Alaska Pipe Trades Association
U. A. Local No. 375

PARTICIPANT
PLAN BOOKLET AND SUMMARY
PLAN DESCRIPTION

Health and Security
Trust Fund

October 2015

KEY CONTACTS

If you have questions about these topics…	See Pages…	Contact…
Eligibility ▪ Active ▪ Self-Pay ▪ Retiree **Hour Bank Status**	**7 - 20** **7 - 8**	Welfare & Pension Administration Service, Inc. In Seattle: (206) 441-7574 Toll-free: (800) 732-1121, opt. 4
Health Care Plans ▪ Medical benefits ▪ Dental benefits ▪ Vision benefits	**22 – 47**	**Welfare & Pension Administration Service, Inc.** In Seattle: (206) 441-7574, opt. 0 Toll-free: (800) 331-6158, opt. 0
Health Care Claims ▪ Submitting claims ▪ Checking on claim status ▪ Appealing a denied claim **Where to mail claims:** Dental, Member Paid and Medicare claims: Alaska Pipe Trades P.O. Box 34687 Seattle, WA 98124-1687 Medical and Vision claims: Aetna P.O. Box 981106 El Paso, TX 79998-1106	**48 – 49**	**Claims Administration Office** Welfare & Pension Administration Service, Inc. **Claims questions:** Toll-free: (800) 331-6158, opt. 0 In Seattle: (206) 441-7574, opt. 0
Surgery/Mental Health Precertification	**28 – 31**	**Qualis Health** (800) 783-8606 7 a.m.– 4 p.m. Alaska Standard Time
Chemical Dependency Treatment Precertification	**30 - 31**	**Magellan Behavioral Health** Toll-free: (800) 478-2812 In Anchorage: (907) 562-2812
Life & AD&D Insurance ▪ Benefits ▪ Filing claims **Where to mail claims:** Alaska Pipe Trades P.O. Box 34687 Seattle, WA 98124-1687	**53 – 54**	**Welfare & Pension Administration Service, Inc.** In Seattle: (206) 441-7574, opt. 4 Toll-free: (800) 732-1121, opt. 4
Administrative ▪ Benefit enrollment forms ▪ Family status changes ▪ Address changes		**Local 375 Union Office** (907) 479-6221

WELCOME!

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

The Health and Security Trust provides you and your family with excellent health care benefits.

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

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

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

Did You Know?

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

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

TAKE ACTION

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

- **Read this Plan Booklet to understand your choices and compare your options.**
- **Look for "KEY POINTS" and "WHAT YOU NEED TO DO" for important information you need to know.**
- **Discuss your benefit needs and choices with your spouse (if applicable).**
- **If you have questions, request additional information.**
- **Keep this Plan Booklet on hand for future reference.**

AUTHORITY TO INTERPRET AND CHANGE THE PLAN

The Board of Trustees has the exclusive authority to interpret the provisions of the Plan, to determine eligibility for an entitlement to Plan benefits or to amend the Plan.

Any interpretation or determination by the Trustees made in good faith, which is not contrary to law, is conclusive on all persons affected.

The Board of Trustees has delegated to the Claims Administration Office and the Local 375 Union Office the authority to administer the Plan and provide information relating to the amount of benefits, eligibility and other Plan provisions.

In administering the Plan, the Claims Administration Office and any medical review organization used by the Trust may utilize its internal guidelines and medical protocols in determining whether or not specific services or supplies are covered under the terms of the Plan.

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

The Trustees reserve the right to make any changes they deem necessary to promote efficiency, economy and better service for the Participants and their covered dependents. The Trustees have no obligation to furnish benefits beyond those that can be provided by the Trust Fund. The Plan, including retiree benefits, is provided to the extent that money is currently available to pay the cost of such programs.

Grandfathered Status

Under the Affordable Care Act, this Plan is a grandfathered health plan.

As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain parts of its health plan coverage already in effect when that law was enacted on March 23, 2010.

Being a grandfathered health plan means that this Plan will continue to apply certain Plan limitations, such as cost sharing for preventive health services.

This Plan must comply with certain other consumer protections in the Affordable Care Act, including the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the Claims Administration Office at (800) 331-6158.

You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at (866) 444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

TABLE OF CONTENTS

Health Care Benefit Claims

Life and AD&D Insurance

Plan Administration

Your Rights

Glossary

Health Trust Information

ELIGIBILITY AND ENROLLMENT

Active Participants

Hour Bank Eligibility Provisions

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

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

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

KEY POINT

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

Continued Eligibility

Each month after satisfying the initial eligibility requirements, 135 hours will be deducted from a Participant's Hour Bank to maintain coverage under the Plan. A Participant will continue to be covered as long as he or she has 135 hours or more in his or her Hour Bank.

Lag Month

To provide sufficient time for receiving and processing employer reports, a lag month is used in determining the monthly eligibility. The work month is the month hours are actually worked, the reporting month is the following month (lag month), and the eligibility month is the month of coverage as described below. For instance, if you worked sufficient hours in January, you will be covered in March.

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

When Active Coverage Terminates

Coverage for active Participants terminates:

- At the end of the second calendar month following the calendar month during which the Participant's Hour Bank is reduced to less than 135 hours.
- On the date the Plan ceases to provide benefits.
- For associate Employees, on the last day of the month prior to the month for which contributions are not received.

If a Participant does not accumulate any hours in his or her Hour Bank for four consecutive months after dropping below 135 hours, those hour credits will revert to the Trust on the first day of the fifth month, unless the Participant elects the Self-Pay Provision. The Participant must then reestablish eligibility as a new Participant.

Reinstatement of Eligibility

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

KEY POINT

If the Participant elects the Self-Pay Provision, his or her hour credits will remain in his or her Hour Bank during any period of continuous self-payment.

If you elect a Self-Pay option provided by the Plan, your hour credits will remain in your Hour Bank during the period you self-pay for coverage. At the end of the self-payment period, the hour credits in your Hour Bank account will remain in your Hour Bank account for four months. At the end of four months your Hour Bank will terminate, unless enough paid hour credits have been added to the Hour Bank to raise the hours above 135.

Active Participants Not Covered under Hour Bank Eligibility Rules

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

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

Continuation Rights for Active Participants

Continuation coverage for active Participants who have lost eligibility may be continued in certain circumstances. See the section on page 11 regarding Inactive Participants and Dependents: Continuation and Self-Pay Plans.

Reciprocity Eligibility Provisions

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

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

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

KEY POINT

Under the "United Association Health and Welfare Fund Reciprocal Agreement," you retain your eligibility and benefits under the Alaska Pipe Trades U.A. Local 375 Health Trust, even though you are working in another U.A. jurisdiction.

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

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

For example, if you were to work in a jurisdiction requiring contributions of $4.50 per hour, the hours submitted to the U. A. Local No. 375 Health and Security Trust Fund would be adjusted according to the current Local 375 contribution rate.

- Reciprocal Trust rate $4.50 per hour remits 180 hours X $4.50 = $810;
- $810 divided by Local 375 Trust $4.05 per hour = 200 hours reported;
- The resultant hours will be credited in your Hour Bank Account.

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

Dependent Eligibility

Your eligible dependents include only your:

- Legal spouse
- Natural children, stepchildren, adopted children and children placed with you for adoption who reside with you, the member, in a regular parent–child relationship, foster children, children for whom you have legal custody, children:
  - From birth to age 26.
  - Who attain age 26 while covered under this program and who are incapable of self-sustaining employment by reason of developmental disability or physical handicap. Proof of such incapacity and dependency must be furnished to the Plan Administrator within 31 days of the child's attainment of age 26 and periodically thereafter as the Plan Administrator may require.

KEY POINT

Your dependents become eligible on the date you become eligible. New dependents become eligible when they acquire dependent status, as defined on page 10.

Qualified Medical Child Support Order (QMCSO)

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

- Provides child support or health benefit coverage to a dependent child, or
- Enforces a state law relating to medical child support pursuant to Section 1908 of the Social Security Act, which provides in part that if the Participant does not enroll the dependent child, then the non-Participant parent or state agency may enroll the child.

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

- The name and last known mailing address of the Participant,
- The name and mailing address of each dependent child covered by the order or the name and mailing address of the state official issuing the order,
- A description of the type of coverage to be provided by the Plan to each such dependent child,
- The period of coverage to which the order applies, and
- The name of each Plan to which the order applies.

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

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

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

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

A properly completed National Medical Support Notice issued by a state agency shall be deemed to be a Qualified Medical Child Support Order. Within a reasonable time, the Participant and each child named

in the order will be notified of the decision. A notice will also be sent to each attorney or other representative named in the order or accompanying correspondence.

If the order is not qualified, the notice will give the specific reason for the decision. The party or parties filing the order will be given an opportunity to correct the order or appeal the decision through the claims review procedures explained in this booklet.

If the order is qualified, the notice will give instructions for enrolling each child named in the order. A copy of the entire Qualified Medical Child Support Order and any required self-payments must be received prior to enrollment. Any child or children enrolled pursuant to an order will be subject to all provisions applicable to dependent coverage under the Plan.

TAKE ACTION

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

Enrolling Your Dependents

The Plan does not have an open enrollment period.

If you have eligible dependents, it will be necessary to include your dependent information on the enrollment form. An enrollment form for your current dependents should be submitted within 30 days of your enrollment in order to avoid delay in processing claims.

If you acquire a new dependent while you have coverage, a new enrollment form must be completed and submitted along with the appropriate documentation. You should complete a new enrollment form and supply an appropriate marriage or birth certificate within 30 days of your marriage, birth, adoption or placement for adoption. Submit the new enrollment form to the Local, even if the required documentation is not yet available.

TAKE ACTION

If you acquire a dependent while you have coverage, you should complete a new enrollment form within 30 days and supply an appropriate marriage or birth certificate.

