United Food and Commercial Workers
Local Union #1496

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Administration and Claims Payment Provided By
Welfare & Pension Administration Service, Inc.

Administration Mailing Address
P.O. Box 34203
Seattle, WA 98124-1203

Claims Submission Address
P.O. Box 34945
Seattle, WA 98124-1945

Physical Address
7525 SE 24th Street, Suite 200
Mercer Island, WA 98040
(800) 478-8329
(206) 441-7574

Member Services (Eligibility) Provided By
Labor Trust Services, Inc.

Mailing Address
P.O. Box 93870
Anchorage, AK 99509-3870

Physical Address
375 W. 36th Avenue, Suite 200
Anchorage AK 99503-5814
(907) 561-5119
(800) 478-8329

Trust Website
www.akufcwtrust.com

451N

ALASKA UNITED FOOD AND COMMERCIAL WORKERS HEALTH AND WELFARE TRUST

Active Employees

Summary Plan Description and Plan Document

June 2017

To All Eligible Employees:

This booklet describes the benefits available to you and your eligible dependents from the Alaska United Food and Commercial Workers Health and Welfare Trust as of June 1, 2017.

The following changes were recently made to your benefits:

- You now have access to the Coalition Health Center in Anchorage and Fairbanks. Visits are subject to only a $20 copayment and the annual medical deductible is waived. (effective April 1, 2017)
- If you use the services of a non-PPO provider, the plan will only pay 60% of the usual, customary and reasonable allowance. Also, the annual out-of-pocket maximum for services received from a non-PPO provider will be $12,000 per person/$24,000 per family. (effective June 1, 2017)
- Non-emergency orthopedic surgery will now be covered only if provided through a PPO provider or through the BridgeHealth surgical benefit. All other medically necessary surgery will be covered as any other benefit. (effective June 1, 2017)

We encourage you to become familiar with your benefits and the valuable protection they offer. This booklet will also help you understand what services are and are not covered and special steps you need to take to receive the highest level of coverage.

Also, don’t forget to notify the Administration Office whenever your address (or the address of a dependent child) changes.

If you have any questions about your eligibility or benefits, please call the Administration Office at (800) 478-8329 or (206) 441-7574.

Sincerely,

Board of Trustees

Employer Trustees

Robert McLauchlin
Frank Jorgensen
H.L. “Buzz’ Ravenscraft

Union Trustees

Gaither “Buster” Martin
Walter Stuart
Silvana Tirban

Notice Informing Individuals About Nondiscrimination and Accessibility Requirements

Alaska United Food and Commercial Workers Health and Welfare Trust (the "Trust") complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. The Trust does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Alaska United Food and Commercial Workers Health and Welfare Trust:

- Provides appropriate auxiliary aids free of charge for individuals with disabilities.
- Provides qualified interpreters free of charge to people whose primary language is not English.

If you need these services, contact Member Services at WPAS, Inc., PO Box 34203, Seattle, WA 98124-1203, (800) 478-8329 option 4, Fax (206) 505-9727.

You may file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Tagalog - PAUNAWA**:** Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-478-8329.

Spanish - ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-478-8329

Korean - 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-478-8329 번으로 전화해 주십시오.

Hmong - LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-800-478-8329.

Russian - ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-478-8329

Samoan - MO LOU SILAFIA: Afai e te tautala Gagana fa'a Sāmoa, o loo iai auaunaga fesoasoan, e fai fua e leai se totogi, mo oe, Telefoni mai: 1-800-478-8329

Chinese - 注意：如果您使用繁體中文, 您可以免費獲得語言援助服務。請致 電 1-800-478-8329

Laotian – . ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-800-478-8329

Japanese - 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます 。1-800-478-8329 まで、お電話にてご連絡ください。

Ilocano - PAKDAAR: Nu saritaem ti Ilocano, ti serbisyo para ti baddang ti lengguahe nga awanan bayadna, ket sidadaan para kenyam. Awagan ti 1-800-478-8329

Vietnamese - CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-478-8329.

Ukrainian - УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 1-800-478-8329.

Thai - **เรียน:** ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-800-478-8329

German - ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-478-8329.

Polish - UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-800-478-8329.

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WEBSITE

The Alaska United Food and Commercial Workers Trust has established a website to provide you with immediate access to your plan information. The site located at www.akufcwtrust.com includes the following Trust related material:

- Plan Booklets
  - Health and Welfare
  - Pension
  - Updates to plan documents
- Website Links
  - Aetna
  - Avia Partners
  - VSP
  - Other useful sites
- Forms
  - Health and Welfare Enrollment
  - Medical, dental, vision claims
  - Retirement
- HIPAA Privacy Notice and Information
- Local Union Contact Information

This site will also provide a link to “My Trust Login” which may be viewed through a secure location requiring the entry of a personal identification number (PIN) and your social security number, or your WPAS ID number as shown on your prescription ID card. A PIN will be assigned and mailed to you after you return a completed PIN request form (available on the website) to the Administration Office. For security purposes you may not choose your own PIN. “My Trust Login” information includes the following data:

- Personal Information – name, address, gender, birth date, marital status, etc.

- Health Eligibility – eligibility in the current and past eleven months
- Retirement – years of service, total hours and benefit amount
- Hours/Contributions – statement showing employers reporting hours and contributions to the Trust on your behalf
- Dependent Enrollment Information – names of enrolled dependents
- Beneficiary Designation
- Medical/Dental Claims Summary

Employees will only have access to their own paid claims history and that of dependents under the age of 13. Spouses and dependent children age 13 and over must request their own PIN. To request a dependent PIN, go to the Trust website (www.akufcwtrust.com) and download a Dependent Only PIN form.

If you have any questions about the contents of the website or access to "My Trust Login" information, please contact the Administration Office at (800) 478-8329 or (206) 441-7574.

SUMMARY OF BENEFITS

The following chart summarizes what the plan will reimburse you for covered expenses. You should carefully read the remainder of this document to determine any other limitations or restrictions that may apply before a claim is recognized as a covered expense.

Medical Benefits	
Calendar Year Deductible	$250 per person $500 per family
Coinsurance Percentage Reimbursed by the Plan	Most covered medical expenses: • 80% for PPO providers • 60% for non-PPO providers
Annual Out-of-Pocket Maximum	Most covered medical expenses: • $4,500 per person/$9,000 per family for PPO providers • $12,000 per person/$24,000 per family for non-PPO providers
Prescription Drug Benefits	See page 48
Dental Benefits	See page 58
Vision Benefits	See page 63
Life Insurance	• Employee – $5,000 • Spouse – $1,000 • Children – $100 to $1,000 (see page 73)
Accidental Death & Dismemberment Insurance	Employee – $5,000 principal sum (see page 75)

Note: All claims must be submitted within one year following the date expenses were incurred. No claim submitted after this deadline will be considered for payment.

ELIGIBILITY

This plan is maintained for employees whose employers contribute to the Alaska United Food and Commercial Workers Health and Welfare Trust on their behalf. To participate in the plan, you must meet the eligibility requirements described below.

Employee Eligibility

Initial Eligibility

To establish your initial eligibility, you must work and have contributions made on your behalf for at least 90 hours per month for three consecutive calendar months. Coverage begins on the first day of the *second* month following the month you meet this requirement.

Example 1: After any applicable probationary period, you worked and contributions were made for 100 hours in May and 90 hours in both June and July, coverage would be effective September 1.

Month	MAY	JUNE	JULY	AUG	SEPT
Hrs. Worked	100	90	90		
Eligible	no	no	no	no	yes

If you did not work at least 90 hours per month in both June and July, your coverage would be delayed.

Example 2: After any applicable probationary period, you worked and contributions were made for May but you do not satisfy the requirement of at least 90 hours per month for which contributions were made on your behalf for three consecutive months until the end of August. In this case, coverage would be effective October 1.

Month	MAY	JUNE	JULY	AUG	SEPT	OCT
Hrs. Worked	20	100	90	90		
Eligible	no	no	no	no	no	yes

Prior to the date you initially become eligible, you should obtain an enrollment form from the Administration Office or your local union office. You should list your eligible dependents (see page 15) and name your life insurance beneficiary and provide all other necessary information requested on the form.

Continuing Eligibility

Once you have established your initial eligibility, coverage continues in the second month following the month you work at least 90 hours under the plan and the required contributions were made on your behalf.

Example 3: If you already established initial eligibility in August, you will continue to be eligible in September if you work at least 90 hours in July.

Month	**JUNE**	**JULY**	**AUG**	**SEPT**
Hrs. Worked	100	110	90	
Eligible	no	no	yes	yes

Eligibility Ends

Your eligibility ends on the earlier of:

- The last day of the calendar month following the calendar month in which you did not work at least 90 hours for which contributions were made.
- The last day of the calendar month in which your employment terminates or your employer stops contributing to the Trust.

Note: Your employment is not considered terminated if you are on an authorized leave (including FMLA and USERRA leaves), participating in a work stoppage, or have been laid off.

Example 4: If you already established eligibility but then worked less than 90 hours in September, coverage would terminate October 31.

Month	AUG	SEPT	OCT	NOV
Hrs. Worked	120	50		
Eligible	yes	yes	yes	no

Example 5: If you already established eligibility, worked 120 hours in August and 90 hours in September, and then quit mid-September, coverage would terminate September 30.

Month	AUG	SEP	OCT	NOV
Hrs. Worked	120	90		
Eligible	yes	yes	no	no

Reinstating Eligibility

If you lose eligibility for any reason, and again work at least 90 hours in a calendar month, you will again become eligible for coverage, starting on the first day of the *second* month following the month you again work 90 hours.

However, if you do not work at least 90 hours in any month for a consecutive 12-month period you must reestablish your initial eligibility.

Associate Agreements

The Board of Trustees may authorize one or more employers to have associate agreements which extend insurance coverage to designated non-bargaining unit employees and owners of the employer. The contribution rates per person and the terms and conditions of such agreements shall be at the sole discretion of the Trustees. However, unless otherwise authorized by the associate agreement, and where appropriate, such things as eligibility, benefits, and coverages will be handled as per the Plan Document.

Coverage

Your months of eligibility determine which benefits are available to you and your eligible dependents. A month of eligibility, as used in this section, means your initial eligibility month and any months thereafter in which you worked at least 90 hours in the second preceding calendar month.

You and your enrolled dependents are covered as follows:

Months of Eligibility	Benefits	Who is Covered
1 – 12	Medical and Prescription Drug	Employee Only
13 – 24	Medical and Prescription Drug	Employee and Enrolled Dependent Children
25 – 48*	Medical, Prescription Drug and Dental	Employee and Enrolled Dependents
49+	Medical, Prescription Drug, Dental, Vision, Life, and AD&D	Employee and Enrolled Dependents

**Note: Your spouse may qualify for medical/prescription drug coverage before your 25th month of eligibility. This happens if you enroll your spouse within 60 days following the end of the month in which you completed your 1,200th hour of covered employment and you self-pay for coverage until the 25th month when weekly employee payroll deductions begin. Contact the Administration Office for information on this option and the monthly self-pay contribution required by you.*

However, if your employer remits contributions to the Trust at a rate other than what is required for the first 48 months, you will receive benefits according to that level of payment, rather than what is indicated in the above chart.

Your Monthly Contribution

In addition to the negotiated employer contribution, you may be required to contribute toward coverage for yourself, your child(ren), and your family, depending on your collective bargaining agreement.

Your contribution for coverage will automatically be made by payroll deduction each pay period. However, if both spouses are participants in the plan:

- The employee + child(ren) contribution is required from both spouses in order to provide dual coverage for their enrolled child(ren).
- The employee + family contribution is required from only one spouse in order to provide dual coverage for both spouses.

