and at the time the claim is submitted for reimbursement.

Covered Expenses – Covered expenses for travel reimbursement shall include the following:

1. Transportation: Amounts paid for transportation primarily for, and essential to medical care. This includes:
    - Bus, train, boat, or plane fares by a regularly scheduled commercial carrier from the employee's place of residence to the city where the treatment is provided. The Plan will cover the cost of documented travel expenses, not exceeding the cost of coach class commercial air transportation between the major airport nearest to the member's residence and the major airport nearest to the location the treatment was provided;
    - Taxi fares;
    - Transportation expenses of a parent who must accompany a child who needs medical care;
    - Transportation expenses of a spouse, nurse or other person who can give injections, medications, or other treatment required by a patient who is traveling to get medical care and is unable to travel alone;
    - Transportation expenses for regular visits to see a mentally ill dependent, if these visits are recommended as a part of treatment; and
    - Parking fees and tolls.
2. Lodging: The cost of lodging not at a Hospital or similar institution not to exceed $250 per night. This expense is reimbursable if:
    - The lodging is primarily for and essential to medical treatment,
    - The medical care is provided by a doctor in a licensed Hospital or in a medical care facility related to, or the equivalent of, a licensed Hospital,
    - The lodging isn't lavish or extravagant under the circumstances, and
    - There is no significant element of personal pleasure, recreation, or vacation in the travel away from home.
3. Per Diem: In addition to the foregoing, for every day of medically necessary travel, you are eligible for reimbursement of incidental travel related expenses up to the per diem amount of $75. The per diem will be paid for everyday transportation or lodging is reimbursed. Please note that the per diem is a taxable benefit and you will receive a 1099 for amounts in excess of $600.

BridgeHealth Surgery Benefit – In conjunction with the Plan's medical travel reimbursement benefit, the Trust has contracted with BridgeHealth to provide non-Medicare eligible participants with access to high quality providers across the United States. This includes access to centers of excellence as well as surgeons who are highly rated in the United States for their specialty.

You should contact BridgeHealth or BridgeHealth may contact you, if you have any planned major surgeries, such as:

- Cardiac surgery
- Vascular surgery
- Spine surgery
- Joint surgery
- Specific cancer treatments

Upon acceptance of your case, the following enhanced Plan provisions will apply when you utilize a BridgeHealth network provider:

- Your Plan Medical Deductible and Coinsurance will be waived; and
- A BridgeHealth Care Coordinator will help coordinate all aspects of your surgery by helping collect the required medical records, assisting with provider selection and making travel arrangements.

To obtain more information about this benefit contact BridgeHealth at (800) 680-1366 and identify yourself as a participant in the 'Alaska Pipe Trades Association – UA Local 375 Health and Welfare Trust Fund' or go online at *www.BridgeHealthMedical.com.*

BridgeHealth is an independent third-party contractor to the Trust. Neither the Trust nor BridgeHealth provide medical services and neither are engaged in the practice of medicine. The BridgeHealth Surgery Benefit program is entirely voluntary.

Medical Travel Benefit Exclusions – The following items are excluded:

- Vacations or travel where the primary purpose is not for medical treatment;
- Travel for a change in environment, improvement of morale, or general improvement of health even if the trip is made on the advice of a doctor;
- Transportation on a non-regularly scheduled commercial carrier;
- Travel for treatment in Hawaii or a country or territory outside the continental United States;
- First class airfare; and
- Travel expenses for which the member was not responsible to pay or which were not actually incurred (airfare purchased using frequent flyer miles, donated lodging, etc.).

Claims Procedure – The following rules apply to requesting reimbursement for travel expenses:

a. All travel expenses must be actually incurred and paid out of pocket. Benefit will not be advanced prior to the date of travel.

b. Within 12 months after the travel is completed and the medical expenses have been incurred, the member that incurred covered travel expenses may request a travel reimbursement claim form from the Administration Office.

c. The claim form shall be completed and returned to the Administration Office within 12 months after the claim is incurred along with the following documentation:

   - An explanation of benefits, signed doctor or treatment notes, or medical bill showing the dates of service for the medical treatment and the location of the medical treatment; and
   - Itineraries, invoices and receipts showing the amounts incurred for which reimbursement is being sought.

   Incomplete claim forms or claims with insufficient supporting documentation will be denied. Claims (including submission of supporting documentation that has been requested) submitted more than 12 months after the date the claims were incurred, will be denied.

d. Once a completed claim is submitted, the Administration Office will review the claim and make a determination whether the claim satisfies the criteria for reimbursement, as set forth above. Following this determination, the Administration Office will issue a decision either approving or denying the claim, in whole or in part. If approved, the approval shall include the reimbursement amount. If denied, the denial shall set forth the reason for the denial.

e. If a claim is denied, the participant may appeal to the Trust's Board of Trustees pursuant to the Plan appeal procedure set forth in the Summary Plan Description. An appeal must be submitted within 180 days of the date of the denial.

f. Participants may contact the Administration Office to pre-certify travel benefits.

PRESCRIPTION DRUG BENEFITS

The Trust is a member of National CooperativeRx, which has contracted with CVS Caremark to provide a retail pharmacy network and mail and specialty pharmacy services to the Plan. CVS Caremark is also the Plan's pharmacy benefits manager, sometimes referred to as a "PBM" or "Rx administrator." You can contact CVS Caremark as follows:

CVS Caremark Member Customer Care
1-866-818-6911
Claims can be submitted at caremark.com OR in writing to:
CVS Caremark
P.O. Box 52136
Phoenix, AZ 85072-2136

CVS Caremark Appeals
Can be submitted in writing via fax or mail.
Prescription Claim Appeals MC 109 - CVS Caremark
P.O. Box 52084
Phoenix, AZ 85072
Fax: 866-443-1172

CVS Caremark Prescriber Prior Authorization Department
1-800-294-5979

Out-of-Pocket Limit

The prescription drug benefit Plan has a separate out-of-pocket limit. Once the out-of-pocket limit has been reached, the Plan will pay 100% of most covered prescription drug expenses for the rest of the calendar year. The out-of-pocket limit for prescription drugs is **$4,500 per individual and $5,600 per family**.

CVS Caremark National Retail Pharmacy Network

You may receive prescription drugs from any CVS pharmacy or any other participating retail pharmacy within the CVS Caremark National Pharmacy Network. This retail pharmacy network includes most major retail pharmacy chains, as well as independent retail pharmacies. You can search for a network retail pharmacy on the CVS Caremark web site, smartphone app, or by calling customer care. All retail prescriptions are limited to 30-day supply.

When you present your card at a Network Retail Pharmacy, the Plan pays:

Generic Drugs - 90% of the allowable cost, subject to a $5 minimum copay per prescription (but not to exceed actual cost of prescription).

Brand Drugs (with no Generic) - 80% of the allowable cost, subject to $100 maximum copay per prescription.

Brand Drugs (when Generic is available) - 70% of allowable cost, subject to $100 maximum copay per prescription.

When your prescription is filled at a Non-Network Retail Pharmacy, the Plan pays:

All Drugs - 70% of the allowable cost, subject to $100 maximum copay per prescription.

For non-network retail pharmacy claims, you are required to pay the claim at time of receipt of prescription and submit a completed claim form in order to receive reimbursement.

CVS Caremark Mail Order Pharmacy Service

Mail order prescriptions may lower your out-of-pocket costs. Mail order prescriptions allows for up to 3-month supplies of medication and is designed for long-term maintenance medications needed for chronic conditions.

Mail order prescriptions will be delivered directly to your home or other address that you choose. You should contact the mail order pharmacy at least two weeks before you need your next fill of your prescription to allow for processing and mailing.

You can get started with Mail Order Pharmacy Services in a variety of ways:

1. Call CVS Caremark (1-866-818-6911). Have your ID card, doctor's contact information, prescription information, and payment method ready.
2. Log in to your Caremark.com account. Select "Prescriptions" from the toolbar and then select "Start Mail Service" to request a new prescription for use at mail service.
3. Ask your prescriber to call, e-prescribe or fax your prescription information to Caremark Mail Service.
    a. Phone: 1-800-378-5697
    b. Fax: 1-800-378-0323
    c. E-prescribe: CVS Caremark Mail Service, NCPDP ID 322038, 9501 E. Shea BLVD. Scottsdale, AZ 85260
4. Mail a hard copy 90-day prescription and a completed Mail Service order form to CVS Caremark. Allow at least two weeks for delivery. Ask your doctor for a 30-day prescription you can fill at a retail pharmacy while you wait for the mail order delivery if you choose this option. A Mail Service order form can be found online at www.caremark.com, under "print plan forms" in the upper right-hand corner of the website.

When your prescription is filled at a Mail Order Pharmacy, the Plan pays

Generic Drugs - 90% of the allowable cost, subject to a $15 minimum copay per prescription (but not to exceed actual cost of prescription).

Brand Drugs (with no Generic) - 80% of the allowable cost, subject to $300 maximum copay per prescription.

Brand Drugs (when Generic is available) - 70% of allowable cost, subject to $300 maximum copay per prescription.

Specialty Medications

Specialty medications are high-cost drugs that are often injected or infused and require special storage and monitoring. Typically, these medications must be obtained through an approved specialty pharmacy and may be subject to prior authorization. Specialty medications are limited to a 30-day supply. Specialty medications largely fall into the formulary brand category but could also fall into the other coverage categories. All specialty medication questions should be directed to:

CVS Specialty Pharmacy
1-800-237-2767
www.CVSSpecialty.com

Utilization Management

Utilization management ensures the safe and cost-effective use of medications. This may include, but not be limited to, prior authorization, quantity limitations, and/or prerequisite therapy requirements.

Certain prescription drugs are subject to prior authorization and must be preapproved by CVS Caremark before they will be a covered drug. The member or authorized prescriber should contact CVS Caremark to confirm whether a prescribed medication is subject to prior authorization.

Certain prescriptions drugs are subject to quantity limitations. In some instances, additional quantity may be available to a Member after obtaining prior authorization. The member or authorized prescriber should contact CVS Caremark to confirm whether a prescribed medication is subject to quantity limitation.

Prerequisite therapy requirements or Step therapy is the practice of beginning drug therapy for a medical condition with the most cost-effective and safest drug and stepping up through a sequence of alternative drug therapies as a preceding treatment option fails. A member or authorized prescriber should contact CVS Caremark prior to commencing any step therapy alternative and discuss the need for prior authorization.

