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ALASKA LABORERS–CONSTRUCTION INDUSTRY

HEALTH AND SECURITY FUND

PLAN 501

ACTIVE LABORERS

ALASKA LABORERS TRUST FUNDS

Alaska Laborers-Construction Industry Health and Security Plan

Physical: 7525 SE 24th St, Suite 200, Mercer Island, WA 98040 • Mailing: P.O. Box 34203, Seattle, WA 98124-1203
Phone: (855) 815-2323 • Fax: (206) 505-WPAS (9727) • Website: www.aklaborerstrust.com

Administered by
Welfare & Pension Administration Service, Inc.

March 17, 2020

To: All Eligible Plan Participants and Dependents of the Alaska Laborers-Construction Industry Health and Security Fund

RE: Response to Coronavirus (COVID-19) Outbreak

This is a Summary of Material Modification describing changes to your health plan adopted by the Board of Trustees. Please be sure that you and your family read it carefully and keep this document with your Summary Plan Description Booklet.

The world, as well as the United States is presently experiencing an outbreak of Coronavirus, known as COVID-19. You may have also heard that some states are issuing emergency orders requiring all insured health plans to take certain steps to cover services related to COVID-19 testing. Even though this Plan is not required to comply with the emergency order, the Board of Trustees of the Alaska Laborers-Construction Industry Health and Security Fund ("the Plan") is closely monitoring governmental recommendations and mandates.

In response to the Coronavirus Outbreak effective March 1, 2020 the Board of Trustees has adopted the following changes to the Plan's Medical and Prescription Drug Benefits which will stay in effect until the COVID-19 emergency orders are lifted:

- The Trust will temporarily waive any out-of-pocket costs associated with diagnostic testing for COVID-19 for both PPO and non-PPO providers. At this time, the waiver only applies to the test. For those testing positive, treatment of COVID-19 will still be subject to applicable cost sharing and PPO/non-PPO benefits depending on the provider's status.

- Crisis Response Lines and 24/7 access to the Aetna Nurse Medical Line are available to all participants at 1-800-556-1555.

- CVS/Caremark is **temporarily relaxing refill-too-soon guidelines** on 30-day maintenance medications at any in-network pharmacy. You are encouraged to keep at least a 30-day supply of prescription medication at hand. You may also choose to use mail order to receive delivery of your medications at home.

Active participants, Non-Medicare Retirees and their eligible dependents have access to **Teladoc** for 24/7 care via telephone at 1 (800) 835-2362 or video chat at no cost to you. A Teladoc doctor can discuss any symptoms you are having and help determine the right treatment or next steps, including providing a prescription if appropriate. Please visit Teladoc.com for more details.

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The Coalition Health Center can help. If you have respiratory symptoms, please call the clinic before coming in. Coalition Health Center team members will do a pre-screening related to travel, exposure and symptoms and determine your care plan. Based on the answers to the screening questions you will be advised to stay home and self-isolate or come into the clinic for evaluation and possible testing. Anyone presenting for medical services with respiratory symptoms will be required to wear a mask and gloves at minimum. This approach will allow us to protect you, other patients in the waiting areas and the medical team. In Anchorage, call 907-264-1370. In Fairbanks, call 907-450-3300.

Alaska Regional Hospital is fully prepared to meet the needs of its patients. If you have question about COVID-19, you may call the Alaska 2-1-1 hotline (800-478-2221 if you live in an area without the 2-1-1 line). If you are seriously ill, go to the emergency department. If you have a cough, fever, or shortness of breath, you will be asked to wear a mask immediately upon arrival.

The best way to protect yourself and others is to avoid being exposed to this virus.

- **Clean your hands often**. Wash your hands with soap and water for at least 20 seconds, especially after being in a public place or after blowing your nose, coughing, or sneezing.
- **Avoid close contact with other people**.
- **Stay home if you are sick**.
- Older adults and people who have severe chronic medical conditions (like heart or lung disease or diabetes) may be at higher risk for developing more serious complications from COVID-19. Please talk with your health care provider about additional steps you may take to protect yourself.

If you have any questions regarding the contents described in this notice, please contact the Administration Office at (855) 815-2323, option 2. Please also reference the trust website, www.aklaborerstrust.com, for additional notices.

If you have questions about your prescription drug benefits, please contact Caremark Customer Service at (866) 818-6911.

Board of Trustees
Alaska Laborers-Construction Industry Health and Security Fund

ALASKA LABORERS TRUST FUNDS

Alaska Laborers-Construction Industry Health and Security Plan

Physical: 7525 SE 24th St, Suite 200, Mercer Island, WA 98040 • Mailing: P.O. Box 34203, Seattle, WA 98124-1203
Phone: (855) 815-2323 • Fax: (206) 505-WPAS (9727) • Website: www.aklaborerstrust.com

Administered by
Welfare & Pension Administration Service, Inc.

October 2019

To: Participants of the Alaska Laborers-Construction Industry Health and Security Fund

This is a summary of material modification describing recent changes adopted by the Board of Trustees. Please be sure that you and your family read this carefully and keep it with your Summary Plan Description material.

The Board of Trustees' of the Alaska Laborers–Construction Industry Health and Security Fund met recently to review the health plan costs and benefits.

Coordination of Benefits (COB) for prescriptions
Effective January 1, 2020, the Plan will coordinate benefits for prescription drugs purchased at retail or mail order pharmacies. If the Alaska Laborers' health plan is your secondary plan and another health plan pays first, the Alaska Laborers' health plan may pay some or all of the expense that is not paid by your primary health plan.

You have multiple options for coordinating prescription benefits.

- Preferred method: At the pharmacy. Your pharmacy may be able to coordinate benefits automatically when they process your prescription. Please provide your pharmacy with both your primary insurance ID card and the Alaska Laborers' plan ID card and ask your pharmacy to submit the claim to both health plans.
- Electronic submission. If your pharmacy does not submit your secondary claim, you may electronically submit it to Caremark yourself through the www.caremark.com website or through the CVS/Caremark mobile app.
- Paper claim submission. You also have the option to submit a paper claim for secondary reimbursement. CVS/Caremark paper claim forms are available on the Trust website www.aklaborerstrust.com. Please note: this method of submission is not the preferred method and may take longer to process.

Cost Effectiveness Plan Design Program
Starting January 1, 2020, the Plan will exclude from coverage any new drug or any new indication for an existing drug approved by the FDA with an incremental cost-effectiveness ratio greater than:

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

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

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

This does not impact coverage for any medication you are currently taking. If you have questions about your prescriptions or coverage, log into caremark.com or call 866-818-6911 (toll-free).

Eligibility for Retiree Coverage

Effective December 1, 2019, only Credited Hours contributed to the Alaska Laborers-Construction Industry Health & Security Fund or the Alaska Laborers-Employers Retirement Plan while working as a Laborer will qualify for eligibility in the Alaska Laborers-Construction Industry Health and Security Fund Retiree Plan. Credited Hours contributed while working as a Trowel Trades participant will not qualify for eligibility in the Retiree Plan. Trowel Trades retirees will no longer have coverage effective December 1, 2019.

If you have any questions regarding the prescription drug benefit changes, please contact the Administration Office at (855) 815-2323, option 2. For questions regarding Eligibility for Retiree Coverage, choose option 4.

Sincerely,

Board of Trustees
Alaska Laborers-Construction Industry Health and Security Fund

In accordance with ERISA reporting requirements, this document serves as your Summary of Material Modifications to the Plan and we are advising you of these Plan changes within 60 days of the adoption of those changes.

ALASKA LABORERS TRUST FUNDS

Alaska Laborers-Construction Industry Health and Security Plan

Physical Address: 7525 SE 24th St Suite 200 Mercer Island, WA 98040 •
Mailing Address: PO Box 34203 Seattle, WA 98124-1203
Phone (855) 815-2323 • Fax (206) 505-WPAS (9727) • Website www.aklaborerstrust.com

Administered by
Welfare & Pension Administration Service, Inc.

June 12, 2018

To: Participants of the Alaska Laborers-Construction Industry Health and Security Fund

Re: Benefit Changes Effective August 1, 2018
This is a summary of material modification describing recent changes adopted by the Board of Trustees. Please be sure that you and your family read this carefully and keep it with your Summary Plan Description material.

The Board of Trustees' of the Alaska Laborers–Construction Industry Health and Security Fund met recently to review the health plan costs and benefits. The following change will be effective August 1, 2018:

Teladoc – for Active participants and Non-Medicare retirees
Now you can visit a doctor without leaving home. Teladoc provides 24/7 access to a board certified, licensed family practice doctor or pediatrician via phone or video. Teladoc is not a substitute for a primary care doctor, but can be used to diagnose and treat acute, non-emergent medical issues that may arise such as:

Cold and flu	Bronchitis
Sore throat	UTI
Rashes	Fever
Allergies	Asthma
Headaches	And much more!

Teladoc doctors can also write short term prescriptions and will send the script electronically to the pharmacy of your choice. After the visit, at your request, the doctor will send electronic chart notes to your primary care doctor.

You pay $0 copay and you do not have to satisfy your deductible. You will receive more information about this benefit prior to August 1st, including instructions on how to register with Teladoc. Watch your mail for more information!

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Changes to the Prescription Drug Benefit
The Trust is making the following changes to the prescription program in order to use our funds wisely without sacrificing patient care:

- Claims Review of Non-Specialty Drugs Exceeding $1,500
  Non-specialty drugs exceeding $1,500 will be reviewed by a Consultant Pharmacist to help ensure appropriate use and billing (dose, quantity, days' supply, charged amounts) or to discuss possible alternatives. You, your doctor or pharmacy may be contacted by a Consultant Pharmacist.

- Utilization Management of Diabetic Test Strips
  The Plan will limit the quantity of diabetic test strips dispensed at one time. The limit will accommodate recommended testing guidelines by the American Diabetes Association (ADA). Your doctor may request higher limits from CVS/Caremark.

- Some products may be excluded:
  - ✓ Products not approved by the Food and Drug Administration (FDA) as drugs, for example, Medical Devices, specifically, topical barriers or artificial saliva
  - ✓ Products not requiring a prescription per FDA guidance, for example, Medical Foods
  - ✓ Costly formulations which have lower cost alternatives
  - ✓ Select brands with an authorized generic

- Specialty medications must be purchased through Caremark specialty mail order pharmacy or at a CVS pharmacy within Target, rather than through a retail pharmacy location. If you are unable to receive these medications through mail order or at a CVS pharmacy within Target, you may obtain an exception when necessary.

No Assignment of Benefits
Medical coverage benefits of this Plan may not be assigned, transferred or in any way made over to another party by a participant. Nothing contained in the written description of medical coverage shall be construed to make the Plan liable to any third-party to whom a participant may be liable for medical care, treatment or services.

If you have any questions regarding these Plan changes, please contact the Administration Office at (800) 331-6158, extension 3512.

Sincerely,

Board of Trustees
Alaska Laborers-Construction Industry Health and Security Fund

In accordance with ERISA reporting requirements, this document serves as your Summary of Material Modifications to the Plan and we are advising you of these Plan changes within 60 days of the adoption of those changes.

ALASKA LABORERS TRUST FUNDS

Alaska Laborers-Construction Industry Health and Security Plan

P.O. Box 34203 • Seattle, Washington 98124-1203
Phone (855) 815-2323 • Fax (206) 505-WPAS (9727) • Website www.aklaborerstrust.com

Administered by
Welfare & Pension Administration Service, Inc.

January 26, 2018

To: Active Participants of the Alaska Laborers-Construction Industry Health and Security Fund

Re: Benefit Changes Effective April 1, 2018

This is a summary of material modification describing recent changes adopted by the Board of Trustees. Please be sure that you and your family read this carefully and keep it with your Summary Plan Description material.

The Board of Trustees' of the Alaska Laborers–Construction Industry Health and Security Fund met recently to review the health plan costs and benefits. Over the past several years, the utilization of services at US Health Works in Fairbanks has declined. Effective April 1, 2018, US Health Works in Fairbanks will no longer be a Wellness and Minor Care Program provider.

- In Fairbanks, you may continue to use the Coalition Health Center for Wellness & Minor Care services, as well as treatment of chronic conditions for $0 copay. They are located at:

  Ridgeview Business Park
  575 Riverstone Way, Unit 1
  Fairbanks, AK 99709
  907-450-3300
  www.coalitionhealthcenter.com

- If you receive services at US Health Works in Fairbanks on or after April 1, 2018, the services will be subject to deductible and coinsurance.

- This does not impact services in Anchorage or Wasilla. For Wellness & Minor Care Services in Anchorage you may continue to use either US Health Works for a $30 copay per visit or the Coalition Health Center for $0 copay. You may use Wasilla Medical Clinic for a $30 copay per visit.

If you have any questions regarding these Plan changes, please contact the Administration Office at (800) 331-6158, extension 3559.

Sincerely,

Board of Trustees
Alaska Laborers-Construction Industry Health and Security Fund

In accordance with ERISA reporting requirements, this document serves as your Summary of Material Modifications to the Plan and we are advising you of these Plan changes within 60 days of the adoption of those changes.

ALASKA LABORERS TRUST FUNDS

Alaska Laborers-Construction Industry Health and Security Fund

Physical Address 7525 SE 24th Street, Suite 200, Mercer Island, WA 98040 • Mailing Address PO Box 34203, Seattle, WA 98124
Phone (855) 815-2323 • Fax (206) 505-WPAS (9727) • Website www.aklaborerstrust.com

Administered by
Welfare & Pension Administration Service, Inc.

June 2, 2017

To: **Participants of the Alaska Laborers-Construction Industry Health and Security Fund**

Re: **Benefit Changes Effective August 1, 2017**

This is a summary of material modification describing recent changes adopted by the Board of Trustees. Please be sure that you and your family read this carefully and keep it with your Summary Plan Description material.

The Board of Trustees' of the Alaska Laborers–Construction Industry Health and Security Fund met recently to review the health plan costs and benefits. The following change will be effective August 1, 2017:

Surgery Center of Anchorage and New Frontier Anesthesia in Anchorage

The Surgery Center of Anchorage and New Frontier Anesthesia are added as Preferred Providers (PPO) in the Municipality of Anchorage. The Surgery Center of Anchorage performs a broad range of outpatient surgical procedures. New Frontier Anesthesia is the anesthesia provider at the surgery center. Please see www.surgerycenterofanchorage.com for more information about the types of procedures that may be performed there.

If you have surgery within the Municipality of Anchorage, you may now choose to use either Alaska Regional Hospital or the Surgery Center of Anchorage and your claims will be paid at the PPO benefit level. (Providence Hospital and all other surgery centers are considered non-PPO and claims will be penalized.)

BridgeHealth – For Non-Emergency Surgery Outside Alaska

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

Here are some of the advantages of using BridgeHealth for surgery:

- You pay $0 deductible and $0 coinsurance
- BridgeHealth arranges the surgery
- First Class travel is covered for you and a companion
- Lodging is provided and the plan provides some coverage for meals and incidental costs.

The program is voluntary, and is available for all participants for whom the Alaska Laborers plan pays primary. (The program is not available if Medicare is primary over the Alaska Laborers plan.)

The BridgeHealth benefit will be available starting August 1, 2017. Watch your mail for more information.

If you have any questions regarding these Plan changes, please contact the Administration Office at (800) 331-6158, extension 3559.

Sincerely,

Board of Trustees
Alaska Laborers-Construction Industry Health and Security Fund

In accordance with ERISA reporting requirements, this document serves as your Summary of Material Modifications to the Plan and we are advising you of these Plan changes within 60 days of the adoption of those changes.

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ALASKA LABORERS TRUSTS

Alaska Laborers-Construction Industry Health and Security Fund

2815 2nd Avenue, Suite 300 • P.O. Box 34203 • Seattle, Washington 98124-1203
Phone (855) 815-2323 • Fax (206) 505-WPAS (9727) • Website www.aklaborerstrust.com

Administered by
Welfare & Pension Administration Service, Inc.

January 6, 2017

To: Active Participants of the Alaska Laborers-Construction Industry Health and Security Fund

Re: Benefit Changes

This is a summary of material modification describing recent changes adopted by the Board of Trustees. Please be sure that you and your family read this carefully and keep it with your Summary Plan Description material.

The Board of Trustees' of the Alaska Laborers–Construction Industry Health and Security Fund met recently to review the health plan costs and benefits.

Massage Therapy is Covered, effective March 1, 2017
Massage therapy services are covered, up to a maximum of 10 visits per calendar year. The services must be prescribed as part of a treatment plan and performed by a licensed professional acting within the scope of their license. For example, the services may be performed by a licensed massage therapist, chiropractor or physical therapist.

Coalition Health Center (CHC) Now Open in Fairbanks!
The CHC recently opened a new Fairbanks clinic. It is located in the Ridgeview Business Park, 575 Riverstone Way, Unit 1. Please call for appointments: (907) 450-3300. This provider is included in the Minor Care – Wellness Program.

Reminder: You may also use the CHC located in Anchorage, on the Alaska Regional Hospital campus, at 2741 DeBarr Road, Suite C210. Please call for appointments: (907) 264-1370.

At both locations, participants may receive:

- Preventive care
- Treatment of chronic and acute illness
- Urgent care for minor illness and injury

When utilizing a CHC clinic, the copay is waived through June 30, 2017, and services are not subject to the deductible. (Thereafter, the copay is $30 per visit, $0 for preventive services).
If you have any questions regarding this Plan change and announcement, please contact the Administration Office at (800) 331-6158, extension 3559.

Sincerely,

Board of Trustees
Alaska Laborers-Construction Industry Health and Security Fund

In accordance with ERISA reporting requirements, this document serves as your Summary of Material Modifications to the Plan and we are advising you of these Plan changes within 60 days of the adoption of those changes.

ALASKA LABORERS TRUSTS

Alaska Laborers-Construction Industry Health and Security Fund

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Phone (855) 815-2323 • Fax (206) 505-WPAS (9727) • Website www.aklaborerstrust.com

Administered by
Welfare & Pension Administration Service, Inc.

November 21, 2016

To: Active Participants of the Alaska Laborers-Construction Industry Health and Security Fund in Plans 501, 502 and 503

Re: Benefit Changes Effective January 1, 2017

This is a summary of material modification describing recent changes adopted by the Board of Trustees. Please be sure that you and your family read this carefully and keep it with your Summary Plan Description material.

The Board of Trustees of the Alaska Laborers–Construction Industry Health and Security Fund met recently to review the health plan costs and benefits. The following change will be effective January1,2017:

Adopt CVS/Caremark Advanced Control Formulary

The Advanced Control Formulary is a list of preferred medications and identifies products that are clinically appropriate and cost-effective. Some medications may be excluded from, or not covered by, the formulary. If you purchase a medication that is not on the formulary, you may be responsible for the full cost of that drug.

CVS/Caremark will provide advance notice to any members who may be affected by the formulary change. Notifications will also be sent to your prescribing doctor or other prescribing provider prior to January 1st, if your medication is not covered by the formulary. If you receive a letter, be sure to discuss it with your doctor.

A formulary appeals exception process is in place if your doctor believes a non-formulary medication is medically necessary. Your doctor can call Caremark at 1-855-582-2062 to request approval.

For a list of medications on the formulary, please go to: www.caremark.com/acdruglist.

If you have any questions regarding this Plan change, please contact the Administration Office at (855) 815-2323, extension 3512.

Sincerely,

Board of Trustees
Alaska Laborers-Construction Industry Health and Security Fund

In accordance with ERISA reporting requirements, this document serves as your Summary of Material Modifications to the Plan and we are advising you of these Plan changes within 60 days of the adoption of those changes.

ALASKA LABORERS' TRUST FUNDS

Alaska Laborers-Construction Industry Health and Security Fund

2815 2nd Avenue, Suite 300 • P.O. Box 34203 • Seattle, Washington 98124-1203
Phone (855) 815-2323 • Fax (206) 505-WPAS (9727) • Website www.aklaborerstrust.com

Administered by
Welfare & Pension Administration Service, Inc.