When Dependent Coverage Begins

- Eligibility for your dependents will be effective:
  - On the date you become covered for your current dependents.
  - On the date of birth, adoption, placement for adoption, on date of foster child legal custody, on date of marriage for stepchildren. If enrollment is not requested and received within 30 days, claims will be pended until all required documentation has been received.
  - On the first day of the first calendar month beginning after the date the completed enrollment is received in the case of marriage.
- If your coverage has lapsed, your dependent's coverage will begin on the first day of the month when you again have coverage.
- A newborn child becomes covered as set forth above from birth providing your coverage has not lapsed. Claims will be pended until all required documentation has been received by the Trust.

If Your Dependent is Eligible for Medical Coverage Through Another Employer

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

Your spouse will not be disqualified from receiving coverage under an Alaska Pipe

Trades U. A. Local No. 375 Health and Security Trust Fund, if your spouse is eligible for other medical coverage and enrolls in it.

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

When Dependent Coverage Terminates

Coverage for an individual dependent terminates:

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

Continuation Rights for Dependents

Continuation coverage for dependents who have lost eligibility may be continued in certain circumstances. See page 12 for information regarding Inactive Participants and Dependents: Continuation and Self-Pay Plans.

Inactive Participants and Dependents: Continuation and Self-Pay Plans

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

KEY POINT

During any month in which your Hour Bank falls below 135 hours, you may continue under the Plan by making the required self-pay contribution for your coverage.

Four-Year Rule: Indefinite Self-Pay Privilege

If your eligibility for benefits has been determined according to the Hour Bank eligibility rules as noted on Page 7, you have been a continuously covered Hour Bank Participant for four or more years, you are eligible for and receiving a pension from Alaska Plumbing and Pipefitting Industry Pension (normal, early or disability), and have a minimum of 25,000 hours immediately prior to applying for self-pay status, you may self-pay indefinitely. This indefinite self-pay privilege runs concurrently with COBRA.

TAKE ACTION

You must enroll immediately upon losing active coverage to take advantage of the "Four-Year Rule."

A delayed application will only be accepted if you:

- Had four or more years of continuous Hour Bank coverage but then lost that coverage because of a disability verified by a medical doctor;
- Lost your ability for indefinite self-paid coverage solely because you attempted to return to work but were unable within six months from your loss of four years of continuous Hour Bank coverage through self-pay; and
- Were unable to remain at work because of the disability.

Payments

Your contribution for this coverage must be received at the Local Union Office by the last day of the month prior to the month for which you are applying for coverage (i.e., May coverage must be received by April 30).

The Local Union Office will be able to advise you of the amount to be paid. It is your responsibility to obtain this information and to make timely payments.

Late payment will result in loss of coverage.

Indefinite Self-Pay Plan Selections

When your coverage would otherwise terminate, you will have the option to choose from the available self-pay plans. You are required to self-pay the full cost for these plans. Contact the Administration Office for rates and details regarding plan selection dates and maximum self-pay periods.

Disability Waiver of Eligibility

A Participant who has obtained eligibility and who ceases active work because of a non-occupational illness or injury and who fails to qualify for coverage in a particular month because of such disability shall continue to be covered for up to three consecutive months after eligibility ceases due to lack of hours in the Hour Bank.

The cost of coverage will be paid by the Trust, provided the Participant is under the personal and regular care of a licensed physician and remains continuously disabled so as to be prevented from engaging in any occupation for compensation, profit, or gain. The Participant must notify the Local 375 Union Office prior to the date eligibility ceases due to lack of hours in the Hour Bank.

The three-month waiver of the cost of coverage shall also apply where a Participant has been maintaining coverage by self-payment and then becomes disabled. Proof of such disability must be received before the waiver of the cost of coverage becomes applicable.

After the three-month waiver period, you may elect to continue your health coverage to the extent other continuation rights may apply. This waiver provision runs concurrently with COBRA.

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

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

Waiver does not apply to Participants receiving unemployment compensation.

COBRA Continuation Coverage

Under the circumstances described below, you, your lawful spouse and eligible dependents each have the independent right to elect to continue your Trust health coverage beyond the time coverage would ordinarily have ended pursuant to a Federal law known as COBRA (Consolidated Omnibus Budget Reconciliation Act).

Qualifying Events

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

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

- The participating Employee's termination of employment or reduction in hours of employment, leaving fewer than 135 hours in the Employee's Hour Bank.
- Death of the participating Employee.
- Divorce from the participating Employee.

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

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

COBRA Notification Responsibilities

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

TAKE ACTION

You or your eligible dependents have the responsibility to inform the Local 375 Union Office of a loss of coverage resulting from a divorce, death or a child losing dependent status.

Your employer is responsible for informing the Trust if your employment is terminated.

The Claims Administration Office will determine when the Employee's Hour Bank falls below 135 hours.

If you or your eligible dependents have a loss of coverage because of divorce, death, or a child losing dependent status you must notify the Local 375 Union Office in writing (see address on Page 75) within 60 days of the date of the qualifying event.

The notice must identify the individual who has experienced the qualifying event, the eligible Employee's name and the qualifying event that occurred.

Failure to provide timely notice will result in your coverage ending as it normally would under the terms of the Plan.

The Board of Trustees, though, reserves the right to determine whether coverage has in fact been lost due to a qualifying event.

Election of COBRA

Once the Local 375 Union Office has received proper notice that a qualifying event has occurred, it will notify you and each of your eligible family members of your rights to elect continuation coverage.

TAKE ACTION

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

Unless otherwise stated on the election form, an election of COBRA coverage under the Trust by one family member covers all other eligible members of the same family. Notice must be sent to the Local 375 Union Office.

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

Available Coverage

The continuation coverage offered is the same as the Trust-paid coverage provided to the Employees of your current employer.

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

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 Local 375 Union Office within 60 days of acquiring the new dependent.

The written notice must identify the Employee, the new dependent, the date the new dependent was acquired and be mailed to the Local 375 Union Office.

Children acquired through birth, adoption, or placement for adoption are entitled to extend their continuation coverage if a second qualifying event occurs as explained on Page 12.

Continuous Coverage Required

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

Cost

A qualified Beneficiary must pay the entire cost of the continuation coverage.

The Trust uses a composite rate, which means that you pay the same monthly rate if you are covering one person or an entire

family. The cost for the coverage available through the Trust is set annually.

KEY POINT

If you have a qualifying event, you will be notified of the applicable monthly self-payment premium for the coverage options available to you.

Monthly Self-Payments Required

COBRA self-payments are due on the first of each month for that month's coverage and must be sent to the Local 375 Union Office (see address on Page 75).

The only exception is that the self-payment for the period preceding the initial election of coverage may be made up to 45 days after the date of election.

Your initial payment must cover all months for which you want coverage and be retroactive to when your Trust coverage ended.

If your initial payment is not received or postmarked within 45 days of when you elected coverage, your right to continuation coverage will be lost.

KEY POINT

Coverage will be terminated if payment is not received by the Local 375 Union Office within 30 days of the due date. Checks that are received and do not clear the bank due to insufficient funds are considered non-payment.

Length of Continuation Coverage

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.

For all other qualifying events (death of Employee, divorce or legal separation from Employee, or a child no longer qualifying as a dependent under the Plan) continuation coverage may last for up to 36 months. However, continuation coverage will end on the last day of the 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 Local 375 Union Office on a timely basis for the next monthly coverage period.
- You or your eligible dependent becomes covered under any other group health plan after the date of your COBRA election.
- You or your eligible dependent provides written notice that you wish to terminate your coverage.
- You or your eligible dependent becomes entitled to Medicare benefits after the date of your COBRA election.
- The date the Plan terminates or the date your employer no longer participates in the Plan unless your employer or its successor does not offer another health plan for any classification of its Employees that formerly participated in the Trust.

KEY POINT

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

Length of Continuation Coverage—Disabled Participants

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

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

To obtain the additional months of coverage, you must notify the Local 375 Union Office in writing within 60 days of

receipt of your Social Security Disability Determination and prior to the end of your initial 18-month period of continuation coverage.

If the disabled individual is subsequently found to not be disabled, you must notify the Local 375 Union Office in writing within 30 days of this determination.

Length of Continuation Coverage—Second Qualifying Event

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

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

If an eligible dependent wants extended coverage as a result of a second qualifying event, he or she must notify the Local 375 Union Office in writing within 60 days of the second qualifying event.

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

KEY POINT

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

Relationship Between COBRA and Medicare or Other Health Coverage

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

If you have coverage under a Trust-sponsored Plan 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.

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

KEY POINT

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

Effect of Not Electing Continuation Coverage

If you do not elect continuation coverage:

- You can lose the right to avoid having preexisting condition exclusions apply to you under a future group health plan if you have more than a 63-day gap in health coverage. Electing continuation coverage may help you avoid such a gap.
- You can lose the right to purchase guaranteed individual health coverage that does not impose a preexisting condition exclusion if you do not obtain continuation coverage for the maximum time available to you.
- You should be aware that Federal law gives you special enrollment rights. You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a spouse's plan) within 30 days

after your group health coverage from the Trust ends because of your qualifying event. You will also have the same special 30-day enrollment right at the end of the maximum continuation coverage period available to you.

Additional Information

For more information about your rights under ERISA (including COBRA) and other laws affecting group health plans, contact the U.S. Department of Labor's Employee Benefits Security Administration or visit its website at www.dd.gov/esba.

To help ensure you receive necessary notices, you should notify the Local 375 Union 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.

Notices to the Trust Concerning COBRA

The Local 375 Union Office is responsible for administering COBRA continuation rights for the Trust. All communications must:

- Be made in writing.
- Identify the person or persons requesting coverage.
- Be sent to the Local 375 Union Office at the address listed on Page 75.

Family and Medical Leave

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

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

The Plan requires documentation from you that your leave is in accordance with the FMLA. FMLA coverage runs simultaneously with other continuation coverage, except COBRA. Your employer will need to notify the Plan that you qualify for leave under the FMLA and must pay the required contribution to the Plan on a timely basis. Your employer can provide additional details concerning your eligibility for FMLA coverage.