Utilization management protocols may be subject to change. Certain high-cost drugs may be subject to prior authorization **and/or quantity limitation beyond those imposed by CVS Caremark.**

Specific Exclusions/Limitations

The following exclusions/limitations apply for purposes of the prescription drug Plan and are not considered covered benefits.

1. Drug products without a NDC (national drug code).
2. Any drug included on National Cooperative Rx's list of excluded drugs.
3. Formulary excluded drugs
4. Prescriptions filled without required prior authorization.
5. Prescriptions that are covered by workers' compensation laws or other county, state or federal programs.
6. Drugs or supplies that are covered under the medical portion of your health care coverage.
7. Experimental, investigational or unproven drugs, or drugs used for a treatment not approved by the FDA.
8. General anesthetics.
9. Drugs obtained outside the United States.
10. Lost, stolen, or damaged drugs.
11. Professional charges in connection with administering or injecting drugs.
12. Any drugs that are not considered medically necessary. "Medically necessary" drugs include prescribed drugs that are required for the diagnosis or treatment of an active illness or injury, that is rendered by or under the direct supervision of the attending physician, and are considered medically necessary in objective, evidence-based, peer-reviewed, medical literature.
13. Therapeutic devices or appliances (such as support garments, ostomy supplies, durable medical equipment, etc.).
14. Experimental or investigational drugs or products, unless as part of enrollment in an approved clinical trial.
15. Non-prescription/over-the-counter drugs. Select OTC diabetic or respiratory supplies may be covered.
16. Infant Formulas.
17. Periodontal Products (subgingival implants).
18. Nutritional supplements (vitamins, dietary supplements, herbal remedies, etc..), unless stated otherwise.
19. Medications for infertility.
20. Gene therapy treatments.
21. Insulin pumps and supplies.
22. Medications for sexual dysfunction.

23. Medications for weight loss.
24. Cosmetic agents (such as hair growth, hair removal, anti-wrinkle agents, etc.).
25. Medications for gender identity disorders (remove if covering transgender care).

DENTAL BENEFITS

This Plan provides dental benefits only for individuals enrolled in the:

- Active Participants Plan.
- Retiree Plan, provided the retiree and dependents have elected dental benefits and pay the dental premium.

Deductible

There is no deductible for Type A expenses. The deductible amount for all other expenses is $25 per person but not more than $75 per family each calendar year.

KEY POINT

The deductible is the amount of covered dental expenses you pay each calendar year before dental expense benefits are payable.

Any expenses incurred during the last three months of a calendar year which are applied against an individual's deductible will also reduce that person's deductible for the next year.

How Benefits Are Paid

After payment of your deductible (if applicable) the dental Plan will pay your dentist 80% of the Allowed Amount up to your Calendar Year Maximum. For dental benefits, the Allowed Amount is based on the Usual, Customary and Reasonable (UCR) rate (not the billed amount). See the Definitions section for the definition of Usual, Customary and Reasonable.

Calendar Year Maximum

Your calendar year maximum (the maximum amount the Plan pays in covered dental benefits) is $2,000 per individual. This calendar year maximum does not apply to Type A and Type B expenses for dependent children under the age of 18.

Covered Dental Expenses

Covered dental expenses are the allowed amounts for services and supplies provided by a dentist, which the Participant is required to pay. To be covered, dental services and supplies must be received by you, or your dependent, in connection with a course of treatment. The Administration Office shall determine that the services and supplies and the course of treatment are:

- Appropriate and meet professionally recognized national standards of quality.
- Necessary for the treatment of Non-Occupational Illness or Injury.
- Customarily employed nationwide for the treatment of dental conditions.
- Additional benefits will be considered under the Medical Plan after dental benefits under the Plan have been applied, for treatment necessitated by degenerative medical conditions such as cancer.

Type A Expenses

Type A expenses are paid at 80% of the usual, customary and reasonable charge. Type A expenses include:

- Oral examinations, but not more than two examinations in any period of a calendar year.
- Topical application of sodium or stannous fluoride for dependent children age 14 and under; up to two applications per year.
- Dental X-rays required in connection with the diagnosis of a specific condition requiring treatment; also other dental X-rays, but not more than one full mouth X-ray or series of seven or more bitewings or a combination of such X-rays in any three calendar years, and not more than one set of up to four bitewing X-rays in any period of one year.

- Cleaning of teeth, periodontal prophylaxis, or scaling but no more than two of any in a period of a calendar year.
- Nightguards, limited to one per lifetime.

Type B Expenses

Type B expenses are paid at 80% of the usual, customary and reasonable charge. Type B expenses include:

- Extractions.
- Oral surgery, including excision of impacted teeth.
- Space maintainers.
- Fillings.
- Anesthetics administered in connection with oral surgery or other covered dental services.
- Treatment of periodontal and other diseases of the gums and tissues of the mouth.
- Endodontic treatment, including root canal therapy.
- Injection of antibiotic drugs by the attending dentist.
- Repair or re-cementing of crowns, inlays, bridgework, or dentures.
- Relining of dentures, but not more than one relining or re-basing in any three-calendar-year period.

Type C Expenses

Type C expenses are paid at 80% of the usual, customary and reasonable charge. Type C expenses included:

- Inlays, gold fillings, and crowns (including precision attachments for dentures).
- Initial installation of fixed bridgework (including inlays and crowns to form abutments) to replace one or more natural teeth.
- Replacement of existing fixed bridgework by new fixed bridgework, or the addition of teeth to existing fixed bridgework. (However, this item will apply only to replacements or additions that meet the "Prosthesis Replacement Rule.")
- Full or partial dentures.

Prosthesis Replacement Rule

Replacement of, or additions to, existing dentures or bridgework as described under Type C expenses will be covered only if evidence satisfactory to the Administration Office is presented that one of the following applies:

- The replacement or addition of teeth is required to replace one or more additional natural teeth extracted after the existing denture or bridgework was installed.
- The existing denture or bridgework cannot be made serviceable.
- The existing denture is an immediate temporary denture and replacement by a permanent denture is required.

Limitations and Exclusions

In addition to any applicable exclusions described in the limitations and exclusion in the prior sections of this Plan booklet (such as medical necessity and experimental and investigational), dental benefits will not be provided for the following:

- Services or supplies for which any other comprehensive major medical benefit is payable under this Plan unless otherwise noted.

- Charges for treatment by anyone except a dentist. However, charges for cleaning or scaling of teeth performed by a licensed dental hygienist under the supervision and direction of the dentist will be covered.
- Charges for services and supplies that are partially or wholly cosmetic in nature, including charges for personalization or characterization of dentures, restoring vertical dimension, or bleaching of teeth.
- Charges for the installation of prosthetic devices (including bridges and crowns) which were ordered while you or your dependent were not covered for this benefit, or which were ordered while you or your dependent were covered for this benefit but were finally installed or delivered to you or your dependent more than 30 days after termination of this coverage.
- Charges for the replacement of a lost or stolen prosthetic device.
- Charges for any orthodontic treatment or related expenses.
- Charges for dental sealants.
- Charges for treatment of TMJ (Temporal Mandibular Joint Disorder).
- Charges for implants and any charges related to or as a result of implants.
- Charges for temporary crowns or dentures (as they should be included in the total cost of the crown or dentures and not charged separately).

Benefits after Termination of Coverage

Benefits for dentures, fixed bridgework, or crowns will be paid after coverage terminates if all the following conditions have been met:

- The item is finally installed or delivered no later than 30 days after termination of coverage.
- For a denture, impressions must have been taken before coverage terminated.
- For any other item mentioned above, the teeth which will serve as retainers or support, or which are being restored, must have been fully prepared to receive the item, and impressions must have been taken before coverage terminated.

These benefits are subject to the calendar year maximum for the year in which coverage terminated, and all the other conditions, limitations, and exclusions of this Plan.

VISION BENEFITS

This Plan provides vision benefits only for individuals enrolled in the:

- Active Participants Plan.
- Retiree Plan, provided the retiree and dependents have elected vision benefits and pay the vision premium.

How Benefits Are Paid

Unless otherwise specified below, the vision plan pays 90% of the Allowed Amount, subject to certain limits. For vision benefits, the Allowed Amount is based on an established payment schedule. For a copy of the Plan's current vision payment schedule, please contact the Administration Office or the Local 375 Union Office.

The maximum benefit during the first 12 months of eligibility is $100 for each family member.

Covered Vision Expenses

The following services performed by a licensed ophthalmologist or optometrist are covered by the Plan:

- One complete visual analysis (includes refraction) during a calendar year.
- Single, bifocal, trifocal, or lenticular lenses prescribed to correct vision; maximum of two during a calendar year for Participants and children age 18 or older. Prescription graduated lenses and prescription sunglasses are covered.
- Contact lenses will be covered up to the maximum allowable cost and any limitations of the single vision lens and frame rate **unless** prescribed after cataract surgery or your visual acuity is correctable to 20/70 or better only by the use of contact lenses. In such event, payment with respect to all contact lenses shall be made at 90% of the allowed amount up to the Vision Schedule's maximum allowable cost.
- Your Plan will pay up to $115 during any two consecutive calendar years for frames necessary to accommodate prescribed lenses.

Exclusions

In addition to any applicable exclusions described in the limitations and exclusion in the prior sections of this Plan booklet (such as medical necessity and experimental and investigational), vision benefits will not be provided for the following:

- Contact lenses, except as specifically provided above.
- Contact lens fitting fee.
- Charges for medical or surgical diagnosis for treatment of the eyes, or special procedures such as orthoptics, vision training, or refractive eye surgery.
- Charges for special purpose vision aids, even if prescribed.
- Charges for an eye examination required by an employer as a condition of employment and which the employer is required to provide by virtue of a labor agreement.
- Charges for services or supplies provided under the other provisions of this Plan.
- Charges for laser eye corrective surgery.

LIFE AND AD&D INSURANCE

General Information

Life, accidental death and dismemberment benefits are insured by Symetra Life Insurance Company. The following information is only a summary of the benefits provided under the insurance policy between the Trust and Symetra Life Insurance Company. A copy of the full policy is available by contacting the Administration Office. Symetra Life Insurance Company retains the exclusive right to interpret terms and conditions of the insurance policy.

Life Insurance Claims

If you die while a covered participant your beneficiaries shall receive a life insurance benefit of $5,000. This amount is reduced if you are over age 70.

Any properly filed claim for Life Insurance benefits will be processed in accordance with applicable state law.