March 8, 2016

TO: All Participants
Alaska Laborers-Construction Industry Health and Security Fund

RE: New Summary Plan Description

The Board of Trustees is pleased to present you with this new 2015 edition of the Summary Plan Description (Plan booklet) for the Alaska Laborers-Construction Industry Health and Security Fund. This Plan booklet supersedes all previous versions of the Plan booklet.

This revised booklet describes the benefits available to eligible participants and their dependents. From time to time the Plan has issued a Summary of Material Modification (SMM) to provide notice of material benefit changes to the Plan. This Plan booklet has incorporated all the SMMs issued through April 30, 2015.

This Plan booklet is also available on the Trust's website at www.aklaborerstrust.com. We encourage you to visit the Trust's website any time you need forms or have questions about your benefits or eligibility.

Please refer to this booklet when health plan questions arise and keep it with your records for future reference. If you have any questions regarding your benefits, please contact the Administration Office at (855) 815-2323, option 2.

Board of Trustees
Alaska Laborers-Construction Industry Health and Security Fund

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To All Participants:

We are pleased to present this updated booklet describing the benefits of your Health and Security benefit plan. We encourage you to review it and keep it handy as a reference. If you have any questions about your benefits, please contact the Administration Office at (855) 815-2323.

Sincerely,

BOARD OF TRUSTEES
Alaska Laborers-Construction Industry
Health and Security Fund

Employer Trustees	Union Trustees
Derald Schoon, Chairman	Dan Simien, Secretary
Mike Brady	Brandon Calcaterra
Jaysen Mathiesen	Augustine J. Merrick II
Steve Geraghty	Kevin Pomeroy

Only the Administration Office or a Local Union Benefit Representative designated by the Board of Trustees is authorized to certify eligibility. The Trust will not be bound by any certification of eligibility by an unauthorized individual.

If you do not understand something about the Plan's benefit program or if you have questions about the cost containment requirements or preferred provider plan provisions described in this booklet, please call or write to the Administration Office.

This Summary Plan Description and booklet contain a summary of your plan rights and benefits. If you have difficulty understanding any part of this Summary Plan Description or booklet, contact the Administration Office.

Administration Office:

Welfare & Pension Administration Service, Inc.
2815 Second Avenue, Suite 300
PO Box 34203
Seattle, WA 98124-1203
(855) 815-2323
www.aklaborerstrust.com

IMPORTANT CONTACTS

Administration Offices

Welfare & Pension Administration Service, Inc. (WPAS)
2815 Second Avenue, Suite 300
PO Box 34203
Seattle, WA 98124-1203
(855) 815-2323
www.aklaborerstrust.com

Labor Trust Services
375 West 36th Avenue, Suite 200
PO Box 93870
Anchorage, AK 99509-3870
(907) 561-5119
(855) 815-2323

Local Union Offices

Laborers' Local 341
Stephanie Parker, Benefit Representative
2501 Commercial Drive
Anchorage, AK 99501-3050
(907) 272-4571
www.local341.com

Laborers' Local 942
Carol Heiter, Benefit Representative
2740 Davis Road
Fairbanks, AK 99709-5231
(907) 456-4584
www.laborerslocal942.org

Laborers' Local 942 Southeastern Office
722 West Ninth
Juneau, AK 99801-1808
(907) 586-2860

Plasterers' & Cement Masons' Local 867
825 East 8th Avenue, #10
Anchorage, AK 99501-3877
(907) 272-5113

Aetna – for Nationwide Preferred Provider Information
www.aetna.com/docfind (Aetna Choice POS II)
Nurseline: (800) 556-1555

Aetna – Utilization Review Provider (for precertification)
Providers call: (888) 632-3862
Aetna Group No: 863873

Vision Service Plan – for Vision Claims
PO Box 997105
Sacramento, CA 95899-7105
(800) 877-7195
www.vsp.com

Caremark – for Retail and Mail Order Prescription Drug Claims
(866) 818-6911
www.caremark.com

Preferred Provider Hospitals

Alaska Regional Hospital
2801 DeBarr Road
Anchorage, AK 99508-2932
(907) 276-1131
www.alaskaregional.com

Geneva Woods Birth Center
3730 Rhone Circle
Anchorage, AK 99508-5054
(907) 561-5152

Mat-Su Regional Medical Center
2500 South Woodworth Loop
Palmer, AK 99645-8984
(907) 861-6000
www.matsuregional.com

Preferred Provider Physical Therapy Providers in Anchorage

Alaska Hand Rehabilitation
4015 Lake Otis Parkway, Suite 200
Anchorage, AK 99508-5235
(907) 563-8318

Ascension Physical Therapy
6200 Lake Otis Parkway, Suite 104
Anchorage, AK 99507-2098
(907) 770-6693

Chugach Physical Therapy
2740 Lake Otis Parkway
Anchorage, AK 99508-4141
(907) 272-8615

Wellness & Minor Care Program Providers

Wasilla Medical Clinic
1700 East Parks Highway, Suite 200
Wasilla, AK
(907) 373-6055

Fairbanks Urgent Care Center
1867 Airport Way, Suite 130B
Fairbanks, AK
(907) 452-2178

Primary Care Associates in Anchorage and Eagle River:

For scheduled appointments:

4100 Lake Otis Parkway Suite 322 Anchorage, AK (907) 562-1234	10928 Eagle River Road, Suite 150 (in the Key Bank Building) Eagle River, AK (907) 694-7223

For walk-in services:

4100 Lake Otis Pkwy. Suite 100 Anchorage, AK (907) 563-4006	12350 Industry Way Suite 160 Anchorage, AK (on the corner of Huffman & Old Seward) (907) 345-4343	10928 Eagle River Rd. Suite 150 Eagle River, AK (in the Key Bank Bldg.) (907) 694-7223

Coalition Health Center
2741 Debarr Road, Suite C210
Anchorage, AK
(907) 264-1370
www.coalitionhealthcenter.com

Alere - Disease Management Provider
www.AKLaborersAlereHealth.com

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IMPORTANT PLAN PROVISIONS

PREFERRED PROVIDERS

The Plan contracts with preferred providers for certain services. You and the Plan receive discounted pricing for these services.

Hospital and Physical Therapy Services within the Municipality of Anchorage

- Alaska Regional Hospital is the preferred provider for all inpatient and outpatient facility services.
- Geneva Woods Birth Center is the preferred provider for birth center services.
- The Plan's preferred physical therapy providers are:
    - Alaska Hand Rehabilitation;
    - Ascension Physical Therapy; and
    - Chugach Physical Therapy.

The Plan's reimbursement will be reduced if you use another provider within the Municipality of Anchorage for non-emergency services that are available at Alaska Regional Hospital, Geneva Woods Birth Center, Alaska Hand Rehabilitation, Ascension Physical Therapy or Chugach Physical Therapy.

Hospital Services within the Mat-Su Borough

Mat-Su Regional Medical Center is the preferred provider for all inpatient and outpatient hospital services.

All Other Services and Services Outside the Municipality of Anchorage and the Mat-Su Borough

You are encouraged to use providers in the Aetna POSII network to save money for yourself and the Plan.

Please see page 46 for more information on the Plan's preferred providers.

PRECERTIFICATION

The Plan requires precertification of all inpatient hospitalizations and certain medical procedures. See page 42 for more information.

HOSPITAL BILL AUDIT PROGRAM

Your hospital bill…it's worth a second look!

Hospital bills are sometimes wrong. Those mistakes can add up to substantial amounts of lost money for both the participant and the Plan. For example, medication may be prescribed but not actually given, and the billing records may not be updated. Data entry and keypunching errors are also common billing mistakes. A misplaced decimal point can cost thousands of dollars.

What can you do? Ask the hospital to send you an itemized bill. Make sure the admissions and discharge dates are correct. Double check charges for tests and medicines. If you find errors or have questions about any charges, call the hospital billing office and ask them to review your records. If you find an overcharge, ask for a corrected bill.

If you find an undetected error on a bill that has been audited and paid by the Administration Office, once the Plan receives the overpayment back, **the Plan will reward you with 50% of your overcharged amount up to a maximum reward of $5,000.** A second look can help control the cost of health coverage and possibly put some dollars back in your pocket!

ELIGIBILITY RULES

The benefits described in this booklet are for eligible employees of employers that are obligated by their Collective Bargaining Agreements or Special Agreements to contribute to the Plan. To be eligible for these benefits, contributions must be made to the Plan on your behalf.

HOUR BANK

All hours worked and paid are credited to your hour bank. Initial eligibility is earned when you have accumulated 360 Credited Hours during 3 consecutive months or less. Your coverage will begin the first day of the second month after the hours are worked because of the Lag Month, explained below. After earning initial eligibility, you must have 130 hours in your hour bank to remain covered by the Plan. 130 hours will be withdrawn from your hour bank for each month's coverage.

MAXIMUM HOUR BANK

The maximum number of hours that can be accumulated in the hour bank will be 1,040, or 8 months of eligibility.

LAG MONTH

The Lag Month is the time between when hours are worked and when eligibility is earned. The Lag Month is required so the Administration Office can process the employer reports. The Lag Month is always a full calendar month (e.g. March 1 though March 31).

ELIGIBILITY TESTS

The Plan uses 2 eligibility tests:

1. Industry Test – used to determine the benefits you and your dependents are entitled to during a month in which you are initially eligible.
2. Current Work Test – used to determine the months you are eligible for benefits after satisfying the industry test.

Industry Test

Benefits are based on the total number of credited hours recorded by this Fund on your behalf since the Plan was established. The Lag Month is also used in this test. The covered benefits for you and your dependents are listed in the following table according to the total number of your credited hours.

Your Total Credited Hours	Your Benefits	Your Dependents' Benefits
360 but less than 600	$10,000 Life, $10,000 AD&D, Weekly A&S, & Medical	None
600 but less than 1,200	All coverages shown above plus Vision and Audio	Life (up to $2,000), Medical, Vision, & Audio
1,200 or more	All coverages shown above plus Dental	All coverages shown above plus Dental

Current Work Test

Once the Industry Test has been satisfied, the Current Work Test is required. As a new employee or an employee returning after a break in eligibility, you will become eligible for coverage under this Plan by meeting the following requirement: accumulation of 360 Credited Hours in a period of 3 months or less, and waiting 1 lag month.

Example:

You work a total of 360 hours in January, February and March. Your Lag Month is April. You are eligible for 2 months of coverage (May and June) and you have 100 hours remaining in your hour bank.

CONTINUING ELIGIBILITY

All hours worked and paid are credited to your Hour Bank. In order to remain covered by the Plan, you must have 130 hours in the Hour Bank; 130 hours will be withdrawn from your Hour Bank for the current month's coverage.

TERMINATION OF ELIGIBILITY

Your coverage will cease on the last day of any month in which your Hour Bank falls below 130 hours. Your eligibility will be restored on the 1st day of the 2nd month after you satisfy the requirements explained in the Eligibility Reinstatement section on the next page.

Example:

Month	Hours Worked	Beginning Hour Bank	-	Hours Used for Coverage	=	Remaining Hour Bank	Eligible?
Apr	100	0		0		0	No
May	110	100		0		100	No
Jun	160	210		0		210	No
Jul	80	370		0		370	No –Lag Mo.
Aug	150	450		130		320	Yes
Sep	0	470		130		340	Yes
Oct	50	340		130		210	Yes
Nov	10	260		130		130	Yes
Dec	0	140		130		10	Yes
Jan	0	10		0		90	No

Your coverage will also be stopped immediately if you enter active military service. You will again become eligible on the date of re-employment with a participating employer if this occurs within 90 days after you are discharged from military service and you have sufficient hours in your Hour Bank.

ELIGIBILTY REINSTATEMENT

If you have been covered by the Plan, then lose eligibility and subsequently return to work, the initial eligibility requirements do not have to be satisfied, provided you return to work and become eligible for benefits in the Plan within 14 months following the date you were last covered for benefits as an active employee. If you do not return to work and become eligible for benefits in the Plan within 14 months following the date you were last covered for benefits as an active employee, you must meet the initial eligibility requirements before becoming eligible for coverage again.

ENROLLMENT FORM REQUIREMENT

A properly completed enrollment form must be on file in the Administration Office for you and your dependents before any claims will be paid. It is necessary to attach copies of your marriage certificate if you enroll your spouse, and birth certificates for any of your eligible children you wish to cover.

It is your responsibility to complete a new enrollment form and send supporting documentation as soon as possible if there are changes in your marital or family status which could affect your benefits.

DEPENDENT'S ELIGIBILITY

Your eligible dependents are:

- Your lawful spouse, unless you are legally separated;
- Your eligible dependent child under age 26. The eligible dependent child must meet one of the following criteria:
  1. Your natural child as shown on the birth certificate.
  2. Your legally adopted child. A minor child, under the age of 18, placed with you for the purpose of legal adoption will be covered from the moment the child is placed in your custody. The child's coverage will continue until the earlier of:
     - The day the child is removed from your custody prior to legal adoption; or
     - The day coverage would otherwise end in accordance with the Plan provisions.
  3. A child for whom you have a court order establishing a legal obligation for coverage.
  4. A natural or adopted child of the spouse of a covered participant.
  5. An unmarried child who has attained age 26 and is incapable of earning his or her own living because of mental or physical incapacity and is chiefly dependent on you for support. Coverage for such child can be continued for the duration of the incapacity provided coverage does not terminate for any other reason. Proof of incapacity must be furnished to the Administration Office within 31 days after the child attains age 23 and must be furnished thereafter as required.

Dependents become eligible on the same day as you do if the industry test is met. If the dependent is acquired after you become eligible, your dependent will be eligible on the date he or she becomes your dependent.

If a medical child support order has been provided to the Administration Office, coverage for the child shall be maintained whether or not the child is your legal dependent or in your custody. Coverage for an otherwise eligible child that is required under the order will become effective on the date that a copy of the medical support order is received in the Administration Office, unless the medical child support order is provided within 30 days of the date of the order. In this case, coverage for the child shall become effective the date of the order.

It is your responsibility to notify the Trust within 30 days if you gain or lose an eligible dependent, such as through marriage or divorce. If you enroll a

dependent who does not meet the eligibility requirements of the Plan or if you fail to notify the Trust of your divorce or other loss of dependent eligibility within 30 days of the event, it is considered intentional misrepresentation of a material fact and the Plan will retroactively terminate coverage for your ineligible dependent. If the plan pays claims on the ineligible dependent, you may be responsible for claims paid on your ineligible dependent's behalf.

DISABILITY BENEFITS AFTER TERMINATION

If an employee or dependent is Totally Disabled from an illness or an injury covered by the Plan at the date of termination of coverage and is under the care of a physician, medical benefits shall be continued for 12 consecutive months after termination of coverage. Such benefits shall be furnished solely in connection with the condition causing the Total Disability. Proof of disability shall be furnished to the Administration Office 90 days after termination of coverage, and as requested thereafter.

SURVIVING DEPENDENT'S ELIGIBILITY

If you die while eligible under this Plan, your surviving dependents will continue to be covered by the Plan for the duration of your Hour Bank eligibility. They will have the same coverage they had in the month of your death.

If you die while eligible under this Plan and your spouse and/or dependent children are entitled to a Pre-Retirement Death Benefit from the Alaska Laborers-Employers Retirement Plan, then your spouse and/or dependent children will have the option to self-pay for coverage under the Retiree Plan after exhausting your Hour Bank eligibility.

Self-pay coverage under the Retiree Plan for surviving dependents will continue until the earliest occurrence of:

- The child attains age 26;
- The spouse or child becomes covered under another group plan;
- The self-payments are not paid on a timely basis;
- The spouse or child dies;
- The spouse remarries.

LIFE INSURANCE AND ACCIDENTAL DEATH & DISMEMBERMENT BENEFITS

Life Insurance for you and your dependents is provided through an insurance policy purchased by the Trust.

In the event of your death, your beneficiary will be paid a life insurance benefit of $10,000.

In the event of the death of a dependent member of your family, a life insurance benefit will be paid in accordance with the following schedule:

- Spouse — $2,000
- Unmarried Children Age:
  - 14 days to 6 months — $200
  - 6 months to 22 years — $2,000

Accidental Death & Dismemberment (AD&D) Insurance is provided to employees only. The principal sum is $10,000.

The full principal sum will be paid for the accidental loss of:

- Life;
- Both hands;
- Both feet;
- Sight of both eyes;
- One hand and sight of one eye;
- One foot and sight of one eye;
- One hand and one foot.

One half of the principal sum will be paid for the accidental loss of one hand, one foot, or the sight of one eye. No more than the principal sum will be paid for all losses resulting from any one accident.

To designate your beneficiary for life insurance and accidental death and dismemberment benefits, fill out the appropriate portion of the enrollment form. If at any time you wish to change your beneficiary, a new form must be filled out. If you have not designated a beneficiary, payment will be made in accordance with the provisions of the policy.

WAIVER OF PREMIUM IF DISABLED

Your life insurance premiums will be waived if you become disabled. You must provide proof that you became disabled prior to your 60th birthday and while

insured for life insurance. You must provide written notice to the insurance company within 3 months after you have been continuously disabled for 9 months. For more information, please refer to your certificate of insurance.

CONVERSION PRIVILEGE

Upon termination of your life insurance coverage or your dependent's life insurance coverage, you may be eligible to convert this insurance to an individual policy, under certain conditions. You must make written application to the insurance company within 31 days of the date your coverage terminates.

CERTIFICATE OF INSURANCE

This is only a brief summary of the life and AD&D benefit. These benefits are more fully described in the insurance certificate provided to you by the insurance company. For a copy, please contact the Administration Office.

WEEKLY ACCIDENT AND SICKNESS COVERAGE

(For Employees Only)

A benefit of $75 per week will be paid to you if, while covered, you become wholly and continuously disabled by a non-occupational accidental injury or sickness (including pregnancy), as documented by your physician, so that you cannot perform any and every duty pertaining to your employment.

The maximum period for which this benefit shall be paid is 26 weeks.

The waiting period for disability caused by illness is 7 days. No waiting period shall apply for disability due to accident.

The Plan pays one-seventh ($1/7^{th}$) of the weekly benefit for each calendar day of disability.

Successive periods of disability separated by less than one full week of active full-time work shall be considered as one period of disability unless the subsequent disability is due to entirely different and unrelated causes and commences after return to active full-time work for a period of at least one day.

This benefit is not payable unless you are under the continual care of a legally qualified physician or surgeon.

This coverage may not be converted to an individual policy.

Benefits are not payable with respect to intentionally self-inflicted injury, or any injury or sickness connected with employment with any employer.

MEDICAL BENEFITS

The benefits described on the following pages apply to eligible expenses incurred for the treatment of an illness or injury as recommended and approved by an attending physician.

To be eligible for benefits under this Plan, the service or supply must be:

- Medically Necessary, and
- A covered service under the Plan.

The Plan's benefit payment will be based on:

- Plan provisions, including any limitations or exclusions, and
- The Allowable Expense of the service or supply.

Some medical benefits are subject to Precertification Requirements, described on page 42. **Failure to follow the Precertification Requirements will result in a reduction of benefits.**

This Plan contracts with Alaska Regional Hospital and Geneva Woods Birth Center as the preferred providers for facility services in the Municipality of Anchorage. Alaska Hand Rehabilitation, Ascension Physical Therapy, and Chugach Physical Therapy are the preferred physical therapy providers in the Municipality of Anchorage.

The Plan's reimbursement will be reduced if you use another provider within the Municipality of Anchorage for non-emergency services that are available at Alaska Regional Hospital or Geneva Woods Birth Center. If you use a physical therapy provider other than Alaska Hand Rehabilitation, Ascension Physical Therapy or Chugach Physical Therapy in Anchorage for services available at the preferred physical therapy provider, the Plan's reimbursement will be reduced. For more information about the preferred provider provisions of the plan, refer to page 46.