Uniformed Services Employment and Reemployment Rights

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

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

Notice of Military Service

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

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

Election of USERRA Continuation Coverage

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

Length of USERRA Continuation Coverage

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

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

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

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

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

Available Coverage

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

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

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

Monthly Self-Payments Required

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

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

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

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

Reinstatement of Eligibility Following Military Service

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

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

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

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

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

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

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

Relationship of USERRA Continuation Coverage to COBRA

You may have the right to elect COBRA continuation coverage in lieu of USERRA continuation coverage. The length of USERRA continuation coverage may be different from that of COBRA continuation coverage. If you have questions regarding election or duration of COBRA continuation coverage, please see Page 12 or contact the Claims Administration Office.

Retiree and Medicare Participants

Retiree Eligibility Provisions

The Board of Trustees is providing this program of Retiree Health and Welfare Benefits to the extent that monies are currently available, and may be available in the future, to pay the cost of such a program.

KEY POINT

Retiree benefits are not guaranteed.

The Board of Trustees retains full and exclusive authority, at its discretion, to determine the extent to which monies are available for the program.

This program is not guaranteed to continue indefinitely and may be terminated or modified at any time by the Board of Trustees.

Early Pension Retirees under Age 62

Early retirees will find your self-pay rights in the "Inactive Self-Pay Participants" section on Page 11. Early retirees are not eligible for Retiree Health and Security Benefits. Early retirees should contact the Local Union 375 Office about their health benefit options.

Retiree Eligibility Rules

A retired Participant will be eligible on the first of the month following your date of retirement provided you have been an Hour Bank Participant covered for welfare benefits either through active employment or self-pay immediately preceding your retirement date. As a Retiree, you must meet one of the following conditions:

- You are totally Medicare Social Security disabled and are receiving a Disability Retirement Benefit from the Alaska Plumbing and Pipefitting Industry Pension Plan.
- You have attained age 62 and are receiving a Normal or Late Retirement Benefit from the Alaska Plumbing and Pipefitting Industry Pension Plan.

Death of the Retiree Survivor Coverage

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

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

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

KEY POINT

This is a one-time selection for your retirement medical coverage. You will not be able to change your selection at any time in the future.

Retiree Plan

The Trust offers you a plan for Retiree medical benefits.

This Retiree plan is offered in addition to any self-pay plan for which you may be eligible.

Retirement under the Local 375 Health and Security Plan is available at 62. There is no early retirement under this Plan.

Retiree Coverage Options

The following chart shows the options available to all Retiree Participants.

Classification	Options
Early Pension Retirees, up to Age 62 ▪ Continuously self-paying	▪ May Re-Elect Retirement Health Plan when eligible
Retiree, Age 62–65 ▪ Continuously covered last four years	▪ Self-Pay Plan I or II (Indefinite) ▪ Retiree Plan (Indefinite)
Retiree, Age 62–65 ▪ NOT continuously covered last four years	▪ Self-Pay Plan I or II (18 Months Maximum) ▪ Retiree Plan (Indefinite)
Retiree, Over Age 65 ▪ Eligible for Medicare	▪ Retiree Plan (Indefinite)
Retiree, Disabled, Over Age 62 ▪ NOT eligible for Medicare ▪ Continuously covered last four years	▪ Self-Pay Plan I or II (Indefinite) ▪ Retiree Plan (Indefinite)
Retiree, Disabled, Over Age 62 ▪ NOT eligible for Medicare ▪ NOT continuously covered last four years	▪ Self-Pay Plan I or II (18 Months Maximum) ▪ Retiree Plan (Indefinite)
Retiree, Disabled, Any Age ▪ Eligible for Medicare	▪ Retiree Plan(Indefinite)

KEY POINT

Regardless of the Plan selected, coverage will be coordinated with Medicare. For Retired Participants and their dependents, Medicare pays primary and this Plan pays secondary.

Cost of Retiree Coverage

If you are eligible for and elect the Retire Plan (medical only, $200 deductible), you will be required to contribute to the cost of the Plan. You may continue under the plan as long as your contributions are paid.

Retiree Coverage Options

These coverage options are offered in addition to the self-pay plans.

- Retiree Medical does not include dental or vision benefits.
- Dental and vision care benefits are only available to Participants who retire and elect the 18-month COBRA Continuation coverage.
- If you elect to continue the medical/ dental/vision coverage provided under COBRA Self-Pay, you will be required to self-pay the full cost of this coverage.
- If you are a Retiree age 62 or older who has elected COBRA Self-Pay, you must enroll for Retiree Medical coverage within 31 days of the date your COBRA coverage terminates.

Participant Eligibility for Medicare

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

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

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

If, while eligible under this Plan, you or your dependent becomes entitled to Medicare because of end-stage renal disease (ESRD), this Plan generally pays first and Medicare pays second for 30 months starting the earlier of the month in which Medicare ESRD coverage begins; or the first month in which the individual receives a kidney transplant. Then, starting with the 31st month after the start of Medicare coverage, Medicare pays first and this Plan pays second.

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

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

Medicare Example:

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

Physicians Who Opt Out of Medicare

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

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

SUMMARY OF HEALTH CARE BENEFITS	ACTIVE PARTICIPANTS Medical + Dental + Vision	INACTIVE SELF-PAY PLAN I Medical + Dental + Vision	INACTIVE SELF-PAY PLAN II Medical Only	RETIREE PLAN Medical Only
MEDICAL BENEFITS				
Annual Deductible Per calendar year	$200/Individual; $600/Family			
Out of Pocket Limit	$2,000/Individual; $6,000/Family			
PRIMARY CARE	**AMOUNT THE PLAN PAYS:**			
Medical Care Physician office visits, etc.	80% of Allowed Amount			
Preventive Care Physical exams	90% of Allowed Amount			
X-ray/Labs	80% of Allowed Amount			
Air Transportation Benefits	80% of Allowed Amount			
HOSPITAL CARE	**AMOUNT THE PLAN PAYS:**			
Inpatient Services ▪ **All days in a hospital must be preauthorized** before any non-emergency admission ▪ **Emergency admission must be certified within 48 hours** of the admission except maternity (48 hours or less for routine deliveries / 96 hours for caesarean sections) **Preadmission testing is required** for tests and X-rays that should be done on an outpatient basis	80% of Allowed Amount			
Inpatient Surgery ▪ **A second surgical opinion is required** for certain types of non-emergency surgeries ▪ All days in a hospital must be preauthorized	80% of Allowed Amount			
Second Surgical Opinion	100% Allowed Amount			

SUMMARY OF HEALTH CARE BENEFITS	ACTIVE PARTICIPANTS Medical + Dental + Vision	INACTIVE SELF-PAY PLAN I Medical + Dental + Vision	INACTIVE SELF-PAY PLAN II Medical Only	RETIREE PLAN Medical Only
Outpatient Surgery Certain outpatient procedures require preauthorization	100% of Allowed Amount			
Preoperative/Preadmission Testing	100% of Allowed Amount			
Organ Transplants	80% of Allowed Amount			
MATERNITY	**AMOUNT THE PLAN PAYS:**			
Birthing Center Expenses	100% of Allowed Amount			
Midwives' Services	No midwives' services are covered			
ALTERNATIVE CARE	**AMOUNT THE PLAN PAYS:**			
Naturopaths Up to 6 visits per individual per calendar year	80% of Allowed Amount			
Chiropractic Care Up to 6 visits per individual per calendar year	80% of Allowed Amount			
ALTERNATIVES TO HOSPITALIZATION	**AMOUNT THE PLAN PAYS:**			
Skilled Nursing Care Up to 100 days per calendar year	100% of Allowed Amount			
Hospice Care Up to 30 days per calendar year	80% of Allowed Amount; $3,000 outpatient maximum			
Home Health Care Up to 100 visits per calendar year	100% of Allowed Amount			

SUMMARY OF HEALTH CARE BENEFITS	ACTIVE PARTICIPANTS Medical + Dental + Vision	INACTIVE SELF-PAY PLAN I Medical + Dental + Vision	INACTIVE SELF-PAY PLAN II Medical Only	RETIREE PLAN Medical Only
MENTAL HEALTH BENEFITS	**AMOUNT THE PLAN PAYS:**			
Mental Health Care Inpatient or outpatient Preauthorization required for inpatient treatment Reimbursement rate reduced to 50% of UCR if Magellan is NOT contacted prior to commencement of inpatient treatment	80% of Allowed Amount			
Chemical Dependency Inpatient or outpatient Reimbursement rate reduced to 50% of UCR if Magellan is NOT contacted prior to commencement of inpatient treatment	80% of Allowed Amount			
PRESCRIPTION DRUG BENEFITS				
RETAIL CARD PLAN **Network Pharmacy** ▪ Deductible does not apply and payments are not subject to the out-of-pocket maximum ▪ limited to a 30-day initial (starter dose) supply and up to a 60-day supply on refills The Retail Card Plan does not coordinate with any other prescription drug plan	**Generic drugs**			Plan pays 90%, $5 minimum copay per prescription (not to exceed actual cost of prescription) per 30-day supply
	Brand name drugs when a generic is <u>not</u> available			Plan pays 80%, $100 maximum copay per prescription per 30 day supply
	Brand name drugs when a generic <u>is</u> available			Plan pays 70%, $100 maximum copay per prescription per 30 day supply
Non-Network Pharmacy Full payment at time of purchase is required; you must submit a claim form to request reimbursement	Plan reimburses 70%, $100 maximum copay per prescription per 30-day supply			
MAIL ORDER PLAN ▪ Deductible does not apply and payments are not subject to the out-of-pocket maximum ▪ Limited to a 90-day supply Does not coordinate with any other prescription drug plan	**Generic drugs**			Plan pays 90%, $15 minimum copay per prescription (but not to exceed actual cost of prescription)
	Brand name drugs when a generic is <u>not</u> available			Plan pays 80%, $300 maximum copay per prescription
	Brand name drugs when a generic <u>is</u> available			Plan pays 70%, $300 maximum copay per prescription

SUMMARY OF HEALTH CARE BENEFITS	ACTIVE PARTICIPANTS Medical + Dental + Vision	INACTIVE SELF-PAY PLAN I Medical + Dental + Vision	INACTIVE SELF-PAY PLAN II Medical Only	RETIREE PLAN Medical Only
DENTAL BENEFITS				
Annual Deductible Per calendar year	$25/Individual $75/Family		No dental coverage	
Out of Pocket Limit	$2,000/Individual (No maximum under age 18)		No dental coverage	
Preventive Care Exams, prophylaxis, X-rays	80% of Allowed Amount (deductible waived)		No dental coverage	
Restorative Care Fillings, extractions, root canals	80% of Allowed Amount		No dental coverage	
Major Care Crowns, bridges, dentures	80% of Allowed Amount		No dental coverage	
VISION CARE BENEFITS				
First-Year Maximum	Up to $100 in vision benefits during first 12 months		No vision coverage	
Eye Examination One per calendar year	90% of Allowed Amount up to the scheduled allowance maximum		No vision coverage	
Contact lenses (in lieu of eyeglass lenses, there is not coverage for both)	90% of Allowed Amount up to the scheduled allowance maximum		No vision coverage	
Prescription Eyeglass Lenses	90% of Allowed Amount up to the scheduled allowance maximum; up to two lenses per calendar year		No vision coverage	
Frames for Prescription Lenses	Up to $115 any two consecutive calendar years		No vision coverage	

Cost Containment Provisions

Several "Cost Containment" features emphasize the efficient use of medical services without sacrificing quality care.