Your beneficiary can obtain claim form from the Administration Office. He or she should complete the form in its entirety and attach a death certificate or proof of loss. All forms should then be returned to:

Alaska Pipe Trades
PO Box 34687
Seattle, WA 98124-1687

Claims will normally be processed in 10 days with a written notice to the claimant.

If additional information is needed from the claimant, follow-up letters will be sent to the claimant every 15 days.

If, due to lack of information from the claimant, a decision cannot be made within 90 days, the claimant will be notified of an extension of 90 days until completion of the claim.

Beneficiary Designation

Your benefit will be paid to your most recently named beneficiary on your submitted beneficiary designation form. If more than one beneficiary is named, they will share equally unless otherwise specified in writing. You may change your beneficiary without the beneficiary's consent by giving written notice to the Administration Office or through the Local 375 Union Office. The change will become effective as of the date you sign the notice.

If you die and you have no named living beneficiaries, your benefit may be paid to your estate or your, spouse, children, parents or siblings at the Symetra’s discretion.

Waiver of Premium—Permanent Total Disability

If, while you are insured, you become totally disabled prior to attaining age 60, and you die within one year from the date premium payment terminated and die while so disabled, payment of your Life Insurance will be made. For this purpose, disabled means a sickness or injury that totally and continuously prevents you from working in any occupation for wage or profit, and which occurred while you are a covered participant and is expected to last for the rest of your life.

Also, if you furnish proof (before or within 12 months after the date premium payment terminated) that you are totally and permanently disabled and that you became so disabled while insured and before attaining age 60, your Life Insurance will be extended without premium for a period of one year from the date proof is submitted.

Year to year extensions for further periods of one year each will be made if further proof of continuance of total and permanent disability is furnished within three months prior to each anniversary of the date of the original proof of such disability.

Conversion of Your Life Insurance

If your group term Life Insurance terminates either because of loss of eligibility, transfer to a class of Participants not eligible under the policy, or as a result of disability, the group term Life Insurance may be converted to any form of individual policy of Life Insurance (without double indemnity or disability riders) except a policy of term insurance. For information contact the Local 375 Union Office.

If the Master Policy terminates or is amended so as to terminate your Life Insurance, and the policy has been in force for at least five years, you may convert your group term Life Insurance. The amount may not exceed the smaller of $2,000 or the amount of your terminated group term Life Insurance less any amount of Life Insurance for which you may be eligible under any other group policy which replaces it within 31 days.

- You have 31 days to make application for conversion and pay the required premium following termination of your group term Life Insurance.
- The premium will be based on your attained age and class of risk.
- No evidence of insurability is required.
- If you should die during the 31-day period, the amount of Life Insurance which you are entitled to convert will be payable to your beneficiary, even if you have not applied for conversion.

Employee Accidental Death & Dismemberment Insurance

The insurance company will pay the following amounts if an Employee suffers losses due to accidental injury .

- Loss of life- $5,000
- Loss of hand or foot - $2,500
- Loss of sight in one eye - $2,500
- Loss of thumb and index finger on same hand - $1,250

SUPPLEMENTAL UNEMPLOYMENT BENEFIT

General Information

The Plan provides supplemental unemployment benefits to eligible participants who are unable to work and who are receiving unemployment compensation from the State of Alaska. This section provides a description of supplemental unemployment benefits, including how to obtain supplemental unemployment benefits, and information which may be of help with respect to obtaining such benefits.

Eligibility

To be eligible to receive a supplemental unemployment benefit you must reside in the State of Alaska and be a journeyman member of the Plumbers and Steamfitters, Local Union 375 ("Local 375"), apprentices under the Local 375 JATC Program, or welders' helpers working out of Local 375. For this purpose, "reside in the State of Alaska" means that an individual maintains and dwells in a physical residence in the State of Alaska. Additionally, to be eligible for supplemental unemployment benefits you cannot have declined a dispatch during the period of unemployment. If you decline a dispatch during the period of unemployment, your supplemental unemployment benefits will end. This applies regardless of the reason for declining the dispatch.

Additionally, to become eligible for benefits in any one year, you must have worked a specific number of hours during the calendar year before the year in question. For example, to be eligible in 2022, you must have worked at least 650 hours in 2021.

Only hours reported on an employer remittance report count toward the number of hours you need to make you eligible. This means hours are limited to those hours worked pursuant to the Collective Bargaining Agreements between Local 375 and the Mechanical Contractors of Fairbanks or any similar agreement.

Amount of Benefit

The schedule of benefits is as follows:

1. For those who worked 649 hours or less in the prior calendar year there is no benefit payable.
2. For those who worked from 650 hours to 849 hours in the prior calendar year, the benefit payable is $50.00 per week.
3. For those who worked from 850 hours to 1049 hours in the prior calendar year, the benefit payable is $75.00 per week.
4. For those who worked 1050 or more hours in the prior calendar year, the benefit payable is $100.00 per week.
5. Apprentices may receive an additional $50.00 per week over the benefit stated above while attending school.

Length of Benefit

Benefits may be paid up to a maximum of 26 weeks in a single calendar year. Any benefits which are based on a previous year's unemployment will be charged to the previous year. No one may collect more than four (4) weeks of supplemental unemployment benefits covering back payments of any sort at any one time. To receive more than one benefit payment, you must provide proof for each payment.

NOTE: If you are coming in from out of town, you must come once every four (4) weeks in order to claim the maximum benefit.

Application and Requirements to Receive Benefits

You are eligible to receive your supplemental benefit for any week in which the State of Alaska determines that you are eligible to receive State unemployment insurance benefits and actually pays you such benefits. To prove receipt of State unemployment benefits you must provide: 1) the top half of a check, 2) letter of determination from the State of Alaska, 3) printout from your bank or credit union showing the direct deposit from the State of Alaska, 4) print out from credit card showing deposit, or 5) other evidence of payment issued by the State of Alaska. Proof must include sufficient information showing the "week ending" date. Proof must be the original of the document and not a photocopy or any facsimile.

Apprentices do not need to meet State of Alaska unemployment insurance eligibility requirements to receive supplemental benefits if required to attend scheduled related training classes. Those apprentices who do not meet the State of Alaska unemployment insurance eligibility requirements will be eligible for supplemental benefits only while attending required training classes. Those apprentices that do not meet the State of Alaska unemployment insurance requirement will have their eligibility verified at the union hall. Those apprentices who meet the State of Alaska unemployment insurance eligibility requirements will remain eligible to receive supplemental benefits after training is complete.

To collect, you must present at the union hall, 3980 Boat Street, Fairbanks, Alaska 99709. **You must be personally present.** Eligible individuals who reside outside the Fairbanks North Star Borough may deliver such documentation in person, via US mail or private delivery service, via facsimile, or electronically. For those individuals who reside outside the Fairbanks North Star Borough, upon receipt of unemployment payment, a check will be mailed to the address on record, via US Postal Service, First class mail.

You must apply for benefits within six months of when you are eligible for a benefit. **If a period of more than six months has elapsed from the week for which you are claiming a benefit, you will not be eligible for that week.**

Exclusions

Benefits are not payable in the following circumstances:

1. When you are no longer eligible to receive unemployment insurance benefits from the State of Alaska.
2. In the event that the funds in the Plan run out.
3. At any time that you have refused three (3) consecutive dispatches (from the hiring hall of Local 375), you are ineligible to collect further supplemental unemployment checks until such time as you have accepted a dispatch and worked more than 2 weeks on the job to which you are dispatched. Note that only dispatches for "suitable work" are covered by this rule.
4. If you have a Do Not Call Letter on file at the Union Hall, you are not eligible for Supplemental Unemployment benefits from this fund.
5. You do not meet the eligibility criteria in this section or have failed to file an application for benefits within six months of when you are eligible for benefits.

BENEFIT CLAIMS

Filing Instructions for Medical Claims

Time Period for Filing a Claim

An enrollment form, with all supporting documentation, must be on file at the Administration Office before claims will be processed. An enrollment form may be obtained on the Plan's website or by contacting the Administration Office. A claim will be denied if the enrollment form is not on file.

Claim forms should be submitted within 90 days after services are rendered or a period of disability commences, or as soon as reasonably possible. All claims, supporting documentation, and additional information that is requested to process the claims must be submitted within one year of the date services are rendered. Incomplete claims will not be considered until all the required information has been provided. Claims submitted or completed more than one year from the date of service will not be considered Covered Services and are excluded from coverage.

Method of Funding Benefits

Medical, prescription drug, dental, vision provided by the Plan are self-funded and paid through Trust assets. The Plan also maintains a stop-loss policy for medical benefits.

The life insurance, accidental death and dismemberment insurance and dependent life insurance benefits are insured under a policy issued to the Trustees by an insurance carrier.

Neither the Board of Trustees nor any individual or entity has liability to provide payments over and beyond the amount in the Trust that has been collected and made available for such purpose. No Participant, dependent or other beneficiary has any vested rights to benefits under this Plan.

What is NOT a Claim

A request for a determination regarding the Plan's coverage of a medical treatment or service that a provider recommended is not a claim under these procedures if the treatment or service has not yet been provided and the treatment or service does not require prior authorization. In this circumstance, a determination may be requested from the Administration Office regarding the Plan's coverage of the treatment or service. However, this will not be a guarantee of payment, because such a request is not a claim as described in this section and therefore will not be subject to the requirements and timelines described in this section. When presenting a prescription to a pharmacy to be filled out under the terms of this Plan, that request is not a claim under these procedures. However, if a request for prescription benefits is denied at the pharmacy, in whole or in part, a claim and appeal may be filed regarding the denial by using these procedures.

How to File a Medical Claim

PPO Providers. PPO Providers bill Aetna directly. Aetna reprices the claim based on the network provider discounts and then forwards the repriced claim to the Administration Office. The Administration Office processes the claim and provides an Explanation of Benefits (EOB) to the Covered Person which describes what the plan paid, the network discount(s) and what is owed by the patient as part of the annual deductible, copayment, coinsurance, and noncovered expenses.

Non-PPO Providers. A Non-PPO Provider may submit claims on a Covered Person's behalf if the Provider has all of the needed information.

If a Non-PPO Provider does not submit a claim, a Covered Person may obtain a claim form from the Administration Office or the Plan's website. The instructions on the claim form must be followed when submitting a claim. A completed claim form, including the itemized bill(s), should be sent to:

Alaska Pipe Trades
PO Box 34687
Seattle, WA 98124-1687

Claims should be submitted within 90 days after the service was received. If a claim, or information that has been requested to process a claim, is received more than one year after the expenses have been incurred, the claim will be denied.