ALLOWABLE EXPENSE

Allowable Expense means the actual costs (billed amount) charged for Medically Necessary services to the extent that such charges are Usual, Customary and Reasonable (UCR) for the area and the type of service, or are the Usual and Reasonable Charge for Outpatient Dialysis Treatment. For Non-PPO inpatient hospital services within the Municipality of Anchorage, the Allowable Expense will be limited to the Contracted Rate at Alaska Regional Hospital. The Allowable Expense for outpatient facility charges at a non-PPO provider within the Municipality of Anchorage will be limited to the case rate at Alaska Regional Hospital or 50% of the billed charges if no case rate is available. The Allowable Expense for physical therapy services at a non-PPO provider within the

Municipality of Anchorage will be limited to the Contracted Rate at the Chugach Physical Therapy.

Charges in excess of the Allowable Expense as determined by the Plan will not be paid by the Plan, and will not apply to your deductible or Out-of-Pocket Limit.

USUAL CUSTOMARY & REASONABLE (UCR)

The charge the Plan determines to be the prevailing rate charged in the geographic area where the service is provided, or the provider's usual charge, whichever is less.

In some cases, data may be insufficient to determine a UCR rate. The Plan may consider items such as the following:

- The prevailing charges in a greater geographic area,
- The complexity of the service or supply,
- The degree of skill needed,
- The type or specialty of the provider, and
- The range of services or supplies provided by a facility.

The Administration Office makes the final determination as to whether or not the fee is Usual Customary and Reasonable. Charges or fees in excess of the UCR charge are your responsibility to pay.

USUAL AND REASONABLE CHARGE FOR OUTPATIENT DIALYSIS TREATMENT

With respect to dialysis-related claims, the Plan shall determine the Usual and Reasonable Charge based upon the average payment actually made for reasonably comparable services and/or supplies to all providers of the same services and/or supplies by all types of plans in the applicable market during the preceding calendar year, based upon reasonably available data, adjusted for the national Consumer Price Index medical care rate of inflation. The Plan may increase or decrease the payment based upon factors concerning the nature and severity of the condition being treated. Charges or fees in excess of Usual and Reasonable charges are your responsibility to pay if you are not enrolled in Part B of Medicare.

MEDICALLY NECESSARY

To be Medically Necessary, the service or supply must be:

- Care or treatment which is expected to improve or maintain your health or to relieve pain and suffering without aggravating the condition or causing additional health problems; or

- A diagnostic procedure which is expected to provide information to determine the course of treatment;
- and must be no more costly than another service or supply which could fulfill these requirements.

In determining if a service or supply is Medically Necessary, the Plan will rely on the professional opinion of the Administration Office, Utilization Review provider, or other health care professionals contracted by the Plan. The Plan will consider:

- Information provided on the affected person's health status;
- Reports in peer-reviewed medical literature;
- Reports and guidelines published by nationally recognized health care organizations that include supporting scientific data;
- Generally recognized professional standards of safety and effectiveness in the United States for diagnosis, care, or treatment;
- The opinion of health professionals in the generally recognized health specialty involved; and
- Any other relevant information brought to the attention of the Administration Office.

In no event will the following services or supplies be considered Medically Necessary:

- Those which are determined to be Experimental or Investigational;
- Those that do not require the technical skills of a medical or dental professional who is acting within the scope of his or her license;
- Those furnished mainly for the comfort or convenience of the person, the person's family, anyone who cares for him or her, a health care provider, or health care facility;
- Those furnished only because the person is in the hospital on a day when the person could safely and adequately be diagnosed or treated while not in the hospital; or
- Those furnished only because of the setting if the service or supply can be furnished in a doctor's or dentist's office or other less costly setting.

No benefits will be paid for Medically Necessary services that are not covered services under the Plan.

PLAN PAYMENTS

Calendar Year Deductible

Individual:	$500
Family:	$1,500

Penalty Per Hospital Confinement

At a PPO Facility:	$0
At a Non-PPO Facility:	$250 in the Municipality of Anchorage

Emergency Room Penalty

$400 per visit; does not apply to the Annual Out-of-Pocket Limit.

Applies only to non-emergency visits. Does not apply:

- If you are admitted to the hospital or if you have surgery following the emergency room visit;
- At night (between 9pm and 8am), on weekends (after 3pm on Saturdays and anytime on Sunday), or on holidays.

Percent Payable

80% of Allowable Expenses until the Annual Out-of-Pocket Limit is reached.

For non-PPO inpatient and outpatient hospital services in Anchorage, and for non-PPO physical therapy services in Anchorage, Alaska, the percent payable is reduced to 60% of Allowable Expenses until the Annual Out-of-Pocket Limit is reached.

After you reach your Annual Out-of-Pocket Limit, the Plan pays 100% of Allowable Expenses for the remainder of the Calendar Year.

Annual Out-of-Pocket Limit

The Annual Out-of-Pocket Limit is the maximum amount you pay for covered medical expenses in a Calendar Year. After you meet your deductible, the Plan pays 80% of the Allowable Expenses and you pay 20% of the Allowable Expenses for most covered services. (For non-PPO hospital services and for physical therapy services in the Municipality of Anchorage, the Plan pays 60% of Allowable Expenses and you pay 40%). Your 20% (40%) applies to your Out-of-Pocket Limit. Your Deductibles also apply to your Out-of-Pocket Limit.

Charges in excess of the Allowable Expense will not apply to your deductible or Out-of-Pocket Limit.

Individual Annual Out-of-Pocket Limit	$3,500
Family Annual Out-of-Pocket Limit	$7,000

For non-PPO hospital services (inpatient and outpatient) and for non-PPO physical therapy services in Anchorage, the Annual Out-of-Pocket Maximum is increased as follows:

Individual Annual Non-PPO Out-of-Pocket Limit	$7,000
Family Annual Non-PPO Out-of-Pocket Limit	$14,000

See page 46 for more information about the preferred provider provisions of the Plan.

Benefit Maximum

The medical benefit has an unlimited benefit maximum.

COVERED SERVICES

- Daily hospital service and related expenses for hospitalization in a semi-private room. (Excludes radio, telephone, meals for guests, and personal comfort items.)
- Intensive care units, including coronary and constant care units and nursing services, provided by hospital employees as a regular hospital service. Benefits are not provided for any other room reserved or held for the patient during the period the patient is confined in an intensive care unit.
- Hospital outpatient expenses.
- Operating, recovery, isolation, cast and cystoscopic rooms.
- Kidney dialysis.
- Oxygen and the administration of oxygen.
- Diagnostic x-ray, imaging, and laboratory examinations, electrocardiograms and physiotherapy.
- Birthing center services.
- Licensed ambulatory surgical center services.
- Services of a Physician.
- Dental services for accidental injuries to sound natural teeth; benefits for these services are only paid after the dental calendar year maximum benefit has been used.
- Nursing services provided by a registered nurse not residing in the home or related by blood or marriage.
- Anesthesia and its administration.
- X-ray, radium and radioactive isotope therapy.

- Purchase of artificial limbs or eyes, casts, splints, trusses, braces, crutches, rental of wheel chairs or other durable medical equipment.
- Physical therapy by a registered physical therapist not residing in the home or related by blood or marriage.
- Services of a licensed ambulance company for ambulance services to or from a hospital when medically necessary.
- Blood transfusions and the cost of blood and blood derivatives, unless replaced by voluntary donors.
- Drugs and medicines directly related to the treatment of an illness or injury and requiring a written prescription and dispensed by a licensed pharmacist or a licensed physician or surgeon, in their office or in a hospital.
- Foot orthotics.
- Colon and rectal cancer screening, as recommended by the American Cancer Society.
- Chelation therapy and associated lab expenses.
- Acupuncture for treatment of covered conditions, provided it is rendered by an acupuncturist or physician licensed in the state in which services are rendered, acting within the scope of the license.
- Hair prosthesis and related services if the prosthesis is required to cover hair loss from a covered injury or illness or from treatment of a covered injury or illness. The maximum allowance is for one hair prosthesis and all related services (i.e. fitting, styling) up to $1,000 every 12 calendar months.
- Safety glasses, up to a maximum of $100, once every 3 years. This benefit is available to employees only, and will not apply to dependents.

Preventive Care Services

The Plan covers physical exams and other preventive care services recommended under the Affordable Care Act (ACA). Physical exams and preventive care services are covered at 100% of Allowable Expenses, and are not subject to the deductible.

ACA recommended services include:

1. Evidence based items or services with a rating of A or B in the current recommendations of the US Preventive Service Task Force;

2. Immunizations for routine use in children, adolescents, and adults with a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control;
3. With respect to infants, children, adolescents, and women, evidence-based preventive care and screenings included in guidelines supported by the Health Resources and Services Administration; and
4. Women's preventive services as listed in the guidelines.

More information regarding the preventive services recommended under the ACA can be found at www.healthcare.gov.

Reconstructive Surgery in Connection with a Mastectomy

These services are covered, including:

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

   Note: up to 4 post-mastectomy bras are covered following a medically necessary mastectomy (additional bras require medical necessity review).

Surgical Treatment of Obesity

Surgical treatment of obesity and complications resulting from surgery will be covered by the Plan, provided the patient satisfies the criteria below.

1. Growth: The patient must be 18 years of age or document completion of bone growth.
2. Duration of the Condition: The patient must demonstrate that morbid obesity has persisted for at least five years.
3. Medical Necessity: The Plan's Utilization Review provider must determine the procedure is Medically Necessary and appropriate.
4. Documented Completion of Prior Nutrition and Exercise Programs: The patient must have participated in prior nutrition and exercise programs, consisting of either:
   (a) A physician supervised nutrition and exercise program (including dietitian consultation, low-calorie diet, increased physical activity, and behavior modification) documented and established in a medical record of the patient. The physician

supervised nutrition and exercise program must be accomplished with the cooperation of dietitians and/or nutritionists, or

(b) Participation in at least 3 nutrition and exercise programs which must be for a cumulative total of 6 months or longer in duration, with participation in 1 program of at least 3 consecutive months prior to the date of surgery. Participation in at least 3 nutrition and exercise programs must occur within 2 years prior to surgery. The patient may precertify the surgery prior to completing the nutrition and exercise programs as long as the patient will complete a cumulative total of 6 months participation in the nutrition and exercise program(s) prior to the date of surgery.

The patient's completion of either a physician or other supervised nutrition and exercise program must be documented in the medical record of the patient. The nutrition and exercise program may be administered as part of a surgical preparatory regimen and participation in the nutrition/exercise program may be supervised by the surgeon who will perform the surgery. Note: a physician summary letter is not sufficient documentation. Documentation should include medical records, contemporaneous with assessment of patient's progress throughout the course of the nutrition and exercise program. For patients who participate in physician-administrated nutrition and exercise programs (e.g., Medifast, Optifast), the program records documenting that patient's participation and progress may substitute for the physician's medical records.

Transportation, Lodging and Meal Allowance

The transportation allowance for eligible participants who are referred by a physician to go outside the area to get treatment is as follows:

- If the care (primary hospital or specialty care) is Medically Necessary and can only be provided in another area, the eligible participant or dependent is allowed reimbursement for coach airfare to the nearest facility capable of providing the required service. If the covered person chooses care at a more distant facility, transportation costs beyond the nearest facility will be the person's responsibility. The Plan will pay transportation costs for 2 people if the patient is a minor child or incapacitated adult.
- The eligible participant must submit a letter from his or her physician stating the necessary care is not available locally.
- Before airfare can be reimbursed, evidence of care must be submitted to the Administration Office.

- Round-trip cab fare for travel to and from the airport to the facility will be covered. No cab fare other than as described above is covered. Car rental is not covered.

The lodging and meal allowance for eligible participants who must go outside the area to get treatment is as follows:

- While the covered person is under medical care, up to $250 is allowed and paid at the applicable percentage after the Deductible is met. This benefit includes lodging and meals, not to exceed $250 per day.
- The eligible participant must submit a letter from his or her physician stating the necessary care is not available locally.
- Before reimbursement is made, evidence of care must be submitted to the Administration Office.

Travel to the Preferred Provider Hospital in Anchorage

In an effort to help reduce health costs to the Trust and reduce out-of-pocket costs to participants, transportation, lodging and meal costs as described above may be covered if you live outside the Municipality of Anchorage and travel to obtain services at the Preferred Provider Hospital in Anchorage, even if services are available locally. These transportation costs will only be considered, if the reduced cost of service at the preferred provider facility is greater than the travel expenses. Please contact the Administration Office for more information.

Skilled Nursing Facility Benefits

A daily semi-private room allowance is provided for care in a skilled nursing facility for a maximum of 120 days when certified as Medically Necessary by the attending physician.

The following ancillary services will be provided when skilled nursing facility care is prescribed by the attending physician and is consistent with the admitting diagnosis:

- Use of special treatment rooms.
- Routine laboratory examinations.
- Physical, occupational or speech therapy treatments.
- Oxygen and other gas therapy.
- Drugs, biologicals and solutions used while the patient is in the facility.
- Gauze, cotton, fabrics, solutions, plaster and other materials used in dressings and casts.

Home Health Care

Home health care benefits are provided to allow you and/or your dependents an alternative to hospital confinement. Benefits are provided for up to 130 visits per calendar year subject to the following conditions:

- Home health care must be prescribed by a physician.
- The service provider must be a Medicare-approved agency.
- The services must be in place of a covered confinement in a hospital. Custodial care is not covered.
- The patient's physician must establish and periodically review a written treatment plan which describes the care to be provided.

The deductible is not applied to home health care benefits, and benefits are covered at 100% of Allowable Expenses.

Hospice Care

This program is designed to minimize the emotional trauma associated with terminal illness. In a hospice program, the terminally ill patient receives health care benefits at home, or in an impatient facility for short periods. The Plan provides hospice care benefits for a terminally ill patient with a life expectancy of 6 months or less.

Hospice care is covered, subject to the following conditions:

- Hospice care must be prescribed by a physician.
- The service provider must be a Medicare-approved agency.
- The services must be in place of a covered confinement in a hospital. Custodial care is not covered.
- The patient's physician must establish and periodically review a written treatment plan which describes the care to be provided.

Physician Services

<u>Non-Hospital</u>

Allowable Expenses for the treatment of illness or injury by a licensed Physician or surgeon will be considered covered services under this Plan.

<u>Hospital</u>

Hospital visits by a Physician or surgeon will be considered up to the Allowable Expense for each day of eligible hospitalization.

Hospital Outpatient

Treatment by a Physician or surgeon in the outpatient department of a hospital will be considered up to the Allowable Expense for such treatment.

Maternity Benefits

Pregnancy and childbirth are covered like any other medical condition. If the patient is confined to a Hospital as a resident inpatient for childbirth, in no event will benefits be less than:

- 48 hours following a vaginal delivery; or
- 96 hours following a cesarean section

for the mother and the newborn infant(s), unless the attending physician, in consultation with the mother, recommends an earlier discharge.

No separate deductible is taken for the newborn's hospital expenses if a deductible is applied to the mother's maternity expenses.

Maternity benefits are not available for dependent children or spouses of deceased active employees unless the spouse's conception occurred prior to the death of the active employee.

Well Baby Care Benefits

Well baby care, including inoculations and physical examinations is provided for 6 months from the date of the infant's birth.

Immunizations provided under this benefit are paid at 100% of the Allowable Expense, and are not subject to the Deductible.

Spinal Manipulation Benefits

Benefits are provided for treatment of musculo-skeletal disorder (bone, muscle and joint) by a licensed chiropractic physician. Benefits include x-rays, lab work and examinations in a chiropractor's office. Physical therapy procedures performed by a chiropractor in Anchorage are subject to the non-PPO provisions of the Plan.

Diagnostic X-ray, Imaging, and Laboratory Tests

Benefits for x-ray, imaging and laboratory examinations will be considered when the examinations are for diagnostic purposes due to accident or illness. Non-PPO penalties may apply within the Municipality of Anchorage.

Nervous and Mental Conditions

Services for nervous and mental conditions for outpatient or inpatient treatment will be paid the same as any other covered condition.

Transplant Benefits

The Plan will cover Medically Necessary charges incurred for the care and treatment due to a solid organ, stem cell, bone marrow or tissue transplant, which are not considered Experimental or Investigational.

The plan covers:

- Charges made by a physician or transplant team.
- Charges made by a hospital, outpatient facility or physician for the medical and surgical expenses of a live donor, but only to the extent not covered by another plan or program.
- Related supplies and services provided by the facility during the transplant process. These services and supplies may include: physical, speech and occupational therapy; bio-medicals and immunosuppressants; home health care expenses and home infusion services.
- Charges for activating the donor search process with national registries.
- Compatibility testing of prospective organ donors who are immediate family members. For the purpose of this coverage, an "immediate" family member is defined as a first-degree biological relative. These are your biological parents, siblings or children.
- Inpatient and outpatient expenses directly related to a transplant.

The four phases of one transplant occurrence and a summary of covered transplant expenses during each phase are:

- Pre-transplant evaluation/screening: Includes all transplant-related professional and technical components required for assessment, evaluation and acceptance into a transplant facility's transplant program;
- Pre-transplant/candidacy screening: Includes HLA typing/compatibility testing of prospective organ donors who are immediate family members;
- Transplant event: Includes inpatient and outpatient services for all covered transplant-related health services and supplies provided to you and a donor during the one or more surgical procedures or medical therapies for a transplant; prescription drugs provided during your inpatient stay or outpatient visit(s), including bio-medical and immunosuppressant drugs; physical, speech or occupational therapy provided during your inpatient stay or outpatient visit(s); cadaveric and live donor organ procurement; and

- Follow-up care: Includes all covered transplant expenses; home health care services; home infusion services; and transplant-related outpatient services rendered within 180 days from the date of the transplant event.

Limitations

Unless specified above, not covered under this benefit are charges incurred for:

- Outpatient drugs including bio-medicals and immunosuppressants not expressly related to an outpatient transplant occurrence;
- Services that are covered under any other part of this plan;
- Services and supplies furnished to a donor when the recipient is not covered under this plan;
- Home infusion therapy after the transplant occurrence;
- Harvesting or storage of organs, without the expectation of immediate transplantation for an existing illness;
- Harvesting and/or storage of bone marrow, tissue or stem cells, without the expectation of transplantation within 12 months for an existing illness;
- Cornea (Corneal Graft with Amniotic Membrane) or Cartilage (autologous chondrocyte or autologous osteochondral mosaicplasty) transplants, unless otherwise authorized by Aetna.

Transplants must be precertified.

Network of Transplant Specialist Facilities

You are encouraged to use a facility designated by Aetna as an Institute of Excellence™ (IOE) for the type of transplant being performed.

Through the IOE network, you will have access to a provider network that specializes in transplants. The IOE facility must be specifically approved and designated by Aetna to perform the procedure you require. Each facility in the IOE network has been selected to perform only certain types of transplants, based on quality of care and successful clinical outcomes.

If you are a participant in the IOE program, the program will coordinate all solid organ and bone marrow transplants and other specialized care you need. Any covered expenses you incur from an IOE facility will be considered network care expenses.

Services obtained from a facility that is not designated as an IOE for the transplant being performed will be not be considered within the PPO network, even if the facility is a network facility or IOE for other types of services.

Costs Associated with Certain Clinical Trials

The Plan may not:

- deny the qualified individual participation in an approved clinical trial with respect to the treatment of cancer or another life-threatening disease or condition;
- deny (or limit or impose additional conditions on) the coverage of routine patient costs for items and services furnished in connection with participation in the trial; and
- may not discriminate against the individual on the basis of the individual's participation in the trial.

Approved clinical trials must be performed by a PPO provider unless a PPO provider is not available in your region.

"Routine patient costs" include all items and services consistent with the coverage provided in the plan that is typically covered for a qualified individual who is not enrolled in a clinical trial. Routine patient costs do not include 1) the investigational item, device or service itself; 2) items and services that are provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; and 3) a service that is clearly inconsistent with the widely accepted and established standards of care for a particular diagnosis.

Coverage for approved clinical trials will be limited to items and services otherwise covered under the Plan if the patient was not enrolled in a clinical trial as required by PPACA. All clinical trials must be preauthorized by the Plan.