Preferred Provider Organization

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

KEY POINT

By working together, we can keep costs reasonable so Plan benefits may continue to provide financial protection well into the future.

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

Annual Deductible

The annual deductible is the amount of covered services you must pay each calendar year before the Plan begins to pay benefits (unless noted otherwise). The same expense may be used to satisfy both the individual or family deductible for Preferred Providers and Non-Preferred Providers. The annual deductible is $200 per individual and $600 per family.

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

How Benefits Are Paid

After payment of your deductible (if applicable) the plan will pay a **Percentage Payable** of the **Allowable Amount**.

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

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

Usual, Customary and Reasonable (UCR)

Payments for benefits are based on what is considered the "usual, customary and reasonable," or UCR, allowances by the Claims Administration Office. See the Glossary for the definition of Usual, Customary and Reasonable.

The provision recognizes that there will be differences in providers' charges because of such factors as geographical location, skill of the provider of service, and the complexity of the service performed.

The Claims Administration Office makes the final determination as to whether or

not the charge is "usual, customary and reasonable."

When you receive services or supplies from a Non-Preferred Provider, the billed amount may exceed the UCR charge. Keep in mind that the Plan only pays a percentage of the UCR charge. For Non-Preferred Providers you may be responsible for 100% of any amount exceeding the UCR charge.

Example: Non-PPO Office Visit

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

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

If a benefit is shown as being "Paid in Full," this means that the benefit will be paid in full if the provider's charge is not greater than what is considered as "usual, customary and reasonable."

KEY POINT

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

Claim Appeal Rights

You may appeal a claim reduced due to the usual, customary and reasonable provision.

Out-of-Pocket Limit

Out-of-pocket expenses are costs you pay for covered services, such as coinsurance or deductible amounts (unless specifically stated otherwise). The most that you pay in out-of-pocket expenses per year is called the out-of-pocket limit. Once the out-of-pocket limit has been reached, the Plan will pay 100% of most covered expenses for the rest of the calendar year (100% of PPO allowance or 100% of UCR for non-PPO charges), up to the benefit maximum allowable. The out-of-pocket limit is $2,000 per individual and $6,000 per family.

Hospital Self Audit Program

Hospitals sometimes make mistakes. Those mistakes can add up to substantial amounts of lost money for the Trust.

If you find errors or have questions about any of the charges, call the hospital billing office and ask them to review your records. If you can find an overcharge, don't forget to get a corrected bill.

To encourage you to check your hospital bills, the Plan will reward you with 50% of the overcharged amount up to the maximum reward of $5,000 if you find an undetected error on the hospital bill after it has been audited and paid by the Claims Administration Office.

In other words, if you find a $1,000 overcharge undetected by the Claims Administration Office, you will receive $500 from the Plan. A second look can help control the cost of your health insurance and possibly put some dollars back in your pocket.

Precertification Requirements

The Trust's Health Plan covers charges that are medically necessary for the care and treatment of a non-occupational illness or injury. The Trust contracts with Qualis Health to provide case management and utilization review services. The Trust's preadmission program requires you or your doctor to contact Qualis Health prior to any non-emergency hospital admission and requires certification prior to certain outpatient surgery.

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

Be sure to have on hand:

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

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

TAKE ACTION

It is your responsibility to inform your physician regarding the requirement of notifying Qualis Health. You and your covered dependents should carry your Health Plan I.D. card showing the Qualis Health telephone number.

QUICK GUIDE

Please see the chart on Page 31 for a summary of the precertification requirements.

Non-Emergency (Elective) Admission

Your request must be reviewed and authorized by Qualis Health prior to any hospitalization in order to obtain the full maximum hospital benefit from the Health Plan. We recommend that you contact Qualis Health at least one week prior to an elective admission.

Emergency Admission

Emergency admission must be reviewed within 48 hours of the admission (within 72 hours on weekends or holidays) with the exception of the Newborns' and Mothers' Health Protection Act. This procedure may also be used for urgent "after hours" admissions when Qualis Health cannot be contacted.

KEY POINT

If you do not comply with the hospital precertification program, benefits will be reduced to 50% of all charges related to that hospitalization.

Exception: The Newborns' and Mothers' Health Protection Act prohibits plans from requiring precertification of maternity hospitalizations of 48 hours or less for routine deliveries and 96 hours for caesarean sections.

Continued Stay Review

If your hospital stay must be extended beyond the days initially authorized, Qualis Health will obtain clinical data from your physician to process an extension of stay authorization. Qualis

Health will contact your physician 24 hours prior to your scheduled discharge to confirm discharge and/or authorize days for your confinement.

QUICK GUIDE

Please see chart on Page 31 for a summary of the precertification requirements.

Preoperative Outpatient Testing Benefits

This Plan covers charges made by a physician, hospital, outpatient surgery center, or licensed diagnostic laboratory facility in its own behalf for preoperative testing prior to scheduled surgery at 100% of usual, customary and reasonable charges, but only if:

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

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

Same-Day Surgery and Preadmission Testing

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

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

To emphasize the savings that can be achieved by preadmission testing, the Plan will reimburse you at 100% of usual, customary and reasonable preadmission testing charges (providing tests relate to subsequent hospitalization).

KEY POINT

Noncompliance with this provision will result in no coverage for hospital room and board charges for any days hospitalized solely for testing purposes.

Call Qualis Health before any non-emergency hospitalization or any surgery where hospitalization is recommended. Benefits will be reduced for noncompliance.

Emergency admissions must be reviewed within 48 hours of the admission (72 hours for weekend admissions).

Second Surgical Opinions

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

The Plan pays 100% of the usual, customary and reasonable charges for the second opinion.

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

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

KEY POINT

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

The choice whether or not to have the surgery is still yours. If you choose to have the surgery, you do so knowing you have made the most informed decision possible.

The Plan covers charges for a second surgical opinion on the need or advisability of performing a surgical, or an oral surgical, procedure which:

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

A surgical opinion is:

- An exam of you or your dependents.
- X-ray and lab work.
- A written report by a physician rendering the opinion.

The surgical opinions must both:

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

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

The Plan pays benefits at the rate of 50% after the deductible, for covered expenses for the performance of these procedures if Qualis Health recommends a second surgical opinion that is not obtained before surgery.

Chemical Dependency

The Trust has contracted with Magellan Behavioral Health to provide counseling and referral services related to chemical dependency treatment.

Prior to scheduling treatment you should contact Magellan at (800) 478-2812 outside of Anchorage or (907) 562-2812 in Anchorage for an appointment.

Magellan will arrange for you or your dependent to meet with a clinician. During the initial session the Magellan clinician will assess the individual's specific needs and recommend a treatment program.

Upon completion of the initial portion of intensive treatment, monthly follow-up sessions with the Magellan clinician are available.

For inpatient admissions, failure to participate in the Magellan program will result in coverage for chemical dependency treatment being reduced to 50% of usual, customary and reasonable charges.

Precertification Quick Guide	Call Qualis Health, (800) 783-8606 Monday through Friday, 7 a.m.– 4 p.m., Alaska Standard Time	
Event	**Requirement**	**Penalty**
Non-Emergency (Elective) Admission	Call at least one week prior to hospitalization	Without precertification, benefits reduced to 50% for all related charges
Emergency Admission	Call within 48 hours of admission (72 hours on weekends or holidays)	Without precertification, benefits reduced to 50% for all related charges
Urgent "After Hours" Admission (when Qualis Health cannot be reached)	Call within 48 hours of admission (72 hours on weekends or holidays)	Without precertification, benefits reduced to 50% for all related charges
Continued Stay Review	Qualis Health calls your physician within 24 hours prior to scheduled discharge	No coverage for hospital room and board charges beyond preauthorized length of stay
Preoperative Outpatient Tests	No precertification requirement, but tests must meet benefit requirements	Not applicable
Same Day Surgery and Preadmission Testing	Inpatient surgery must be approved by Qualis Health; certain preadmission tests may be done on an outpatient basis	Without precertification, no coverage for hospital room and board charges for days hospitalized solely for testing purposes
Outpatient Surgery	The following outpatient surgeries or hospitalizations must be approved by Qualis Health: ▪ Abdominoplasty, panniculectomy, and lipectomy abdomen ▪ Back surgery, including discectomy, laminectomy, and spinal fusion ▪ Breast surgery, including breast reconstruction and mammoplasty (both unilateral and bilateral) ▪ Hysterectomy, including abdominal, vaginal, and unspecified hysterectomy ▪ All nasal surgery ▪ Orthognathic surgery ▪ Uvulopalatopharyngoplasty (UPPP); a procedure to eliminate snoring ▪ Knee surgery ▪ Bunionectomy and/or hammertoe ▪ Varicose vein surgery	If outpatient surgery or hospitalization occurs without precertification, benefits will be reduced to 50% for all related charges
Second Surgical Opinion	Qualis Health may require a second opinion for certain types of surgeries	If a second opinion is required and you do not obtain one, your benefits are reduced to 50%
Alcohol and Drug Abuse Treatment	Prior to scheduling treatment, contact Magellan Behavioral Health at (800) 478-2812 for precertification	If precertification is not obtained, your benefits are reduced to 50%

COVERED MEDICAL EXPENSES

The medical, dental and vision benefits in this booklet are non-occupational.