Non-PPO Provider payments will be made, at the Trust's option, to the Covered Person, to the Covered Person's estate, to the Provider or as required under federal law, such as for a Qualified Medical Child Support Order. No assignment whether made before or after services are provided, of any amount payable according to this Plan shall be recognized or accepted as binding upon the Trust, unless otherwise required by federal law.

Non-PPO Providers that claim payment under the Plan shall be obligated to submit to a prompt audit of their claims by the Plan, notwithstanding any internal rules the Provider may have to the contrary. In the event a Non-PPO Provider refuses or delays a reasonable audit request by the Plan, the Plan shall have the right to withhold payment on the claim in question and on other pending or future claims from the Non-PPO Provider.

How to File a Prescription Drug Claim

Claims for prescription drugs purchased at a participating retail pharmacy will be filed electronically with CVS Caremark by the pharmacy. No claim form is required when using a CVS Caremark pharmacy.

Claims for prescription drugs that are not purchased at a CVS Caremark pharmacy must be filed with CVS Caremark by mailing to:

CVS Caremark
P.O. Box 52136
Phoenix, AZ 85072-2136

Claim forms may be obtained from the Administration Office.

Claims should be submitted within 90 days after the service was received. If a claim, or information that has been requested to process a claim, is received more than one year after the expenses have been incurred, the claim will be denied.

How to File a Dental or Vision Claim

A dental or vision care Health Care Provider may submit claims on behalf of a Covered Person. If a Health Care Provider does not submit a claim, a Covered Person may obtain a claim form from the Administration Office or online at www.akpipe375healthtrust.com. The instructions on the claim form must be followed when submitting a claim. A completed claim form, including the itemized bill(s), should be sent to:

Alaska Pipe Trades
PO Box 34687
Seattle, WA 98124-1687

Claims should be submitted within 90 days after the service was received. If a claim, or information that has been requested to process a claim, is received more than one year after the expenses have been incurred, the claim will be denied.

Health Care Provider payments will be made, at the Trust's option, to the Covered Person, to the Covered Person's estate, to the Health Care Provider or as required under federal law, such as for a qualified medical child support order. No assignment whether made before or after services are provided, of any amount payable according to this Plan shall be recognized or accepted as binding upon the Trust, unless otherwise required by federal law.

Health Care Providers that claim payment under the Plan shall be obligated to submit to a prompt audit of their claims by the Plan, notwithstanding any internal rules the Health Care Provider may have to the contrary. In the event a Health Care Provider refuses or delays a reasonable audit request by the Plan, the Plan shall have the right to withhold payment on the claim in question and on other pending or future claims from the Health Care Provider.

How to File a Life Insurance, Accidental Death and Dismemberment, or Dependent Life Insurance Claim

A properly completed claim form for life insurance, accidental death and dismemberment, or Dependent life insurance must be filed with Symetra Live Insurance Company within 90 days after the date of loss. Failure to file the form within 90 days will not invalidate or reduce the claim if it is not reasonably possible to complete the claim form within that time period, provided the form is furnished as soon as reasonably possible. However, in no event, except in the absence of legal capacity, may the properly completed claim form and all required documentation be submitted later than one year from the time proof is otherwise required. Claim forms are available from the Administration Office.

How to File a Supplemental Unemployment Benefit Claim

Claims for supplemental unemployment benefit should be presented in person at the union hall, 3980 Boat Street, Fairbanks, Alaska 99709, along with all supporting information needed to process the claim. Claims must be filed within six months of when you are eligible for a benefit.

Procedures for Processing Claims

Claims which are properly filed will be processed in accordance with the following guidelines.

Post-Service Health Claims

Any properly filed claim for medical, prescription drug, dental, or vision benefits (that is not an urgent care or pre-service claim as defined on page 60) will be processed as a post-service health claim.

- A claim will ordinarily be processed within 30 days of receipt. This may be extended by an additional 15 days if a notice is provided within the initial 30-day period.
- If additional information is needed, the Participant or beneficiary will be notified and given 45 days to provide the additional required information.

If the requested information is not received within 45 days, you claim will be processed based on the information provided to the Administration Office.

Pre-Service Claims

These procedures apply only to properly filed claims that must be preauthorized to receive full Plan benefits from the Trust.

- Claimants will be notified within five days if additional information is required to complete a pre-service claim or to allow processing. Claimants will be provided 45 days to submit any additional information.
- If the requested information is not received within 45 days, your claim will be processed based on the information provided to the Pre-certification reviewer (Comagine Health).
- A decision on a pre-service claim will ordinarily be made within 15 days. If additional time is necessary, the claims administrative agent may extend this 15-day period by an additional 15 days by providing notice to the claimant prior to the expiration of the initial 15-day period.
- If services which require preauthorization have been provided and the issue is what payment, if any, will be made, the Trust will process the claim as a post-service health claim.

Urgent Care Health Claims

Urgent care claims are claims for services where the application of the normal time frames for appeals could seriously jeopardize the health of the claimant or expose him or her to severe pain.

- Urgent care claims may be filed, orally or in writing, by the Participant or beneficiary or a health care provider with knowledge of the individual's medical condition.
- Claimants will be informed within 24 hours if additional information is needed to process the claim. Claimants will have at least 48 hours to submit the additional information.

- The Administration Office and the Pre-certification reviewer will develop procedures for identifying urgent care claims which may include seeking additional information from the Participant or beneficiary or his/her providers about why the treatment involves urgent care.
- If services which constitute urgent care have been provided and the issue is what payment, if any, will be made, the Trust will process the claim as a post-service claim.

Other Benefit Claims.

For other benefits claims, such as life or supplemental unemployment benefits, claimants will be notified of a determination on a claim within 45 days after receipt of the claim by the Plan. This period may be extended for up to 30 days (to a total of 75 days) if the Plan determines that an extension of time is necessary due to matters beyond the control of the Plan, and notifies the claimant prior to the expiration of the initial 45-day period of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision. If the Plan determines that an additional extension of time is necessary due to matters beyond the control of the Plan, and notifies the claimant prior to the expiration of the first 30-day extension period of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision, then the period for making a benefit determination may be extended by the Plan for an additional 30 days (to a total of 105) days. If an extension is necessary due to the claimant's failure to submit information necessary to process the claim, the notification of the extension will describe the necessary information, and the claimant will be provided at least 45 days from receipt of the notification to submit the additional information. The period for making a determination will be tolled from the date on which the notification of the extension is sent to the claimant until the date on which the claimant responds to the request for additional information.

Claim Appeals

Denied Claim

A denial of benefits will provide the following information:

- The reason for the denial.
- A reference to the Plan provision relied on.
- A description of any additional material needed to perfect the claim.
- An indication if any internal guidelines or protocols have been relied on in denying the claim and statement that any such internal guidelines are available on request.
- If the denial is based on medical necessity, the service or supply being experimental or investigational in nature or an equivalent exclusion, a statement that an explanation of the medical judgment will be provided upon request.
- An explanation of the Plan appeal procedures.
- The denial will be mailed to the Participant or beneficiary at his/her last known address.

Appeal Procedures

The procedures specified below shall be the exclusive procedures available to a Participant or beneficiary who is dissatisfied with an eligibility determination, benefit denial, or partial benefit award or any other adverse benefit determination by the Board of Trustees or its authorized agents.

These procedures must be exhausted before a claimant may file suit under Section 502(a) of ERISA.

TAKE ACTION

Claimants will have 180 days from the date of denial to appeal an adverse benefit determination.

An appeal must be submitted by the Participant or beneficiary or an authorized representative in writing. It must be submitted to the proper address for the Administration Office. An appeal must

identify the benefit determination involved, set forth the reasons for the appeal, and provide any information the claimant believes is pertinent.

Except for urgent care claims, appeals will be accepted from an authorized representative only if accompanied by a written statement signed by the claimant (or parent or legal guardian where appropriate) that identifies the representative and authorizes him or her to seek benefits for the claimant. An assignment of benefits is not sufficient to make a provider an authorized representative.

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

Information to Be Provided upon Request

The claimant and/or his/her authorized representative may, upon request and free of charge, have reasonable access to all relevant documents to the claim for benefits.

Relevant documents shall include information relied upon, submitted, considered, or generated in making the benefit determination.

It will also include internal guidelines, procedures, or protocols concerning the denied treatment option without regard to whether such document or advice was relied on in making the benefit determination.

Absent a specific determination by the Trustees that disclosure is appropriate, relevant documents do not include any other individual's medical or claim records or information specific to the resolution of other individuals' claims.

If a denial is based upon a medical determination, an explanation of that determination and its application to the claimant's medical circumstances is also available upon request.

Conduct of Hearings by the Appeal Committee

Except for urgent care and pre-service health claims, an appeal will be presented to the Trust's Appeals Committee at its next quarterly meeting.

If an appeal is received less than 30 days before the next quarterly meeting, consideration of the appeal may be postponed until the second quarterly meeting following receipt of the appeal.

The Appeals Committee shall consist of at least one Employer and one Union Trustee.

The Appeals Committee will review the administrative file, which will consist of all documents relevant to the claim. It will also review all additional information submitted by the Participant or on the Participant's behalf. The review will be de novo and without deference to the initial denial.

If the denial is based on medical judgment, the Appeals Committee will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment.

The Appeals Committee may have an individual with a different licensure review a matter if they are trained to deal with the condition involved. The health care professional consulted will not be the individual who made the initial benefit determination nor the subordinate of that individual.

The Appeals Committee will identify by name any individuals consulted for medical or vocational advice.

Upon written request, the claimant or his/her representative may request to appear before the Appeal Committee and present any evidence or witnesses. If the claimant does not request to appear, the hearing will be determined based on the administrative file. If the claimant does appear at the hearing (or if the Appeals Committee otherwise determines that such a record is appropriate) a stenographic record shall be made of any testimony provided.

The Appeals Committee may in its discretion set conditions upon the conduct of the hearing or the testimony or attendance of any individual or may address other procedural matters which could occur during a specific hearing.

Issuance of a Decision

The Appeals Committee will provide the claimant written notification of its decision within five business days. Where appropriate, the Appeals Committee may issue a more detailed explanation of the reasons for its decision within 30 days of the hearing.