Multiple Surgical Procedures

For multiple surgeries performed during the same operative session which are not incidental, or not part of some other procedure, and which add significant time or complexity to the complete procedure, as determined by the Administration Office, benefits will be determined as:

- 100% of the Allowable Expense for the primary procedure;
- 50% of the Allowable Expense for the secondary or any additional procedures.

Assistant Surgeon Charges

For Medically Necessary surgical assistance by a physician or physician assistant (PA), the benefit payable will be based on 20% of the Allowable Expense for the corresponding surgery.

Prescription Drug Card Program

Prescription Drug Copays

Generic Copay	20% of the Allowable Expense
Formulary Brand Copay	30% of the Allowable Expense
Non-Formulary Brand Copay	50% of the Allowable Expense

If you obtain a brand name medication when a generic equivalent is available, you will pay a $50 penalty in addition to your brand name copay. The $50 penalty will not apply to your prescription copay maximum. This penalty may be waived if you have a Medically Necessary reason to take the brand name drug instead of the generic.

Annual Maximum Out-of-Pocket Limit for Prescription Drugs

$3,000 per person

$6,000 per family

Once you have paid $3,000 in prescription copays per person or $6,000 per family in a Calendar Year, the Plan pays 100% of the Allowable Expense for the remainder of the Calendar Year.

Retail Pharmacies

The Plan provides benefits for prescriptions purchased at retail pharmacies for an initial 30-day supply of a prescription, plus one refill. Additional refills should be purchased through mail order. (See below.)

You may purchase prescriptions using your prescription card at any preferred pharmacy. You pay only the required copayment for each prescription and the Plan is billed electronically for the remaining costs. A list of preferred pharmacies is available from your local union office or the Administration Office.

If a participating pharmacy is available and not utilized, the participant will be responsible for the sum of the copay listed above in addition to the difference in the cost of the prescription compared to the cost at a participating pharmacy. It is the responsibility of the participant to submit a paper claim form in order for the claim to be processed. Claim forms are available at the union office or on the website.

Mail Order Program

Prescription refills of maintenance medications should be filled through the Plan's contracted mail order provider. You may obtain up to a 90-day supply of mail order medication at one time. If your doctor prescribes a new medication, ask for 2 prescriptions: Take the first prescription to a preferred pharmacy for an

immediate fill and submit the second prescription to the mail order provider for future refills.

Specialty Medications

The Plan requires prior authorization for certain specialty prescriptions, and coverage for specialty medications is limited to a 30-day supply at a time.

The Plan also requires Step Therapy for certain types of specialty medications, including growth hormones, auto-immune medications, and drugs used to treat multiple sclerosis. Step therapy means an individual must first try an alternative to the brand name drug, typically a generic drug, before the plan will cover certain medications. To view a list of specialty medications requiring step-therapy, go to www.cvscaremarkspecialtyrx.com or call 1-800-237-2767 to speak with a representative.

Dialysis Treatment – Outpatient

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

A) Reasons for the Dialysis Program. The Dialysis Program has been established for the following reasons:

   (1) the concentration of dialysis providers in the market in which you and your dependents reside may allow such providers to exercise control over prices for dialysis-related products and services,

   (2) the potential for discrimination by dialysis providers against the Plan because it is a non-governmental and non-commercial health plan, which discrimination may lead to increased prices for dialysis-related products and services charged to you and your dependents,

   (3) evidence of (i) significant inflation of the prices charged to you and your dependents by dialysis providers, (ii) the use of revenues from claims paid on behalf of you and your dependents to subsidize reduced prices to other types of payers as incentives, and (iii) the specific targeting of the Plan and other non-governmental and non-commercial plans by the dialysis providers as profit centers, and

   (4) the fiduciary obligation to preserve Plan assets against charges which (i) exceed reasonable value due to factors not beneficial to you and your dependents, such as market concentration and discrimination in charges, and (ii) are used by the dialysis providers for purposes contrary to you and your dependents' interests, such as subsidies for other plans and discriminatory profit-taking.

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

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

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

(3) Mandated Cost Review. All dialysis-related claims will be subject to cost review by the Plan to determine whether the charges indicate the effects of market concentration or discrimination in charges. In making this determination the Plan shall consider factors including:

i) Market concentration: The Plan shall consider whether the market for outpatient dialysis products and services is sufficiently concentrated to permit providers to exercise control over charges due to limited competition, based on reasonably available data and authorities. For purposes of this consideration multiple dialysis facilities under common ownership or control shall be counted as a single provider.

ii) Discrimination in charges: The Plan shall consider whether the claims reflect potential discrimination against the Plan, by comparison of the charges in such claims against reasonably available data about payments to outpatient dialysis providers by governmental and commercial plans for the same or materially comparable goods and services.

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

i) Where the Plan deems it appropriate in order to minimize disruption and administrative burdens for you and your dependents, dialysis-related claims received prior to the cost review determination may, but are not required to be, paid at the face or otherwise applicable rate.

ii) Where the provider is or has been a participating provider under a Preferred Provider Organization (PPO) available to you and your dependents, upon the Plan's determination that payment limitations should be implemented, the rate payable to such provider shall be subject to the limitations of this Section.

iii) Maximum Benefit. The maximum Plan benefit payable to dialysis-related claims subject to the payment limitation shall be the Usual and Reasonable Charge for covered services and/or supplies, after deduction of all amounts payable by coinsurance or deductibles.

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

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

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

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

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

(7) A provider that accepts the payment from the Plan will be deemed to consent and agree that (i) such payment shall be for the full amount due for the provision of services and supplies to a Plan member and (ii) it shall not "balance bill" a Plan member for any amount billed but not paid by the Plan.

LIMITATIONS AND EXCLUSIONS

Coverage will not be provided for:

- Any condition, ailment or injury for which the participant is entitled to receive benefits in whole or in part under occupational coverage voluntarily obtained by his or her employer, or if self-employed, occupational coverage he or she has obtained or should have obtained or as required by state or federal workers' compensation acts, employer liability acts, or other legislative acts providing compensation for work incurred injuries or, to the extent allowed by law, services rendered in a hospital owned or operated by a state or US governmental agency, even though the participant waives rights to such benefits.
- Any services furnished by an institution which is primarily a place of rest, a place for the aged, a nursing home, a convalescent home or any institution of like character, except as specifically provided under this program, or for convalescent or custodial services regardless of where such services are rendered, or that portion of any hospital confinement beginning on the day that such confinement develops into primarily convalescent or custodial care.
- Medical services received from a medical department maintained by or on behalf of an employer, a mutual benefit association, labor union, trustee or similar person or group.
- Skilled nursing benefits are not provided for custodial care or care that is principally for senile deterioration.
- Hospitalization solely for physiotherapy or for diagnostic studies; medical examinations or tests not Medically Necessary for the diagnosis and treatment of actual illness, disease or injury.
- Treatment for obesity, except as otherwise provided in the Plan.
- Eye refractions, eye glasses or the fitting of eye glasses for the correction of vision, except as specifically provided under the Plan.
- Hearing devices except as specifically provided.
- Services performed for cosmetic purposes, unless performed for correction of functional disorders or as a result of an accidental injury.
- Mental psychoneurotic and personality disorders, except as specifically provided under Nervous and Mental Conditions, or unless hospitalized.
- The cost of blood that is replaced by voluntary means.

- Dental treatment or dental examinations, except as otherwise provided in this Plan.
- This Plan does not provide for hospital care for the extraction of teeth or other dental processes, except when adequate care cannot be provided without use of hospital facilities and where there is an underlying medical condition that requires hospitalization.
- Pregnancy, obstetrical care and complications arising from pregnancy of dependent children.
- Routine footcare procedures such as the trimming of nails, corns or calluses, fallen arches, and routine hygienic care.
- Except as provided under the Skilled Nursing benefit, admissions or treatment primarily for rehabilitative care including, but not limited to, speech and occupational therapy. Further, when the type of care rendered during a continuous period of hospital confinement develops into primarily rehabilitative care, that portion of the stay beginning on the day of such development is not covered under this Plan.
- Any services or supplies for which no charges are made.
- Conditions caused or arising out of an act of war, armed invasion or aggression.
- X-ray, imaging, laboratory, pathological services and machine diagnostic tests not related to a specific illness or injury or a definitive set of symptoms, except as specifically provided under the Plan.
- Services or supplies not Medically Necessary for treatment of disease, illness or injury.
- Marital, sexual or family counseling.
- Visual analysis, therapy or training relating to muscular imbalance of the eye; orthoptics.
- Services or procedures which are not customary and generally accepted by the medical profession, and services or procedures which are Experimental or Investigational or for the purposes of research.
- Any confinement treatment or service in connection with sex transformations or sexual inadequacies except for penile implant surgery which is necessary due to the direct result of an organic disorder and is determined to be Medically Necessary. Prior written approval from the Administration Office is required.
- Naturopathic services.
- Services by a massage therapist.

- Services provided by a residential treatment facility.
- Alcohol or substance abuse treatment.
- Reversal of sterilization.
- Custodial care.
- Treatment provided as a substitute for social or community resources.
- Fertility treatment including, but not limited to:
  - Fertility tests.
  - Reversal of surgical sterilization.

    Any attempts to cause pregnancy by hormone therapy, artificial insemination, in vitro fertilization and embryo transfer or any similar treatment or method.

    Any services or supplies received in connection with a participant or covered dependent acting as a Surrogate Mother, regardless of whether a participant or covered 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 an covered dependent if the child is not the biological child of a participant or adult covered 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 covered 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.
- Vitamins, over-the-counter food supplements, or prescription food supplements that are not the primary source of caloric intake.

COST CONTAINMENT PROVISIONS

In order to provide cost effective health coverage, the Plan contains the following Cost Containment Provisions:

- Hospital Confinement Review (Precertification)
- Second Surgical Opinion
- Outpatient Procedure Review
- Case Management
- Preadmission Testing Benefits

Note: We encourage you to read these provisions thoroughly. In some cases, the Plan provides more favorable benefits if you follow the Cost Containment Provisions. In some instances, less favorable benefits are provided if the Cost Containment Provisions are not used.

Aetna provides precertification (inpatient and outpatient) and case management services to the Plan.

HOSPITAL CONFINEMENT REVIEW (PRECERTIFICATION)

The Plan requires review of all hospital and treatment center confinements. It is your responsibility to initiate the hospital review. If your hospital confinement is not reviewed according to these procedures, your benefits will be reduced to 50% of the Allowable Expense, not subject to the Annual Out-of-Pocket Maximum.

Effect on Benefits

1. Reviewed and Certified: Allowable Expenses for hospital confinements which are certified by Aetna (or by the participant's primary health plan) as Medically Necessary will be considered according to Plan provisions.
2. Not Reviewed: If the hospital confinement is not reviewed timely (see Rules for a Hospital Review, below), any benefits payable for that period of hospital confinement will be reduced to 50% of the Allowable Expense, not subject to the Annual Out-of-Pocket Maximum. No benefits will be payable unless the services are Medically Necessary and all other Plan requirements are satisfied.
3. Reviewed and Not Certified: If the hospital confinement is reviewed timely, but inpatient care is not certified as Medically Necessary:
   - Benefits for hospital room and board will not be payable; and
   - Expenses for other covered hospital services will be considered according to Plan provisions.

Certification does not automatically mean benefits are payable. No benefits will be payable for services which are not Medically Necessary or are not covered by the Plan. PPO provisions may apply.

Rules for a Hospital Review

1. For a Non-emergency Admission. Your health care provider must notify Aetna by phone prior to the scheduled hospital admission. Aetna will send you, the physician, and the hospital written notice of certification or non-certification of the hospital admission. Please allow sufficient time to process your hospital review – do not wait until the last minute to contact Aetna.
2. For an Emergency Admission. Your provider must notify Aetna by phone no later than the second business day following admission. Aetna will send you, the physician, and the hospital written notice of certification or non-certification of the hospital admission.
3. For Continued Confinement. If your physician is considering lengthening your hospital stay past the period which was originally certified, your provider must call Aetna to request certification of the additional days.

Exception

These provisions will not apply when Medicare or another health plan has primary responsibility for the patient's claims. The precertification requirement is waived for normal deliveries, post-partum tubal ligations, and vasectomies.

SECOND SURGICAL OPINION

On occasion, the Plan may request that you obtain a second surgical opinion. You are responsible for scheduling your own appointment. The second surgical opinion must be rendered by a board-certified surgeon or specialist who is not financially associated with your doctor.

The Allowable Expenses of the second surgical opinion consultation, including additional diagnostic tests if required, are paid at 100% by the Plan if the Plan recommends a second surgical opinion. No Deductible applies.

If the second opinion does not agree with the first, you may obtain a third opinion. The cost of the third opinion will also be paid by the Plan.

OUTPATIENT PROCEDURE REVIEW

Aetna reviews certain outpatient procedures. The list of outpatient procedures requiring precertification is found on the Trust website. Contact the Administration Office for more information.

CASE MANAGEMENT PROGRAM

If you have injuries or an illness that may extend for some time, the Plan provides for services through case management. For example, if you are facing an extended period of care or treatment and these services may be accomplished in a skilled nursing facility or in your home, the case management program may be helpful in facilitating and coordinating this care. This can be beneficial to you because these settings may offer cost savings as well as other advantages to you and your family.

When reviewing claims for the case management program, the case management provider always works with you, your family, and your physician so you receive close, personal attention.

Through case management, the case management provider can consider recommendations involving expenses usually not covered for reimbursement. This includes suggestions to use alternative medical management techniques or procedures, or suggestions for cost-effective use of existing Plan provisions such as home health care and convalescent facilities. In order to be considered for payment under the Plan, the alternative care must result in savings without detracting from the quality of care. You, your provider, and the Plan must approve alternate care before it is provided in order to be covered by the Plan.

Case management is voluntary. There is no penalty for not participating in case management or for leaving the case management program during its course.

If you have questions regarding case management and its possible application to you, call the Administrative Office.

PREADMISSION TESTING BENEFITS

If you or your dependent receives preadmission tests, the Plan will pay the Allowable Expenses according to the Plan provisions.

Benefits will only be payable under the Preadmission Testing Benefit if:

- Your physician determines that hospital confinement is required, before the tests are performed;
- The tests would be covered if performed during hospital confinement;
- The tests are performed:
  - On an outpatient basis;

  - Within 7 days of admission as an inpatient; and
  - In connection with a covered hospital confinement; and
- The hospital where the covered person is confined:
  - Accepts the preadmission testing in lieu of tests which would have been performed during hospital confinement; and
  - Does not repeat the tests upon admission, unless your medical record shows both:
    - The results of the preadmission tests; and
    - That repeated tests are Medically Necessary.

PREFERRED PROVIDER ORGANIZATION (PPO) PROVISIONS

When you or your dependents require health care, you may choose any physician, hospital or other health care provider you wish. If you use the services of a preferred provider, however, you may receive a discounted rate for services and Plan benefits may be more favorable. Regardless of the provider you choose, benefits will be subject to all terms, conditions, and limitations of the Plan. The Plan does not supervise, control, or guarantee the health care services of any provider (Preferred or Non-Preferred).

HOSPITAL PREFERRED PROVIDER WITHIN THE MUNICIPALITY OF ANCHORAGE

Alaska Regional Hospital is the preferred provider for all inpatient and outpatient hospital services within the Municipality of Anchorage. Geneva Woods Birth Center is the preferred provider for birth center services.

If you use a non-PPO provider within the Municipality of Anchorage for services available at Alaska Regional Hospital, the Allowable Expense will be limited. For inpatient hospital services the Allowable Expense will be limited to the Contracted Rate at the preferred provider hospital. The Allowable Expenses for outpatient hospital charges at a non-PPO provider within the Municipality of Anchorage will be the case rate at the preferred provider hospital, if any, or 50% of the billed charges. Any amount charged in excess of the Allowable Expense will be your responsibility and will not apply to your Annual Out-of-Pocket Limit.

In addition, you will be responsible for a hospital confinement deductible of $250, the Plan's reimbursement percentage will be reduced from 80% to 60% of Allowable Expenses, and your Annual Out-of-Pocket Limit is increased to $7,000 per person, $14,000 per family.

Exceptions

- No penalty will be assessed for emergency services at a non-PPO emergency facility; however, the patient must be transferred to a preferred provider as soon as medically possible. Services incurred after the patient is able to be transferred will be subject to non-PPO reimbursement.
- No penalty will be assessed for services unavailable at a PPO. No penalty will apply to services performed in your doctor's office, with your doctor's staff, using your doctor's equipment.
- Penalties for services at a non-PPO provider apply only within the Municipality of Anchorage.

PHYSICAL THERAPY PREFERRED PROVIDER WITHIN THE MUNICIPALITY OF ANCHORAGE

Alaska Hand Rehabilitation, Ascension Physical Therapy, and Chugach Physical Therapy are the preferred physical therapy preferred providers within the Municipality of Anchorage.

If you use a non-PPO physical therapy provider within the Municipality of Anchorage for services available at a preferred physical therapy provider, the Allowable Expense will be limited to the Contracted Rate at the Chugach Physical Therapy. Any amount charged in excess of the Allowable Expense will be your responsibility and will not apply to your Annual Out-of-Pocket Limit.

In addition, the Plan's reimbursement percentage will be reduced from 80% to 60% of Allowable Expenses, and your Annual Out-of-Pocket Limit is increased to $7,000 per person, $14,000 per family.

HOSPITAL PREFERRED PROVIDER WITHIN THE MAT-SU BOROUGH

Mat-Su Regional Medical Center is the PPO provider in. the Matanuska-Susitna Borough. The Plan receives discounted rates at this facility. Plan benefits are the same whether you use a preferred provider or a non-preferred provider in the Matanuska Susitna Borough, however, by utilizing preferred providers, you and the Trust enjoy the benefit of discounted fees.

NATIONWIDE AETNA PPO

Aetna is the nationwide Preferred Provider Organization (PPO) network for your Plan. The network includes hospitals, physicians, and specialty providers nationwide, so you have a wide selection of network providers available. You are not required to use Aetna network providers, but by utilizing the Aetna network, you will save yourself and the Trust money.

Please note: The Aetna PPO network is separate from and in addition to the Alaska Regional Hospital, Geneva Woods Birth Center and physical therapy preferred provider arrangements. As described above, the Plan's reimbursement will be reduced if a provider other than Alaska Regional Hospital, Geneva Woods Birth Center, or the physical therapy PPO providers are used within the Municipality of Anchorage for services available through these providers, even if the provider is in the Aetna network.

PPO provisions may not apply to dialysis claims. Please see the Outpatient Dialysis Treatment provisions for more information.

MINOR CARE – WELLNESS PROGRAM FOR ACTIVE PARTICIPANTS

The Minor Care -- Wellness Program benefits are available to you when you are eligible for coverage under the Alaska Laborers-Construction Industry Health and Security Fund. The Trust can offer you this program and obtain discounted rates for these services by virtue of its association with the Health Care Cost Management Corporation of Alaska (the Coalition). You are not required to use the Minor Care -- Wellness Program, but by using this program, you may pay less in out-of-pocket expenses, reduce your waiting time and eliminate claim forms.

The Minor Care -- Wellness Program Providers are listed on page 5.

SUMMARY OF CLINIC SERVICES

- Routine and Minor Care: including treatment for colds, flu, minor illness or accident, general minor medical care and x-rays or lab tests.
- Preventive Care for Adults: including physical exams, mammograms and prostate-specific antigen testing, annual pap smears and associated lab and x-rays.
- Preventive Care for Children age 2 and over: including physical exams, sports physicals and children's immunizations.

In addition, the Coalition Health Center will provide services for ongoing and chronic conditions.

Following your examination or tests, a referral may be made to the medical doctor of your choice to discuss the findings.

In Anchorage, mammograms may be referred to the PPO hospital. You will be given a referral notice to take with you to the hospital to obtain the mammogram. If you go to a non-PPO facility, penalties may apply.

SERVICES NOT COVERED

- Occupational accidents or illnesses.
- Treatment of infants under the age of one or health maintenance exams for children under the age of two.
- Treatment for substance abuse.
- Treatment for chronic conditions (except at the Coalition Health Center).
- Medicare-covered expenses.