Only non-occupational accidental bodily injuries and non-occupational illnesses are covered.

Covered medical expenses include charges for the following services and supplies for treating a non-occupational injury or disease.

KEY POINT

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

Primary Care

A Licensed Physician or Surgeon

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

- Registered Nurse (R.N.).
- Licensed Practical Nurse during hospital confinement, provided a Registered Nurse is not available and the attending physician prescribes the services of the Licensed Practical Nurse.
- Treatment by a Licensed Physical Therapist.
- The cost and administration of anesthesia.
- Radiation therapy, X-ray treatments and examinations (other than dental X-rays not necessitated by an injury), microscopic tests, or any laboratory tests or analysis made for diagnostic or treatment purposes.
- Professional local ambulance service for transportation to the nearest hospital equipped to treat the condition.
- Drugs and medicines requiring the written prescription of a physician and which must be dispensed by a licensed pharmacist.
- Blood plasma or whole blood.
- Artificial limbs or eyes.
- Casts, splints, trusses, crutches, and medical type braces.
- Oxygen and rental to purchase price of the equipment needed for the administration of oxygen.
- Rental (or purchase if approved by the Claims Administration Office) of durable medical equipment and supplies, including, but not limited to, wheelchair and hospital bed, which are:
    - Ordered by a physician.
    - Of no further use when medical need ends.
    - Usable only by the patient.
    - Not primarily for the comfort of hygiene of the patient.
    - Not for exercise.
    - Manufactured solely for medical use.
    - Diabetic Education.

- Approved as effective and usual and customary treatment of the condition (as determined by the Plan).
- Not for prevention purposes or useable only for certain activities such as running or swimming.

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

KEY POINT

Rental or purchase of durable medical equipment that meets the Plan guidelines and is approved by the Claims Administration Office is a covered expense.

Physical Exams, Lab Tests and Immunizations

This Plan covers routine physical exam charges. Charges will be payable at 90% for the exam and other routine charges, such as inoculations, immunizations, Pap tests, mammograms and laboratory tests.

Colorectal Cancer Screening Benefits

This Plan covers colorectal cancer screening and is not considered routine or preventive in nature. Colonoscopies and Sigmoidoscopies are considered surgical procedures. After the deductible has been satisfied, charges will be payable at 80% of PPO allowance or UCR and subject to the same conditions and limitations as any other covered procedure.

Air Transportation Benefits

Charges will be paid for a licensed air ambulance and/or round-trip coach air transportation within Alaska or from Alaska to Seattle, Washington, for:

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

  Such air transportation must be recommended by a physician because the necessary treatment is not available locally or elsewhere in the State of Alaska.

Dental Benefits and the Medical Plan

- Dental benefits due to injury.
- Dental treatment necessitated by degenerative medical conditions, such as cancer, will be considered a covered medical expense under this Plan.
- Dental services by a physician or dentist for the treatment of a dental injury to sound natural teeth (including the initial replacement of the injured teeth and any necessary dental X-rays), provided the expense is incurred within one year after the injury. Dental injury means an accidental injury to sound natural teeth that is the direct result of a sudden, unexpected and unintended external force, such as a blow or fall, which requires treatment by a physician or dentist. It must be dependent of sickness or any other causes. It does not include tooth breakage while biting or chewing.
- Sound natural teeth are teeth that: are whole or properly restored, are without impairment or periodontal disease, are not in need of the

treatment provided for reasons other than dental injury.

- The Plan does not pay benefits for extraction of teeth or other dental work or surgery for any reason that involves any tooth or tooth structure, alveolar process, abscess or periodontal disease, or disease of the gingival tissue, except for emergency treatment of dental pain when a dentist is not available. The Plan also pays benefits for covered expenses for general anesthesia in a hospital or ambulatory surgical center for treatment of a dental condition, including any related facility charges, in the same manner and subject to the same conditions and limitations as any other covered service.

Benefits are payable only if the covered person: 1) is under the age of seven, or physically or developmentally disabled, with a dental condition that cannot be safely and effectively treated in a dental office; 2) has a medical condition that, as determined by a physician, would place the covered person at undue risk if the procedure were performed in the dental office. Please refer to the Dental Plan section of this Summary Plan Description for routine benefit coverage.

Hospital Care

Hospital Expenses

These represent all charges for daily room and board in other than a private room. For private room accommodations, only charges for room and board up to the average semi-private room rate of the hospital in which you are confined are considered covered medical expenses.

Intensive Care Unit

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

Qualified Organ(s)/Tissue Transplant Services

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

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

Benefits for all transplants must be authorized in writing by Qualis in advance (see the "Precertification Requirements" section, Page 28). Approval will be based on medical necessity, the patient's medical condition, the qualifications of the providers, appropriate medical indications for the transplant, and the availability of appropriate, non-experimental medical procedures for the condition. If a transplant is not successful, only one re-transplant will be covered, subject to the same conditions and limitations applicable to the original transplant.

If you or your eligible dependent is the recipient of a donated human organ, the donor's medical expenses (including compatibility testing of donors and potential donors).

Prescription Drugs

Retail Card Plan is provided. The deductible does not apply and payments are not subject to the out-of-pocket maximum; limited to a 30-day supply. This Plan does not coordinate with any other plan.

When you present your card at a Network pharmacy, Plan pays:

- 90% for generic drugs, $5 minimum copay per prescription (but not to exceed actual cost of prescription).
- 80% for brand name drugs when a generic is not available, $100 maximum copay per prescription.
- 70% for brand name drugs when a generic is available, $100 maximum copay per prescription.

When your prescription is filled at a Non-Network pharmacy:

- All prescriptions will be reimbursed at the 70% level, $100 maximum copay per prescription.
- Full payment at time of receipt of prescription is required with a completed claim form submitted in order to receive reimbursement.

Mail Order Plan is provided. The deductible does not apply and payments are not subject to the out-of-pocket maximum; limited to a 90-day supply. This Plan does not coordinate with any other plan. Plan pays:

- Plan pays 90%, $15 minimum copay per prescription (but not to exceed actual cost of prescription).
- 80% for brand name drugs when a generic is not available, $300 maximum copay per prescription.
- 70% for brand name drugs when a generic is available, $300 maximum copay per prescription.

Maternity Benefits

This Plan covers charges for pregnancy, childbirth, miscarriage, or abortion, on the same basis as any other medical expense, for you or your spouse.

- This Plan covers expenses on the same basis as for any other illness or injury.
- Pregnancy does not have to begin while a person is covered.
- If coverage under the Plan ends for any reason, benefits continue to be payable only if the person is totally disabled.

Midwives

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

Birthing Center Benefits

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

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

Alternatives to Hospitalization

Skilled Nursing

This provision encourages use of such a facility when the level of medical care required no longer necessitates continued confinement in a full service hospital.

TAKE ACTION

Tell your physician that skilled nursing care benefits are covered by the Plan so that a timely transfer from a full service hospital to a skilled nursing care facility will be accomplished.

Coverage for a skilled nursing facility is provided at 100% of eligible PPO allowance or usual, customary and reasonable charges for up to 100 days.

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

A physician must recommend and approve confinement in a skilled nursing facility. Also, the patient must be under a physician's continuing care.

When Confinement Begins

Confinement in the skilled nursing facility must begin within 14 days after a hospital stay.

The person must be confined as a registered bed patient on the certification of a physician that such skilled nursing facility confinement is necessary.

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

All periods of skilled nursing facility confinement during any disability will be considered one confinement.

Covered Expenses

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

Facility Requirements

The term ”skilled nursing facility” means only an institution which meets fully all of the following requirements:

- It is regularly engaged in providing skilled nursing care for sick or injured persons with 24 hours a day supervision of a physician or a graduate Registered Nurse.
- It has available, at all times, the services of a physician who is a staff member of a general hospital.
- It has on duty, 24 hours a day, a graduate Registered Nurse, Licensed Vocational Nurse, or Licensed Practical Nurse and has a graduate Registered Nurse on duty at least eight (8) hours per day.
- It maintains a daily medical record for each patient.

- It complies with all licensing and other legal requirements.
- It is not, other than incidentally, a place for rest, a place for custodial care, a place for the aged, a place for drug addicts, a place for alcoholics, a hotel, or similar institution.

Expenses Not Covered

The Plan's skilled nursing benefit does not include benefits for custodial care. Physician services and private duty or special nursing services provided by the skilled nursing facility also are not part of the skilled nursing benefit.

Home Health Care

As your health begins to improve following a surgery or illness, the level of medical care you need should decrease.

KEY POINT

If you have been hospitalized or have been recuperating in an extended care facility, you may reach a point where confinement is no longer necessary even though some degree of professional care is required.

Home health care services may be an appropriate alternative. Benefits have been added to this Plan for home health care at 100% of eligible usual, customary and reasonable charges for up to 100 visits per calendar year.

Requirements

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

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

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

Covered Expenses

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

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

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

Expenses Not Covered

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

Hospice Care Benefits

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

KEY POINT

Hospice care is a program 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 an inpatient facility. Care focuses on controlling pain and other symptoms associated with terminal illness while also helping the family, as well as the patient, acknowledge the approach of death.

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

Requirements

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

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

Facility Inpatient Benefits

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

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

Other Hospice Care Benefits

Charges listed below are covered in accordance with the Summary of Health Care Benefits and on the same basis as services and supplies covered by home health care benefits.

The hospice care maximum benefit is shown in the "Summary of Health Care Benefits" beginning on Page 22.

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

- Part-time or intermittent nursing care by an R.N. or L.P.N. up to eight hours a day.
- Medical supplies, drugs and medicines prescribed by a physician.
- Medical social services under the direction of a physician.