Enrollment

Initial Enrollment

Upon initial eligibility you, as the employee, must complete an enrollment form and send it to the Administration Office. No claims will be processed unless an enrollment form is on file at the Administration Office. Enrollment forms can be obtained on the Trust's website as well as from the Administration Office or your local union office.

When you become eligible for employee/dependent children and then later for employee/spouse or family coverage benefits, you must complete and return an authorization form to the Administration Office within 60 days of the date you first become eligible for dependent coverage. If you do not return an authorization form within 60 days, your dependents will not be eligible for benefits, and you will not have another opportunity to elect dependent coverage until the next annual open enrollment. An enrollment form must be on file listing all eligible dependents you wish to cover. Supporting documentation such as marriage or birth certificates may be required.

If you choose not to enroll yourself, your children, or your family, because of other coverage available through employment, you may be allowed to enroll at a later date if you have a change in family status as described in the Change in Family Status section below.

Annual Open Enrollment

Once each year in the fall, there will be an open enrollment period. At this time you can:

- Opt in or out of coverage for yourself. If you do opt out of coverage, you and your dependents will not be eligible for any plan benefits for the following year.
- Add or remove eligible dependents from your medical, dental and vision coverage.

Any changes you make will be effective on January 1 of the following year. You enroll by submitting a completed enrollment form to the Administration Office by the required date, and provide any supporting documentation (like a marriage certificate or a birth certificate).

Note: You are required to submit an enrollment form each year. Failure to complete and return this form to the Administration Office by the open enrollment deadline will cause the loss of your health plan eligibility for the next calendar year unless you experience a change in family status as indicated below.

Change in Family Status

If you have a change in family status during the year (such as marriage, divorce, legal separation, birth or adoption of a child or death of any dependent) or you lose coverage under your spouse's plan, or a dependent currently not enrolled loses other insurance coverage, you will be allowed to revise your coverage option, provided you notify the Administration Office within 60 days of the change.

This change will be effective the first day of the month following the status change (except newborns who are effective the date of birth). If the change in family status is due to marriage, you must provide a copy of the marriage certificate. If the change is due to divorce, you must provide a copy of the divorce decree. If the change is due to the birth of a child, you must provide a copy of the birth certificate.

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

If you do not enroll within 60 days of the change, then you will not have another opportunity to elect coverage until the next open enrollment.

Dependent Eligibility

Eligible Dependents

Eligible dependents include your:

- Legal spouse
- Children through age 25 including:
  - Natural children
  - Legally adopted children and children placed with you for adoption
  - Stepchildren
  - Children placed with you by an authorized agency or by legal order.

  The plan also provides benefits to certain dependent children (called alternate recipients) if directed to do so by a qualified medical child support order (QMCSO) issued by a court or state agency of competent jurisdiction. Contact the Administration Office for a copy of plan procedures for determining the status of medical child support orders.

Note: If someone is eligible as both an employee and an employee's dependent, or as a dependent child of two employees, the total amount of medical, prescription drug, dental, and vision benefits payable will not exceed the total amount of covered expenses actually incurred.

Coverage

Coverage for your dependents starts as follows:

- Medical/prescription drug – Coverage for your children starts after you complete 12 months of eligibility. Coverage for your spouse starts after you complete 24 months of eligibility. However, your spouse may qualify for coverage before your 25th month of eligibility if you enroll your spouse within 60 days following the

end of the month in which you completed your 1,200th hour of covered employment and you self- pay for coverage until the 25th month when weekly employee payroll deductions begin.

- Dental – Coverage for your spouse and/or children starts after you complete 24 months of eligibility.
- Vision, Life – Coverage for your spouse and/or children starts after you complete 48 months of eligibility.

These rules are illustrated on page 12.

You must submit an enrollment form naming your dependents before any claims will be paid for them.

Spouses acquired while your coverage is in effect, and after you have met the requirements for spouse coverage, will be covered as of the date of marriage provided they are enrolled within 60 days of your marriage and the required family contribution is made.

Children acquired while your coverage is in effect, and after you have met the requirements for child coverage, are eligible as follows:

- for children you acquire through adoption, coverage starts on the date they are placed for adoption,
- for all other children, coverage starts on the date they meet the definition of an eligible dependent,

provided they are enrolled within 60 days of acquisition and the required child contribution is made.

Example 1: Initially, only you will be eligible to receive medical and prescription drug benefits. After you complete 12 months of eligibility, your children will be eligible to receive medical and prescription drug benefits, provided you submit an enrollment form and a payroll authorization form (to authorize a payroll deduction for children coverage) within 60 days of the date your child was first eligible to participate in the plan.

Example 2: If you have more than 48 months of eligibility on the date you get married, your new spouse will be eligible to receive medical, prescription drug, dental, vision, and dependent life insurance benefits. Your spouse’s coverage will be effective on the date you were

married, provided you submit an enrollment form and a payroll authorization form (to authorize a payroll deduction for family coverage) within 60 days of your marriage.

If Your Child Becomes Disabled

You may continue medical, prescription drug, dental, and vision benefits beyond the ordinary age limit if your enrolled child is disabled and otherwise eligible for coverage. For this purpose, disabled means incapable of self-sustaining employment because of a mental or physical condition on the date the child would otherwise lose eligibility due to age. Within 31 days following that date, you must provide satisfactory proof of the incapacity. Contact the Administration Office for the required forms.

Benefits will be continued during the period of incapacity, as long as the child is otherwise eligible for coverage and you provide periodic proof of the continuing incapacity as requested by the Administration Office.

If Your Spouse Is Eligible for Benefits Coverage Through Another Employer

If your spouse is eligible for benefits coverage through his or her employment with another employer, and does not enroll for that coverage, they will be disqualified from receiving benefits under this plan. You will be required to submit proof that your spouse is not eligible for other benefits coverage through their employer.

Your spouse will not be disqualified from receiving coverage under the Alaska UFCW Health and Welfare Trust plan, if your spouse is eligible for other benefits coverage and enrolls in it; this plan's coordination of benefits provisions will apply.

Termination of Coverage

Your coverage and your dependents' coverage terminate at the earliest of the following:

- The last day of the month following any month you work less than 90 hours, unless you have elected to self-pay.

- The last day of the month that your employment terminates, unless you have elected to self-pay.
- The last day of the month that your employer stops contributing to the plan.
- The date the self-pay option expires.
- The end of the period for which any required self-pay contributions have been made.
- The day you begin active duty with the armed services of any country if the active duty is expected to exceed 30 days (unless you elect continuation coverage which is provided in accordance with the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA)).
- The date the plan is terminated.
- For a dependent, the last day of the month in which he or she ceases to meet the definition of eligible dependent (see page 15).

Disability Waiver of Premium

If you are unable to engage in any occupation for a period of two or more weeks (14 days or more) in any calendar month, you may be eligible for a disability waiver of premium once your hours fall below 90 in a month.

With a waiver, you and your eligible dependents, who were enrolled in the plan before you became disabled, are eligible for benefits without having to contribute for the cost of coverage. Only those benefits that you were eligible for at the time of disability will be continued.

You must contact the Administration Office to apply for a disability waiver. A physician's certification of your disability is required. In addition, you must be under the regular care of a physician.

Coverage under this provision begins on the first day of the second month following the month you are disabled for two or more weeks and may continue for up to three consecutive months, provided you are continuously disabled. Under no circumstances will you be provided with more than three consecutive months of eligibility for any and all disabling conditions until you reestablish employer paid eligibility.

Note: The three months of disability waiver will be counted when determining the maximum number of months mandated by COBRA. For example, the COBRA continuation period is 18 months for termination of employment, and if the three month's waiver of contributions is taken there will remain 15 subsequent months of COBRA continuation coverage.

Continuation of Coverage Through COBRA Self-Payment

You may be eligible to continue medical/prescription drug only or medical/prescription drug-dental-vision coverage after it would otherwise terminate based on a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). If you are an employee covered by the plan, you and your enrolled dependents may choose COBRA self-pay coverage benefits for up to 18 months if you lose coverage because you no longer satisfy the requirements for hours worked or your employment terminates, or you no longer qualify for a disability waiver of premium as described above.

If you or your enrolled dependent is determined by the Social Security Administration to be disabled on the date you lose coverage due to termination of employment or reduction in hours – or within the first 60 days of continuation coverage – you and your enrolled dependents may be eligible for a disability extension of continuation coverage from 18 to 29 months, provided you notify the Administration Office within the initial 18-month continuation coverage period.

Your spouse and/or dependent child may independently elect up to 18 months of continued coverage on a self-pay basis if the loss of coverage is due to a reduction in your hours worked or termination of your employment.

Your spouse and/or dependent child may choose continuation coverage for up to 36 months on a self-pay basis if the loss of coverage is due to:

- Your death.
- Your divorce or legal separation.

- Your entitlement to Medicare benefits, but only if it occurs while you are eligible for coverage as an active member.
- The dependent child ceasing to be an “eligible dependent” under the plan.

If your spouse and/or dependent child is receiving continuation coverage for 18 months due to termination of your employment or reduction in hours, the spouse or child may elect up to an additional 18 months of coverage if, during the first 18-month period:

- You die,
- You become divorced or legally separated, or
- Your dependent child ceases to be an “eligible dependent” under this plan.

You do not have to show that you are insurable to choose continuation coverage. However, you will have to pay all of the costs for your continuation coverage. Payment may be made by check or money order payable to:

Alaska United Food and Commercial Workers
Health and Welfare Trust
P.O. Box 34203
Seattle, WA 98124-1203

It is your responsibility as the employee or family member to inform the Administration Office within 60 days of your divorce or legal separation or of your child losing “eligible dependent” status under the plan. Those qualifying events result in loss of health care coverage, unless you act to preserve your right to continuation coverage by giving the Administration Office timely notice of the qualifying event.

Your employer is responsible for giving notice to the Administration Office of your death, Medicare entitlement, termination of employment, or reduction in hours.

When the Administration Office receives information from you, another family member or your employer concerning a qualifying event, the Administration Office will send you an election form that notifies you of your rights to continuation coverage and describes the options available and their costs. If you or a family member

wishes to continue coverage, you have 60 days from the later of the date you are notified of your continuation coverage rights or the date coverage normally ends to elect coverage by returning a completed election form to the Administration Office. Failure to make such an election within this time period will result in waiver of any rights you may have under these continuation of coverage provisions.

If you do not choose continuation coverage, your group health coverage will terminate in the normal manner.

If you choose to continue coverage, your health care coverage will be identical to that provided under the plan to similarly situated employees or family members who have not experienced a COBRA event unless you elect to drop dental and vision coverage. Continuation coverage is not available for life insurance and accidental death and dismemberment benefits.

If you gain a dependent while participating in self-pay coverage, the usual rules for enrolling new dependents apply.

Continuation coverage will terminate before the end of the 18-month, 29-month, or 36-month continuation coverage period if any of the following occurs:

- Your employer no longer provides group health coverage to any of its employees.
- Your self-payment is not paid on time.
- You become covered under another group health plan as an employee or otherwise after electing continuation coverage, unless the other plan limits coverage for your preexisting health condition.
- You become entitled to Medicare benefits after electing continuation coverage.

Contact the Administration Office if you have any questions about continuation of coverage.

Health Insurance Coverage Options

There may be other coverage options for you and your family through the Health Insurance Marketplace. In the Marketplace, you could be eligible for a tax credit that lowers your monthly premiums right away, and you can see what your premium, deductibles, and

out-of-pocket costs will be before you make a decision to enroll. Being eligible for COBRA does not limit your eligibility for coverage for a tax credit through the Marketplace. Additionally, you may qualify for a special enrollment opportunity for another group health plan for which you are eligible (such as a spouse's plan), even if the plan generally does not accept late enrollees, if you request enrollment within 30 days.