If the clinic provides you with services that are not specifically covered under the Minor Care – Wellness Program, those charges would be submitted under the Medical Plan and the standard Medical Plan provisions would apply. If you are unsure if the services you want are covered under the Minor Care – Wellness Program, please contact the clinic and inquire.

COSTS FOR SERVICE

$30 per person per visit for minor care services.

No copay for preventive care services.

No deductible applies. No copay is required for follow-up visits for lab/x-ray only.

APPOINTMENTS

It is preferred, but not required, that you make an appointment.

When call to make an appointment and when you arrive at the clinic, tell the receptionist you are covered by Alaska Laborers-Construction Industry Health & Security Plan.

NOTE FOR MEDICARE ELIGIBLE PARTICIPANTS

Medicare-covered expenses are not covered by the Minor Care – Wellness Program.

Preventive care benefits not covered by Medicare are available through the Wellness Program. Medicare eligible participants will not be asked to pay the co-payment at the time of service. If the services are not covered by Medicare, the co-payment will be billed to you.

If the provider does not participate in Medicare, the provider cannot provide services to Medicare enrolled participants under the Minor Care – Wellness Program.

AUDIO BENEFITS

If you or your dependent(s) incur expenses for a hearing evaluation examination and a hearing aid device, the Plan will pay 100% of the Allowable Expense up to a maximum of $3,500 per ear in a period of 3 consecutive calendar years.

You must be examined by a physician before obtaining a hearing aid. A written certification from the examining physician stating that you are suffering from a hearing loss that may be lessened by the use of a hearing aid must be submitted to the Administration Office. Benefits will not be provided without this certification.

In conjunction with the purchase of a hearing aid, benefits will be provided for:

- An otologic examination by a physician.
- An audiologic examination and hearing evaluation by a certified or licensed audiologist including a followup consultation.
- The hearing aid (monaural or binaural) prescribed as a result of such examination, which shall include:
    1. ear molds,
    2. the hearing aid instrument,
    3. the initial batteries, cords and other necessary ancillary equipment,
    4. a warranty, and
    5. follow-up consultation within 30 days following delivery of the hearing aid.
- In the event that a participant elects to return the hearing aid before actual purchase, the Plan will pay 80% of the Allowable rental charges for use of the instrument for a period of up to, but not to exceed, 30 days.

DENTAL BENEFITS

The Plan shall pay an amount equal to 80% of the Allowable Expense for preventive services and 50% of the Allowable Expense for restorative and major services. The total benefits payable under this benefit shall not exceed $2,500 for all services incurred by any covered participant during the Calendar Year, except for dependent children as required by the Affordable Care Act.

COVERED SERVICES

The dental benefit will cover the following dental service for you and your dependents.

Preventive Services – Payable at 80% of Allowable Expense

- Oral examinations, including scaling and cleaning of teeth, limited to one examination in any period of 6 consecutive months.
- Dental exams by a specialist when Medically Necessary for the diagnosis and treatment of an identified condition. Specialists may include:
  - Endodontist
  - Pediatric dentist
  - Periodontist
  - Prosthodontist
  - Oral Surgeon
- Topical application of sodium or stannous fluoride limited to one in any period of 6 consecutive months.
- Dental x-rays.
- Supplementary bitewing x-rays once in a 6-month period.
- Panoramic film once in a 6-month period.
- Complete mouth series once in a 24-month period.
- Sealants for dependent children to age 14. The application to unrestored permanent first and second molars is covered once in a 4-year period to age 14.

Restorative Services – Payable at 50% of Allowable Expense

- Extractions.
- Oral surgery, including excision of impacted teeth.
- Fillings.

- General anesthesia required in connection to covered complex oral surgery.
- Treatment of periodontal and other disease of the gums and tissues of the mouth.
- Endodontic treatment, including root canal therapy.
- Root planing and scaling is limited to once each quadrant in a 12-month period.
- Space maintainers for missing primary teeth.
- Injections of antibiotic drugs by the attending dentist.

Major Services – Payable at 50% of Allowable Expense

- Inlays, gold fillings, crowns (including precision attachments for dentures), and initial installation of fixed bridgework(including inlays and crowns to form abutments) to replace one or more natural teeth.
- Initial installation (including adjustments for the 6-month period following installation) of partial or full removable dentures to replace one or more teeth.
- Replacement of an existing partial or full removable denture or fixed bridgework by a new denture or new bridgework, or the addition of teeth to an existing partial removable denture or to bridgework to replace extracted natural teeth, but only if evidence satisfactory to the Administration Office is presented that:
    1. 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; and
    2. The existing denture or bridgework was installed at least 5 years prior to its replacement and that the existing denture or bridgework cannot be made serviceable.
- Repair or recementing of crowns, inlays, bridgework or dentures, or relining of dentures.
- Adjustments to dentures, provided the dentures have been installed for at least 6 months.
- Dental implants, including surgery and prosthetics.

PRETREATMENT REVIEW OF DENTAL SERVICES OVER $400

When charges for a proposed dental service or series of services is expected to exceed $400, your dentist may submit a claim form to the Administration Office indicating pretreatment review, showing the treatment plan and fees before

treatment begins. The Administration Office will then use pretreatment reviews to determine the benefits which will be payable for each dental service according to the terms of this dental plan and notify you and your dentist accordingly.

LIMITATIONS AND EXCLUSIONS

Dental services are not provided for:

- Dental services received from a dental or medical department maintained by or on behalf of an employer, a mutual benefit association, labor union, trustee or similar person or group.
- Dental services for congenital malformations.
- Services rendered by a dentist beyond the scope of his or her license. Services rendered by denturists are covered provided the services they are performing are within the scope of their licenses and are covered services under this Plan.
- Appliances or restorations solely necessary to increase vertical dimensions or restore occlusion.
- Dental services for which charges exceed that which would have been made and actually collected if no coverage existed.
- Orthodontic services.
- Prosthetic services or devices (including bridges and crowns) started prior to the effective date of coverage.
- In the event that the services of more than 1 dentist are used, the Plan shall be liable for not more than the amount it would have been liable for had but 1 dentist rendered the service.
- In all cases in which there are optional techniques of treatment carrying different fees, the Plan shall be liable only for treatment carrying the lesser fee.
- A temporary appliance or crown is considered to be permanent unless replaced within 12 months.
- Diagnosis, treatment or surgery for temporomandibular joint dysfunction (TMJ) or myofascial pain dysfunction (MPD).
- Analgesics (such as nitrous oxide) or euphoric drugs, injections or application of desensitizing medicines, except during oral surgery. Analgesics and calming agents will be covered for patients under age 7.
- Crowns for the primary purpose of splinting.

- Cosmetic services or supplies including personalization or characterization of dentures.
- Replacement of a lost, missing, or stolen prosthetic device.
- Oral hygiene and dietary instructions.
- Hospital or related anesthesia charges due to dental work.
- Duplicate appliances or prosthetic devices.

If the procedure performed is not addressed by any of the terms of this Plan, a procedure of equivalent gravity and severity may be used as a basis for determining the maximum amount payable. The final determination of allowances, if any, is within the sole discretion of the Trust.

DENTAL BENEFITS AFTER TERMINATION

Dental benefits will be provided for up to 60 days after termination for prosthetics including bridges and crowns which were fitted and ordered prior to the date your eligibility ended. Any benefits payable during the period of extended coverage will be subject to the maximum benefit limitation and all other provisions of the Plan.

VISION BENEFITS

The vision benefits described in the following section are administered by Vision Service Plan (VSP).

The vision plan covers charges for eye care when provided or prescribed by an ophthalmologist or optometrist. The Plan covers only those expenses which are reasonable and customary for the services provided in the area where the expenses are incurred.

You and your dependents (if dependent coverage has been selected) may use the services of a VSP member doctor or any other licensed ophthalmologist or optometrist.

SCHEDULE OF BENEFITS

Frequency		
Exam	Every 12 months from the last date of service	
Lenses	Every 12 months from the last date of service	
Frames	Every 24 months from the last date of service	
Copay		
Exam	$10 per person	
Materials	$25 per person	
Covered Services	VSP Doctor	Non-VSP Provider
Exam	100%	$45
Lenses		
Single	100%	$45
Lined Bifocal	100%	$65
Lined Trifocal	100%	$85
Frames	$120	$47
Contact Lenses	$170	$170

Exam

This Plan covers one complete examination or vision survey per person every 12 months, from your last date of service, according to the Schedule of Benefits.

Conventional Lenses

Prescription lenses will be covered once every 12 months, from your last date of service, if a visual analysis indicates new lenses are necessary. Lenses are covered according to the Schedule of Benefits. Lens options are provided at a discount from a VSP member doctor.

Frames

New frames will be covered whenever necessary, but not more than once every 24 months, from your last date of service, and will be covered according to the

Schedule of Benefits. A 20% discount will apply on frames purchased from a VSP member doctor that exceed the frame allowance.

Contact Lenses

If contact lenses are elected instead of eyeglasses, this Plan will provide a benefit. This benefit will use up your lenses and frame benefit. For example, you will not be eligible again for a frame until 24 months after the date you purchased your contacts.

A patient who has received contact lenses either Elective or Medically Necessary would again be eligible for vision benefits as follows:

- Examination and conventional lenses, after 12 months from the last date of service;
- Frames, after 24 months from the last date of service; and
- Contact lens replacement, after 12 months from the last date of service if a change in prescription so indicates.

SERVICES NOT PAID UNDER VISION BENEFITS

- Replacement of lost or broken lenses or frames which are furnished under the Plan, except at the normal intervals when services are otherwise covered;
- Glasses secured when no prescription change is warranted;
- Sunglasses, plain or prescription;
- Photosun lenses or tinted lenses, except pink shades No. 1 and 2;
- Pano (non-prescription) lenses;
- Two pairs of glasses in lieu of bifocals;
- Any excess charge for no-line bifocals (blended type), unless the doctor certifies that the no-line bifocal (blended type) is necessary and prior approval is obtained.
- Special procedures, such as orthoptics and visual training;
- Contact lenses and subnormal vision aids, except as described in this section;
- Medical or surgical treatment of the eyes. You will be notified if an examination indicates that this type of treatment is required and, if desired, a referral will be made. However, the Vision Benefit will not pay for medical or surgical treatment, whether or not a referral is made. (See Medical Benefits section for medical and surgical coverage.);

- Services or materials which are payable under Workers' Compensation, employer liability or similar program;
- Services which are provided without cost through any government agency;
- Eye examinations required as a condition of employment, which the employer must provide by virtue of a labor agreement; and
- Eye examinations required by a government body.

VISION BENEFITS AFTER TERMINATION

Vision care benefits will be provided for up to 3 months after the date a covered individual's coverage is terminated if the services required are due to accidental injury to the eye while the individual is covered under this Plan.

COBRA CONTINUATION COVERAGE

The following information about your COBRA rights sets out in detail your rights and responsibilities under the Trust's COBRA continuation provisions, as well as other health coverage alternatives that may be available to you through the Health Insurance Marketplace. It provides additional information about the effect of your legal rights of not electing COBRA coverage, what alternative coverage (if any) is available from the Trust and your notification obligations. This includes how to obtain an 11-month extension of COBRA continuation coverage if you or an eligible family member is found to be disabled by the Social Security Administration; notifying the Administration Office within 60 days of the later of your qualifying event; the date you receive your disability determination; or your responsibility to notify the Administration Office within 60 days if a second qualifying event occurs while you are on COBRA.

Other Coverage Options Besides COBRA Continuation Coverage

Instead of enrolling in COBRA continuation coverage, there may be other more affordable coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage.

You should compare your other coverage options with COBRA continuation coverage and choose the coverage that is best for you. For example, if you move to other coverage you may pay more out of pocket than you would under COBRA because the new coverage may impose a new deductible.

When you lose job-based health coverage, it's important that you choose carefully between COBRA continuation coverage and other coverage options, because once you've made your choice, it can be difficult or impossible to switch to another coverage option.

If you have questions after reading the notice, you may contact the Administration Office or you may contact the nearest office of the Department of Labor Employee Benefits Security Administration. Addresses and phone numbers are available through EBSA's website at www.dol.gov/ebsa.

Continuation Coverage (COBRA)

Pursuant to a federal law known as COBRA, and under the circumstances described below, you, your lawful spouse and your eligible dependents each have an independent right to elect to continue your Trust health coverage beyond the time coverage would ordinarily have ended. You or your spouse may elect

COBRA on behalf of other eligible family members. A parent or legal guardian may elect COBRA on behalf of a minor child.

Notices to Trust Concerning COBRA

The Administration Office for the Alaska Laborers-Construction Industry Health & Security Fund is responsible for administering COBRA continuation rights for the Trust. All communications must be made in writing; identify you; the eligible employee, if different; the Trust's name (Alaska Laborers-Construction Industry Health & Security Fund) and be sent to the Administration Office at the following address:

Alaska Laborers-Construction Industry
Health & Security Fund
P.O. Box 34203
Seattle, WA 98124-1203

Qualifying Events

COBRA coverage is available if you or your dependents lose coverage because of specific qualifying events. You (as the participating employee) have the right to elect continuation coverage if you would otherwise lose eligibility because of a reduction in hours of employment or termination of employment.

Your lawful spouse has the right to choose continuation of coverage if he or she would otherwise lose eligibility for any of the following reasons:

- The participant's termination of employment or reduction in hours of employment;
- Death of the participant; or
- Divorce or legal separation from the participant;

A dependent child has the right to elect continuation of coverage if eligibility would otherwise be lost for any of the following reasons:

- The participant's termination of employment or reduction in hours of employment;
- Death of the participant;
- Divorce or legal separation of a lawful spouse from the participant; or
- The child no longer qualifying as an eligible dependent under the Plan.

Child Covered Pursuant to Qualified Domestic Relations Order. A child of the participating employee who is covered under the Trust's health plan pursuant to a qualified medical child support order (QMCSO) received during the participating employee's period of covered employment is entitled to the same rights to elect

continuation coverage as an eligible dependent child of the participating employee.

COBRA Notification Responsibilities

The Trust offers continuation coverage only after it has been notified of a qualifying event. You or your eligible dependents have the responsibility to inform the Administration Office of a loss of coverage resulting from a divorce or a child losing dependent status. You or your eligible dependents must provide this notice to the Administration Office in writing within 60 days of the later of: the date of the qualifying event; the date coverage would be terminated as the result of the qualifying event; or the date you are first provided this notice, or another notice (e.g., the plan booklet) describing the procedure for electing continuation coverage. Notice of the qualifying event must identify the individual who has experienced the qualifying event; the participant's name, if different; the qualifying event that occurred; and the Trust. Even after you have made a written election with the Administration Office, you may later revoke, change or modify your election notice with a follow-up written election notice made and forwarded to the Administration Office any time before the 60 days has expired. Elections, changes or revocations must be sent to the Administration Office at the address listed on page one within the 60-day period.

Failure to provide timely notice will result in your coverage ending as it normally would under the terms of the Plan, and you and your dependents will lose the right to elect continuation coverage.

Your employer is responsible for informing the Trust of any other qualifying event. The Board of Trustees reserves the right to determine whether coverage has in fact been lost due to a qualifying event.

Election of COBRA

Once the Administration Office has received proper notice that a qualifying event has occurred, it will notify you, your lawful spouse and each of your eligible dependents of your right to elect continuation coverage. A written election must be made within 60 days from the later of the date coverage would otherwise end or 60 days from the date the notification is furnished by the Trust.

Failure to elect continuation within this 60-day period will cause eligibility to end as it normally would under the terms of the Plan, and you and your dependents will lose the right to elect continuation coverage.

Available Coverage

The continuation coverage offered is the same as provided to current participating employees of your former employer.

You and/or your eligible dependents may elect the following coverage options:

- Medical, prescription, dental, vision, and audio. (Based on level of coverage at time of terminating event.)
- Medical and prescription drug only.

Continuation coverage is not available for time loss or life and accidental death and dismemberment benefits. Once the coverage option is selected by active participants and/or their dependents, it cannot be changed. Dependents of retirees may elect to continue medical and prescription drug coverage or medical only.

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, and the date the new dependent was acquired and be mailed to the Administration Office at the address listed on page one. A copy of the marriage certificate, birth certificate or adoption papers must be included with the written notice. If timely written notice is not provided to the Administration Office, you will not be entitled to add a new dependent.

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

Continuous Coverage Required

Your coverage under COBRA must be continuous from the date your Trust coverage would have ended if monthly self-payments were not made.

Cost

There is a cost for continuation coverage. The cost for the coverage available through the Trust is set annually. If you or your dependents are eligible for a disability extension of continuation coverage, discussed below, the cost of the coverage may be 150% of the COBRA self-payment rate for the additional 11 months of coverage provided as a result of your or your dependent's disability.

Other coverage options may cost less. If you choose to elect continuation coverage, you don't have to send any payment with the Election Form.

Additional information about payment will be provided to you after the election form is received by the Plan. Important information about paying your premium can be found at the end of this notice.

You may be able to get coverage through the Health Insurance Marketplace that costs less than COBRA continuation coverage. You can learn more about the Marketplace below.

What is the Health Insurance Marketplace?

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 and cost-sharing reductions (amounts that lower your out-of-pocket costs for deductibles, coinsurance, and copayments) 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.

Coverage through the Health Insurance Marketplace may cost less than COBRA continuation coverage. Being offered COBRA continuation coverage won't limit your eligibility for coverage or for a tax credit through the Marketplace.

When Can I Enroll in Marketplace Coverage?

You always have 60 days from the time you lose your job-based coverage to enroll in the Marketplace. That is because losing your job-based health coverage is a "special enrollment" event. **After 60 days your special enrollment period will end and you may not be able to enroll, so you should take action right away.** In addition, during what is called an "open enrollment" period, anyone can enroll in Marketplace coverage.

To find out more about enrolling in the Marketplace, such as when the next open enrollment period will be and what you need to know about qualifying events and special enrollment periods, visit www.HealthCare.gov.

If I Sign Up for COBRA Continuation Coverage, Can I Switch to Coverage in the Marketplace? What if I Choose Marketplace Coverage and Want to Switch Back to COBRA Continuation Coverage?

If you sign up for COBRA continuation coverage, you can switch to a Marketplace plan during a Marketplace open enrollment period. You can also end your COBRA continuation coverage early and switch to a Marketplace plan if you have another qualifying event such as marriage or birth of a child through something

called a “special enrollment period.” But be careful, though--if you terminate your COBRA continuation coverage early without another qualifying event, you'll have to wait to enroll in Marketplace coverage until the next open enrollment period, and could end up without any health coverage in the interim.

Once you've exhausted your COBRA continuation coverage and the coverage expires, you'll be eligible to enroll in Marketplace coverage through a special enrollment period, even if Marketplace open enrollment has ended.

If you sign up for Marketplace coverage instead of COBRA continuation coverage, you cannot switch to COBRA continuation coverage under any circumstances.

Can I Enroll In Another Group Health Plan?

You may be eligible to enroll in coverage under another group health plan (like a spouse's plan), if you request enrollment within 30 days of the loss of coverage.

If you or your dependent chooses to elect COBRA continuation coverage instead of enrolling in another group health plan for which you're eligible, you'll have another opportunity to enroll in the other group health plan within 30 days of losing your COBRA continuation coverage.

What Factors Should I Consider When Choosing Coverage Options?

When considering your options for health coverage, you may want to think about:

- **Premiums**. Your previous plan can charge up to 102% of total plan premiums for COBRA coverage. Other options, like coverage on a spouse's plan or through the Marketplace, may be less expensive.
- **Provider Networks**. If you're currently getting care or treatment for a condition, a change in your health coverage may affect your access to a particular health care provider. You may want to check to see if your current health care providers participate in a network as you consider options for health coverage.
- **Drug Formularies**. If you're currently taking medication, a change in your health coverage may affect your costs for medication–and in some cases, your medication may not be covered by another plan. You may want to check to see if your current medications are listed in drug formularies for other health coverage.
- **Severance Payments**. If you lost your job and got a severance package from your former employer, your former employer may have offered to pay some or all of your COBRA payments for a period of time. In this scenario, you may want to contact the Department of Labor at 1-866-444-3272 to discuss your options.