The Plan provides benefits for charges of a **home health care agency** for such services as:

- Part-time or intermittent home health aide services up to eight hours a day.
- Physical or occupational therapists for therapy.
- Physicians for consultation or case management services.

Hospice Care Agency

This agency or organization must:

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

Expenses Not Covered

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

Alternative Care

Naturopaths

A charge for treatment by naturopaths is limited to six visits per calendar year. Vitamins and supplements are not covered.

Spinal Manipulations/Chiropractic Treatment

Charges made by a physician or chiropractor for manual manipulation of the spine are limited to six visits per calendar year.

Mental Health Benefits

Mental and Nervous Benefits

Medically necessary expenses incurred for the treatment of mental and nervous conditions will be paid in the same manner as any other medical condition.

Chemical Dependency Benefits

Medically necessary expenses incurred for the treatment of chemical dependency, benefits will be paid in the same manner as any other medical condition.

KEY POINT

Expenses for medically necessary inpatient chemical dependency treatment will be paid at 50% if Magellan Behavioral Health is not contacted prior to treatment.

The benefit amounts specified above will be payable only if the entire course of treatment is completed.

Limitations and Exclusions

Medical benefits are not payable for the following expenses:

Experimental or Investigational Treatment

This is defined as any one of the following:

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

Exceptions

A service or supply will not be considered experimental or investigational if it is part of an approved clinical trial. An approved clinical trial is one that meets each of the criteria in either Category 1 or 2 below.

Category 1 Exceptions

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

Category 2 Exceptions

- The trial is to treat a condition which is too rare to qualify for approval under Category 1.
- The trial has been reviewed and approved by a qualified institutional review board.
- The facility and personnel have sufficient experience or training to provide the treatment or use the supplies.
- The available clinical or pre-clinical data provide a reasonable

expectation that the trial treatment will be at least as effective as non-investigation therapy.

- There is no therapy that is clearly superior to the trial treatment.

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

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

Organ Transplants

Benefits are not payable, except as specified in the covered benefits section.

Benefits for all transplants must be authorized in writing by Qualis Health in advance (see the "Precertification" section starting on Page 28). Approval will be based on medical necessity, the patient's medical condition, the qualifications of the providers, appropriate medical indications for the transplant, and the availability of appropriate, non-experimental medical procedures for the condition.

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

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

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

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

Dental Benefits under Medical Plan

Dental benefits are only payable as provided above. See Page 33.

Other Plan Limitations

Medical benefits are not payable for the following expenses:

Expenses incurred in connection with any **accidental bodily injury or sickness arising out of or in the course of employment or self-employment**, which is or would be compensable under any Worker's Compensation or Occupational Disease Act or Law had a claim been filed.

- These expenses are the result of an occupational injury or disease. Only expenses as a result of a non-occupational injury or disease are covered under this Plan.

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

Charges for any services, treatments, or supplies which **exceed the usual,**

customary and reasonable charge, as defined on Page 71.

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

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

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

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

Expenses for **refractive eye surgery**.

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

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

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

Services or supplies by a **provider who normally resides in your home** or is related to you by blood or marriage.

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

Expenses incurred for charges made by a **midwife**, except as otherwise provided.

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

Dental implants, regardless of whether due to an accident or injury, except as otherwise provided.

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

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

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

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

Expenses for **acupuncture** or an acupuncturist.

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

Expenses incurred for **massage therapy**.

Any expense or charge for **birth control drugs or devices** including, but not limited to, oral contraceptives, IUDs, contraceptive implants, and any similar drugs, devices, or other birth control methods and all related expenses.

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

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

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

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

Services where a patient is not physically seen by a physician or other covered provider.

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

COVERED DENTAL EXPENSES

Dental Benefits

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

- Active Participants Plan.
- Inactive Participants Self-Pay Plan I.

Deductible

There is no deductible for Type A expenses.

The deductible amount for all other expenses is $25 per person but not more than $75 per family each calendar year.

KEY POINT

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

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

How Benefits Are Paid

After payment of your deductible (if applicable) the dental plan will pay your dentist 80% of the Allowed Amount up to your Calendar Year Maximum. For dental benefits, the Allowed Amount is based on an established payment schedule. For a copy of the Trust's current dental payment schedule, please contact the Trust's Claims Administration Office or the Local 375 Union Office

Calendar Year Maximum

Your calendar year maximum (the maximum amount the Plan pays in covered dental benefits) is $2,000 per individual.

This calendar year maximum shall not apply to Type A and Type B expenses for dependent children under the age of 18.

Covered Dental Expenses

Covered dental expenses are the allowed amounts for a dentist which the Participant is required to pay, for services and supplies listed on page 44. These must be received by you, or your dependent, in connection with a course of treatment. The Claims Administration Office must determine that the services rendered and supplies furnished and the course of treatment are:

- Appropriate and meet professionally recognized national standards of quality.
- Necessary for the treatment of non-occupational disease or injury.
- Customarily employed nationwide for the treatment of dental conditions.

Dental treatment necessitated by degenerative medical conditions such as cancer will be considered a dental expense under this Plan.

Additional benefits will be considered under the Health Plan after dental benefits under the Plan have been applied.

Type A Expenses

These are paid at 80% of the usual, customary and reasonable charge:

- Oral examinations, but not more than two examinations in any period of a calendar year.
- Topical application of sodium or stannous fluoride for dependent children age 14 and under; up to two applications per year.
- Dental X-rays required in connection with the diagnosis of a specific condition requiring treatment; also other dental X-rays, but not more than one full mouth X-ray or series of seven or more bitewings or a combination of such X-rays in any three calendar years, and not more than one set of up to four bitewing X-rays in any period of one year.
- Cleaning of teeth, periodontal prophylaxis, or scaling but no more than two of any in a period of a calendar year.
- Nightguards, limited to one per lifetime.

Type B Expenses

These are paid at 80% of the usual, customary and reasonable charge:

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

Type C Expenses

These are paid at 80% of the usual, customary and reasonable charge:

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

Prosthesis Replacement Rule

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

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

Limitations and Exclusions

The following are not covered dental expenses under this Plan:

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

Benefits after Termination of Coverage

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

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

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

COVERED VISION EXPENSES

Vision Benefits

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

- Active Participants Plan.
- Inactive Participant Self-Pay Plan I.

How Benefits Are Paid

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

KEY POINT

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

Covered Vision Expenses

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

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

Exclusions

In addition to the exclusions described in the limitations and exclusions in prior sections of this booklet, benefits will not be provided for the following:

- Contact lenses, except as specifically provided above.
- Contact lens fitting fee.
- Charges for medical or surgical diagnosis for treatment of the eyes, or special procedures such as orthoptics, vision training, or refractive eye surgery.
- Charges for special purpose vision aids, even if prescribed.
- Charges for an eye examination required by an employer as a condition of employment and which the employer is required to provide by virtue of a labor agreement.
- Charges for services or supplies provided under the other provisions of this Plan.
- Services for which no charge is made to the person.
- Charges for laser eye corrective surgery.

HEALTH CARE BENEFIT CLAIMS

Filing Instructions for Medical, Dental and Vision Claims

Obtain a claim form from the Local 375 Union Office.

- Complete your portion of the form (Part I) by filling in all the information requested.
- Have your doctor complete the physician's portion of the form (Part 2, 3 or 4). If your doctor wishes to use his/her own forms indicating diagnosis, type and date, service and charge, it is not necessary to have them complete "Physician Statement" on the claim form. Just attach their statement to your claim form.
- Attach any other bills, listing all services, supplies, and treatments you have received.
- After the above has been completed, send your claim to:

  Alaska Pipe Trades
  PO Box 34203
  Seattle, WA 98124-1203

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

KEY POINT

Claim forms should be submitted within 90 days. All claims and supporting documentation must be submitted within one year. Incomplete claims will not be considered until all the required information has been provided.

If you have questions about filing claims, or want to check on the status of your claim, call the Claims Administration Office at:

- (800) 331-6158
- (206) 441-7574

Procedures for Processing Claims

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

Post-Service Health Claims

Any properly filed claim for medical, dental, or vision benefits (that is not an urgent care or pre-service claim as defined on page 48) will be processed as a post-service health claim.

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

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

TAKE ACTION

All non-emergency hospital admissions and non-emergency surgeries where hospitalization is recommended must be preauthorized.

Pre-Service Health Claims

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

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

Urgent Care Health Claims

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

- Urgent care claims may be filed, orally or in writing, by the Participant or Beneficiary or a health care provider (physician, osteopath, licensed nurse practitioner) with knowledge of the individual's medical condition.
- Claimants will be informed within 24 hours if additional information is needed to process the claim. Claimants will have at least 48 hours to submit the additional information.
- The Claims Administration Office and the Pre-certification Provider will develop procedures for identifying urgent care claims which may include seeking additional information from the Participant or Beneficiary or his/her providers about why the treatment involves urgent care.
- If services which constitute urgent care have been provided and the issue is what payment, if any, will be made, the Trust will process the claim as a post-service claim.

Health Care Claim Appeals

Appealing a Denied Claim

A denial of benefits will provide the following information:

- The reason for the denial.
- A reference to the Plan provision relied on.
- A description of any additional material needed to perfect the claim.

- An indication if any internal guidelines or protocols have been relied on in denying the claim and statement that any such internal guidelines are available on request.
- If the denial is based on medical necessity, the service or supply being experimental or investigational in nature or an equivalent exclusion, a statement that an explanation of the medical judgment will be provided upon request.
- An explanation of the Trust's appeal procedures.

The denial will be mailed to the Participant or Beneficiary at his/her last known address.

Appeal Procedures

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

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

TAKE ACTION

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

An appeal must be submitted by the Participant or Beneficiary or an authorized representative in writing.

It must be submitted to the proper address for the Trust's Claims Administration Office (see Page 75).

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

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

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

Information to Be Provided upon Request

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

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

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

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

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

Conduct of Hearings by the Appeal Committee

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

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

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

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

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

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

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

The claimant or his/her representative will be allowed to appear before the Appeal Committee and present any evidence or witnesses.