For more information about insurance options available through a Health Insurance Marketplace, visit www.healthcare.gov.

Family and Medical Leave Act (FMLA)

When you work for an employer with 50 or more employees within a 75-mile radius, you may have certain family and medical leave rights.

To be eligible, you must have worked for your current employer for at least 12 months, and for at least 1,250 hours in the 12 months before your leave. If you meet these requirements, and if your employer has enough employees to be covered under the FMLA, you will be treated as if you had continued working the same number of hours you would normally have worked before your FMLA leave. Your employer, as applicable, will continue contributions for your medical, prescription drug, dental, and vision coverage for up to 12 weeks during a 12-month period while you are on family or medical leave due to:

- Birth of your child, or placement of a child with you for adoption or foster care,
- Serious health condition of your child, spouse, or parent, or
- Your own serious health condition. (FMLA coverage will run concurrently with the Trust's disability waiver of premium provisions as described on page 18.)

Under the Trust's current procedures, you are also entitled to life and accidental death and dismemberment insurance coverage during your FMLA leave.

You should contact your employer as soon as you think you are eligible for a family or medical leave since the law requires you to give 30 days' notice, or tell your employer immediately if your leave

is caused by a sudden, unexpected event. Your employer can tell you of your other obligations under the FMLA. Employees who make contributions to the health plan must continue to do so while on leave. Coverage during a leave may lapse if an employee fails to pay their contributions.

When your 12 weeks of FMLA leave ends, you and your dependents may elect to continue medical, prescription drug, dental, and vision coverage through COBRA self-payment (see page 19).

If you do not return to work with your employer after your leave, the FMLA permits your employer, under certain circumstances, to recover the amount it contributed on your behalf during your FMLA leave.

USERRA Uniformed Service Leave

If you leave employment under the plan to perform certain United States uniformed service (generally the military, National Guard, and commissioned corps of the Public Health Service), you and your enrolled dependents may have the right to continue your medical, prescription drug, dental, and vision coverage for up to 24 months. If your military service lasts less than 31 days (for example, active duty for training), the plan will continue to cover you and your dependents. If your military service lasts 31 days or longer, you and your dependents will be eligible to continue coverage, in accordance with your rights under the Uniformed Services Employment and Reemployment Rights Act (USERRA), by making the required monthly payment. When you return, your regular coverage will begin immediately, provided you meet the requirements summarized below.

Under USERRA, you must notify your employer before taking leave (unless precluded by military necessity or other reasonable cause). You should also tell your employer how long you expect to be gone. Your period of uniformed service cannot exceed five years. Upon release from military duty, you must apply for reemployment as follows:

- Less than 31 days military service – apply immediately, taking into account safe transportation plus an 8-hour rest period

- 31-180 days military service – apply within 14 days
- More than 180 days military service – apply within 90 days

If you're hospitalized or convalescing, these reemployment deadlines are extended while you recover (but not longer than two years).

If your employer has a policy to pay contributions for its employees who are returned to active military service, the plan will accept those contributions and extend eligibility as long as all required payments are made.

To ensure proper crediting of service under USERRA, you should notify the Administration Office when you take USERRA leave. You should also tell the Administration Office how long you expect to be gone and notify them when you apply for reemployment after your leave. Please call the Administration Office for details on service under USERRA.

USERRA only applies if you seek reemployment after December 11, 1994. For information on military service provisions before that date, please contact the Administration Office.

MEDICAL BENEFITS

The plan's medical benefits are designed to reimburse you for covered expenses for medically necessary treatment of a non-occupational illness or injury, after you satisfy the deductible.

Deductible

The deductible is the amount of covered medical expenses you are responsible for paying before your medical benefits are available – $250 per person, but not more than $500 per family per calendar year. Once your family reaches $500, no further deductible is required for any family member that calendar year.

Covered medical expenses applied against the deductible during the last three months of a calendar year will also be used to reduce the deductible for the next calendar year.

If two or more eligible family members are injured in the same accident, they only need to satisfy one deductible for covered medical expenses for treatment of injuries related to the accident in that calendar year and the next calendar year.

Coinsurance Payable

After you satisfy your deductible, benefits for most services that calendar year are paid as follows:

	Plan Pays	**You Pay**
PPO Provider	80%	20%
Non-PPO Provider	60%	40%

Some services, like preventive care, skilled nursing facility and home health care, are paid at 100%.

However, if you do not have access to a PPO provider within 75 miles of your home, your claim will be reimbursed as if you were treated by a PPO provider.

Coinsurance amounts are based on:

- PPO contracted rate for services or supplies provided by PPO providers. The contracted rate is the fee negotiated by the PPO with the PPO provider.
- Usual, customary and reasonable (UCR) amount for services or supplies provided by non-PPO providers.

Out-of-Pocket (OOP) Maximum

After you and your family reach the annual out-of-pocket (OOP) maximum, the plan pays 100% of the PPO contracted rate or UCR for covered services for the rest of that calendar year. The out-of-pocket maximums are as follows:

	PPO Providers	Non-PPO Providers*
Per Person	$4,500	$12,000
Per Family	$9,000	$24,000

*If you (or your family) use a combination of PPO and non-PPO hospital, physician or other covered services during the year, your annual out-of-pocket maximum will not exceed this amount.

Included in the above out-of-pocket maximums are your annual deductible and the coinsurance percentages you pay. Non-covered services and amounts in excess of UCR charges do not apply toward the annual out-of-pocket maximum.

Preferred Provider Organization (PPO)

In Anchorage and the Mat-Su Valley, Alaska Regional Hospital and Mat-Su Regional Medical Center are the plan's preferred provider (PPO) hospitals. All other hospitals in these two areas are non-PPO hospitals. However, you may use any hospital – the choice is yours any time you need care.

There are PPO physicians, hospitals and other providers in Alaska and all other states through an arrangement with the Aetna network. These providers have agreed to provide services or supplies at a discounted fee to employees and eligible dependents covered by this plan. This helps the Trust and can also reduce your out-of-pocket costs. To find out if your doctor and care facility are part of the Aetna PPO network, please refer to Aetna's online preferred provider (PPO) directory at

www.aetna.com/docfind. The Aetna plan you belong to is Aetna Choice® POS II (Open Access).

- **PPO providers.** PPO contracts are reviewed periodically based on predetermined standards or credentials. PPO providers must meet or exceed these credentialing standards. Plan benefits and your share of covered expenses (typically 20%) are based on the discounted fee charged by your provider. You never have to worry about paying amounts over the plan's UCR charge, because the provider limits its charges to the plan's allowance. The PPO provider bills the Trust directly, so you don't have to fill out a claim form. In addition, if you use a PPO hospital, you receive a $50 credit towards your calendar year deductible if you have not already satisfied it.
- **Non-PPO providers.** If you use a non-PPO provider, your share of covered expenses is higher and plan benefits are based on the provider's going rate, not a discounted fee. In addition, you may need to pay for services at the time you receive them and file a claim for reimbursement. Also, you will have to pay for expenses in excess of the UCR charges.

Pre-certification of Services

To help ensure the efficient use of medical services, the Trust has contracted with Aetna to work with you and your provider to determine the treatment options that will provide the most beneficial or cost-effective care in your specific case. You or your provider can reach Aetna at (888) 632-3862.

Certain health care services such as hospitalization, outpatient surgery and some outpatient services, require pre-certification.

- **If you use an Aetna PPO provider**, your provider is responsible for obtaining necessary pre-certification for you. Because pre-certification is the provider's responsibility, if your provider fails to pre-certify required services, the provider's reimbursement will be limited and the provider cannot pass those costs on to you unless you sign an agreement with the provider to perform any unauthorized service(s).
- **If you use a non-PPO provider**, your provider may pre-certify for certain services on your behalf. If the provider fails to pre-certify those services, Aetna will review the medical necessity of

those services when the claim is filed. If the service is not medically necessary and is not approved, no benefits will be paid. If the service is medically necessary, benefits will be paid according to the plan.

Pre-certification is required for **inpatient confinements** in a hospital, skilled nursing facility, rehabilitation facility or hospice.

Pre-certification is also required for some **outpatient services** such as:

- Ambulance transportation by airplane
- Dialysis visits
- Electric or motorized wheel chairs or scooters
- Home health care related services
- Orthognatic and tmj surgery procedures
- Reconstructive or other procedure that may be considered cosmetic
- Spinal procedures

A complete list of surgeries or other outpatient services that require pre-certification can be found on the Trust's website at www.akufcwtrust.com.

Pre-certification may also be required for some behavioral health, mental health and substance abuse services such as:

- Inpatient admission
- Residential treatment center admission
- Partial hospitalization programs
- Psychological testing
- Biofeedback
- Outpatient detoxification

A complete list of these services requiring pre-certification can be found on the Trust's website at www.akufcwtrust.com.

When You Are Hospitalized

Pre-Admission Certification

Your doctor must contact Aetna at least 14 days *before* any nonemergency hospital admission (other than for childbirth) and obtain hospital pre-certification. For emergency admissions, your doctor or hospital must contact Aetna within 48 hours after admission. In some cases, failure to pre-certify a hospital stay will result in *no benefit* for hospital room and board charges if it is determined after the fact that the hospitalization or surgery was not medically necessary.

Pre-Admission Testing

In most cases, inpatient care before the scheduled day of nonemergency surgery is not medically necessary. If you need surgery-related tests and have them done on an outpatient basis, rather than as a hospital inpatient, the plan will pay 100% of the PPO contracted rate or UCR charges rather than the plan's usual 80% or 60%. Of course, in a situation where inpatient care is medically necessary before the scheduled day of surgery, it will be covered as provided under the covered medical expenses section (see page 32). *If inpatient care before surgery is not medically necessary, the plan will not provide any benefit for those days.*

Continued Stay Review

Aetna will contact your physician or facility on the day of your scheduled discharge to confirm discharge. If your physician or facility recommends extending your hospital stay beyond the number of days originally certified, Aetna will obtain clinical data from the physician or facility and determine whether an extended stay is covered under the terms of the plan. If it is covered, Aetna will authorize an extension of stay. If it is not covered, there will be no coverage for hospital room and board charges beyond the length of stay originally certified by Aetna.

Remember, it is always up to you and your physician to determine which services and supplies are appropriate for your condition.

Aetna is only responsible for determining which of these services and supplies are covered under the terms of the plan.

Reward For Catching A Mistake

Hospitals sometimes make mistakes on their bills. Those mistakes can add up to substantial amounts of lost money for the Trust. Consequently, we encourage you and your eligible dependents to ask the hospital for an *itemized bill*. Make sure the admission and discharge dates are correct and double-check the charges for tests and medication. 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 find an overcharge, don't forget to get a corrected bill and contact the Administration Office.

To encourage you to check your hospital bills, the Trust will reward you with 50% of the overcharged amount, up to a maximum reward of $5,000 if you find an error on the hospital bill after it has been audited and paid by the Administration Office. For example, if you find a $1,000 overcharge that the Administration Office did not catch, you will receive $500 from the Trust. A second look can help control your health care costs and possibly put some dollars back in your pocket.

Alternatives to Hospitalization

There are frequently less costly alternatives to hospitalization. Note that the plan pays a higher level of benefits for skilled care facility and home health care (see the covered medical expenses section starting on page 32 for details).