- **Service Areas**. Some plans limit their benefits to specific service or coverage areas–so if you move to another area of the country, you may not be able to use your benefits. You may want to see if your plan has a service or coverage area, or other similar limitations.
- **Other Cost-Sharing**. In addition to premiums or contributions for health coverage, you probably pay copayments, deductibles, coinsurance, or other amounts as you use your benefits. You may want to check to see what the cost-sharing requirements are for other health coverage options. For example, one option may have much lower monthly premiums, but a much higher deductible and higher copayments.

Monthly Self-Payments Required

You or your eligible dependents are responsible for the full cost of continuation coverage. All payments must be sent to the Administration Office at the address printed on the payment coupons.

The first payment is due 45 days from the date the election form is sent to the Administration Office. The first payment must cover all months since the date coverage would have otherwise terminated. Eligibility for continuation coverage will not commence, nor will claims be processed until the initial payment has been made. You or your dependents will lose the right to continuation coverage if the initial payment is not postmarked or received by the Administration Office by the due date.

After the initial payment, monthly payments are due on the first of each month for that month's coverage. 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.

Length of Continuation Coverage

Continuation of coverage may last for up to 18 months following loss of coverage as a result of a termination of employment or reduction in hours, unless COBRA is extended as provided below for "Disabled Individuals," a "Second Qualifying Event," or "Medicare Entitlement." For all other qualifying events (death of the participant, divorce from the participant or a child no longer qualifying as a dependent under the Plan) continuation coverage may last for up to 36 months.

Continuation coverage will end on the last day of the monthly premium payment period 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 (unless the other group health plan limits or excludes coverage for a pre-existing condition of the individual seeking continuation coverage). You are required to notify the Administration Office when you become eligible under another group health plan (note: there are limitations on plans imposing a pre-existing condition exclusion and such exclusions will become prohibited beginning in 2014 under the Affordable Care Act);
- You or your eligible dependent provide written notice that you wish to terminate your coverage;
- You or your eligible dependent become entitled to Medicare after the date of the election of COBRA;
- The Plan terminates; or
- Your employer no longer participates in the Trust unless your employer or its successor does not offer another health plan for any classification of its employees that formerly participated in the Trust.

Length of Continuation Coverage – Disabled Individuals

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, you and your eligible dependents can extend COBRA for up to an additional 11 months beyond the original 18 months, up to a maximum of 29 months. To obtain the additional months of coverage, you must notify the Administration Office in writing within 60 days of the later of your qualifying event or your receipt of your Social Security Disability Determination and prior to the end of your initial 18-month period of continuation coverage. A copy of the Social Security Disability Determination must be included with the written notice. If the disabled individual is subsequently found to not be disabled, you must notify the Administration Office 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 that are entitled to continuation coverage as the result of a participant'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 participating employee's death, a divorce or legal separation from the participating employee, a child losing dependent status or the participating

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

Length of Continuation Coverage – Medicare Entitlement

If you have an 18-month qualifying event after becoming entitled to Medicare, your dependents may continue COBRA coverage until the later of:

- 18 months from the date coverage would normally end due to the termination of employment or reduction of hours; or
- 36 months from the date you become entitled to Medicare.

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 your Medicare or other group health coverage already existed when you elect COBRA, however, you can be eligible for both.

If you have Trust 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 only pay secondary and coordinate with Medicare. 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.

Retirees and their spouses are expected to enroll in Medicare Part A and Part B when first eligible. Even if you retire and elect COBRA continuation coverage in lieu of Retiree benefits, you must enroll in Medicare Part A and Part B. If you are eligible to enroll in Medicare Part A and Part B, benefits are provided by the Plan as if you are enrolled, regardless of whether you actually did enroll.

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

Effect of Not Electing Continuation Coverage

In considering whether to elect continuation coverage, please be aware that 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.

Alternative Coverage

There is no conversion option available for medical, prescription drug, dental, vision or AD&D benefits provided by the Trust. The Trust offers certain other alternatives that may be elected in lieu of COBRA continuation coverage.

There is a conversion option for life benefits, provided you complete the application form and send it to the Trust's life insurance provider with the first premium payment within 31 days of the termination of the Trust's Life insurance benefits. See the Plan booklet for details.

If you leave employment with a contributing employer for military service, you may elect to continue coverage for up to 24 months in accordance with the Uniformed Services Employment and Reemployment Rights Act ("USERRA"). If leave is less than 32 days, coverage is continued at no cost to you. If leave exceeds 31 days, a monthly self-payment is required at the rate established by the Trustees. The maximum length of coverage is the lesser of 24 months, or the period ending the day after you fail to return to employment within the time allowed by USERRA.

If you qualify for both COBRA continuation coverage and retiree medical, you and your eligible dependents may elect COBRA in lieu of retiree medical. Following termination of COBRA, you and your dependents may apply for retiree medical. However, if COBRA continuation coverage is declined in favor of retiree medical, COBRA may not thereafter be elected, unless there is a new qualifying event.

Additional Information

For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, visit the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) website at www.dol.gov/ebsa or call their toll-free number at 1-866-444-3272. For more information about health insurance options available through the Health Insurance Marketplace, and to locate an assister in your area who you can talk to about the different options, visit www.HealthCare.gov.

To help insure 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.

If you have any questions regarding your eligibility/COBRA, please contact the Administration Office at (855) 815-2323 option 4.

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 coverage may be continued on the same basis as if you were actively-at-work for up to 12 weeks during the 12 month period, as defined by your employer, for any of the following reasons:

(a) 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;

(b) To care for your spouse, child, foster child, adopted child, stepchild, or parent who has a serious health condition; or

(c) For your own serious health condition.

In the event you or your spouse are both covered as employees of the same employer, the continued coverage under (a) may not exceed a combined total of 12 weeks. In addition, if the leave is taken to care for a parent with a serious health condition, the continued coverage may not exceed a combined total of 12 weeks.

CONDITIONS:

(a) If, on the day your coverage is to begin, you are already on an FMLA leave of absence you will be considered actively at work. Coverage for you and any eligible dependent will begin in accordance with the terms of the plan. However, if your leave of absence is due to your own or any eligible dependent's serious health condition, benefits for that condition will not be payable to the extent benefits are payable under any prior group plan.

(b) You are eligible to continue coverage under FMLA if:

    (1) You have worked for your employer for at least 1 year;

    (2) You have worked at least 1,250 hours over the previous 12 months;

    (3) Your employer employs at least 50 employees within 75 miles from your worksite; and

    (4) You continue to pay any required contribution for yourself and any eligible dependents in a manner determined by your bargaining agreement.

(c) In the event you choose not to pay any required contribution during your leave, your coverage will not be continued during the leave. You will be able to reinstate your coverage on the day you return to work, subject to any changes that may have occurred in the Plan during the time you were not

covered. Any partially-satisfied waiting periods which are interrupted during the period of time coverage was not continued will be applied once coverage is reinstated.

(d) You and your dependents are subject to all conditions and limitations of the Plan during your leave, except that anything in conflict with the provisions of the FMLA will be construed in accordance with the FMLA.

(e) If requested by the administrator, you or your employer must submit proof that your leave is in accordance with FMLA.

(f) This FMLA continuation is concurrent with any other continuation option except for COBRA, if applicable. You may be eligible to elect any COBRA continuation available under the Plan following the day your FMLA continuation ends.

(g) FMLA continuation ends on the earliest of:

    (1) The day you return to work;

    (2) The day you notify your employer that you are not returning to work;

    (3) The day your coverage would otherwise end; or

    (4) The day coverage has been continued for 12 weeks.

Contact your employer or the Administration Office for additional information regarding FMLA.

UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS

DEFINITIONS:

Health coverage means hospital, surgical, medical, dental, vision, audio or prescription drug coverage provided under the Plan. Health coverage is subject to change as a result of open enrollments or Plan modifications.

USERRA means the Uniformed Services Employment and Reemployment Rights Act of 1994 (including amendments to such Act and any interpretive rulings or regulations).

Service in the uniformed services means the performance of duty on a voluntary or involuntary basis in a uniformed service under competent authority and includes active duty, active duty for training, initial active duty for training, inactive duty training, full-time National Guard duty, and a period for which a person is absent from a position of employment for the purpose of an examination to determined the fitness of the person to perform such duty.

Uniformed services means the United States Armed Forces, the Army National Guard and the Air National Guard when engaged in active duty for training, inactive duty training, or full-time National Guard duty, the commissioned corps of the Public Health Service, and any other category of persons designated by the President in time of war or emergency.

CONTINUATION OF GROUP HEALTH COVERAGE

1. For you and your eligible dependents: If health coverage ends because of your service in the uniformed services, you may elect to continue such health coverage, if required by USERRA, until the earlier of:
   (a) the end of the period during which you are eligible to apply for reemployment in accordance with USERRA; or
   (b) 24 consecutive months after coverage ended.
2. To continue coverage, you or your dependent must self-pay the required cost of coverage unless your service in the uniformed services is for fewer than 31 days. The Administration Office will inform you or your dependent of procedures to self-pay.
3. End of Continuation. Your continued health coverage will end at midnight on the earliest of:
   (a) The day the Trust ceases to provide the group health plan;
   (b) The day your self-payment is due and unpaid;

(c) The day you again become covered under the Plan;

(d) The day health coverage has been continued for the period of time provided in part 1(a) or 1(b) above (or any longer period provided in the Plan; or

(e) The day the Plan terminates.

Any Health coverage for an eligible dependent will also end when your health coverage terminated.

4. Other Continuation Provisions. In the event coverage is continued under any other self-pay provision of the Plan, the periods of continued coverage will run concurrently.

REEMPLOYMENT (following service in the uniformed services)

Following your discharge from such service, you may be eligible to apply for reemployment with your former employer in accord with USERRA. Such reemployment includes your right to elect reinstatement in any then existing health coverage by the Trust.

IMPORTANT NOTICE

In the event of a conflict between this provision and USERRA, the provisions of USERRA, as interpreted by your employer or former employer, will apply.

GENERAL PROVISIONS

COORDINATION OF BENEFITS

This Plan is designed to help you meet the cost of medical, dental and vision care expenses. 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 have under other plans, as defined below. 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 equal 100% of the Allowable Expense for this Plan.

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 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 normally be allowed.

A plan means any of the following, even if it does not have its own coordination of benefits provisions:

- Group, individual or blanket disability insurance policies and health care service contractor and health maintenance organization agreement issued by insurers, health care service contractors and health maintenance organizations.
- Labor-management trustee plans, labor organization plans or employee benefit organization plans.
- Government programs which provide benefits for their own civilian employees or their dependents (including Medicare).
- Coverage required or provided by any statute, including automobile insurance policies required by statute to provide medical benefits.

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). The primary plan is determined by the following order:

- The plan that does not have a coordination of benefits (COB) provision.
- The plan covering the person as an active employee.
- The plan covering the person as a dependent. If the person is a dependent child:

- If the parents of the dependent child are married, the plan covering the parent whose month and date of birth falls earlier in the year. However, if one of the parent's plans does not have this birthday rule, the plan covering the father is primary.
- If the parents of the dependent child are divorced:
  - ✓ The plan of the natural parent with custody.
  - ✓ The plan of the new spouse of the natural parent with custody.
  - ✓ The plan of the natural parent without custody.
  - ✓ The plan of the new spouse of the natural parent without custody.

For unmarried parents who live together (i.e. parents who are not separated) like married parents, the birthday rule will apply. Under the birthday rule, the primary plan is the plan of the parent whose birthday is earlier in the year.

If the parents are never married and are separated, the same rule used for divorced parents will apply.

However, if the court decrees financial responsibility for the dependent child's health care, the plan of the parent with that responsibility is the primary plan.

If the court decree establishes provisions for joint custody but doesn't establish financial responsibility for the child's health care, the birthday rule will apply.

- The plan covering the person as a retired or laid off employee or dependent of such employee.
- The plan covering the individual (or a dependent) as a non-COBRA self-payer is primary over a plan covering the individual (or a dependent) as a COBRA self-payer.
- If the above order does not establish the primary plan, the plan that has covered the person for the longest period of time is the primary plan.
- If none of the above rules determine the order of benefits, the benefits of the plan which covered an employee (the person in whose name coverage is established) longer are determined before those of the plan which covered that person for the shorter time.

If you or your dependents are covered by another group or individual medical, dental, or vision plan, claims should be filed with this Plan and the other plan(s) at the same time to avoid delays in claim payments due to coordination of benefits.

Effect of Medicare

Generally, anyone age 65 or older is entitled to Medicare coverage. Anyone under age 65 who is entitled to Social Security Disability Income benefits is also entitled to Medicare coverage (generally after a waiting period).

If the total amount of benefits provided by the Plan together with the amount of "like benefits" you or your dependent receives or is entitled to receive from Medicare exceeds the actual expenses incurred for such benefits, the benefits provided by the Plan will be reduced so that the combined benefits do not exceed the actual expenses for such benefits.

"Like benefits" refers to reimbursement for the cost of services and supplies for which benefits would otherwise be payable under the Plan.

Active Employees and their spouses will normally have benefits paid first by this Plan, then by Medicare. The law allows you to choose Medicare as your primary coverage. However, if you choose Medicare as primary, you cannot receive benefits from this Plan.

Retirees and their spouses are expected to enroll in both Part A and Part B of Medicare. This Plan will not pay benefits for services which would have been reimbursed by Medicare, even if you fail to enroll in Medicare. 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 as if your claims had been paid by Medicare.

Retirees and their spouses who are eligible to enroll in Medicare and enter into a private contracting arrangement with a provider, will have benefits for covered charges paid as if they are enrolled in Medicare. This will result in substantial out-of-pocket expenses.

You should also confirm that your doctor accepts Medicare payments and has not opted out. If you receive services from a provider who has opted out of Medicare, you will be responsible to pay the amount Medicare would have paid, as well as any costs above the allowable charges. You may be responsible for significant uncovered out-of-pocket expenses.

Coverage Under Medicare and This Plan for End-Stage Renal Disease: If, while actively employed, an eligible individual under this Plan 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.

Entitlement to Medicaid

Benefits will be provided under this Plan without taking into account your entitlement to Medicaid benefits. Benefits will be made in accordance with any assignment of rights by or on your behalf as required by a State Medicaid Plan. If benefits have been provided under a State Medicaid Plan, and the Plan has liability to make payment, benefits will be paid by the Plan in accordance with any applicable State law which provides that the State acquired the rights with respect to such payment to you.

Secondary Coverage

Plan members who are eligible for secondary coverage by any other health plan are encouraged to obtain such coverage. Failure to obtain secondary coverage may result in you and your dependents incurring costs, which are not covered by the Plan and which would otherwise be covered by the secondary coverage. The Plan will not pay for any costs which would have been payable by such secondary coverage, except to the extent that such costs are payable in any event by the Plan.

FUTURE OF THE HEALTH AND SECURITY PLAN

This Plan is intended to operate for an indefinite period of time. However, the Board of Trustees has the authority to amend or terminate the Plan at any time. The Plan will also terminate upon the expiration of all Collective Bargaining Agreements requiring the payment of contributions to the Plan. In the event of the termination of the Plan, any and all monies and assets remaining in the Plan, after payment of expenses, shall be used for the continuance of the benefits provided by the then existing benefit plans, until such monies and assets have been exhausted.

PLAN ADMINISTRATION

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

The Board of Trustees has the discretionary authority to decide whether a charge is Usual and Reasonable. Benefits under this Plan shall be paid only if the Board of Trustees decides in its discretion that a Plan member is entitled to them.

REIMBURSEMENT AND RECOVERY FOR ACTS OF THIRD PARTIES / FIRST PARTIES

If you require hospital or medical services because of an accident caused by someone else's or your negligence, the person who caused the accident is responsible for your hospital and medical expenses. (The terms "you" and "your" apply to and include any eligible dependents under the Plan.) If the Plan initially paid those expenses, it has the right to recover them. The Plan may assert its claims against the third party through subrogation or may seek reimbursement from you directly, from any recovery or proceeds of settlement or judgment.

If you seek a recovery from the third party directly, you are doing so with the understanding that you are also asserting the right of the Plan to be reimbursed (not just your own rights). Any recovery you make relating to medical or hospital expenses paid by the Plan constitutes a constructive trust on behalf of the Plan, and the Plan is entitled to restitution from you (or your estate).

When you (or your estate) receive reimbursement for damages caused by you or by a third party, you must reimburse the Plan for any benefits paid or advanced relating to that illness or injury, up to the full amount of compensation you receive from the other party or any insurer (regardless of how that compensation is characterized). The Plan is entitled to recover as a right of first reimbursement even if you are not made whole for the injuries suffered. The reimbursement required under this provision will not be reduced to reflect any costs or attorney fees incurred in obtaining the compensation unless separately agreed to, in writing, by the Board of Trustees in the exercise of its sole discretion. This provision for reimbursement applies whenever someone else (including your own insurer if you are at fault in whole or part under an automobile or other policy) is legally responsible or agrees to compensate you for an illness or injury.

Benefits for this illness or injury will not be payable until you acknowledge the obligation to reimburse the Plan as described above. The Administration Office will send you an acknowledgement form to sign and return, but your acceptance of any Plan benefits relating to this illness or injury shall be deemed your acknowledgement of this obligation, even if you do not sign the form.

If you or your dependents fail to comply with this obligation and fail to reimburse the Plan from any recovery you have from a third-party or any insurer, the Plan and its administrator in its discretion, may offset any future medical or health benefits claimed by you or your dependents under the Plan until the amounts that should have been reimbursed to the Plan are paid or offset in full. You will be notified of what amount the Plan would have paid to your service provider but not paid until your reimbursement obligation is satisfied.

After any recovery on a third-party claim or the participant's own insurance, the Plan shall be relieved from any obligation to pay further medical benefits under the Plan for any illness or injury related to the third-party claim or to the participant's insured claim up to the total amount of the balance remaining on the recovery obtained by the participant or Beneficiary after any reimbursement payments made to the Plan.

HEALTH CLAIM PROCEDURES

The procedures outlined below must be followed by covered participants to obtain payment of health benefits under this Plan.

HEALTH CLAIMS

All claims and questions regarding health claims should be directed to the Administration Office (Welfare & Pension Administration Service, Inc.). The Trustees shall be ultimately and finally responsible for providing full and fair review of the decision on such claims in accordance with the following provisions and with the Employee Retirement Income Security Act of 1974, as amended (ERISA). Benefits under the Plan will be paid only if the Administration Office decides in its discretion that the participant is entitled to them. The responsibility to process claims in accordance with the Summary Plan Description is delegated to the Administration Office.

Each participant claiming benefits under the Plan shall be responsible for supplying, at such times and in such manner as the Administration Office in its discretion may require, written proof that the expenses were incurred or that the benefit is covered under the Plan. If the Administration Office determines that the participant has not incurred a covered expense or that the benefit is not covered under the Plan, or if the participant fails to furnish such proof as required, no benefits shall be payable under the Plan.

The US Department of Labor (DOL) has established 4 types of claims: Pre-Service (Urgent and Non-urgent), Concurrent Care and Post-Service.

Pre-Service Claims

A Pre-Service Claim is a claim for a benefit under the Plan where the Plan conditions receipt of a benefit, in whole or in part, on approval of the benefit in advance of obtaining medical care. Pre-Service Claims are only claims to the extent that precertified services are reviewed and a determination is made regarding the Medical Necessity of the service or the appropriate level of care. Pre-Service Claim determinations do not address a participant's eligibility or Plan coverage for specific service items.

A Pre-Service Urgent Care Claim is any claim for medical care or treatment which respect to which the application of the time periods for making non-urgent care determinations could seriously jeopardize the life or health of the participant or the participant's ability to regain maximum function, or, in the opinion of a physician with knowledge of the participant's medical condition, would subject the participant to severe pain that cannot be adequately managed without the care or treatment that this the subject of the claim.

It is important to remember that, if a participant needs medical care for a condition which could seriously jeopardize his/her life, there is no need to contact the Plan for prior approval. The participant should obtain such care without delay.