- If the claimant elects to appear before the Appeal Committee, a copy of the administrative file will be mailed to the Participant.
- If the claimant does not elect to appear, the hearing will be determined based on the administrative file and the comments of any witnesses consulted.

If the claimant does appear at the hearing (or if the Appeals Committee otherwise determines that such a record is appropriate) a stenographic record shall be made of any testimony provided.

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

Issuance of a Decision

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

The decision will include the following points:

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

- If a denial is based on a medical judgment, explain the medical judgment, applying it to the claimant's case, or state that such information is available.

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

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

The following modifications will be made in the appeal procedures, starting on Page 49, for claims involving pre-service claims or urgent care claims.

Pre-Service Claims

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

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

Urgent Care Claims

Appeals involving denial of urgent care will be subject to the rules set forth starting on Page 49 with the following modifications:

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

Review of Denied Claims

The Trust provides for no voluntary alternative dispute resolution procedures.

If a claimant remains dissatisfied with the Trust's determination after exhausting the claim appeal procedures, he or she has the right to pursue a civil action under 29 U.S.C. § 1132(a).

Any civil action must be brought no later than one year after the date of issuance of the Trustees' decision on an appeal.

The question on review will be whether, in the particular instance, the Trustees: (1) were in error upon an issue of law; (2) acted arbitrarily or capriciously in the exercise of their discretion; or (3) whether their findings of fact were supported by substantial evidence.

LIFE AND AD&D INSURANCE

KEY POINT

The Health Trust automatically provides all active Participants with Life Insurance coverage of $5,000.

The Life Insurance coverage amount is payable in the event of your death from any cause, at any time or place.

- Payment will be made to your Beneficiary.
- You choose your Beneficiary when you first become eligible.
- You can change your Beneficiary at any time by filing a Change of Beneficiary Form which is available from the Claims Administration Office or the Local Union Office.
- Your Life Insurance may not be assigned.

Beneficiary Designation

You may change your Beneficiary without the Beneficiary's consent by giving written notice to the Claims Administration Office or through the Local 375 Union Office. The change will become effective as of the date you sign the notice.

Life Insurance Claims

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

Your Beneficiary can obtain claim forms from Welfare & Pension Administration Service, Inc. He or she should complete the form in its entirety and attach a death certificate or proof of loss. All forms should then be returned to:

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

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

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

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

Waiver of Premium— Permanent Total Disability

If, while you are insured, you become totally disabled (as defined in the Master Policy) prior to attaining age 60, and you die within one year from the date premium payment terminated and die while so disabled, payment of your Life Insurance will be made.

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

- Year to year extensions for further periods of one year each will be made if further proof of continuance of total and

permanent disability is furnished within three months prior to each anniversary of the date of the original proof of such disability.

- There is no disability benefit for dependents.

Conversion of Your Life Insurance

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

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

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

Employee Accidental Death & Dismemberment Insurance

The insurance company will pay up to the Life Insurance amount if an Employee suffers losses (such as life, one hand or one foot by dismemberment, or sight in one eye) due to injury and meets all of the stated Conditions. Please see the Life Insurance Certificate for a schedule and more specific information.

PLAN ADMINIS-TRATION

Coordination of Benefits (with Other Plans)

For Active Participants

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

Coordination with Other Benefits

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

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

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

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

This reduced amount plus the benefits payable by the other plans will not exceed 100% of allowable expenses.

- Allowable expenses means any necessary, usual, customary and reasonable expense you incur in a calendar year while covered under this Plan, but not any expenses contained in the list of Plan exclusions.

If, because of the coordination provision, this Plan does not pay its regular benefit, a record is kept of the reduction.

This amount will be used to increase your later claim payments under the Plan in the same calendar year, to the extent there are allowable expenses that otherwise would not be fully paid by this Plan and the other plans.

Therefore, on a later claim you may receive a greater benefit under our Plan than would be normally allowed.

Definition of Other Plans

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

- Group, blanket, or franchise insurance (except blanket accident-only coverage or student accident insurance).
- Group Blue Cross and/or Blue Shield and other prepayment coverage on a group basis, including HMOs (Health Maintenance Organizations).
- Coverage under a labor-management trustee plan, a union welfare plan, an employer organization plan or an Employee benefits plan.
- Coverage under government programs, other than Medicare or Medicaid, and any other coverage required by law.

- Group or individual automobile "fault or no fault" coverage.
- Other arrangements of insured or self-insured group coverage.

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

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

Order of Benefit Determination

The primary plan is determined as follows:

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

Rule 1: Non-Dependent or Dependent

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

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

Rule 2: Dependent Child Covered Under More Than One Plan

A. The Plan that covers the parent whose birthday falls earlier in the calendar year pays first; and the Plan that covers the parent whose birthday falls later in the calendar year pays second, if:

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

B. If both parents have the same birthday, the Plan that has covered one of the parents for a longer period of time pays first; and the Plan that has covered the other

parent for the shorter period of time pays second.

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

D. If the specific terms of a court decree state that one parent is responsible for the child's health care expenses or health care coverage, and the plan of that parent has actual knowledge of the terms of that court decree, that plan pays first. If the parent with financial responsibility has no coverage for the child's health care services or expenses, but that parent's current Spouse does, the plan of the Spouse of the parent with financial responsibility pays first. However, this provision does not apply during any Plan Year during which any benefits were actually paid or provided before the Plan had actual knowledge of the specific terms of that court decree.

   If the specific terms of a court decree state that both parents are responsible for the dependent child's health care expenses or health care coverage, the Plan that covers the parent whose Birthday falls earlier in the calendar year pays first, and the Plan that covers the parent whose birthday falls later in the calendar year pays second.

E. If the parents are not married, or are separated (whether or not they ever were married), or are divorced, and there is no court decree allocating responsibility for the child's health care services or expenses, the order of benefit determination among the plans of the parents and their Spouses (if any) is:

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

Rule 3: Active/Laid-Off or Retired Employee

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

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

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

Rule 4: Continuation Coverage

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

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

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

Rule 5: Longer/Shorter Length of Coverage

A. If none of the four previous rules determines the order of benefits, the plan that covered the person for the longer period of time pays first; and the plan that covered the person for the shorter period of time pays second.

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

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

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

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

KEY POINT

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

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

Right of Recovery/ Reimbursement

The Plan excludes benefits for a covered person if the covered person is injured from an illness or injury caused by the act or omission of another person (known as the "third party") for which there is a potential opportunity to recover from the third-party, the third-party's insurer or any liability policy.

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

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

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

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

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

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

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

If the covered person fails to honor the terms of this provision or any agreement to reimburse, any advanced benefits will be treated as overpaid benefits and the Plan may take appropriate action to collect the overpaid benefits, including, but not limited to, seeking refunds from providers, offsetting future benefits, including those of family members, denying future payments, bringing a breach of contract action in state court to enforce the Plan's right to reimbursement under this Plan provision and seeking a constructive trust in Federal court under ERISA

§ 502(a)(3). In addition to the overpaid benefits, the covered person will be liable for interest, and all costs of collection, including reasonable attorney fees and court costs.

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

Motor Vehicle Accidents

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

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

Repayment of Improperly Paid Benefits

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

YOUR RIGHTS

Notice of Privacy Practices

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

Protected Health Information

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

Use and Disclosure of Health Information

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

To Make or Obtain Payment

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

To Facilitate Treatment

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

To Conduct Health Care Operations

The Trust may use or disclose health information for its own operations to facilitate the administration of the Trust and as necessary to provide coverage and services to all of the Trust's Participants. Health care operations include such activities as: contacting health care providers; providing Participants with information about health-related issues or treatment alternatives; developing clinical guidelines and protocols; conducting case management, medical review and care coordination; handling

claim appeals; reviewing health information to improve health or reduce health care costs; participating in drug or disease management activities; conducting underwriting, premium rating or related functions to create, renew or replace health insurance or health benefits; and performing the general administrative activities of the Trust (such as providing customer service, conducting compliance reviews and auditing, responding to legal matters and compliance inquiries, including cost management and planning related analyses and formulary development, and accreditation, certification, licensing or credentialing activities).

In Connection With Judicial and Administrative Proceedings

If required or permitted by law, the Trust may disclose your health information in the course of any judicial or administrative proceeding in response to an order of a court or administrative tribunal as expressly authorized by such order or in response to a subpoena, discovery request or other lawful process. The Trust will make reasonable efforts to either notify you about the request or to obtain an order protecting your health information.

When Legally Required For Law Enforcement Purposes

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

To Conduct Health Oversight Activities

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

In the Event of a Serious Threat to Health or Safety

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

For Specified Government Functions

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

To Your Personal Representative

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

To Individuals Involved in Your Care or Payment for Your Care

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

To Business Associates

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

For Workers' Compensation

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

For Disclosure to the Plan Trustees

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

Authorization to Use or Disclose Health Information

Other than as stated above, the Trust will not disclose your health information without your written authorization. Authorization forms are available from the Privacy Contact Person, listed on page 65. If you have authorized the Trust to use or disclose your health information, you may revoke that authorization in writing at any time. The revocation should be in writing, include a copy of or reference your authorization and be sent to the Privacy Contact Person, listed on page 65.

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

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

Your Rights With Respect to Your Health Information

Right to Request Restrictions

You may request restrictions on certain uses and disclosures of your health information. You have the right to request a limit on the Trust's disclosure of your health information to someone involved in the payment of your care. However, the Trust is not required to agree to your request unless the disclosure is to another health plan for the purpose of carrying out payment or health care operations and your health care provider has been paid out of pocket in full. If you wish to request restrictions, please make the request in writing to the Trust's Privacy Contact Person listed on page 65.

Right to Confidential Communications

You have the right to request that the Trust communicate with you in a certain way if you feel the disclosure of your health information through regular procedures could endanger you. For example, you may ask that the Trust only communicate with you at a certain telephone number or by e-mail. If you wish to receive confidential communications, please make your request in writing to the Trust's Privacy Contact Person, listed on page 65. The Trust will attempt to honor your reasonable requests for confidential communications.