BridgeHealth Medical Surgery Benefit

The Trust has contracted with BridgeHealth to provide employees and their enrolled dependents with access to high quality providers across the United States. This includes access to centers of excellence, as well as surgeons who are highly rated in the United States for their specialty.

Upon acceptance of your case, the following enhanced plan provisions will apply when you utilize BridgeHealth network providers:

- Your plan medical deductible and coinsurance will be waived;

- Air and hotel are covered for the patient and companion, if medically required;
- A meals and incidentals allowance will be provided; and
- A BridgeHealth Care Coordinator will help coordinate all aspects of your surgery by helping collect the required medical records, assisting with provider selection and making travel arrangements.

You should contact BridgeHealth for information about the program if you or your dependents have planned major surgeries such as:

- Hip surgery
- Knee surgery
- Shoulder surgery
- Back surgery
- Heart surgery
- Women's health surgery
- General surgery

This benefit is not available for individuals for whom Medicare is primary.

To obtain more information about this benefit, contact BridgeHealth at (855) 423-1294 and identify yourself as an Alaska UFCW Health and Welfare Trust participant or email them at akufcw@bridgehealthmedical.com.

Individual Benefits Management

For certain illnesses or injuries, Aetna will work with you and your provider to determine the treatment options that will provide the most beneficial or cost-effective care in your specific case. In some cases, Aetna may authorize medical benefits that would not normally be covered under the plan, subject to approval by the Administration Office. You must receive this authorization from Aetna before receiving the service. The final decision on the course of your treatment will rest with you and your provider.

Covered Medical Expenses

Covered expenses are based on the plan's usual, customary and reasonable (UCR) charges, except PPO providers are based on the PPO contracted rate, for the following services and supplies when medically necessary:

Ambulance to the nearest hospital equipped to treat your condition. If air transport is medically necessary, the plan covers licensed air ambulance and/or round trip coach fare for the patient within Alaska, or from Alaska to Seattle, Washington. If the patient is a child or a disabled adult, the plan also covers air transport for an adult to accompany the patient. You must provide proof from your physician that air transport is necessary because treatment is not available in your locale or elsewhere in the state of Alaska. The plan will not prepay for air transport.

Anesthesia and its administration.

Birthing center for services and supplies for you or your spouse in connection with a pregnancy, including:

- Prenatal care
- Delivery and post-delivery care received *within 24 hours* after delivery, payable at 100%

Chiropractic treatment by a licensed chiropractor, up to a maximum of 24 visits per calendar year.

Cranial prosthesis for loss of hair resulting from treatment of a malignancy or permanent loss of hair from an accidental injury, up to $500 per calendar year.

Diagnostic x-ray and lab tests, analysis, and treatment including lab and microscopic tests, x-rays, radium and radioactive isotope therapy.

Dietary/nutritional counseling by a licensed dietician, when part of a treatment plan prescribed by a physician to treat a covered illness, up to a 10 visit lifetime maximum.

Durable medical equipment rental up to the purchase price (or outright purchase if approved by the Administration Office) including but not limited to:

- Standard hospital bed
- Wheelchair

Medical equipment will not be covered unless it meets all of the following conditions: is of no further use when the medical need ends, is usable only by the eligible person, is not primarily for comfort or hygiene, is not for environmental control, is not for exercise, is manufactured solely for medical use, is approved as effective and usual and customary treatment of the condition (as determined by the Administration Office), and is not for prevention purposes. Pre-certification by Aetna is required for some equipment (see page 27). Duplicate durable medical equipment is not covered.

Emergency room services provided in hospital emergency rooms when you are suffering from an emergency condition as defined on page 78. You do not have to obtain prior authorization before seeking emergency services in a hospital emergency room. The plan will charge you the same coinsurance whether you obtain those services from a PPO hospital or from a non-PPO hospital. However, if you obtain those services from a non-PPO hospital, that hospital may bill you the difference between what the hospital charges and the plan's UCR charge.

End stage renal disease (ESRD) may make you eligible for Medicare coverage by nature of the diagnosis. You are not obligated to apply for and enroll in Medicare Part A and/or Part B if you have ESRD. However, enrolling in Medicare when eligible may offer some protection from balance billing by the provider of ESRD services. Balance billing means the difference between the billed amount and the amount allowed by the plan and/or Medicare.

The plan provides the following benefits for outpatient kidney dialysis for treatment of ESRD:

- If you or your eligible dependents are not yet eligible to enroll in Medicare, benefits are provided for dialysis the same as any other condition.
- If you or your eligible dependents are enrolled in, or are eligible to enroll in Medicare, and Medicare becomes or is eligible to become the secondary payer for ESRD services and supplies (regardless of whether you are actually enrolled in Medicare),

benefits for kidney dialysis are provided at 150% of the current Medicare allowed amount.

- If Medicare becomes primary payer for ESRD services, the plan pays secondary to Medicare and coordinates benefits up to 100% of the then current Medicare allowed amount for kidney dialysis.

Notwithstanding the above, the plan may, at its sole discretion, agree to a contractual arrangement for payment with a provider of ESRD services. The contract may allow for a different payment for ESRD services than listed above, but in no circumstances will a contractual arrangement allow for a payment less than the payments listed above.

In order to ensure the correct coordination of claim payments between the plan and Medicare, you are required to provide the Administration Office with a copy of your card showing the effective date of your Medicare Part A and Part B coverage.

If you or your dependent is diagnosed with end stage renal disease (ESRD) contact the Administration Office for assistance.

Home health care up to 100 visits per calendar year is payable at 100%. Home health care is only covered when used as an alternative to inpatient treatment in a hospital or skilled care facility. Before home health care begins, the physician must certify that the patient would need inpatient care if there was no health care at home and submit a written treatment plan to the Administration Office for preapproval. Then, at the beginning of each 60-day period, the physician must review the treatment plan and certify that the condition and treatment continue to meet the above criteria. Pre-certification by Aetna is required for some services (see page 27).

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 hospitalized
- Part-time or periodic care by a registered nurse (or a licensed practical nurse if a registered nurse is not available)
- Part-time or periodic care by a home health aide.

The home care benefit does *not* cover the following:

- Care that is not specified in the treatment plan
- Care that is 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, up to 30 inpatient days per calendar year. Hospice care is only covered for the terminally ill, which means the patient has a medical prognosis of death within six months (as certified by a physician). Hospice care may be received on an inpatient basis or at home, but only care specified in the treatment plan can be covered.

Note: Failure to contact Aetna could result in no benefits for room and board charges if it is later determined that an inpatient stay was not medically necessary.

Care focuses on controlling pain and other symptoms associated with terminal illness while also helping the patient and the family acknowledge the approach of death. A hospice care program must be established by the patient's physician and outlined in writing. The treatment plan must be reviewed periodically by the patient's attending physician and the hospice care agency, must provide palliative care to the patient and supportive care to both the patient and the family, must include an assessment of patient needs, and must describe care that will be rendered to meet those needs.

Coverage is available for inpatient charges by a hospice, hospital, or skilled care facility for room and board (up to the facility's most common semiprivate rate) and other services and supplies for pain control and other acute and chronic symptom management.

Coverage is available for care at home by a hospice care agency for such services as:

- Part-time or intermittent nursing care by a registered nurse or licensed practical nurse up to eight hours a day
- Medical supplies, drugs, and medicines prescribed by a physician

- Medical social services under the direction of a physician

Coverage is also available for care at home by 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

These are covered on the same basis as services and supplies covered by the home health care benefit and count against the home health care maximum benefit.

The hospice benefit does *not* cover the following:

- 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, house-cleaning, and house maintenance
- Respite care, which means 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 the eligible person's needs for any reason

If you exhaust the hospice care limit, Aetna may authorize extensions in limited circumstances, subject to approval by the Administration Office.

Hospital services and room and board (up to the hospital's average semiprivate rate). Covered hospital services include staff physician services billed by the hospital, nursing care, intensive care unit, and outpatient hospital services. Hospital services are reimbursed at different rates, depending on whether they are received at a PPO hospital or a non-PPO hospital (see page 25 for details). You must obtain hospital pre-certification by Aetna (see page 27).

Note: Failure to contact Aetna could result in no benefits for room and board charges if it is later determined that an inpatient stay was not medically necessary.

Mastectomies are covered the same as any other treatment and benefits include:

- Reconstruction of the breast on which the mastectomy was performed
- Surgery and reconstruction of the other breast to produce a symmetrical appearance, and
- Prostheses and treatment of physical complications at all stages of mastectomy, including lymphedema

These reconstructive benefits are available for eligible individuals who are receiving benefits for a mastectomy and elect breast reconstruction or prostheses in connection with the mastectomy and in consultation with their attending physician.

Maternity benefits for you or your spouse, including pregnancy, childbirth, miscarriage or abortion.

Maternity services are covered on the same basis as any other condition. No maternity benefits are provided for dependent children. In accordance with federal law, the plan does not restrict lengths of hospital stay for a mother or newborn to less than 48 hours following normal vaginal delivery, or 96 hours following cesarean delivery. (In consultation with your physician, you may choose not to stay the full 48/96 hours.) Preauthorization is not required for these lengths of stay, but your physician should call Aetna to arrange approval if a longer stay is medically required.

Medical supplies including but not limited to:

- Blood plasma or whole blood
- Braces (except dental braces)
- Casts
- Crutches
- Oxygen and rental of equipment for its administration
- Splints
- Trusses

Naturopathic services are covered for medically necessary treatment of an illness or injury. Only the office visit and medically necessary lab work and x-rays are covered; charges for vitamins and

supplements prescribed or dispensed by the naturopath are not covered.

Nurse charges for medical care and treatment by a registered nurse (RN). The plan also covers licensed practical nurse (LPN) charges during hospital confinement if an RN is not available and the attending physician prescribes the services of an LPN.

Outpatient surgery, and all services related to the surgery, are covered the same as any other covered condition.

Physical therapy, occupational therapy and speech therapy services are covered, when prescribed by a physician and medically necessary as follows:

- For rehabilitative care to correct the effects of illness or injury
- For habilitative care when rendered due to congenital or developmental conditions to maintain or improve function where significant deterioration in function would result without the therapy. This includes therapy services for autism spectrum disorder

Physician services for medical treatment when received in the hospital, at home, in the doctor's office, or elsewhere.

Pre-Admission testing by a physician, hospital, outpatient surgery center, or licensed diagnostic laboratory facility is payable at 100% of the PPO contracted rate or UCR, but only if all of the following are true:

- The surgery is covered under the plan
- The tests relate to the scheduled surgery, are done on an outpatient basis within seven days before the scheduled surgery, and would have been covered if the patient was confined as a hospital inpatient
- Results of the tests appear in the patient medical record kept by the hospital or outpatient surgery center where the surgery is to be done
- The tests are not repeated in or by the hospital or other facility where the surgery is performed
- The patient undergoes the scheduled surgery in the hospital or outpatient surgery center. This does not apply if the reason for canceling the surgery is that the tests show it is not medically appropriate at that time. (If the patient cancels the scheduled surgery

for any other reason, these preoperative tests will be paid at the plan's regular benefit level – see page 25.)

Preventive care services performed by a PPO provider will be covered at 100% of the contracted rate, with no coinsurance or deductible. Preventive care services performed by a non-PPO provider are covered, subject to the plan's deductible and coinsurance. The following services are covered:

- Preventive care services and screenings per the US Preventive Services Task Force (USPSTF) A and B recommendations. Covered procedures include such services as blood pressure and cholesterol screening, various cancer and sexually transmitted infection screenings, as well as counseling in defined areas. A complete list of these services and screenings can be reviewed at www.uspreventiveservicestaskforce.org/recommendations.
- Routine immunizations as recommended by the Advisory Committee on Immunization Practices (ACIP) and published in the Centers for Disease Control (CDC) annual immunization schedules for children and adults. Current ACIP recommendations and immunization schedules can be found at www.cdc.gov/vacines.
- Preventive care services and screenings for infants, children and adolescents as recommended by the Health Resources and Services Administration (HRSA).
- Preventive care services and screenings for women recommended by the Health Resources and Services Administration (HRSA). A complete list of these services can be reviewed at www.hrsa.gov/womensguidelines.