Further, if the Plan does not require the participant to obtain approval of a medical service prior to getting treatment, then there is no Pre-Service Claim. The participant simply follows the Plan's procedures with respect to any notice which may be required after receipt of treatment and files the claim as a Post-Service Claim.

Please see the Hospital Confinement Review (Precertification) provisions on page 42 for information on when prior approval is required for this plan.

Concurrent Claims

A Concurrent Claim arises when the Plan has approved an on-going course of treatment to be provided over a period of time or number of treatments, and either (a) the Plan determines that the course of treatment should be reduced or terminated, or (b) the participant requests an extension of treatment beyond that which the Plan has approved.

If the Plan does not require the participant to obtain approval of a medical service prior to getting treatment, then there is no need to contact the Administration Office or the Precertification / Utilization Review Provider to request an extension of a course of treatment. The participant simply follows the Plan's procedures with respect to any notice which may be required after receipt of treatment, and files the claim as a Post-Service Claim.

Please see the Hospital Confinement Review (Precertification) provisions on page 42 for information on when prior approval is required for this plan.

Post-Service Claims

A Post-Service Claim is a claim for a benefit under the Plan after the services have been rendered.

WHEN HEALTH CLAIMS MUST BE FILED

Health claims must be filed with the Administration Office or designated claim processor (Aetna for provider-filed medical claims, Caremark for prescription drug claims and VSP for vision claims) as soon as possible, however all claims must be submitted to the Administration Office designated claim processor (Aetna for provider-filed medical claims, Caremark for prescription drug claims and VSP for vision claims) within one year following the date expenses are incurred. No claim will be considered for payment if it is submitted more than one year after the service is rendered.

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

A Pre-Service Claim (including a Concurrent Claim that also is a Pre-Service Claim) is considered to be filed with the request for approval of treatment or services is made and received by the Administration Office in accordance with the Plan's procedures. However, a Post-Service Claim is considered to be filed when the following information is received by the Administration Office:

1. The date of service;
2. The name, address, telephone number and tax identification number of the provider of the services or supplies;
3. The place where services were rendered;
4. The diagnosis and procedure codes;
5. The amount of the charges;
6. The name of the Plan;
7. The name of the covered employee; and
8. The name of the patient.

Upon receipt of this information, the claim will be deemed to be filed with the Plan. The Administration Office will determine if enough information has been submitted to enable proper consideration of the claim. If not, more information may be requested. This additional information must be received by the Administration Office within 45 days from the date of the request for additional information. Failure to do so may result in claims being declined or reduced.

TIMING OF CLAIM DECISIONS

The Administration Office shall notify the participant, in accordance with the provisions set forth below, of any adverse benefit determination (and in the case of Pre-Service Claims and Concurrent Claims, the Precertification / Utilization Review Provider shall notify the participant of decisions that a claim is certified) within the following timeframes:

Pre-Service Non-Urgent Care Claims

- If the participant has provided all of the information needed to process the claim, in a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after receipt of the claim, unless an extension has been requested, then prior to the end of the 15-day extension period.

- If the participant has not provided all of the information needed to process the claim, then the participant will be notified as to what specific information is needed as soon as possible, but not later than 5 days after receipt of the claim. The participant will be notified of a determination of benefits in a reasonable period of time appropriate to the medical circumstances, either prior to the end of the extension period (if additional information was requested during the initial processing period), or by the date agreed to by the Administration Office and the participant (if additional information was requested during the extension period.)

Concurrent Claims

- If the Administration Office or Precertification / Utilization Review Provider is notifying the participant of a reduction or termination of a course of treatment (other than by a Plan amendment or termination), before the end of such period of time or number of treatments, the participant will be notified sufficiently in advance of the reduction or termination to allow the participant to appeal and obtain a determination on review of that adverse benefit determination before the benefit is reduced or terminated.
- If the Administration Office or Precertification / Utilization Review Provider receives a request from the participant to extend the course of treatment beyond the period of time or number of treatments that is a claim not involving Urgent Care, the request will be treated as a new benefit claim and decided within the time frame appropriate to the type of claim (either as a Pre-Service Non-Urgent Claim or a Post-Service Claim).

Post-Service Claims

- If the participant has provided all of the information needed to process the claim, in a reasonable period of time, but not later than 30 days after receipt of the claim, unless an extension has been requested, then prior to the end of the 15-day period.
- If the participant has not provided all of the information needed to process the claim and additional information is requested during the initial processing period, then the participant will be notified of a determination of benefits prior to the end of the extension period, unless additional information is requested during the extension period, then the participant will be notified by a determination by a date agreed to by the Administration Office.

Extensions for Pre-Service Non-Urgent Care Claims

This period may be extended by the Plan for up to 15 days, provided that the Administration Office or Precertification / Utilization Review Provider both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the participant, prior to the expiration of the initial 15-day processing period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision.

Extensions for Post-Service Claims

This period may be extended by the Plan for up to 15 days, provided that the Administration Office both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the participant, prior to the expiration of the initial 30-day processing period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision.

Calculating Time Periods

The period of time within which a benefit determination is required to be made shall begin at the time a claim is deemed to be filed in accordance with the procedures of the Plan.

NOTIFICATION OF AN ADVERSE BENEFIT DETERMINATION

The Administration Office shall provide a participant with a notice, either in writing or electronically containing the following information:

1. Information to identify the claim involved;
2. A reference to the specific portions(s) of the Summary Plan Description upon which a denial is based;
3. Specific reason(s) for a denial;
4. A description of any additional information necessary for the participant to perfect the claim and an explanation of why such information is necessary;
5. A description of the Plan's review procedures and the time limits applicable to the procedures, including a statement of the participant's right to bring a civil action under Section 502(a) of ERISA following an adverse benefit determination on final review;
6. A statement that the participant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the participant's claim for benefits;

7. The identity of any medical or vocational experts consulted in connection with a claim, even if the Plan did not rely upon their advice (or a statement that the identity of the expert will be provided upon request);
8. Any rule, guideline, protocol or similar criterion that was relied upon in making the determination (or a statement that is was relied upon and that a copy will be provided to the participant, free of charge, upon request); and
9. In the case of denials based upon a medical judgment (such as whether the treatment is Medically Necessary or Experimental or Investigational), either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the participant's medical circumstances, or a statement that such explanation will be provided to the participant, free of charge, upon request.

APPEALS OF ADVERSE BENEFIT DETERMINATION

Full and Fair Review of All Claims

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

1. Participants 180 days following notification of an adverse benefit determination within which to appeal the determination;
2. Participants the opportunity to submit written comments, documents, records, and other information relating to the claim for benefits;
3. For a review that does not afford deference to the previous adverse benefit determination and that is conducted by an appropriate named fiduciary of the Plan, who shall be neither the individual who made the adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual;
4. For a review that takes into account all comments, documents, records and other information submitted by the participant relating to the claim, without regard to whether such information was submitted or considered in any prior benefit determination;
5. That, in deciding an appeal of any adverse benefit determination that is based in whole or in part upon a medical judgment, the Plan fiduciary shall consult with a health care professional who has appropriate

training and experience in the field of medicine involved in the medical judgment, who is neither an individual who was consulted in connection with the adverse benefit determination that is the subject of the appeal, nor the subordinate of any such individual;

6. For the identification of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a claim, even if the Plan did not rely upon their advice; and

7. That a participant will be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the participant's claim for benefits in possession of the Administration Office or the Claims Administrator; any internal rule, guidelines, protocol or other similar criterion relied upon in making the adverse determination; and any explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the participant's medical circumstances.

APPEAL LEVEL

Requirements for Appeal

The participant must file the appeal in writing within 180 days following notice of an adverse benefit determination. To file an appeal in writing, the participant's appeal must be addressed as follows:

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

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

1. The name of the employee/participant;

2. The employee/participant's social security number;

3. All facts and theories supporting the claim for benefits. Failure to include any theories or facts in the appeal will result in them being deemed waived. In other words, the participant will lose the right to raise factual arguments and theories which support this claim if the participant fails to include them in the appeal.

4. A statement in clear and concise terms of the reason or reasons for disagreement with the handling of the claim; and

5. Any material or information that the insured has which indicates that the participant is entitled to benefits under the Plan.

If the participant provides all of the required information, it may be that the expenses will be eligible for payment under the Plan.

Timing and Notification of Benefit Determination on Appeal

The Administration Office shall notify the participant of the Plan's benefit determination on review within the following timeframes:

- Urgent Care Claims: Within a reasonable period of time appropriate to medical circumstances, but not later than 72 hours after receipt of approval.
- Pre-service Non-Urgent Care Claims: Within a reasonable period of time appropriate to the medical circumstances, but not later than 30 days after receipt of the appeal.
- Concurrent Claims: The response will be made in the appropriate time period based on the type of claim (Pre-Service Non-Urgent or Post-Service).
- Post-Service Claims: Within a reasonable period of time, but not later than 30 days after receipt of the appeal; unless notice is required within 30 days of the trustee meeting, and then within 5 days of the next regularly scheduled trustee meeting.

The period of time within which the Plan's determination is required to be made shall begin at the time an appeal is filed in accordance with the procedures of this Plan, without regard to whether all information necessary to make the determination accompanies the filing.

Manner and Content of Notification of Adverse Benefit Determination on Appeal

The Administration Office shall provide a participant with notification, in writing or electronically, of a Plan's adverse benefit determination on review, setting forth:

1. Information to identify the claim involved;
2. The specific reason(s) for the denial;
3. Reference to the specific portions(s) of the Summary Plan Description upon which a denial is based;
4. The identity of any medical or vocational experts consulted in connection with a claim, even if the Plan did not rely upon their advice;
5. A statement that the participant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the participant's claim for benefits;

6. If an internal rule, guideline, protocol or similar criterion was relied upon in making the adverse determination, a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge to the participant, upon request.
7. If the adverse benefit determination is based upon a medical judgment, a statement that an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the participant's medical circumstances, will be provided free of charge upon request.
8. A description of any additional information necessary for the participant to perfect the claim and an explanation of why such information is necessary;
9. A description of the Plan's External Review procedures and the time limits applicable to the procedures.

Furnishing Documents in the Event of an Adverse Determination

In the case of an adverse benefit determination on review, the Administration Office shall provide such access to, and copies of, documents, records, and other information described in items 4 through 8 of the section relating to Manner and Content of Notification of Adverse Benefit Determination on Appeal as appropriate.

APPEAL LEVEL – EXTERNAL REVIEW

Adverse Decision on Appeal; Request for External Review

This Plan has an external review procedure that provides for a review conducted by a qualified Independent Review Organization (IRO). The participant may request a review by an IRO within 4 months following receipt of the notice of the Plan's adverse decision regarding the first level internal review appeal. If there is no corresponding day 4 months after the date of receipt of the notice, then the request must be filed by the 1st day of the fifth month following receipt of the notice. As with the appeal, the participant's request for external review must be in writing and must include all of the items set forth in the section entitled Requirements for Appeal. The Plan is entitled to charge a fee of $25 to initiate an External Review, which must be paid when the participant submits the Request for External Review Form to initiate the process.

Preliminary Review

Within 6 business days following the date of receipt of the external review request, the Plan will provide a written notice stating whether the request is eligible for external review and if additional information is necessary to process the request. If the request is determined to be ineligible, the notice will include the

reasons for ineligibility and provide contact information for the appropriate federal oversight agency. If additional information is required to process the participant's request, the notice will describe the information needed and the participant may submit the additional information within the 4 month filing period or within 48 hours of receipt of the notification, whichever is later.

Timing of Notification from the IRO

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

Expedited External Review

A participant may request an expedited external review:

- At the time of the initial adverse benefit determination if the participant has filed a request for an expedited internal appeal, but the timeframe for completion of an expedited internal appeal would seriously jeopardize the life or health of the participant or would jeopardize the participant's ability to regain maximum function; or
- At the time of an adverse benefit determination of an internal appeal if the timeframe for completion of a standard external review would seriously jeopardize the life or health of the participant or would jeopardize the participant's ability to regain maximum function, or if the appeal involves an admission, availability of care, continued stay or health care item or service for which the claimant has received emergency services, but has not been discharged from a facility.

If the review is accepted as an expedited external review, the IRO will provide written notice of the final external review decision within 72 hours after the IRO receives the request for expedited external review.

Decision of IRO is Final

The decision by the IRO will be binding and conclusive and will be afforded the maximum deference permitted by law.

WEEKLY ACCIDENT AND SICKNESS (DISABILITY) CLAIM PROCEDURES

WHAT YOU SHOULD DO AND WHAT YOU SHOULD EXPECT IF YOU HAVE A CLAIM

All claims and questions regarding health claims should be directed to the Administration Office (Welfare & Pension Administration Service, Inc.). The Trustees shall be ultimately and finally responsible for providing full and fair review of the decision on such claims in accordance with the following provisions and with the Employee Retirement Income Security Act of 1974, as amended (ERISA). Benefits under the Plan will be paid only if the Administration Office decides in its discretion that the participant is entitled to them. The responsibility to process claims in accordance with the Summary Plan Description is delegated to the Administration Office.

Each participant claiming benefits under the Plan shall be responsible for supplying, at such times and in such manner as the Administration Office in its discretion may require, written proof that the expenses were incurred or that the benefit is covered under the Plan. If the Administration Office determines that the participant has not incurred a covered expense or that the benefit is not covered under the Plan, or if the participant fails to furnish such proof as required, no benefits shall be payable under the Plan.

For purposes of the Plan's claims procedures, you will be considered to have filed your claim under the Plan when your claim form or written statement is received at the Administration Office.

Disability claims must be filed with the Administration Office as soon as possible, however all claims must be submitted to the Administration Office within one year from the date expenses are incurred. No claim will be considered for payment if it is submitted more than one year after the service is rendered.

TIMING OF CLAIM DECISIONS

The Administration Office shall notify the participant, in accordance with the provisions set forth below, of any adverse benefit determination within the following timeframes:

The Administration Office has 45 days from the date your claim is filed to determine whether or not benefits are payable to you in accordance with the terms and provisions of the Plan, and, if so, the amount of benefits. If more time is needed to review your claim, the Administration Office must notify you in writing that the review period has been extended. The extension notice will describe the circumstances requiring the extension, the expected date of a decision, the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision on your claim, and the additional information needed to resolve those issues. This extension may be for up to 30 days beyond

the end of the normal 45-day review period. A second 30-day extension may apply if, for reasons beyond the Plan's control, additional time, beyond the first 30-day extension, is needed to review your claim. In this case, the Administration Office will notify you in writing that the review period has been further extended. The Administration Office will provide the same information required in the first notice of extension.

If an extension of the review period is made because you must furnish additional information in order for the Administration Office to decide your claim, the Administration Office will specify the additional information that is needed in the extension notice. You will have at least 45 days to return the specified information to the Administration Office. Until you return that information (or the time to provide the information expires), the review period will be "tolled," further extending the review period beyond the normal 45-day period or the extended 75- or 105-day period. For example, if the Administration Office advises you on the 20th day after your claim was filed that your claim is incomplete because it lacks a physician's statement regarding your ability to perform various tasks, the number of days from the date of the Administration Office's request for the physician's statement until you provide the physician's statement will not count as part of the review period. In this example, the day you provided the physician's statement will be treated as the 21st day of the review period.

Calculating Time Periods

The period of time within which a benefit determination is required to be made shall begin at the time a claim is deemed to be filed in accordance with the procedures of the Plan.

NOTIFICATION OF AN ADVERSE BENEFIT DETERMINATION

The Administration Office shall provide a participant with a notice, either in writing or electronically, containing the following information:

1. A reference to the specific portions(s) of the Summary Plan Description upon which a denial is based;
2. Specific reason(s) for a denial;
3. A description of any additional information necessary for the participant to perfect the claim and an explanation of why such information is necessary;
4. A description of the Plan's review procedures and the time limits applicable to the procedures, including a statement of the participant's right to bring a civil action under Section 502(a) of ERISA following an adverse benefit determination on final review;
5. A statement that the participant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents,

records and other information relevant to the participant’s claim for benefits;

6. Any rule, guideline, protocol or similar criterion that was relied upon in making the determination (or a statement that is was relied upon and that a copy will be provided to the participant, free of charge, upon request); and
7. In the case of denials based upon a medical judgment (such as whether the treatment is Medically Necessary or Experimental or Investigational), either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the participant’s medical circumstances, or a statement that such explanation will be provided to the participant, free of charge, upon request.

APPEALS OF ADVERSE BENEFIT DETERMINATION

Full and Fair Review of All Claims

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

1. Participants 180 days following notification of an adverse benefit determination within which to appeal the determination;
2. Participants the opportunity to submit written comments, documents, records, and other information relating to the claim for benefits;
3. For a review that does not afford deference to the previous adverse benefit determination and that is conducted by an appropriate named fiduciary of the Plan, who shall be neither the individual who made the adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual;
4. For a review that takes into account all comments, documents, records and other information submitted by the participant relating to the claim, without regard to whether such information was submitted or considered in any prior benefit determination;
5. That, in deciding an appeal of any adverse benefit determination that is based in whole or in part upon a medical judgment, the Plan fiduciary shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment, who is neither an individual who was consulted in

connection with the adverse benefit determination that is the subject of the appeal, nor the subordinate of any such individual;

6. For the identification of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a claim, even if the Plan did not rely upon their advice; and

7. That a participant will be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the participant's claim for benefits in possession of the Administration Office; any internal rule, guidelines, protocol or other similar criterion relied upon in making the adverse determination; and any explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the participant's medical circumstances.

APPEAL LEVEL

Requirements for Appeal

The participant must file the appeal in writing within 180 days following receipt of the notice of an adverse benefit determination. To file an appeal in writing, the participant's appeal must be addressed as follows:

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

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

1. The name of the employee;

2. The employee's social security number;

3. All facts and theories supporting the claim for benefits. Failure to include any theories or facts in the appeal will result in them being deemed waived. In other words, the participant will lose the right to raise factual arguments and theories which support this claim if the participant fails to include them in the appeal.

4. A statement in clear and concise terms of the reason or reasons for disagreement with the handling of the claim; and

5. Any material or information that the insured has which indicates that the participant is entitled to benefits under the Plan.

If the participant provides all of the required information, it may be that the expenses will be eligible for payment under the Plan.

Timing and Notification of Benefit Determination on Appeal

The Administration Office shall notify the participant of the Plan's benefit determination on review within 45 days from the date it receives the appeal.

The period of time within which the Plan's determination is required to be made shall begin at the time an appeal is filed in accordance with the procedures of this Plan, without regard to whether all information necessary to make the determination accompanies the filing.

Under special circumstances, the Administration Office may require more time to review your claim. If this should happen, the Administration Office must notify you, in writing, that its appeal review period has been extended for an additional 45 days, noting the special circumstances requiring the extension and the date by which a decision on the appeal is expected.

If an extension of the appeal review period is made because you must furnish additional information in order for the Plan to decide your appeal, the Administration Office will specify the additional information that is needed in the extension notice. You will have at least 45 days to return the specified information to the Administration Office. Until you return that information (or the time to provide the information expires), the review period will be "tolled," further extending the review period beyond the normal 45-day period.

Manner and Content of Notification of Adverse Benefit Determination on Appeal

The Administration Office shall provide a participant with notification, in writing or electronically, of a Plan's adverse benefit determination on review, setting forth:

1. The specific reason(s) for the denial;
2. Reference to the specific portions(s) of the Summary Plan Description upon which a denial is based;
3. The identity of any medical or vocational experts consulted in connection with a claim, even if the Plan did not rely upon their advice;
4. A statement that the participant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the participant's claim for benefits;
5. If an internal rule, guideline, protocol or similar criterion was relied upon in making the adverse determination, a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of the rule, guideline,

protocol, or other similar criterion will be provided free of charge to the participant, upon request.