Right to Inspect and Copy Your Health Information

You have the right to inspect and copy your health information. This right, however, does not extend to psychotherapy notes or information compiled for civil, criminal or administrative proceedings. The Trust may deny your request in certain situations subject to your right to request review of the denial. A request to inspect and copy records containing your health information must be made in writing to the Privacy Contact Person, listed on page 65. If you request a copy of your health information, the Trust may charge a reasonable fee for copying, assembling costs and postage, if applicable, associated with your request.

Right to Amend Your Health Information

If you believe that your health information records are inaccurate or incomplete, you may request that the Trust amend the records. That request may be made as long as the information is maintained by the Trust. A request for an amendment of records must be made in writing to the Trust's Privacy Contact Person, listed on page 65. The Trust may deny the request if it does not include a reasonable reason to support the amendment. The request also may be denied if your health information records were not created by the Trust, if the health information you are requesting be amended is not part of the Trust's records, if the health information you wish to amend falls within an exception to the health information you are permitted to inspect and copy, or if the Trust determines the records containing your health information are accurate and complete.

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

Right to an Accounting

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

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

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

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

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

Right to a Paper Copy of this Notice

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

Right to Opt Out of Fundraising Communications

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

Privacy Contact Person

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, listed below.

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

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

Duties of the Trust

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

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

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

believe that your privacy rights have been violated.

Any complaints to the Trust should be made in writing to the Privacy 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.

ERISA Rights

As a Participant in the Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974.

ERISA provides that all Plan Participants shall be entitled to the following rights.

Receive Information about Your Plan and Benefits

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

Continue Group Medical, Dental and Vision Plan Coverage

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

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

- If your claim for a benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.
- Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator.
- If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court.
- In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in Federal court.
- If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

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

Newborns' and Mothers' Health Protection Act

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

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

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

Women's Health and Cancer Rights Act

On October 21, 1998, the Federal government passed the Women's Health and Cancer Rights Act of 1998. One of the provisions of this act requires group health plans to notify health plan members of their rights under this law.

What benefits does the law guarantee?

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

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

The law also states "the services will be considered in a manner determined in consultation with the attending physician and the patient." In other words, you and your physician will determine the most appropriate treatment for your individual situation.

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

Medical, Dental and Vision Plan Disclosures

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

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

- Qualified Medical Child Support Orders.
- Any cost-sharing provisions, including premiums, deductibles, coinsurance and copayments, maximums.
- Details about the level of benefits, providers, precertification and utilization review rules, coverage for medical tests, devices and procedures, out-of-network coverage, limits on emergency care, coverage of existing and new drugs.
- Employee and dependent eligibility requirements.
- Any participating provider requirements; a current listing of such providers shall be furnished automatically as a separate document.
- When insurance ends.
- When benefits may be denied or reduced, including right of recovery

or reimbursement, and coordination of benefits provisions.

- State or Federal continuation rights.
- Claims procedures; additional details shall be furnished upon request.
- Maternity hospitalization for the mother and newborn infant.

Life and Accidental Death & Dismemberment Benefits Plan Disclosures

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

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

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

Plan Changes

The persons with authority to change, including the authority to terminate, the Plan or the policies on behalf of the Plan are:

- The Board of Trustees or other governing body.
- Any person or persons authorized by resolution of the Board or other governing body to take such action.

The Board of Trustees and the Plan Administrator are authorized to apply for and accept the Policies and any changes to the Policies on behalf of the Plan.

GLOSSARY

Approved Treatment Facility means a facility that is licensed by the state in which it is located for treatment of chemical dependency.

Chemical Dependency means an illness characterized by:

- A physical and/or psychological dependency on alcohol or controlled substances; or
- Habitual lack of self-control in using alcohol or controlled substances to the extent that the covered person's health is substantially impaired or social or economic function is substantially disrupted.

Chemical Dependency Treatment means inpatient or outpatient medical care at an approved treatment facility including, but not limited to:

- Detoxification;
- Medical or psychiatric evaluation;
- Activity or family therapy;
- Counseling; or
- Prescription drugs and supplies.

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

Covered Medical Expenses means covered expenses for services, including supplies furnished incident to those services, which are medically necessary and for which benefits will be provided subject to the deductible, coinsurance, stated benefit maximums, and all terms, conditions, limitations, and exclusions of the Plan.

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

A **Dentist** means a legally qualified dentist practicing within the scope of his or her license.

Degenerative means deterioration of tissue in which its function is diminished or its structure is impaired.

Disabled and **Disability** refers to any disability which:

- Results from sickness or injury;
- Occurs while you are insured;
- Totally and continuously prevents you from working in any occupation for wage or profit; and
- Is expected to last for the rest of your life.

A **Hospital** is an institution that fully meets every one of the following tests:

- It is primarily engaged in providing, for compensation and on an inpatient basis, facilities for the surgical and medical diagnosis, treatment, and care of injured and sick persons under the supervision of a staff of physicians.
- It continuously provides 24-hour registered graduate nursing (R.N.) service.
- It is not, other than incidentally, a place for rest, for the aged, for drug addicts, for alcoholics, or a nursing home.

A **Medically Necessary Procedure** is a service or supply that meets all of the following criteria:

- Is essential and appropriate for the diagnosis and/or treatment of illness or injury.
- Is professionally and broadly accepted as the usual, customary, and effective means of diagnosing or treating illness or injury.
- Is not primarily for the convenience of the patient or provider.

- When applied to an inpatient, cannot safely be provided to an outpatient.

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

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

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

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

A **Physician** means a legally qualified physician practicing within the scope of his or her license as required by law. Charges for the services of a hospital resident or intern are covered under the "Comprehensive Major Medical Benefits" sections, but not under any other coverage description.

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

Room and Board Charges are the institution's charges for room and board and its charges for other necessary institutional services and supplies, made regularly at a daily or weekly rate as a condition of occupancy of the type of accommodations occupied.

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

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

Usual, Customary and Reasonable (UCR) charge means a charge for a service, treatment, or supply which does not exceed the 90th percentile of the charges for that service, treatment, or supply in the health care database utilized by the Trust, which reflects a current statistical sampling of charges for services and supplies in the same or a comparable area.

- In the event of multiple surgery or multiple surgeons in attendance during one operation, or for services, treatment, or supplies for which adequate data is unavailable, usual, customary and reasonable charges will be determined by the Claims Administration Office.

HEALTH TRUST INFORMATION

Summary Plan Description

For Alaska Pipe Trades Local 375 Health and Security Trust Fund

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

Plan Name

This Plan is known as the Alaska Pipe Trades U. A. Local No. 375 Health and Security Trust Fund, formerly known as Fairbanks Plumbing and Pipefitting Industry Health and Security Trust.

Board of Trustees—Plan Administrator

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

Board of Trustees
Alaska Pipe Trade Local 375
Health and Security Trust Fund
c/o Alaska Pipe Trades U. A. Local No. 375
3980 Boat Street
Fairbanks, AK 99709
(907) 479-6221

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

Plan Identification Number

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

Type of Plan

This Plan is a health and welfare plan, providing Life, Medical, Prescription, Dental and Vision benefits.

The benefits under the Plan are self-insured.

Type of Administration

This Plan is administered by the Board of Trustees with the assistance of Welfare & Pension Administration Service, Inc., a third party administrator.

Agent for Service of Legal Process

The administrative manager at the Claims Administration Office is designated as agent for purposes of accepting service of legal process on behalf of the Plan. The name, address and telephone number of the administrative manager is listed on Page 75.

Each member of the joint Board of Trustees is also authorized to accept service of legal process on behalf of the Plan. The names and addresses of the individuals currently serving on the joint Board of Trustees are listed on Page 75.

Description of Collective Bargaining Agreement

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

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

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

Eligibility and Benefits

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

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

Circumstances That May Result in Ineligibility or Denial of Benefits

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

- The employee's failure to work the required hours to maintain 135 or more hours in his or her Hour Bank. See the "Eligibility and Enrollment" section, Page 7.
- The failure of the employee's employer to report the hours and remit contributions on his or her behalf to the Trust Fund.
- In the case of beneficiaries who are dependents of an eligible employee, they may become ineligible if:
  - They are no longer dependents.
  - They have attained the disqualifying age.

See the "Eligibility and Enrollment" section beginning on Page 7.

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

- The failure of the Participant to file a complete claim for benefits.
- The failure of the Participant to file a complete and truthful benefit application.
- Where the Participant has other group insurance coverage, it is possible that benefits payable under this Plan may be reduced or denied due to coordination of benefits between the two plans. See the "Coordination of Benefits" section, Page 56.

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

In the event of the termination of the Trust Fund, any and all monies and assets remaining in the Trust Fund, after payment of expenses, will be used for the continuance of the

benefits provided by the then-existing health plans, until such monies and assets have been exhausted.

Source of Contributions

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

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

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

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

Plan Year

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

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

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

Claims must be submitted within one year from the date expenses for the services or supplies for which benefits are sought were first incurred.

Unless the Participant or Beneficiary can establish to the Trustees' satisfaction that it was not possible to file a claim within this one-year period, failure to submit a claim will result in a permanent denial of benefits.

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

For any claim, the Trust may require additional information to process claims or to meet Plan requirements.

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

Health Trust Directory

TRUSTEES

Union Trustees

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

Charlie Bennett
1161 Holmes Road
North Pole, AK 99705

Rodney Brown
U.A. Local 375
3980 Boat Street
Fairbanks, AK 99709

Employer Trustees

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

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

Richard Rutland
Doyon Associated
c/o 615 Bidwell Avenue, Suite 100
Fairbanks, Alaska 99701

LOCAL 375 UNION OFFICE

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

LEGAL SERVICES

McKenzie, Rothwell, Barlow & Coughran. P.S.
1325 Fourth Avenue, Suite 910
Seattle, WA 98101-1800

ACTUARIAL AND CONSULTING SERVICES

Propel Insurance
925 Fourth Avenue, Suite 3200
Seattle, WA 98104

CLAIMS ADMINISTRATION OFFICE

Welfare & Pension Administration Service, Inc.
2815 2nd Avenue, Suite 300
PO Box 34203
Seattle, WA 98124-1203