If you have any questions about what is covered under the plan's preventive care benefit, please contact the Administration Office.

Prostheses to replace natural limbs or eyes. Pre-certification by Aetna is required for some services (see page 27).

Psychiatric inpatient treatment while confined in a hospital or approved treatment facility is payable the same as any other covered condition.

Note: Failure to contact Aetna could result in no benefits for room and board charges if it is later determined that an inpatient stay was not medically necessary.

Psychiatric outpatient treatment is payable the same as any other covered condition. Pre-certification by Aetna is required for some services (see page 27). Before you receive psychiatric outpatient treatment, check with the Administration Office to verify your provider is a covered provider for this treatment.

Refractive (eye) surgery up to a lifetime maximum of $1,000 per eye (maximum applies to preoperative and follow-up visits as well as the actual surgery).

Skilled care facility charges, for up to 100 days during any disability, are payable at 100% of the PPO contracted rate or UCR charge. All periods of skilled care confinement during any one disability are considered one confinement unless separated by a 90-day period. To be covered:

- The patient must be confined as a registered bed patient
- A physician must certify that confinement in the skilled care facility is necessary
- The patient must remain under the continuing care of a physician
- The confinement must begin within 14 days after a hospital confinement of one day or longer and be for the same injury or disease that required the hospitalization

Note: Failure to contact Aetna could result in no benefits for room and board charges if it is later determined that an inpatient stay was not medically necessary.

The following are covered:

- Room and board (up to the facility's most common charge for a standard semiprivate room)
- General nursing care in connection with room and board
- Use of special treatment rooms
- X-ray and laboratory exams
- Physical, occupational, and speech therapy
- Oxygen and gas therapy
- Other medical services customarily provided to patients

- Drugs, biologicals, solutions, dressings, and casts (but no other supplies)

The skilled care facility benefit does *not* cover:

- Custodial care
- Treatment of mental disorders such as drug addiction, chronic brain syndrome, alcoholism, mental disability, or senility
- Physician services and private duty or special nursing services provided by a skilled nursing facility

Substance abuse inpatient treatment while confined in a hospital or approved treatment facility is payable the same as any other covered condition.

Note: Failure to contact Aetna could result in no benefits for room and board charges if it is later determined that an inpatient stay was not medically necessary.

Substance abuse outpatient treatment is payable the same as any other covered condition. Pre-certification by Aetna is required for some services (see page 27).

Surgical services for medically necessary surgery when received in the hospital, at the doctor's office, or elsewhere. However, non-emergency orthopedic surgery expenses will be covered **only** if the doctor and facility are PPO providers or the service is approved through BridgeHealth (see page 30).

Charges for an assistant surgeon will be covered at 25% of the allowed amount for the surgeon's fee.

If you or your dependents have planned major surgery, the BridgeHealth surgery benefit, as described on page 30, is available for certain surgeries.

Transplants if preauthorized in writing by Aetna. Only the following human to human organ or tissue transplants are covered:

- Bone marrow
- Cornea
- Heart
- Heart/lung

- Intestinal
- Kidney
- Liver
- Lung
- Pancreas
- Peripheral blood stem cell

Transplant services are defined as the recipient's medical, surgical and hospital services; immunosuppressive medications; and organ procurement. Organ procurement costs include compatibility testing, donor transportation, hospitalization and surgery, organ transportation, and other charges which are directly related to the procurement, but only if benefits are not provided under the donor's own group health plan. This plan does not provide any coverage if you or your eligible dependent is a donor.

Exclusions and Limitations

All claims must be submitted within one year following the date expenses were incurred. No claim submitted after this deadline will be considered for payment.

No medical benefits are payable for the following:

- Dental x-rays (unless necessitated by an injury)
- Services rendered and supplies acquired when you are not eligible for plan benefits
- Accidental bodily injury or sickness arising out of or in the course of employment (including self-employment), or which is compensable under any worker's compensation or occupational disease act or law, whether or not a claim is made
- Expenses which the attending physician does not certify as necessary, and hospital charges which a physician has not recommended and approved
- Services of a provider, such as a massage therapist, who does not meet the plan's definition of physician (see page 82), except as specifically provided by the plan's terms

- Charges for any services, treatments or supplies which exceed the UCR charge, as determined by the Trust
- Hypnotism, stress or anger management, and any goal oriented behavior modification therapy (for example, weight-loss or pain control)
- Services which are primarily for weight-loss (except surgery for morbid obesity which has received prior authorization from Aetna)
- Expenses related to cosmetic surgery, except as necessary for the repair of an accidental bodily injury
- Expenses related to dental care and treatment, except as necessitated by accidental bodily injury to sound, natural teeth
- Expenses for dental implantology, except when the patient is totally edentulous (without teeth) and the gum is severely resorbed and cannot support regular dentures, or when necessary due to an accidental injury to sound natural teeth
- Expenses related to learning disabilities and behavioral problems, except for necessary medication management services
- Any services or supplies received in connection with an employee or covered dependent acting as a surrogate mother, regardless of whether an employee or covered dependent is a biological parent. This exclusion applies to services or supplies related to the surrogate mother becoming pregnant, pregnancy and delivery charges. Additionally, a child of a surrogate mother shall not be considered a covered dependent if the child is not the biological child of an employee or adult covered dependent or if the surrogate mother has entered into a contract or has an understanding prior to becoming pregnant that she will relinquish the child following its birth. The plan also does not cover services or supplies provided to an individual not covered by the plan who acts as a surrogate mother for an employee or covered dependent. "Surrogate mother" is defined as a woman who becomes pregnant through artificial or assisted methods for the purpose of carrying the fetus to term for a third party.
- Confinement, treatment or service to restore fertility or to promote conception, including (but not limited to) the reversal of a tubal

ligation or vasectomy, tubal plasty, fertility drugs, artificial insemination, in-vitro fertilization and embryo transplantation

- Eye examinations to prescribe corrective lenses or fit glasses
- Eyeglasses, contact lenses, hearing aids, or cochlear implants
- Educational services, or marital counseling
- Vitamins, minerals, herbs; food supplements that are not the primary source of caloric intake
- Accidental bodily injury or sickness caused by war, or by any act of war, declared or undeclared, or by participating in a riot, or as the result of your commission of a felony
- Expenses incurred while confined in a US government hospital or any other hospital operated by a governmental unit, unless legally required to pay it without regard to the existence of insurance, or unless the plan is required by law to pay for it
- Expenses related to any intentionally self-inflicted bodily injury, unless the injury is the result of a medical condition
- Job retraining therapy (except rehabilitation treatment to restore function lost following a stroke or injury)
- Charges made by a physician, registered nurse, licensed practical nurse, or any covered provider who is related to, or ordinarily resides with, the person requiring treatment
- Treatment of temporomandibular joint dysfunction (TMJ), including appliances and related fittings, or adjustment services except as medically necessary due to an injury
- Any services which are not medically necessary (see page 81)
- Services that are not specifically listed in this plan as a covered expense, or for which the eligible person is not legally obligated to pay
- Procedures, services, drugs, and other supplies that are determined to be experimental or investigational (see page 78)
- Benefits for expenses incurred due to illness or injuries caused by the act or omission of a third party if the costs associated with the illness or injury are recoverable from a third party or other source

- Charges for missed appointments, telephone, internet, or other consultations where a patient is not physically seen by a physician or other covered provider
- Acupuncture, unless performed by a MD or DO, and is determined to be medically necessary
- Professional fees for interpretation of automated lab tests
- Non-emergency orthopedic surgery provided by a non-PPO provider (both the physician and the facility), unless approved through BridgeHealth

COALITION HEALTH CENTER

As an alternative to visiting your regular provider, the Coalition Health Center in Anchorage and Fairbanks is also available to plan participants.

Charges for services provided at the Coalition Health Center do not apply towards your annual medical deductible, or medical out-of-pocket maximum. Also, the medical coinsurance percentages do not apply. Instead you will be charged a flat dollar copayment for each visit.

Summary of Health Center Services

The Coalition Health Center is staffed by mid-level providers providing the following services:

- Acute episodic care and symptoms relief (strains, sprains and pains)
- Cholesterol, hypertension, and diabetes screenings, treatment, and management
- Treatment of sore throats, earaches, headaches
- Treatment of cough and sinus
- Treatment of rashes and allergies
- Treatment of acute urinary symptoms
- Well-woman, well-man and well-child exams
- Treatment of minor injuries
- Physicals (annual, school and sports)
- Health education
- Standard immunizations and flu shots

In addition, labs are performed on site and some generic prescriptions are dispensed at no cost to you.

Cost of Service

- $20 copayment per visit per person
- $0 copayment per visit for preventive care services required under federal law

The copayment includes the visit and any lab work needed as well as any prescription medications dispensed at the Health Center.

Payment is due at the time of services and you will not have to fill out a claim form.

Health Center Locations

The Coalition Health Center in Anchorage is on the Alaska Regional Hospital campus, 2741 DeBarr Road, Suite C210. They can be reached by phone at (907) 264-1370.

The Coalition Health Center in Fairbanks is located in the Ridgeview Business Park, 575 Riverstone Way, Unit 1. They can be reached by phone at (907) 450-3300.

Both centers can also be reached online at coalitionhealthcenter.com if you have any questions or want to schedule an appointment.

Walk-in visits may be available if their schedule permits.

Services Not Covered

- Treatment for children under age 2 for Fairbanks and under age 5 for Anchorage.
- Treatment for active employees or their dependents who are enrolled in Medicare if Medicare is primary.
- Treatment for eligible retirees or their spouses who are eligible for Medicare.

PRESCRIPTION DRUG BENEFITS

The plan's prescription drug benefit is provided through an agreement with Avia Partners. The contract between the Trust and Avia Partners is incorporated here by reference. If there is any conflict between the contract and the description here, the contract will govern.

You will receive an Avia Partners ID card and information directly from Avia Partners. If you do not receive your card or information packet, contact the Administration Office.

Market Priced Drug (MPD) Program

The MPD program will help you and your provider identify lower cost drugs for treating common health conditions. The MPD program applies to many, but not all, medical conditions.

Under the MPD program, lower cost drugs are called "preferred" drugs. These drugs are determined to be cost effective for treating a specific condition. The preferred drug will be similar in clinical effectiveness to the non-preferred drug in achieving the intended health goal.

If you are prescribed a non-preferred drug, you and/or your enrolled dependents will receive the first fill at the pharmacy for the preferred copay/coinsurance. However, you will also be notified that subsequent refills may cost you more unless you switch to a preferred drug. This notification will provide the alternative preferred drugs available and the estimated costs and will assist you on getting a new prescription for a preferred drug. We encourage you to discuss this program with your provider(s) and ask if a less costly preferred drug is right for you. Your provider knows your full medical history and which drug therapies he/she prefers for you. The cost for a prescription however, is determined by the Plan's prescription drug and MPD program.

If you have questions regarding your prescription drug benefits, or if you and your provider decide a preferred drug is not right for you, you may call Avia Partners at (800) 273-9166, 24 hours a day 7 days a week to discuss your benefits or to request an exception. Your provider must complete a short form and provide to Avia Partners

evidence of a recognized medical reason for the exception request. If approved, you will pay the preferred copayment for the medication.