The decision will include the following points:

- Note the specific reasons for an adverse decision.
- Reference the Plan procedure involved.
- Inform the claimant that all information relevant to the individual's claim is available upon request and free of charge.
- Notify the claimant of his/her rights under section 502(a) of ERISA.
- Identify any internal rule or guideline relied on (or reference that it is available free of charge).
- If a denial is based on a medical judgment, explain the medical judgment, applying it to the claimant's case, or state that such information is available.

If a decision cannot be reached at the initial meeting at which an appeal is heard, the Appeals Committee may defer a decision on an appeal until the next quarterly scheduled appeals meeting, provided that written notice is provided to the claimant.

Modifications to the Appeal Procedures for Pre-Service and Urgent Care Claims

The following modifications will be made in the appeal procedures, starting on page 61, for claims involving pre-service claims or urgent care claims.

Pre-Service Claims

Pre-service health claims will be conducted in accordance with the above procedures with the following modifications:

- A decision or an appeal of a denial of a pre-service health claim will be issued within 30 days of receipt of the appeal.
- Unless the appeal hearing coincides with a quarterly Appeal Committee meeting, the Appeal Committee meeting will be conducted by a telephone conference call. The claimant or his/her authorized representative may participate to the extent necessary for the Appeal Committee to develop an adequate record. If the claimant wishes to appear in person, he or she may elect to postpone the hearing until the next quarterly Appeal Committee meeting.

Urgent Care Claims

Appeals involving denial of urgent care will be subject to the rules set forth starting on page 61 with the following modifications:

- An initial decision will be made within 72 hours if the initial claim was complete when submitted or an additional 48 hours after receiving additional information if it was necessary to process the claim.
- The appeal may be made orally or in writing.
- A health care professional with knowledge of the claimant's medical condition may act as an authorized representative of the claimant without a prior written authorization.
- Information will be provided to the claimant or authorized representative via telephone, facsimile, or other expedited method.
- A decision will be issued within 72 hours of an appeal of an initial denial.

External Reviews

If the Board of Trustees denies a participant's appeal for a claim involving a medical judgment or the retroactive rescission of health coverage, the participant may request an external review of the Board of Trustees' decision by an Independent Review Organization ("IRO"). There is no external review

for health claims not involving medical judgment and non-healthcare claims, such as weekly disability, accidental death and dismemberment, or life insurance.

A request for external review must be filed with the Administration Office within four months from the claimant's receipt of the Board of Trustees' decision on appeal. Requests for external review may be mailed to the following address:

Attn: Appeals
WPAS, Inc.
PO Box 34203
Seattle, WA 98124-1203

Failure to file a request for external review within the four-month period will end the claimant's ability to seek external review.

Preliminary Review of External Review Request

Within five business days of receipt of a request for external review, the Trust will complete a preliminary review of the request to determine whether the claim is eligible for an external review. The preliminary review will be expedited if the request satisfies the requirements for an urgent care claim. Within one business day after completion of this review, the Plan will notify the claimant of its decision. If the request is not eligible for external review, the Plan will notify the claimant. If the request for external review is incomplete, the Plan will identify what is needed and the claimant will have the longer of 48 hours or the remaining portion of the four-month external review request period to provide the information. If the external review request is complete and eligible for external review, the Plan will refer the matter to an IRO.

Review by Independent Review Organization

If a properly filed request for external review is received, the Plan will provide the IRO with the required documentation in the time required by applicable federal regulations. The IRO will provide a response to the claimant within 45 days after it has received the request to review.

The Plan's existing Claim and Appeal Procedures provide for an expedited review of an urgent care claim. If an urgent care claim is submitted to an IRO, a decision will be made within 72 hours.

If the IRO directs benefits be paid, benefits will be provided under the Plan in accordance with the decision. If the decision continues to be adverse, the claimant has the right to bring a civil action under ERISA § 502(a). A claimant must exhaust the Plan's Claim and Appeal Procedures prior to filing a civil action.

Review of Denied Claims

The Plan provides for no voluntary alternative dispute resolution procedures, other than the External Review provision below. If a claimant remains dissatisfied with the Board of Trustees' determination after exhausting the claim appeal procedures, including the external review process, he or she has the right to pursue a civil action under 29 U.S.C. § 1132(a). Any civil action must be brought no later than one year after the date of issuance of the Trustees' decision on an appeal.

The question on review will be whether, in the particular instance, the Trustees: (1) were in error upon an issue of law; (2) acted arbitrarily or capriciously in the exercise of their discretion; or (3) whether their findings of fact were supported by substantial evidence. Any civil action seeking to overturn a denial or other decision of the Trustees must be brought within 180 days of the Trustees' issuance of a written decision on appeal. A failure to file a civil action within the 180 days will bar the right to further review of the appeal.

PLAN ADMINISTRATION

Coordination of Benefits (with Other Plans)

For Active Participants

If you or your eligible dependents are entitled to benefits under any other plan which will pay part or all of the expenses incurred for usual, customary and reasonable charges for treatment of an illness or injury, the amount of benefits payable by this Plan and the other plan will be coordinated so that the aggregate amount paid will not exceed l00% of the expenses incurred.

Coordination with Other Benefits

This Plan is designed to help you meet the cost of medical, dental and vision care expenses. Prescription Drug benefits will not be coordinated.

Since it is not intended that you receive greater benefits than the actual expenses incurred, the amount payable under this Plan will take into account any coverage you or your dependents have under other plans.

This means the benefits under this Plan will be coordinated with the benefits of the other plans.

When coordinating with other plans, this Plan will pay either its regular benefits in full, or a reduced amount.

This reduced amount plus the benefits payable by the other plans will not exceed 100% of allowable expenses. Allowable expenses means any necessary, usual, customary and reasonable expense you incur in a calendar year while covered under this Plan, but not any expenses contained in the list of Plan exclusions.

If, because of the coordination provision, this Plan does not pay its regular benefit, a record is kept of the reduction. This amount will be used to increase your later claim payments under the Plan in the same calendar year, to the extent there are allowable expenses that otherwise would not be fully paid by this Plan and the other plans. Therefore, on a later claim you may receive a greater benefit under our Plan than would be normally allowed.

Definition of Other Plans

Plan means any of the following coverages, including policy coverage and any coverage which is declared to be excess to all other coverages, which provide benefit payments or services to an insured person for Hospital, medical, surgical, dental, or vision care:

- Group health insurance and other prepayment coverage on a group basis, including HMOs (Health Maintenance Organizations).
- Coverage under a labor-management plan, a union welfare plan, an employer organization plan or an Employee benefits plan.
- Coverage under government programs, other than Medicare or Medicaid, and any other coverage required by law.
- Group or individual automobile "fault or no fault" coverage.
- Other arrangements of insured or self-insured group coverage.

The following guidelines have been established to ensure that all plans coordinate benefits in a consistent manner.

The primary plan pays benefits first. The secondary plan pays benefits second (after the primary plan has paid).

Order of Benefit Determination

The primary plan is determined as follows:

- Plans determine the sequence in which they pay benefits, or which plan pays first, by applying a uniform set of order of benefit determination rules that are applied in the specific sequence outlined below. 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-funded plans. Any group plan that does not use these same rules always pays its benefits first.
- When two group plans cover the same person, the following order of benefit determination rules establish which plan is the primary plan that pays first and which is the secondary plan that pays second. If the first of the following rules does not establish a sequence or order of benefits, the next rule is applied, and so on, until an order of benefits is established. These rules are:

Rule 1: Non-Dependent or Dependent

A. The plan that covers a person other than a dependent, for example, as an Employee, Retiree, member or subscriber is the primary plan that pays first; and the plan that covers the same person as a dependent is the secondary plan that pays second.

B. There is one exception to this rule. If the person is also a Medicare beneficiary, and Medicare is secondary to the plan covering the person as a dependent; and primary to the plan covering the person a retired Employee; then the order of benefits is reversed, so that the plan covering the person as a dependent pays first; and the plan covering the person as a retired Employee pays second.

Rule 2: Dependent Child Covered Under More Than One Plan

A. 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:

   1. The parents are married;
   2. The parents are not separated (whether or not they ever have been married); or
   3. A court decree awards joint custody without specifying that one parent has the responsibility for the child's health care expenses or to provide health care coverage for the child.

B. If 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 plan that has covered the other parent for the shorter period of time pays second.

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

D. 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. However, this provision does not apply during any Plan Year during which any benefits were actually paid or provided before the Plan had actual knowledge of the specific terms of that court decree.

   If the specific terms of a court decree is silent on who is responsible for the dependent child's health care expenses, or if the court decree provides that both parents are responsible for health care coverage or if the child is no longer subject to the court decree due to age, 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.

E. 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 benefit determination among the plans of the parents and their Spouses (if any) is:

   1. The plan of the custodial parent pays first; and
   2. The plan of the Spouse of the custodial parent pays second; and
   3. The plan of the non-custodial parent pays third; and

4. The plan of the Spouse of the non-custodial parent pays last.

Rule 3: Active/Laid-Off or Retired Employee

A. The plan that covers a person 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. For the purpose of this rule, unless the person is eligible for Medicare, running out an hour bank after leaving employment with a contributing employer shall not be consider active coverage.

B. 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.

C. If a person is covered as a laid-off or retired Employee under one plan and as a dependent of an active Employee under another plan, the order of benefits is determined by Rule 1 rather than by this rule.

Rule 4: Continuation Coverage

A. 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. For the purpose of this rule, running out an hour bank after leaving employment with a contributing employer shall be considered continuation coverage.

B. 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.

C. If a person is covered other than as a dependent (that is, as an Employee, former Employee, Retiree, Member or Subscriber) under a right of continuation coverage under Federal or state law under one plan and as a dependent of an active Employee under another plan, the order of benefits is determined by Rule 1 rather than by this rule.

Rule 5: Longer/Shorter Length of Coverage

A. 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.

B. To determine how long a person was covered by a plan, two plans are treated as one if the person was eligible for coverage under the second plan within 24 hours after the first plan ended.

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

1. In the amount or scope of a Plan's benefits;
2. In the entity that pays, provides or administers the Plan; or
3. From one type of plan to another (such as from a single employer plan to a multiple employer plan).

D. The length of time a person is 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.

This Plan has the right to release and obtain any information or recover any payments it considers necessary to administer this provision.

Right of Recovery/Reimbursement

The Plan excludes benefits for a Covered Person if the Covered Person is injured from an illness or injury caused by the act or omission of another person (known as the "third party") for which there

is a potential opportunity to recover from the third-party, the third-party's insurer or any liability policy.