6. If the adverse benefit determination is based upon a medical judgment, a statement that an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the participant's medical circumstances, will be provided free of charge upon request.
7. A description of any additional information necessary for the participant to perfect the claim and an explanation of why such information is necessary;
8. A description of the Plan's review and arbitration procedures an the time limits applicable to the procedures;
9. A statement of the participant's right to bring a civil action under Section 502(a) of ERISA following an adverse benefit determination on final review; and
10. The following statement: "You and your Plan may have other voluntary alternative dispute resolution options, such as mediation and arbitration. One way to find out what may be available is to contact your local US Department of Labor Office and your state insurance regulatory agency."
11. You have a right to bring a lawsuit in US federal court to review or dispute any denial of claim of benefits. All claim review procedures provided for in the Plan must be exhausted before any legal action is brought.

Furnishing Documents in the Event of an Adverse Determination

In the case of an adverse benefit determination on review, the Administration Office shall provide such access to, and copies of, documents, records, and other information described in items 3 through 7 of the section relating to Manner and Content of Notification of Adverse Benefit Determination on Appeal as appropriate.

ARBITRATION APPEAL LEVEL

Adverse Decision on Appeal; Request for Arbitration

As an alternative to filing a lawsuit in US federal court, upon receipt of the notice of the Plan's adverse decision regarding the first appeal, the participant has 60 days to file notice of arbitration for any appeal denial of benefits. The participant again is entitled to a "full and fair review" of any denial made at the appeal, which means the participant has the same rights during the arbitration as he or she had during the appeal. The question for the arbitrator shall be (1) whether the Trustees were in error upon an issue of law, (2) whether the Trustees acted

arbitrarily or capriciously in the exercise of their discretion or (3) whether their findings of fact are supported by substantial evidence.

As with the appeal, the participant's request for arbitration must be in writing and must include all of the items set forth in the section entitled Requirements for Appeal.

Timing of Notification of Benefit Determination on Second Appeal

The Administration Office shall notify the participant of the Plan's referral of appeal review to the American Arbitration Association within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after receipt of the notice.

Arbitration Costs

All costs and fees for arbitration will be borne by the Plan. Participants will pay for their own costs or fees for an attorney.

Arbitration Final

The decision by the arbitrator will be binding and conclusive and will be afforded the maximum deference permitted by law.

ALASKA LABORERS-CONSTRUCTION INDUSTRY HEALTH AND SECURITY FUND

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW YOUR MEDICAL INFORMATION MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
PLEASE REVIEW THIS NOTICE CAREFULLY.

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 PHI 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

PHI generally means information that: (1) is created or received by a health care provider, health plan, employer, or health care clearing house; 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, to determine benefit responsibility under the Plan, or to coordinate Plan coverage. For example, the Trust may use health information to pay your claims or share information regarding your coverage or health care treatment with other health plans to coordinate payment of benefits. The Trust may also share your protected health

information with another entity to assist in the adjudication of reimbursement of your health claims.

To Facilitate Treatment: The Trust may disclose information to facilitate treatment which involves providing, coordinating or managing health care or related services. For example, the Trust may disclose the name of your treating Physician to another Physician so that the Physician may ask for your x-rays.

To Conduct Health Care Operations: The Trust may use or disclose health information for its own operations, to facilitate the administration of the Trust and as necessary to provide coverage and services to all of the Trust's Participants.

Health care operations include: making eligibility determinations; contacting health care providers; providing Participants with information about health-related issues or treatment alternatives; developing clinical guidelines and protocols; conducting case management; medical review and care coordination; handling claim appeals; reviewing health information to improve health or reduce health care costs; participating in drug or disease management activities; conducting underwriting; premium rating or related functions to create, renew or replace health insurance or health benefits; and performing the general administrative activities of the Trust (such as providing customer service, conducting compliance reviews and auditing, responding to legal matters and compliance inquiries, handling quality assessment and improvement activities, business planning and development including cost management and planning-related analyses and formulary development, and accreditation, certification, licensing or credentialing activities). For example, the Trust may use your health information to conduct case management of ongoing care or to resolve a claim appeal you file.

For Disclosure to the Plan Trustees: The Trust may disclose your health information to the Board of Trustees (which is the Plan sponsor) and to necessary advisors which assist the Board of Trustees in performing Plan administration functions, such as handling claim appeals. The Trust also may provide Summary Health Information to the Board of Trustees so that it may solicit bids for services or evaluate its benefit plans.

Summary Health Information is information which summarizes Participants' claims information but from which names and other identifying information have been removed. The Trust may also disclose information about whether you are participating in the Trust or one of its available options.

For Disclosure to You or Your Personal Representative: When you request, the Trust is required to disclose to you or your personal representative your protected health information that contains medical records, billing records, and

any other records used to make decisions regarding your health care benefits. Your personal representative is an individual designated by you in writing as your personal representative, attorney-in-fact. The Trust may request proof of this designation prior to the disclosure. Also, absent special circumstances, the Trust will send all mail from the Trust to the individual's address on file with the Trust Administration Office. You are responsible for ensuring that your address with the Trust Administration Office is current. Although mail is normally addressed to the individual to whom the mail pertains, the Trust cannot guarantee that other individuals with the same address will not intercept the mail. You have the right to request restrictions on where your mail is sent as set forth in the request restrictions section below.

Disclosure Where Required By Law: In addition, the Trust will disclose your health information where applicable law requires. This includes:

1. *In Connection With Judicial and Administrative Proceedings.* The Trust may disclose your health information to a health oversight agency for authorized activities (including audits; civil; administrative or criminal investigations; inspections; licensure or disciplinary action); government benefit programs for which health information is relevant; or to government agencies authorized by law to receive reports of abuse, neglect or domestic violence as required by law. The Trust, however, may not disclose your health information if you are the subject of an investigation and the investigation does not arise out of or is not directly related to your receipt of health care or public benefits.

2. *When Legally Required and For Law Enforcement Purposes.* The Trust will disclose your protected health information when it is required to do so by any federal, state or local law. Additionally, as permitted or required by state law, the Trust may disclose your health information to a law enforcement official for certain law enforcement purposes, such as identifying a suspect or to provide evidence of criminal conduct.

3. *To Conduct Public Health and Health Oversight Activities.* The Trust may disclose your protected health information to a health oversight agency for authorized activities (including audits, civil administrative or criminal investigations, inspections, licensure or disciplinary action), government benefit programs for which health information is relevant, or to government agencies authorized by law to receive reports of abuse, neglect or domestic violence as required by law. The Trust, however, may not disclose your health information if you are the subject of an investigation and the investigation does not arise out of or is not directly related to your receipt of health care or public benefits.

4. *In the Event of a Serious Threat to Health or Safety.* The Trust may, consistent with applicable law and ethical standards of conduct, disclose your health information if the Trust, in good faith, believes that such disclosure is necessary to prevent or lessen a serious and imminent threat to your health or safety or to the health and safety of the public. For example, the Trust may disclose evidence of a threat to harm another person to the appropriate authority.

5. *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.

6. *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.

AUTHORIZATION TO USE OR DISCLOSE HEALTH INFORMATION

Other than as stated above, the Trust will not disclose your health information without your written authorization.

Generally, you will need to submit an Authorization if you wish the Trust to disclose your health information to someone other than yourself. Authorization forms are available from the Privacy Contact Person listed below.

If you have authorized the Trust to use or disclose your health information, you may revoke that Authorization in writing at any time. The revocation should be in writing, include a copy of or reference to your Authorization and be sent to the Privacy Contact Person listed below.

Special rules apply about disclosure of psychotherapy notes. Your written Authorization generally will be required before the Trust will use or disclose psychotherapy notes. Psychotherapy notes are a mental health professionals separately filed notes which document or analyze the contents of a counseling session. Psychotherapy notes do not include summary information about your mental health treatment or information about medications, session stop and start times, the diagnosis and other basic information. The Trust may use and disclose psychotherapy notes when needed to defend against litigation filed by you or as necessary to conduct Treatment, Payment and Health Care Operations.

Additionally, 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

You have the following rights regarding your health information that the Trust maintains:

Right to Request Restrictions: You may request restrictions on certain uses and disclosures of your health information. You have the right to request a limit on the Trust's disclosure of your health information to someone involved in payment for your care. However, the Trust is not required to agree to your request unless the disclosure at issue is to another health plan for the purpose of carrying out payment or health care operations and your health care provider has been paid by you out-of-pocket and in full.

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 proceeding. The Trust may deny your request in certain situations subject to your right to request review of the denial. A request to inspect and copy records containing your health information must be made in writing to the Privacy Contact Person listed below. 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. Notwithstanding the foregoing, the fee for a copy of your health information in electronic format shall not be greater than the Trust's labor costs in responding to the request.

Right to Receive Confidential Communications: You have the right to request that the Trust communicate with you in a certain way if you feel the disclosure of your health information through regular procedures could endanger you. For example, you may ask that the Trust 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 Contact Person listed below. The Trust will attempt to honor reasonable requests for confidential communications.

Right to Amend the Your Health Information: If you believe that your health information records are inaccurate or incomplete, you may request that the Trust amend the records. That request may be made as long as the information is maintained by the Trust. A request for an amendment of records must be made in writing to the Trust's Privacy Contact Person listed below. The Trust may deny the request if it does not include a reasonable reason to support the amendment.

The request also may be denied if your health information records were not created by the Trust, if the health information you are requesting to amend is not part of the Trust's records, if the health information you wish to amend falls within an exception to the health information you are permitted to inspect and copy, or if the Trust determines the records containing your health information are accurate and complete.

Right to an Accounting: You have the right to request a list of disclosures of your health information made by the Trust. The request must be made in writing to the Privacy Contact Person. The request should specify the time period for which you are requesting the information. No accounting will be given of disclosures made: to you or any one authorized by you; for Treatment, Payment or Health Care Operations; disclosures made before April 14, 2003; disclosures for periods of time going back more than six years; or in other limited situations. The Trust will provide the first accounting you request during any 12-month period without charge. Subsequent accounting requests may be subject to a reasonable cost-based fee. The Trust will inform you in advance of the fee, if applicable.

Right to Opt Out of Fundraising Communications. If the Trust participates in fundraising, you have the right to opt-out of all fundraising communications.

Right to a Paper Copy of this Notice: You have a right to request and receive a paper copy of this Notice at any time, even if you have received this Notice previously or agreed to receive the Notice electronically. To obtain a paper copy, please contact the Privacy Contact Person listed below. If this Notice is modified, you will be mailed a new copy. You will also be able to obtain a copy of the current version of the Trust's Notice at its web site, www.aklaborerstrust.com.

Privacy Contact Person/Privacy Official: To exercise any of these rights related to your health information you should contact the Privacy Contact Person listed below. The Trust has also designated a Privacy Official to oversee its compliance with the Privacy Rules who is also listed below.

Privacy Contact Person
Assistant Claims Manager
c/o Welfare & Pension Administration Service, Inc.
P.O. Box 34203
Seattle, WA 98124-1203
Toll Free: 800-331-6158
Fax No: 206-441-9110

Privacy Official
Heidi Campbell
c/o Welfare & Pension Administration Service, Inc.
P.O. Box 34203
Seattle, WA 98124-1203
Toll Free: 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 Contact Person 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.

EFFECTIVE DATE

This Notice was originally effective **April 14, 2003**, as amended September 3, 2013**.**

SPECIAL REPORTING AND DISCLOSURE REQUIREMENTS

NAME AND IDENTIFICATION OF PLAN

The Employer Identification number and Plan Number assigned to this Plan by the Internal Revenue Service are:

> Alaska Laborers-Construction Industry Health & Security Fund
> EIN 91-6028565, PN 501

BOARD OF TRUSTEES

The Plan is operated by a joint labor-management Board of Trustees, with the assistance of administrative agents. The name, address, and telephone number of the administrative agents are:

> Alaska Laborers-Construction Industry Trust Funds
> Welfare & Pension Administration Service, Inc.
> 2815 Second Avenue, Suite 300
> PO Box 34203
> Seattle, WA 98124-1203
> (855) 815-2323

> Labor Trust Services, Inc.
> 375 West.36th Avenue, Suite 200
> PO Box 93870
> Anchorage, AK 99509-3870
> (907) 561-5119
> (855) 815-2323

MEMBERS OF THE BOARD OF TRUSTEES

This Trust is administered and maintained by a labor-management Board of Trustees. The names and addresses of the Trustees as of the printing of this booklet are as follows:

Employer Trustees	Union Trustees
Derald Schoon, Chairman Unit Company 620 Whitney Road, Suite 1 Anchorage, Alaska 99501-1622	Dan Simien, Secretary Laborers Local No. 942 2740 Davis Road Fairbanks, Alaska 99709-5231
Steve Geraghty Great Northwest, Inc. PO Box 74646 Fairbanks, Alaska 99707-4646	Brandon Calcaterra Laborers Local No. 341 2501 Commercial Drive Anchorage, Alaska 99501-3049

Mike Brady
Ken Brady Construction, Inc.
4001 Turnagain Blvd. E
Anchorage, AK 99517-2419

Jaysen Mathiesen
M-AK Construction, LLC
PO Box 241568
Anchorage, AK 99524-1568

Augustine J. Merrick II
Laborers Local No. 341
2501 Commercial Drive
Anchorage, AK 99501-3049

Kevin Pomeroy
Laborers Local No. 942
2740 Davis Road
Fairbanks, AK 99709-5231

LEGAL COUNSEL

The name and address of the Fund's legal counsel is:

Jermain, Dunnagan & Owens
3000 A Street, Suite 300
Anchorage, AK 99503-4040

AGENT FOR SERVICE OF LEGAL PROCESS

Any member of the Board of Trustees, the Administrative Agents (Welfare & Pension Administration Service, Inc., or Labor Trust Services, Inc.) and the Attorney (Jermain, Dunnagan & Owens) are agents for the purposes of accepting service of legal process on behalf of this Plan.

TYPE OF PLAN

This Plan is an employee welfare benefit plan which provides disability income for employees; and death, medical, audio, dental and vision benefits for employees and families.

TYPE OF ADMINISTRATION

The Plan is administered by the Board of Trustees with the assistance of Welfare & Pension Administration Service, Inc., and Labor Trust Services, Inc., contract administrative organizations.

DESCRIPTION OF COLLECTIVE BARGAINING AGREEMENTS

This Plan is maintained under several Collective Bargaining Agreements between contributing employers and Alaska State District Council of Laborers and Laborers' Locals 341 and 942, and Plasterers' and Cement Masons' Local 867, which control the duties, rights and benefits under the Plan. These Collective Bargaining Agreements, along with a list of participating employers, can be examined at the Administration Office.

FUNDING MEDIUM

This Plan is funded through the payment by employers at the negotiated contribution rate. Life insurance, accidental death and dismemberment, and stop loss coverages under this Plan are provided under an insurance contract. All other benefits are self-funded by the Health & Security Fund.

PLAN AMENDMENT

The Board of Trustees of the Alaska Laborers-Construction Industry Health & Security Fund reserves the right to amend all or any part of this Plan or any Component Plan at any time; to amend any contract providing insured benefits or other services; and to remove or change any insurance company or service company at any time.

Any amendment must be in writing and shall be effective upon adoption by the Board of Trustees, or at any such time as may be otherwise specified in the amendment, unless prohibited by applicable law.

TERMINATION

The Board of Trustees of the Alaska Laborers-Construction Industry Health & Security Fund reserves the right to terminate the Plan at any time, and to terminate any Component Plan and any contract providing insured benefits or other services. If a Component Plan is terminated and replaced with another plan that provides similar benefits, any wage reduction amounts that were designated to pay premiums and/or monthly coverage costs for the terminated plan will be applied instead to pay premiums and/or monthly coverage costs for the new plan.

PLAN YEAR

The fiscal year of this fund ends June 30. The Plan year, however, ends December 31.

YOUR RIGHTS UNDER ERISA

As a participant in the Alaska Laborers-Construction Industry Health & Security Fund, 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:

1. Examine without charge, at the Administration Office, all Plan documents, including insurance contracts, collective bargaining agreements and copies of all document filed by the plan and with the US Department of Labor, such as annual reports and plan descriptions.
2. Obtain copies of all Plan documents and other Plan information upon written request to the Administration Office. The Administration Office may make a reasonable charge for copies.
3. Receive a summary of the Plan's annual financial report. The Administration Office is required by law to furnish each participant with a copy of this summary financial report.

In addition to creating rights for Plan participants, ERISA imposes obligations upon the persons who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called fiduciaries of the Plan, have the 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 to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan and do not receive them within 30 days, you may file suit in federal court. In such a case, the court may require the Administration Office to provide the materials and pay you up to $100 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administration Office.

If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. If 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 US Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to

pay these costs and fees. If you lose, the court may order you to pay these costs and fees; for example, if it finds your claim is frivolous.

If you have any questions about this statement of your rights under ERISA, you should contact the Administration Office or the nearest Area Office of the US Labor-Management Service Administration, Department of Labor.

HOW TO APPEAL YOUR CLAIM FOR BENEFITS IF THEY ARE DENIED

Complete details regarding filing of claims and appeals can be found in the Claims Submission and Appeal Procedures section of this booklet.

AVAILABILITY OF INFORMATION

Plan documents and all other pertinent documents required to be made available under ERISA are available for each of the Trusts for inspection at the Administration Office during regular business hours. Upon written request, copies of these documents will be provided. However, the Trustees may make a reasonable charge for the copies; the Administration Office will state the charge for specific documents on request so you will know the cost before ordering.

DEFINITIONS

Calendar Year – January 1 through December 31.

Credited Hours – hours worked for which the Trust has received contributions on your behalf from your employer.

Experimental or Investigational means that:

- The drug or device cannot be lawfully marketed without the approval of the US Food and Drug Administration and approval for marketing has not been given for regular nonexperimental or noninvestigational purposes at the time the drug or device is furnished;
- The drug, device, medical treatment, or procedure has been determined to be an Experimental or Investigational procedure by the treating facility's Institutional Review Board or other body servicing a similar function, and the patient has signed an informed consent document acknowledging such experimental status;
- Federal law classifies the drug, device or medical treatment under the investigative program;
- Reliable evidence shows that the drug, device, medical treatment or procedure is the subject of on-going Phase I, II, III or IV 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; or
- Reliable evidence shows that the prevailing opinion among experts regarding the drug, device, medical treatment or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with standard means of treatment or diagnosis.

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.

Hospital Confinement – a Medically Necessary hospital stay of 24 consecutive hours or more in any single or multiple departments or parts of a hospital for the purpose of receiving any type of medical service. These requirements apply even if the hospital does not charge for daily room and board. How the hospital classified the stay is irrelevant.

Any Hospital Confinement satisfying this definition will be subject to all Plan provisions relating to inpatient hospital services or admissions, including any applicable preadmission review requirements. Hospital stays or services not satisfying this definition will be considered under the Plan provisions for outpatient services.

Lag Month – the time between when hours are worked and when eligibility is earned. The Lag Month is required so the Administration Office can process the employer reports. The Lag Month this always a full calendar month (e.g. March 1 though March 31).

Total Disability, Totally Disabled or Disabled means for health coverage, that because of an injury or sickness:

- you are completely and continuously unable to perform the material and substantial duties of your regular occupation and are not engaging in any work or occupation for wages or profit; or
- your dependent is:
  - whether physically or mentally unable to perform all of the usual and customary duties and activities (the "normal activities") of a person of the same age and gender who is in good health; and
  - not engaged in any work or occupation for wages or profit.

Physician – a licensed practitioner who is acting within the scope of his/her license and providing a service covered under the Plan. Physicians may include:

- A doctor of medicine (MD), osteopathy (DO), podiatry (DPM), or chiropractic (DC);
- A licensed doctoral clinical psychologist;
- A Master's level counselor and licensed or certified social worker who is acting under the supervision of a doctor of medicine or a licensed doctoral clinical psychologist;
- A licensed marital and family therapist (LMFT);
- A licensed physician's assistant (PA);
- A licensed advanced nurse practitioner
- A therapist with a MA who is licensed as a professional counselor (LPC);
- Licensed midwife or registered nurse midwife.

A physician does not include a person who lives with you or is part of your family (you, your spouse, or a child, brother, sister or parent of you or your spouse).