What Prescription Drugs Are Part of the MPD Program

The MPD prescription drug program is subject to review and update by the Trustees, as advised by the MPD program provider. As such, the following list may be updated periodically. Currently, the following drug categories are subject to the MPD program:

- **ADHD/Weight Loss**
  Amphetamines
- **Allergy symptoms/Asthma/Various Inflammatory Conditions**
  Adrenals
  Leukotrene Modifers
  Second Generation Antihistamines
- **Birth Control/Hormones**
  Androgens
  Contraceptives
  Estrogens
- **Blood Clots**
  Coumarin Derivatives
  Platelet Aggregation Inhibitors
- **Benign Prostatic Hyperplasia**
  Selective-1Adrenergic Blocking Agents
- **COPD or Digestive Tract Spasms/Heartburn/GERD**
  Antimuscarinics/Antispasmodics
  Histamine H2-Antagonists
  Prokinetic Agents
  Proton-pump Inhibitors
- **Diabetes**
  Alpha-Glucosidase Inhibitors
  Biguanides
  DPP-4 Inhibitors
  Insulins

Indcretin Mimetics
Sulfonylureas
Thiazolidinediones

- **Erectile Dysfunction**
  Phosphodiesterase Type-5 Inhibitors
- **Glaucoma/Ears, Eyes, Nose and Throat Conditions**
  Antiallergic Agents
  Beta-Adrenergic Blocking Agents
  Corticosteroids
  Prostaglandin Analogs
- **High Blood Pressure/Swelling**
  Alpha-Adrenergic Blocking Agents
  Angiotensin-Converting Enzyme Inhibitors
  Angiotensin II Receptor Angatonists
  Beta-Adrenergic Blocking Agents
  Calcium-Channel Blocking Agents, Misc.
  Dihydropyridines
  Loop Diuretics
  Mineralocorticoid (Aldost) Recept Antag
  Potassium-sparing Diuretics
  Thiazide Diuretics
  Thiazide-like Diuretics
- **High Cholesterol**
  Antilipemic Agents, Misc.
  Fibric Acid Derivatives
  HMG-CoA Reductase Inhibitors
- **Mood Disorders**
  Anxiolytics, Sedatives and Hypnotics Misc
  Atypical Antipsychotics
  Benzodiazepines
  Misc. Antidepressants
  Serotonin Modulators
  Selective Serotonin-reuptake Inhibitors
  Selective Serotonin and Norepinephrine-reuptake Inhibitors
  Tricyclics and Other Norepinephrine-reuptake Inhibitors
- **Muscle Spasms/Muscle Pain/Arthritis**
  Centrally Acting Skeletal Muscle Relaxants

Opiate Agonists
Other Nonsteroidal Anti-inflammatory Agents

- **Parkinsons Disease**
  Dopamine Precursors
  Monoamine Oxidase B Inhibitors

- **Various Conditions**
  5-alpha Reductase Inhibitors
  5-HT3 Receptor Antagonists
  Anticonvulsants, Misc.
  Antigout Agents
  Antimuscarinics
  Bone Resorption Inhibitors
  Nucleosides & Nucleotides
  Skin and Mucous Membrane Agents, Misc.
  Selective Serotonin Agonists
  Thyroid Agents

Retail Pharmacy

The prescription drug program features a custom network of pharmacies for your convenience. However, you may use most Avia Partners pharmacy outside the custom network, or most other pharmacies – the choice is yours each time you need to fill a prescription.

- **Custom network.** When you use a custom network pharmacy in Alaska, simply take your prescription and your Avia Partners ID card to the pharmacy and make the appropriate copayment. The pharmacy will bill the Trust directly, so you won't have to fill out a claim form.

- **Avia Partners pharmacies in Alaska but outside the custom network.** If you fill your prescription at an Avia Partners pharmacy outside the custom network in Alaska (except Kmart, Wal-Mart, or Walgreens), you must pay the full cost at the time of purchase, then file a claim with Avia Partners and wait for reimbursement. Your reimbursement will be based on the Avia Partners discounted price, minus the appropriate copayment.

- **Avia Partners pharmacies outside Alaska.** If you fill your prescription at an Avia Partners pharmacy outside Alaska (except

Kmart, Wal-Mart, or Walgreens), simply take your prescription and your Avia Partners ID card to the pharmacy and make the appropriate copayment. The pharmacy will bill the Trust directly, so you won't have to fill out a claim form.

- **Non-Avia Partners pharmacies.** If you fill your prescription at a non-Avia Partners pharmacy (except Kmart, Wal-Mart, or Walgreens), you must pay the full cost at the time of purchase, then file a claim with Avia Partners and wait for reimbursement. Your reimbursement will be based on the Avia Partners discounted price, minus the appropriate copayment.
- **Excluded pharmacies.** Benefits *will not* be provided, nor will the plan reimburse you, for the cost of a prescription filled at Kmart, Wal-Mart, or Walgreens, regardless of whether the prescription was filled in or out of the State of Alaska.

For prescriptions obtained at a retail pharmacy, you pay the following copayments for a 34-day supply:

If You Use a…	You Pay the Greater of…
Preferred Generic Drug	$5 or 10% of the retail price (up to $30 maximum per prescription)
Preferred Brand Name Drug	
• **If no generic alternative exists**	$15 or 20% of the retail price (up to $75 maximum per prescription)
• **If a generic alternative exists**	$25 or 30% of the retail price
Non-Preferred Generic or Brand Name Drug	If you use a non-preferred generic or brand name drug, you will pay the difference in the cost between the preferred and non-preferred drug in addition to the applicable brand or generic copayment/coinsurance shown above

If you have questions or need to locate a custom network pharmacy or other Avia Partners pharmacy, contact Avia Partners at (800) 273-9166 or https://avia.procarerx.com/account/login.

Mail Order Pharmacy

The mail order pharmacy program is designed for maintenance medications for ongoing or chronic conditions. For mail-order prescriptions, you pay the following copayments for a 90-day supply:

If You Use a…	You Pay the Greater of…
Preferred Generic Drug	$10 or 10% of the retail price (up to $60 maximum per prescription)
Preferred Brand Name Drug	
• **If no generic alternative exists**	$30 or 20% of the retail price (up to $150 maximum per prescription)
• **If a generic alternative exists**	$50 or 30% of the retail price
Non-preferred Generic or Brand Name Drug	If you use a non-preferred generic or brand name drug, you will pay the difference in the cost between the preferred and non-preferred drug in addition to the applicable brand or generic copayment/coinsurance shown above

For a mail-order prescription form, call:

- Alaska Managed Care Pharmacy at (800) 730-2627, if you live in Alaska.
- Well Partner Pharmacy at (866) 888-6150, if you live outside of Alaska.

Prescription Drug Out-of-Pocket Maximum

Once you and/or your dependents have reached the following out-of-pocket maximums for prescription drugs, all copayments and/or coinsurance are waived for that person or family for the rest of the calendar year:

	Out-of-Pocket Maximum
Person	$2,650 per calendar year
Family	$5,300 per calendar year

Prescription drugs filled at retail or mail order apply to the out-of-pocket maximum. However, the following charges will not apply to the prescription drug out-of-pocket maximum:

- Your copayment/coinsurance if you purchase your prescription from a non-Avia Partners network pharmacy.
- Your copayment/coinsurance if you purchase a brand name drug where generic drug is available.
- Your copayment/coinsurance and the difference in cost between the preferred and non-preferred drug if you purchase a non-preferred drug, unless there is a medical necessity exception approval from Avia Partners.
- Any prescription drugs purchased from Kmart, Wal-Mart or Walgreens.

Preventive Care Prescription Drugs

In accordance with federal law, the plan covers preventive care drugs at 100% with no copayment. Currently included are aspirin and smoking cessation drugs for adults, contraceptive drugs and devices for women as well as certain vitamin and mineral supplements for adults and children. Please note that over the counter (OTC) drugs require a prescription to be covered and quantity limits may apply to some drugs.

A complete and up-to-date list can be found at www.hhs.gov/healthcare. This list may be subject to change.

Routine Immunizations

Routine immunizations are available from many retail pharmacies with no copayment.

The plan provides benefits for routine immunizations as recommended by the Advisory Committee on Immunization Practices (ACIP) and published in the Centers for Disease Control (CDC) annual immunization schedules for children and adults. Current ACIP recommendations and immunization schedules can be found at www.cdc.gov/vaccines.

Covered Expenses

The prescription drug benefit covers prescription drugs and medications when prescribed by a physician or other lawful prescriber. This includes:

- Federal legend drugs
- Diabetic supplies (if prescribed) including insulin, insulin syringes, sugar test tablets, sugar test tape, acetone test tablets, and Benedict's solution or equivalent

Prior Authorization Drugs

For these categories of drugs, your pharmacist must obtain prior authorization from Avia Partners:

- Antivirals specifically indicated to treat HIV/AIDS
- Growth hormones (for example, Humatrope or Protropin)
- Hematinics (for example, folic acid, Chromagen, or iron supplements)
- Immunization agents
- Interferon (for example, Avonex or Betaseron)
- Vitamins (singly or in combination)
- All compound drugs exceeding $200

Exclusions

The prescription drug benefit does not cover any of the following:

- Anabolic steroids (for example, Winstrol or Durabolin)
- Anorectics (drugs used for the purpose of weight loss), except that Adderall and Dexedrine are covered
- Anti-wrinkle agents (for example, Renova)
- Blood or plasma
- DESI drugs, which are drugs the U.S. Food & Drug Administration has determined lack substantial evidence of effectiveness for the condition for which they are prescribed
- Dietary supplements (for example, Oxiplen or Zincate)
- Drugs requiring a prescription by state law, but not federal law (state controlled)
- Fluoride supplements (for example, Gel-kam, Luride, Prevident, or sodium fluoride tablets)
- Infertility medications (for example, Clomid, Metrodin, Pergonal, or Profasi)
- Injectable drugs, except that Glucagon, Insulin, and any drug covered under this plan in another form are covered
- Levonorgestrel (Norplant)
- Minerals (for example, Phoslo or Potaba)
- Minoxidil (Rogaine) for the treatment of baldness
- Non-legend drugs other than those listed above
- Pigmenting/depigmenting agents (for example, Solaquin Forte or Hydroquinone)
- Therapeutic devices or appliances, including support garments, and other non-medicinal substances, regardless of intended use, except those listed above
- Charges for the administration or injection of any drug

- Drugs labeled “Caution-limited by federal law to investigational use,” and experimental drugs, even though a charge is made to the individual
- Medication for a patient in a hospital, rest home, sanitarium, skilled care facility, nursing home, or similar institution which operates a facility for dispensing pharmaceuticals on its premises (or allows one to be operated on its premises)
- Viagra and other impotence agents
- Benefits for expenses incurred due to illness or injuries caused by the act or omission of a third party if the costs associated with the illness or injury are recoverable from a third-party or other source

DENTAL BENEFITS

The plan is designed to reimburse you for covered expenses for medically necessary dental treatment after you satisfy the deductible.

Deductible

The deductible is the amount of covered dental expenses you are responsible for paying each calendar year before your dental benefits are available – $25 per person, but not more than $50 per family. Once your family reaches $50, no further deductible is required for any family member that year.

Covered dental expenses applied against the deductible during the last three months of a calendar year will also be used to reduce the deductible for the next calendar year.

The deductible is waived for Type A (diagnostic and preventive) expenses.