If a Covered Person is pursuing or investigating a claim or lawsuit against a third party or insurer for an illness or injury caused by the act or omission of the third party, the Plan may initially advance payment for benefits related to the third-party illness or injury. By accepting advance payment for benefits, the Covered Person agrees that the Plan's payment related to the illness or injury is conditioned on reimbursement from any recovery from the third party, the third party's insurer, under an automobile policy (including first party automobile insurance, uninsured and underinsured motorist policy), commercial premises policy, homeowner's policy, medical malpractice policy, renter's policy, or any other liability policy.

The Plan shall be entitled to first dollar priority to 100% reimbursement from the Covered Person, with respect to any full or partial recovery by the Covered Person, whether by judgment, settlement, award or otherwise, from any third party, insurer or persons making payments on behalf of a third party. If the Covered Person and the Covered Person's attorney or personal representative recognize the Plan's right to reimbursement, comply with the terms of the Plan and cooperate fully with the Plan, the Plan will deduct reasonable attorney fees and a pro rata share of the costs from the reimbursement amount.

The Plan's right to reimbursement applies without regard to the characterization of the recovery by the Covered Person and/or any third party or the source of the recovery. The Plan does not recognize the make whole doctrine, which is expressly rejected, or otherwise agree to limit its right to reimbursement based on the amount of the Covered Person's actual or stipulated recovery. The Plan's right to reimbursement will not exceed the amount of the Covered Person's gross recovery, regardless of characterization.

Before advancing benefits, the Plan may require that the Covered Person and/or the Covered Person's attorney or personal representative execute, in writing, an agreement acknowledging this reimbursement right, the name and address of the party at fault, the name of any insurance company through which coverage may be available, the name of any other lien holders involved and a factual description of the accident and/or injury.

The Covered Person and/or the Covered Person's attorney or personal representative also agree that in the event of a dispute as to the amount of the Plan's claimed reimbursement, the Plan's reimbursement amount will be paid into a trust account and held there until the Plan's claim is resolved by mutual agreement or court order. The obligation to place the reimbursement amount in trust is independent of the obligation to reimburse the Plan. If the funds necessary to satisfy the Plan's reimbursement amount are not placed in trust, the Covered Person or the individual named to hold the funds in trust shall be liable for any loss the Plan suffers as a result.

If the Plan is forced to bring a legal action against the Covered Person to enforce the terms of Plan provisions, it shall be entitled to its reasonable attorney fees, costs of collection and court costs.

If there is a reasonable basis to believe that this provision or any agreement to reimburse the Plan is not enforceable or that the Covered Person will not honor the terms of this provision or any agreement to reimburse, the Plan will deny coverage and may seek refunds of overpaid benefits from providers. The Plan may also cease advancing benefits and exclude future expenses incurred after a judgment, settlement, or proposed settlement of the claim, irrespective of the amount of the recovery, if such expenses are related to the third-party recovery.

If the Covered Person fails to honor the terms of this provision or any agreement to reimburse, any advanced benefits will be treated as overpaid benefits and the Plan may take appropriate action to collect the overpaid benefits, including, but not limited to, seeking refunds from providers, offsetting future benefits, including those of family members, denying future payments, bringing a breach of contract action in state court to enforce the Plan's right to reimbursement under this Plan provision and seeking a constructive trust in Federal court under ERISA § 502(a)(3). In addition to the overpaid benefits, the Covered Person will be liable for interest, and all costs of collection, including reasonable attorney fees and court costs.

Venue for any enforcement action of this Plan provision will be in the U.S. District Court for the District of Alaska. The Plan may bring an action in an appropriate court to enforce the agreement to reimburse, enforce the requirement that funds be placed in trust or seek other appropriate relief.

Motor Vehicle Accidents

The Plan will not pay benefits for health care costs to the extent that the Covered Person is able to, or is entitled to, recover from motor vehicle insurance, including payments under a personal injury protection (PIP) policy. Benefits will not be provided to the extent a Covered Person has failed to acquire PIP coverage where required to do so by law or PIP coverage has been terminated before being exhausted for failure to cooperate or otherwise for cause. The Plan will pay benefits toward expenses over the amount covered by motor vehicle insurance subject to the Plan's Right of Recovery/Reimbursement provision.

If the Plan pays benefits before motor vehicle insurance payments are made, the Plan is entitled to reimbursement out of any subsequent motor vehicle insurance payments made to the Covered Person and, when applicable, the Plan may recover benefits the Plan has paid directly from the motor vehicle insurer or out of any settlement or judgment which the Covered Person obtains in accordance with the Plan's Right of Recovery/ Reimbursement provision.

Repayment of Improperly Paid Benefits

If the Plan mistakenly makes a payment for a participant to which they are not entitled, if the Plan makes a payment on behalf of a person who is not eligible for benefits or if a Covered Person fails to observe the Plan's Right of Recovery/ Reimbursement provision, the Plan has the right to recover the payment from the Covered Person paid or anyone else who benefited from it, including a provider of services. The Plan may also pursue recovery from any individual or entity responsible for providing misinformation to or failing to provide necessary information to the Plan which has resulted in the payment of improper benefits. The Plan's right of recovery includes the right to deduct the amount paid by mistake from future benefits payable to the affected Covered Person or any other individual where eligibility is established through the same Covered Person. The Plan may also recover benefits from the person responsible for misreporting any person for eligibility purposes.

YOUR RIGHTS

Notice of Privacy Practices

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

Protected Health Information

Protected health information generally means information that: (1) is created or received by a health care provider, health plan, employer, or health care clearinghouse; and (2) relates to the past, present, or future physical or mental health or condition of an individual, the provision of health care to an individual, or the past, present, or future payment for the provision of health care to an individual; and (3) identifies the individual, or there is a reasonable basis to believe the information can be used to identify the individual.

Use and Disclosure of Health Information

Your health information may be used and disclosed without an authorization for the purposes listed below. The health information used or disclosed will be limited to the "minimum necessary", as defined under the Privacy Rules.

To Make or Obtain Payment

The Trust may use or disclose your health information to make payment to or collect payment from third parties, such as other health plans or providers, for the care you receive. For example, the Trust may use your health information to pay claims, or share information regarding your coverage or health care treatment with other health plans to coordinate payment of benefits.

To Facilitate Treatment

The Trust may disclose information to facilitate treatment which involves the provision, coordination or management of health care or related services. For example, the Plan may disclose the name of your treating provider to another treating provider for the purpose of obtaining x-rays.

To Conduct Health Care Operations

The Trust may use or disclose health information for its own operations to facilitate the administration of the Trust and as necessary to provide coverage and services to all of the Trust's Participants. Health care operations include such activities as: contacting health care providers; providing Participants with information about health-related issues or treatment alternatives; developing clinical guidelines and protocols; conducting case management, medical review and care coordination; handling claim appeals; reviewing health information to improve health or reduce health care costs; participating in drug or disease management activities; conducting underwriting, premium rating or related functions to create, renew or replace health insurance or health benefits; and performing the general administrative activities of the Trust (such as providing customer service, conducting compliance reviews and auditing, responding to legal matters and compliance inquiries, including cost management and planning related analyses and formulary development, and accreditation, certification, licensing or credentialing activities).

In Connection With Judicial and Administrative Proceedings

If required or permitted by law, the Trust may disclose your health information in the course of any judicial or administrative proceeding in response to an order of a court or administrative tribunal as expressly authorized by such order or in response to a subpoena, discovery request or other lawful

process. The Trust will make reasonable efforts to either notify you about the request or to obtain an order protecting your health information.

When Legally Required For Law Enforcement Purposes

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

To Conduct Health Oversight Activities

The Trust may disclose your health information to a health oversight agency for authorized activities including audits, civil, administrative or criminal investigations, inspections, licensure or disciplinary action. The Trust, however, may not disclose your health information if you are the subject of an investigation and the investigation does not arise out of or is not directly related to your receipt of health care or public benefits.

In the Event of a Serious Threat to Health or Safety

The Trust may, consistent with applicable law and ethical standards of conduct, disclose your health information if the Trust, in good faith, believes that such disclosure is necessary to prevent or lessen a serious and imminent threat to your health or safety or to the health and safety of the public.

For Specified Government Functions

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

To Your Personal Representative

The Trust may disclose your health information to an individual who is considered to be your personal representative under applicable law.

To Individuals Involved in Your Care or Payment for Your Care

The Trust may disclose your health information to immediate family members, or to other individuals who are directly involved in your care or payment for your care.

To Business Associates

The Trust may disclose your health information to its Business Associates, which are entities or individuals not employed by the Trust, but which perform functions for the Trust involving protected health information, such as claims processing, utilization review, or legal, consulting, accounting or administrative services. The Trust's Business Associates are required to safeguard the confidentiality of your health information.

For Workers' Compensation

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

For Disclosure to the Plan Trustees

The Trust may disclose your health information to the Board of Trustees (which is the Plan sponsor) and to necessary advisors for Plan administration functions, such as those listed in this summary, or to handle claim appeals, solicit bids for services, or modify, amend or terminate the Plan. The Trust may also disclose information to the Trustees regarding whether you are participating or enrolled in the Plan.

Authorization to Use or Disclose Health Information

Other than as stated above, the Trust will not disclose your health information without your written authorization. Authorization forms are available from the Privacy Officer, listed on page 73. If you have authorized the Trust to use or disclose your health information, you may revoke that authorization in writing at any time. The revocation should be in writing, include a copy of or reference your authorization and be sent to the Privacy Officer, listed on page 73.

Special rules apply to disclosure of psychotherapy notes. Your written authorization will generally be required before the Plan will use or disclose psychotherapy notes. Psychotherapy notes are separately filed notes about your observations with your mental health professional during a counseling session. They do not include summary information about your mental health treatment. The Plan may use and disclose such notes when needed to defend against litigation filed by you.

Your written authorization will be required for any disclosure of your health information that involves marketing, the sale of your health information, or any disclosure involving direct or indirect remuneration to the Trust.

Your Rights with Respect to Your Health Information

Right to Request Restrictions

You may request restrictions on certain uses and disclosures of your health information. You have the right to request a limit on the Trust's disclosure of your health information to someone involved in the payment of your care. However, the Trust is not required to agree to your request unless the disclosure is to another health plan for the purpose of carrying out payment or health care operations and your health care provider has been paid out of pocket in full. If you wish to request restrictions, please make the request in writing to the Privacy Officer listed on page 73.