Percentages Payable

After you satisfy your deductible, benefits are paid at a percentage of the plan's usual, customary and reasonable (UCR) charges as follows:

- 80% for Type A expenses (diagnostic and preventive)
- 80% for Type B expenses (basic dentistry)
- 50% for Type C expenses (major dentistry)

Maximum Annual Benefit

The maximum amount payable for any one eligible person during the calendar year is $1,500. For enrolled dependent children under age 19, this annual maximum does not apply.

Advance Claim Review

Advance claim review helps you determine your out-of-pocket expense before authorizing your dentist to complete a recommended

treatment plan. *If treatment begins before advance claim review, you may experience unanticipated out-of-pocket expenses.*

Before you begin a course of treatment expected to be $400 or more in dentist charges, you should file a description of the proposed course of treatment and charges with the Administration Office. The Administration Office will perform an advance claim review and tell you and your dentist the estimated benefits payable before treatment begins.

A course of treatment is a planned program, involving one or more dentists, to treat a dental condition diagnosed by your attending dentist as a result of an oral examination. The course of treatment begins on the date a dentist first renders a service to correct or treat the diagnosed dental condition.

Emergency treatments and oral examinations including prophylaxis and dental x-rays are considered part of a course of treatment, but these services may be rendered before an advance claim review is made.

If you do not furnish required materials (such as x-rays and written reports), the benefits for a course of treatment may be lower than they would otherwise be.

As a part of an advance claim review (and as part of any claim), the plan may require that you be examined at the plan's expense.

Covered Dental Expenses

Covered expenses are based on the plan's UCR charges for the following services and supplies, but only to the extent the plan determines the services, supplies, and course of treatment are:

- Appropriate and meet professionally recognized national standards of quality
- Necessary to treat the condition, and
- Customarily employed nationwide to treat the dental condition, taking into account the patient's current total oral condition.

Type A Expenses (Diagnostic and Preventive)

- Oral examinations, including scaling and cleaning of teeth, but not more than one examination in any period of six consecutive months
- Topical application of sodium or stannous fluoride
- Dental x-rays required to diagnose a specific condition requiring treatment
- Other dental x-rays, but not more than one full-mouth x-ray or series in any 36-month period and not more than one set of supplementary bitewing x-rays in any one-year period

Type B Expenses (Basic Dentistry)

- 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
- Dental sealants, but only if applied to the first and second permanent molars of an eligible dependent child under age 16, and only if the child has not been treated with sealants for at least four years
- Repair or recementing of crowns, inlays, bridgework, or dentures, or relining of dentures, but not more than one relining or rebasing in any 36-month period
- If a composite or filled resin restoration is placed on a posterior tooth, an amalgam allowance will be made for such procedure

Type C Expenses (Major Dentistry)

- 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 a new fixed bridgework or the addition of teeth to an existing fixed bridgework; however, this item will apply only if satisfactory evidence is given that one of following conditions is met:
  - 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 and has been in place four or more years, or
  - The existing denture is an immediate temporary denture and replacement by a permanent denture is required
- First installation of removable dentures to replace one or more natural teeth, including adjustments for the six-month period following the installation date
- If a tooth can be restored with a filling material such as amalgam, silicate or plastic, an allowance will be made for such procedure toward the cost of any other type of restoration that may be provided

Exclusions and Limitations

No dental benefits are payable for the following:

- Occupational illnesses or injuries
- Services or supplies which are covered under this plan’s medical benefit or payable under another medical plan
- Treatment by anyone besides a dentist, except that charges for cleaning or scaling of teeth by a licensed dental hygienist under a dentist’s supervision and direction will be covered
- Cosmetic services (whether partially or wholly cosmetic), including charges for personalization or characterization of dentures

- Installation of prosthetic devices (including bridges and crowns) which were ordered before you became eligible for plan benefits, or which were ordered while coverage was in effect but are installed or delivered more than 30 days after coverage terminates
- Replacement of a lost or stolen prosthetic device
- Orthodontic treatment
- Implants and related expenses
- Temporomandibular joint dysfunction (TMJ) treatment, such as appliances and related fittings, and adjustment services, except as provided for injury

Benefits After Termination of Coverage

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

- The item is installed or delivered within 30 days after termination of coverage
- For a denture, impressions were taken before coverage terminated
- For any other item mentioned above, the teeth which will serve as retainers or support, or which are being restored, have been fully prepared to receive the item, and impressions were taken before coverage terminated

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

VISION BENEFITS

Vision benefits are administered by VSP. The administrative services contract between the Trust and VSP is incorporated here by reference. If there is any conflict between the contract and the description here, the contract will govern.

Copay

There is a $25 copay toward the exam and a $35 copay toward the eyewear. The payment limits (if any) on the Schedule of Benefits are applied after you have paid your copay.

Schedule of Benefits

Services are available through either a VSP network doctor or a non-VSP provider.

If you need assistance locating a VSP network doctor, call VSP at (800) 877-7195, visit www.vsp.com, or contact the Administration Office. Then make an appointment and tell the doctor you are a VSP member. Your doctor and VSP will handle the rest.

The table on the following page summarizes vision benefits, both in and out of network, ***after*** you pay your $25 exam copay and $35 copay toward your eyewear:

Covered Expense	If You See a VSP Network Doctor...	If You See a Non-VSP Provider...
Eye Exam (once every 12 months from your last date of service)	Paid in full	Up to $50
Lenses (one pair every 24 months from your last date of service)		
Single vision	Paid in full*	Up to $50
Lined bifocal	Paid in full*	Up to $75
Lined trifocal	Paid in full*	Up to $100
Lenticular	Paid in full*	Up to $125
Frames (once every 24 months from your last date of service)	Paid up to $120**	Up to $70
Contacts instead of lenses and frames (once every 24 months from your last date of service)		
Necessary***	Paid in full*	Up to $210
Cosmetic	You pay up to $60 copay for contact lens exam (fitting and evaluation). The plan pays up to $120 for contact lenses	Up to $105
Lens Options (once every 24 months from your last date of service)		
Standard progressive lenses	$50 copay	Up to $75
Premium progressive lenses	$80-$90 copay	Up to $75
Custom progressive lenses	$120-$160 copay	Up to $75

* Lenses are paid in full, excluding cosmetic extras. Cosmetic extras include (but are not limited to) oversize lenses (61mm or larger), coated lenses, tinted or photochromic lenses, progressive or blended lenses. An average 30% discount on lens options is available from any VSP doctor.

** A 20% discount is provided on the out-of-pocket costs for frames that exceed the $120 allowance from a VSP network doctor.

*** Medically necessary contact lenses may be prescribed by a provider for certain conditions. The provider must receive prior approval from VSP for such contact lenses.

Additional Discounts

In addition to the benefits listed above, VSP network doctors have also agreed to provide the following:

- 30% discount on additional glasses and sunglasses, including lens options, purchased on the same day with the same provider who performed the exam
- 20% discount on additional glasses and sunglasses, including lens options. This is available from any VSP doctor within 12 months of your last eye exam
- Laser vision correction average 15% discount off the regular price, or 5% off the promotional price, of laser vision correction from contracted facilities

Low Vision Benefit

A low vision benefit is available for severe visual problems that are not correctable with regular lenses. This benefit requires a prior approval from VSP. Please discuss your options with your provider. Coverage includes:

- Supplemental testing – Covered in full
- Supplemental care – 75% of cost (25% copayment)
- Benefit maximum – $1,000 every two years

Low vision benefits secured from a non-VSP provider are subject to the same time limits and copay arrangements as described above for a VSP network doctor. You should pay the non-VSP provider's full fee. You will then be reimbursed up to the amount that would have been paid to a VSP network doctor in similar circumstances.

Expenses Not Covered

There is no benefit for professional services or materials connected with:

- Orthoptics or vision training and any associated supplemental testing
- Plano lenses (less than a +.50 diopter power)

- Two pair of glasses in lieu of bifocals
- Replacement of lenses and frames furnished under this plan which are lost or broken, except at the normal intervals when services are otherwise available
- Medical or surgical treatment of the eyes
- Corrective vision treatment of an experimental nature
- Costs for services and/or materials above plan allowances
- Services and/or materials not indicated on this schedule as covered plan benefits

COORDINATION OF BENEFITS

Many people enroll in more than one group health care plan in order to protect themselves against the high costs of medical and dental care. To keep the cost of plan benefits as low as possible, the Administration Office will coordinate benefit payments with other group health care plans.

For this purpose, group health care plan means any plan providing group coverage of medical, prescription drug, dental, or vision expenses which is arranged through an employer, trustee, union, member benefit or other association, school or other educational institution, or governmental program. This coverage may be through group insurance or any other arrangement to cover individuals in a group; it does not have to be insured. It may be government-sponsored as defined by federal laws such as Medicare Parts A and B and veterans benefits. It may be legally-required automobile reparations (no-fault) insurance even if not group insurance, but only to the extent of benefits required under that no-fault law.

If you or your dependents are covered under another group plan, you must submit identical itemized bills to both plans at the same time. The Administration Office and your other plan will determine which plan pays first (primary).

When coordinating with other group health care plans, the following applies:

Medical Coordination of Benefits

For Spouses:

- If the Trust plan is primary, it will pay benefits first. Benefits under the Trust plan will not be reduced or increased because you have benefits payable under other plans.
- If the Trust plan is secondary, its benefits may be reduced by benefits payable under the primary plan. The Trust plan will determine the amount of benefits you would receive if there were no other coverage, and then subtracts the amount paid by the other (primary) plan. The Trust plan will pay the difference, but no more than 20% of the amount that would be allowed under the primary

plan. However, if it can be documented that the claim is for benefits that would have been covered by this plan, but are not covered by the primary plan, then this plan's benefits will be paid as if it were primary.

For Children:

- If the Trust plan is primary, it will pay benefits first. Benefits under the Trust plan will not be reduced or increased because you have benefits payable under other plans.
- If the Trust plan is secondary, its benefits may be reduced by benefits payable under the primary plan. The Trust plan will determine the amounts of benefits you would receive if there were no other coverage, and then subtracts the amount paid by the other (primary) plan. The Trust plan will pay the difference.

  As an example, if your enrolled dependent child is covered under both your plan and your spouse's plan, and it is determined that the spouse's plan is primary, this is how the plan would work:

  Let's assume your child sees a doctor and the total charge for the services received is $150. The primary plan covers 75% of those services and the Trust plan covers 80%. This means the Trust plan will pay the 5% difference in the eligible charges after the primary plan pays benefits. For example:

Total charge	$150.00
Primary plan covers 75%	$112.50
Trust plan would have covered as primary (80%)	$120.00
Trust plan pays the difference between what the Trust plan would cover as primary and the actual payment by the primary plan	$7.50
Participant pays the rest	$30.00

Dental Coordination of Benefits

When coordinating with other dental plans, this plan will pay either its regular benefits in full (if primary) or a reduced amount (if secondary). This reduced amount, plus the benefits payable by the other plans, will under no circumstances exceed 100% of allowable expenses.

For this purpose, allowable expense means any necessary, usual, customary and reasonable expense incurred in a calendar year while eligible for plan benefits (but not any excluded expenses).