Right to Confidential Communications

You have the right to request that the Trust communicate with you in a certain way if you feel the disclosure of your health information through regular procedures could endanger you. For example, you may ask that the Trust only communicate with you at a certain telephone number or by e-mail. If you wish to receive confidential communications, please make your request in writing to the Privacy Officer, listed on page 73. The Trust will attempt to honor your reasonable requests for confidential communications.

Right to Inspect and Copy Your Health Information

You have the right to inspect and copy your health information. This right, however, does not extend to psychotherapy notes or information compiled for civil, criminal or administrative proceedings. The Trust may deny your request in certain situations subject to your right to request review of the denial. A request to inspect and copy records containing your health information must be made in writing to the Privacy Officer, listed on page 73. If you request a copy of your health information, the Trust may charge a reasonable fee for copying, assembling costs and postage, if applicable, associated with your request.

Right to Amend Your Health Information

If you believe that your health information records are inaccurate or incomplete, you may request that the Trust amend the records. That request may be made as long as the information is maintained by the Trust. A request for an amendment of records must be made in writing to the Privacy Officer, listed on page 73. The Trust may deny the request if it does not include a reasonable reason to support the amendment. The request also may be denied if your health information records were not created by the Trust, if the health information you are requesting be amended is not part of the Trust's records, if the health information you wish to amend falls within an exception to the health information you are permitted to inspect and copy, or if the Trust determines the records containing your health information are accurate and complete.

If the Trust denies a request for amendment, you may write a statement of disagreement. The Trust may write a rebuttal statement and provide you with a copy. If you write a statement of disagreement, then your request for amendment, your statement of disagreement, and the Trust's rebuttal will be included with any future release of the disputed health information.

Right to an Accounting

You have the right to request a list of disclosures of your health information made by the Trust. The request must be made in writing to the Privacy Officer listed below.

The request should specify the time period for which you are requesting the information, but may not start earlier than April 14, 2003, when the Privacy Rules became effective.

Accounting requests may not be made for periods of time going back more than six (6) years. An accounting will not include disclosure made to carry out treatment, payment, and health care operations; disclosures that were made to you; disclosures that were incident to a use or disclosure that is otherwise permitted by the Privacy Rules; disclosures made pursuant to an authorization; or in other limited situations.

The Trust will provide the first accounting you request during any 12-month period without charge.

Subsequent accounting requests may be subject to a reasonable cost-based fee. The Trust will inform you in advance of the fee, if applicable.

Right to a Paper Copy of this Notice

You have a right to request and receive a paper copy of this Notice at any time, even if you have received this Notice previously or agreed to receive the Notice electronically. To obtain a paper copy, please contact the Privacy Officer, listed below.

Right to Opt Out of Fundraising Communications

If the Trust participates in fundraising, you have the right to opt-out of all fundraising communications.

Privacy Officer

To exercise any of these rights related to your health information you should contact the Privacy Officer listed below.

Privacy Officer

c/o Welfare & Pension Administration Service, Inc.
P.O. Box 34203
Seattle, WA 98124-1203
Phone No: (800) 331-6158
Fax No: (206) 441-9110

Duties of the Trust

The Trust is required by law to maintain the privacy of your health information as set forth in this Notice, to provide to you this Notice of its duties and privacy practices, and to notify you following a breach of unsecured protected health information.

The Trust is required to abide by the terms of this Notice, which may be amended from time to time. The Trust reserves the right to change the terms of this Notice and to make the new Notice provisions effective for all health information that it maintains.

If the Trust changes its policies and procedures, the Trust will revise the Notice and will provide a copy of the revised Notice to you within 60 days of the change. You have the right to express complaints to the Trust and to the Secretary of the Department of Health and Human Services if you believe that your privacy rights have been violated.

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

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

ERISA Rights

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

Receive Information about Your Plan and Benefits

You have the right to examine, without charge, at the Administration 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 Pension and Welfare Benefit Administration.

You have the right to 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 Plan Administrator may make a reasonable charge for the copies.

You have the right to 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 Medical, Dental and Vision Plan Coverage

You have the right to 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.

You have the right to reduce or eliminate exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan. You should 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 up to 12 months after your enrollment date.

Prudent Actions 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 Employee Health Plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan Participants and Beneficiaries. 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 benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a 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. 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 Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue NW, Washington, DC 20210.
- You may also obtain certain publications about our rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

Newborns' and Mothers' Health Protection Act

Under Federal law, maternity benefits for inpatient confinement otherwise payable under the Plan shall not be restricted to less than:

- 48 hours following a normal vaginal delivery.
- 96 hours following a cesarean section for the mother and the newborn.

A provider is not required to obtain any preauthorization from the Plan for prescribing a length of stay not in excess of the above periods.

Women's Health and Cancer Rights Act

Under Federal law, group health plans that provide medical and surgical benefits in connection with a mastectomy must provide benefits for certain reconstructive surgery. This includes:

- Reconstruction of the breast on which a mastectomy has been performed.
- Surgery and reconstruction of the other breast to produce a symmetrical appearance.
- Prostheses and physical complications of all stages of mastectomy, including lymphedemas.

Coverage of these services is subject to the terms and conditions of the Plan, including the Plan's normal copayment, annual deductibles and coinsurance provisions.

Medical, Dental and Vision Plan Disclosures

You or your dependent is entitled to request from the Administration Office, without charge, information applicable to the Plan's benefits and procedures.

In addition, your Certificate includes, as applicable, a description of:

- Qualified Medical Child Support Orders.
- Any cost-sharing provisions, including premiums, deductibles, coinsurance and copayments, maximums.

- Details about the level of benefits, providers, preauthorization and utilization review rules, coverage for medical tests, devices and procedures, out-of-network coverage, limits on emergency care, coverage of existing and new drugs.
- Employee and dependent eligibility requirements.
- Any participating provider requirements; a current listing of such providers shall be furnished automatically as a separate document.
- When insurance ends.
- When benefits may be denied or reduced, including right of recovery or reimbursement, and coordination of benefits provisions.
- State or Federal continuation rights.
- Claims procedures; additional details shall be furnished upon request.
- Maternity Hospitalization for the mother and newborn infant.

Life and Accidental Death & Dismemberment Benefits Plan Disclosures

You or your dependent is entitled to request from the Administration Office, without charge, information applicable to the Plan's benefits and procedures.

In addition, your certificate includes, as applicable, a description of:

- Employee and dependent eligibility requirements.
- When insurance ends.
- State or Federal continuation rights.
- Claims procedures; additional details shall be furnished upon request.

Plan Changes

The Board of Trustees reserves the right, at its sole discretion, to make any changes it deems necessary to promote efficiency, economy and better service for the Participants and their covered dependents. The Administration Office and the Local 375 Union Office does not have the authority to change the provisions of the Plan. An interpretation of the Plan by the Administration Office or the Local 375 Union Office is subject to review by the Board of Trustees. No individual trustee, employer, employer association, labor organization, or any individual employed by an employer or labor organization, has any authority to interpret or change the Plan.

The Trust has no obligation to furnish benefits beyond those described in the Plan. All Plan benefits, including retiree benefits, are provided to the extent that money is currently available to pay the cost of such benefits.

DEFINITIONS

Administration Office means the organization with which the Board of Trustees has contracted to process claims and issue Plan benefit payments on behalf of the Health Trust.

Cosmetic means any procedure, any portion of an operative procedure or any other treatment performed primarily for the purpose of improving or reshaping structures of the body in order to enhance a patient's appearance and self-esteem and is not needed to correct or improve a bodily function or treat and injury or illness.

Covered Medical Expenses means covered expenses for services, including supplies furnished incident to those services, which are medically necessary and for which benefits will be provided subject to the terms, conditions, limitations, and exclusions described in this Plan.

Covered Person means any Participant or dependent who is eligible to receive Plan benefits.

Custodial Care means care primarily to assist the individual in meeting the activities of daily living. Coverage is not provided for Custodial Care.

Experimental or Investigational treatment, means any one of the following:

- A drug or device that cannot be lawfully marketed without the approval of the U.S. Food and Drug Administration and for which approval for marketing has not been given for regular non-experimental or non-investigational purposes at the time the drug or device is furnished.
- A drug, device, medical treatment, or procedure that has been determined to be an experimental or investigative procedure by the treating facility's Institutional Review Board or other body serving a similar function, for which the patient has signed an informed consent document acknowledging such experimental status.
- Federal law that classifies the drug, device, or medical treatment under an investigative program.
- Reliable evidence which shows that the drug, device, medical treatment, or procedure is the subject of ongoing Phase I or Phase II clinical trials or is otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with standard means of treatment or diagnosis (except as provided below).
- For purposes of this section, "reliable evidence" shall mean only published reports and articles in peer reviewed authoritative medical and scientific literature; the written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same drug, device, medical treatment, or procedure; or the written informed consent used by the treating facility or by another facility studying substantially the same drug, device, medical treatment, or procedure.

The Administration Office will investigate each claim for benefits which might include experimental or investigational treatment.

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

Health Care Provider means a healthcare provider who is acting within the scope of the provider's license or certificate under applicable state law. Certain licensed or certified professionals providing services covered by the plan may be required to be under the supervision of an MD, DO, DDS, or DMD as determined by the plan. Covered providers may include:

a. Acupuncturist
b. Anesthetist
c. Certified Nurse Midwife
d. Chiropodist
e. Chiropractor

f. Clinical Psychologist
g. Denturist
h. Licensed Practical Nurse
i. Marriage and Family Therapist
j. Mental Health Counselor
k. Nurse Practitioner
l. Physical Therapist
m. Physician's Assistant
n. Optometrist
o. Registered Nurse

Before receiving treatment from any practitioner other than an MD or DO, check with the Trust Office to find out if the expenses will be recognized as covered.

Hospital is a facility which:

- Is licensed (if required) as a Hospital; and
- Is open at all times; and
- Is operated mainly to diagnose and treat illnesses on an inpatient basis, and
- Has a staff of one or more doctors on call at all times; and
- Has 24-hour nursing services by registered nurses; and
- Is not mainly a Skilled Nursing Facility, clinic, nursing home, rest home, convalescence home or like place; and
- Has organized facilities for major surgery.

Medically Necessary means those services and supplies that are required for diagnosis or treatment of an illness or injury, which, in the judgement of the Plan, are:

- essential and appropriate for the diagnosis and/or treatment of illness or injury;
- professionally and broadly accepted as the usual, customary, and effective means of diagnosing or treating illness or injury;
- not primarily for the convenience of the patient or provider;
- the least costly of the alternative supplies or levels of services which can be safely
- provided to the participant; and
- when applied to an inpatient, cannot safely be provided to an outpatient.

Medically necessary procedures, services or supplies may be necessary in part only. The fact that a procedure, service, or supply may be furnished, prescribed, recommended, or approved by a provider does not make it medically necessary.

A **Non-Occupational Injury** is an accidental bodily injury that does not arise out of (or in the course of) any work for pay or profit, nor in any way results from an injury which does.

A **Non-Occupational Illness** is an illness that does not arise out of (or in the course of) any work for pay or profit, nor in any way results from an illness which does.

A **Participant** is an individual who has met the eligibility requirements and is covered under the Plan.

A **Physician** means a doctor of medicine (M.D.) or doctor of osteopathy (D.O.) who is licensed and acting within the scope of their license.

Plan Administrator is the Board of Trustees of the Alaska Pipe Trades Association – U. A. Local No. 375 Health and Security Trust Fund.

Room and Board Charges are the reasonable and appropriate charges for room and board and for other necessary institutional services and supplies, made regularly at a daily or weekly rate as a condition of occupancy of the type of accommodations occupied. Non-provider services and supplies that are commonly and routinely provided to patients admitted to a facility shall be considered part of the Room and Board Charge.

Semi-Private Room Rate is the daily Room and Board Charge which an institution applies to the greatest number of beds in its semi-private rooms containing two or more beds. If the institution has no semi-private rooms, the semi-private rate will be the daily room and board rate most commonly charged for semi-private rooms with two or more beds by similar institutions in the area. Area means a city, a county, or any greater area necessary to obtain a representative cross section of similar institutions.

Trust or Trust Fund is the Alaska Pipe Trades Association – U. A. Local No. 375 Health and Security Trust Fund.

Usual, Customary and Reasonable (UCR) charge means a charge for a service, treatment, or supply which does not exceed the 90th percentile of the charges for that service, treatment, or supply in the health care database utilized by the Trust, which reflects a current statistical sampling of charges for services and supplies in the same or a comparable area. When there is, in the Trust's determination, minimal data available from the database for a covered service, the Trust will determine the UCR amount by calculating the unit cost for the applicable service category using the database and multiplying that by the relative value of the covered service assigned by the Medicare resource based relative value scale (supplemented with a commercially available relative value scale selected by the Trust where one is not available from Medicare). In the event of an unusually complex procedure, a new procedure, or a procedure that otherwise does not have a relative value that is in the Trust's determination applicable, the Trust will assign one.

UCR charge for any provider subject to the No Surprises Act or similar federal balance billing protection, shall be the median in-network allowed amount or other amount determined by the applicable federal law.

Non-PPO providers (including both professionals and facilities) seeking claim payment under the Plan shall be obligated to submit to a prompt audit of their claims by the Trust, notwithstanding any internal rules they may have to the contrary. In the event a non-PPO provider refuses or delays a reasonable audit request by the Trust, the Trust shall have the right to withhold payment to the said non-PPO provider on the claim in question and on other pending or future claims by said non-PPO provider.

UCR charges are also subject to the following:

1. Charges for services or supplies which are not provided or billed in accordance with generally accepted professional standards and/or medical practice are not considered UCR regardless of the amount billed;
2. In no event will the UCR charge exceed the amount billed or the amount for which the Covered Person is financially responsible;
3. UCR may not reflect the actual billed charges and does not take into account the professional service provider's training, experience or category of licensure;
4. The Trust's UCR methodology may vary between claims based on the facts and circumstance of the claim, the services provided and the expected savings;
5. The Trust may hire a third-party reviewer to determine the UCR amount consistent with this provision; and
6. Irrespective of the Trust's methodology or UCR determination, the Trustees reserve the right to negotiate an acceptable UCR amount directly with a provider.

PLAN INFORMATION

Summary Plan Description

For Alaska Pipe Trades Association – U.A Local 375 Health and Security Trust Fund

The Employee Retirement Income Security Act of 1974 (ERISA) requires that certain information be furnished to eligible Participants in an Employee benefits plan. The Employee Benefits Plan maintained by the policyholder shall be referred to herein as the "Plan."

Plan/Trust Name

This Plan is legally known as the Alaska Pipe Trades Association – U. A. Local No. 375 Health and Security Trust Fund.

Board of Trustees—Plan Administrator

This Trust is sponsored and administered by a joint labor-management Board of Trustees, the name, address and telephone number of which is:

Board of Trustees
Alaska Pipe Trade Local 375 Health and Security Trust Fund
PO Box 34203
Seattle, WA 98124-1203
(907) 561-5119
(800) 325-6532

Participants can receive, upon written request, information as to whether a particular employer or employee organization is a sponsor of the Trust, and, if so, the appropriate address.

Identification Number

The employer identification number assigned to the Trust Fund by the Internal Revenue Service is EIN 92-0023819. The Plan number is 501.

Type of Plan

This Plan is a health and welfare plan, providing, medical, prescription drug, dental and vision and life and accidental death and dismemberment benefits.

All Plan benefits except life and accidental death and dismemberment are self-insured.

Type of Administration

This Trust and its Plan are administered by the Board of Trustees with the assistance of Welfare & Pension Administration Service, Inc., a third-party administrator.

Agent for Service of Legal Process

The administrative manager at the Administration Office is designated as agent for purposes of accepting service of legal process on behalf of the Plan. The name, address and telephone number of the administrative manager is listed on page 83.

Each member of the joint Board of Trustees is also authorized to accept service of legal process on behalf of the Plan. The names and addresses of the individuals currently serving on the joint Board of Trustees are listed on page 82.

Description of Collective Bargaining Agreement

The Trust are maintained in accordance with the collective bargaining Agreement between Alaska Pipe Trades U. A. Local No. 375 and the Mechanical Contractors of Fairbanks, the Employers' Association, acting for employers who are members of such Association, and with various other employers.

A copy of this Agreement may be obtained by Participants and Beneficiaries upon written request to the Plan Administrator.

As there may be a reasonable charge for this document, you may wish to determine what the charge will be before making such a request. This Agreement is also available for examination by Participants and beneficiaries at the Local Union Office.

Eligibility and Benefits

Employees are entitled to participate in the Plan if they work under the collective bargaining agreement described in the preceding paragraph, and if their employer is required to make contributions to the Trust Fund on their behalf.

The eligibility rules that determine which Employees and Beneficiaries are entitled to benefits are set forth in this booklet. The benefits to which eligible Employees and Beneficiaries are entitled are set forth in this booklet.

Circumstances That May Result in Ineligibility or Denial of Benefits

A Participant who is eligible for benefits may become ineligible as a result of one or more of the following circumstances:

- The employee's failure to work the required hours to maintain 135 or more hours in his or her Hour Bank. See the "Eligibility and Enrollment" section, page 6.
- The failure of the employee's employer to report the hours and remit contributions on his or her behalf to the Trust Fund.
- In the case of beneficiaries who are dependents of an eligible employee, they may become ineligible if:
  - They are no longer dependents.
  - They have attained the disqualifying age.

See the "Eligibility and Enrollment" section beginning on page 6.

A Participant who is eligible may nonetheless be denied benefits as a result of one or more of the following circumstances:

- The failure of the Participant to file a complete claim for benefits.
- The failure of the Participant to file a complete and truthful benefit application.
- Where the Participant has other group insurance coverage, it is possible that benefits payable under this Plan may be reduced or denied due to coordination of benefits between the two plans. See the "Coordination of Benefits" section, page 65.

The Board of Trustees has the authority to terminate the Trust Fund. The Trust Fund will also terminate upon the expiration of all collective bargaining agreements requiring the payment of contributions to the Trust Fund.

In the event of the termination of the Trust Fund, any and all monies and assets remaining in the Trust Fund, after payment of expenses, will be used for the continuance of the benefits provided by the then-existing health plans, until such monies and assets have been exhausted.

Source of Contributions

Contributions to the Plan are made by participating employers who are parties to the collective bargaining Agreement between Alaska Pipe Trades U. A. Local No. 375 and the Mechanical Contractors of Fairbanks, the Employers' Association acting for employers who are members of such Association, and with various other employers.

This Agreement provides that the participating employers will make monthly contributions to the Trust Fund in amounts specified in the Agreement.

The employer contributions are received and held in trust by the Board of Trustees pending the payment of insurance premiums and administrative expenses.

Funds remaining after the payment of insurance premiums and other operating expenses of the Plan are also held in trust.

Trust and Plan Year

The end of the Trust and Plan's policy year is December 31.

Procedures to Be Followed in Presenting Claims for Benefits and Appealing Claims Which Are Denied

To be considered a claim, the Participant or beneficiary must request that the Trust provide benefits for a specific service or supply.

Claims, and all reasonably requested supporting information and documentation, must be submitted within one year from the date expenses for the services or supplies for which benefits are sought were first incurred.

Unless the Participant or beneficiary can establish to the Trustees' satisfaction that it was not possible to submit or complete a claim within this one-year period, the claim will be denied without the right to appeal.

Subject to the special provisions dealing with urgent claims, claims must be submitted in writing by a Participant or beneficiary and to the proper address.

For any claim, the Trust may require additional information to process claims or to meet Plan requirements. This may include inquiries related to eligibility, the nature of services or supplies provided, coordination of benefits, other insurance, third party reimbursement requirements, or other Plan provisions. Failure to provide this required information may result in the denial of a claim for benefits.

Health Trust Directory

Trustees

Union Trustees

John Plutt, Chairman
2600 17th Avenue
Fairbanks, AK 99709

Robert Hubbard
U.A. Local 375
3980 Boat Street
Fairbanks, AK 99709

Domenic Monzingo
501 Golden Leaf Dr
Fairbanks, AK 99712

Employer Trustees

Greg Campbell, Secretary
Houston Contracting Co.
3311 Lathrop Street
Fairbanks, AK 99701

Eric Chase
Alaska Integrated Services
619 11th Avenue, Suite 101
Fairbanks, AK 99701

Mel Weeks
Patrick Mechanical LLC
3307 International Street
Fairbanks, AK 99701-7383

Local 375 Union Office

3980 Boat Street
Fairbanks, AK 99709
(907) 479-6221

Legal Services

Barlow Coughran Morales & Josephson
1325 Fourth Avenue, Suite 910
Seattle, WA 98101-1800

Administration Office

Welfare & Pension Administration Service, Inc.
PO Box 34203
Seattle, WA 98124-1203

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