Coordination With Plans Other Than Medicare

The following rules determine which plan is primary:

- If the other plan does not have a coordination of benefits provision, that plan is primary
- The plan covering the individual as an employee is primary
- For children, the plan of the parent whose birthday comes first in the calendar year is primary. This is called the birthday rule. However, if the other plan does not have the birthday rule – resulting in conflicting orders of benefit determination – the other plan’s provisions determine the order of benefits
- For children of divorced or separated spouses, benefit payments are made by the plans in the following order:
  - Parent with court-ordered financial responsibility for the child’s healthcare. If both parents have financial responsibility, the parent with custody is primary and the parent without custody is secondary
  - Parent with custody
  - Spouse of the parent with custody
  - Parent without custody

- If the parents have joint custody and neither parent has court-ordered financial responsibility for the child's healthcare, the birthday rule will apply
- If the parents were never married and are separated the same rules apply as for divorced parents

- A plan covering the individual (or a dependent) as an active employee is primary over a plan covering the individual (or a dependent) as a retired or laid-off person. However, if the other plan does not have this rule – resulting in conflicting orders of benefit determination – this rule will not apply
- A plan covering the individual (or a dependent) as a non-COBRA self-payer is primary over a plan covering the individual (or dependent) as a COBRA self-payer
- The plan that has covered the individual for the longer period of time is primary
- If two plans are primary under these rules, the plan that has covered the employee the longest is primary

Coordination With Medicare

For nonretired employees and their dependents, the benefits payable under this plan will normally be primary and Medicare will normally be secondary. However, nonretired employees have the option of electing Medicare as their primary coverage. If a Medicare-eligible employee or dependent spouse makes such an election, the plan will pay no further medical benefits.

An exception to this rule is Medicare coverage for a person with end stage renal disease (ESRD). During the first 30 months, ESRD coverage through this plan is primary and Medicare is secondary. After 30 months of ESRD, Medicare becomes the primary coverage.

Subrogation and Recovery For Acts Of Third Parties

Your acceptance of benefits from the plan means that you have agreed to reimburse the plan in full for any benefits it has paid from any settlement, judgment, insurance, or other payment you, your eligible dependent, or your attorney receive as a result of an illness or injury. The plan shall be subrogated to all rights of recovery that you or your dependent may have against any person or organization. This provision applies whenever someone else (including your own insurer under an automobile or other policy) is legally responsible or agrees to compensate you for an illness or injury.

When you (or your estate) receive reimbursement for damages caused by a third party, you must reimburse the plan for any benefits it advanced, up to the full amount of compensation you receive from the other party, or the actual amount of benefits paid by this plan if less. The plan is entitled to recover as a right of first reimbursement from this compensation even if you are not made whole for the illness or injury suffered. It does not matter how the compensation is characterized, why it is paid, or whether or not the payment is specified as payment for pain and suffering, for medical bills or benefits, for the illness or injury suffered, or for other specified damages. The plan's reimbursement or subrogation rights will not be reduced because the recovery is not described as being related to medical costs or because it is characterized as loss of income, consortium, or the like. And the plan's reimbursement or subrogation rights will not be reduced to reflect any costs or attorney fees incurred in obtaining the compensation unless separately agreed to, in writing, by the Board of Trustees in the exercise of its sole discretion.

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

You are not entitled to multiple recoveries for the same injury. Once you have been compensated for an injury by a third party, the plan may no longer provide coverage for that injury or for medical conditions or complications that are directly caused by the injury.

If you or your dependents fail to comply with this provision, the Plan Administrator in its discretion may offset any future benefits claimed by you or your dependents under the plan until the amounts that should have been reimbursed to the plan are recovered.

LIFE INSURANCE

The plan provides life insurance for active employees and their dependents, which is payable for death from any cause, at any time or place while insured.

Life insurance is provided by the plan through an insurance contract with United of Omaha. An insurance certificate is available; contact the Administration Office if you would like a copy. Both the insurance contract and the certificate are incorporated here by reference. If there is any conflict between those documents and the description here, the insurance contract and certificate will govern.

Employee Life Insurance

The plan benefit is $5,000. You choose your beneficiary when you first become eligible. You can change your beneficiary at any time by filing a change of beneficiary form with the Administration Office. Forms are available on the Trust's website (www.akufcwtrust.com) and from the Administration Office or your local union office. If you do not name a beneficiary, payment will be made to your estate or a surviving relative, at the discretion of United of Omaha.

Dependent Life Insurance

You will receive the amount shown below if your insured dependent dies from any cause. If you die before payment is made, United of Omaha will make payment to your estate or surviving spouse, at its discretion.

Insured Dependent	Benefit
Spouse	$1,000
Children	
14 days – 6 months	$100
6 months – 2 years	$200
2 years – 3 years	$400
3 years – 4 years	$600
4 years – 5 years	$800
5 years and over	$1,000

The following are not eligible for coverage:

- Dependents in full-time active military service
- Children under 14 days of age, and
- Children age 26 or over.

Extended Life Insurance for Disability

If you become totally and permanently disabled before age 60, your life insurance will remain in force as long as you remain totally disabled. Total and permanent disability means illness or injury that prevents you from engaging in any gainful occupation, and will continue to prevent you from engaging in any occupation for which you are or may become fitted by education, training, or experience.

To qualify for extended life insurance during total disability, you must meet the following conditions:

- United of Omaha must be notified within three months after coverage would have terminated for insufficient hours
- The disability must continue for six months, and
- You must provide proof of the total and permanent disability within 12 months after coverage would have terminated.

If you satisfy these conditions, your life insurance continues without premium payment as long as you are unable to work.

Conversion Privilege

Life insurance and dependent life insurance may be converted to an individual policy of any of the types customarily issued by United of Omaha, except term insurance, without medical examination. In the event of death during the period allowed to elect conversion, your beneficiary will automatically receive the amount of life insurance in effect at the time plan coverage terminates. Contact the Administration Office for an application for conversion.

ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE

This benefit is payable for you in the event of death or dismemberment resulting within 90 days from an accident. Payment is made to your beneficiary in the event of your death, or to you in the case of dismemberment.

Accidental death and dismemberment coverage is provided by the plan through an insurance contract with United of Omaha. An insurance certificate is available; contact the Administration Office if you would like a copy. Both the insurance contract and the certificate are incorporated here by reference. If there is any conflict between those documents and the description here, the insurance contract and certificate will govern.

United of Omaha will pay the maximum benefit of $5,000 for the accidental loss of:

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

United of Omaha will pay one-half the maximum benefit ($2,500) for the accidental loss of one hand, one foot, or the sight of one eye. $5,000 is the most that will be paid for all losses resulting from any one accident.

Loss of a hand or foot means complete severance through or above the wrist or ankle joint. Loss of sight means entire and irrecoverable loss of sight in an eye.

Exclusions and Limitations

No benefit is payable for a loss resulting from any of the following:

- Suicide
- Ptomaines
- Disease or bacterial infection (except infections occurring through an accidental cut or wound)
- Intentionally self-inflicted injury,
- Bodily or mental infirmity, or
- Medical or surgical treatment (except certain treatments due to injury)

DEFINITIONS

The following terms, when used in this document, have the following meaning, unless a different meaning is clearly required by the context.

Administration Office: Welfare & Pension Administration Service, Inc. which acts as the plan's administrative agent under a contract with the Board of Trustees.

Approved treatment facility: A facility that provides treatment for mental health or substance abuse and that is operating under the direction and control of the appropriate licensing or regulatory agency of the jurisdiction in which the facility is located.

Birthing center: A facility which is equipped and operated solely to provide prenatal care; perform uncomplicated, spontaneous deliveries; and provide immediate postpartum care. A birthing center must either be licensed by the state or satisfy all of the following:

- Be directed by at least one physician specializing in obstetrics or gynecology
- Have a physician or nurse midwife present during each delivery
- Provide skilled nursing services in the delivery and recovery rooms (under the direction of an RN or nurse midwife)
- Have at least two birthing rooms or beds, diagnostic X-ray and lab equipment (or a contract to use that of an area medical facility), and emergency equipment
- Admit only patients with low-risk pregnancies (and contract with an area hospital for transfer of emergency cases)
- Regularly charge patients for services and supplies

Board of Trustees: The Employer and Union Trustees of the Alaska United Food and Commercial Workers Health and Welfare Trust.

Covered expense: Any expense incurred by an eligible employee or eligible dependent which is covered under the medical, prescription drug, dental, or vision (as applicable) provisions of the plan, subject to the exclusions and limitations and coverage by eligibility classification.

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

Dental benefit or dental plan: The dental expense benefit provided under the plan.

Dentist: A legally qualified dentist practicing within the scope of his or her license.

Emergency: Medical or dental care and treatment provided after the sudden unexpected onset of a medical or dental condition manifesting itself by acute symptoms, including severe pain, which are severe enough that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in:

- The patient's life or health being placed in serious jeopardy
- A serious dysfunction or impairment of a bodily organ or part
- In the event of a behavioral health disorder, the patient harming himself or herself and/or other persons.

The plan has the discretion and authority to determine if a service or supply is or should be classified as an "Emergency".

Experimental or Investigational service or supply means:

- The drug or device cannot be lawfully marketed without the approval of the U.S. Food and Drug Administration and approval for marketing has not been given for regular nonexperimental or noninvestigational purposes at the time the drug or device is furnished
- The drug, device, medical treatment, or procedure has been determined to be an Experimental or Investigative procedure by the treating facility's Institutional Review Board or other body serving a similar function, and the patient has signed an informed consent document acknowledging such experimental status
- Federal law classifies the drug, device, or medical treatment under an investigative program
- Reliable evidence shows the drug, device, medical treatment, or procedure is the subject of ongoing Phase I, II, or III clinical trials or is otherwise under study to determine its maximum tolerated dose,

its toxicity, its safety, its efficacy, or its efficacy as compared with standard means of treatment or diagnosis, or

- Reliable evidence shows that the prevailing opinion among experts regarding the drug, device, medical treatment, or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with standard means of treatment or diagnosis.

For purposes of this section, “reliable evidence” means 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.

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 the criteria in either Category 1 or 2 below:

Category 1

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

Category 2

- The trial is to treat a condition 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 preclinical data provide a reasonable expectation that the trial treatment will be at least as effective as noninvestigational therapy; and
- There is no therapy that is clearly superior to the trial treatment.

The Administration Office will investigate each claim for benefits which might include Experimental or Investigational treatment. The Administration Office will consult with medical professionals to determine whether the treatment is excluded as Experimental or Investigational. The Administration Office and Board of Trustees may rely on the advice of these medical professionals in deciding all claims and appeals related to Experimental or Investigational services or supplies.

Generic drug or medicine: A drug or medicine that meets all of the following conditions:

- Manufactured and marketed under its chemical name (or a shortened version of its chemical name)
- Approved by the U.S. Food and Drug Administration for safety and effectiveness
- Manufactured after the original patent expires by a company other than the one which originally patented its chemical formulation, and
- Less expensive than the version manufactured by the company that originally patented it

Home health care agency: An organization or agency that is considered a home health care agency under Medicare.

Hospital: An institution which fully meets each 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 service
- It is not (other than incidentally) a place for rest, a place for the aged, a place for drug addicts or alcoholics, or a nursing home

Hospice care agency: An agency which:

- Has hospice care available 24 hours per day

- Is licensed or certified as a hospice in the jurisdiction where it is located
- Provides skilled nursing services, medical social services, psychological and dietary counseling, and bereavement counseling for the immediate family
- Establishes policies governing the provision of hospice care
- Assesses the patient's medical and social needs
- Develops a hospice care program
- Provides or otherwise arranges for services to meet those needs

Intensive care unit: 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 or other highly trained hospital personnel. (A hospital facility maintained to provide normal post-operative recovery treatment or service is not an intensive care unit.)

Life insurance and dependent life insurance: The life insurance benefit for eligible employees and eligible dependents provided under the plan.

Medical benefit or medical plan: The medical expense coverage provided under the plan.

Medically necessary: A medically necessary service or supply is one which the Administration Office, in its sole discretion, determines is:

- Provided to diagnose or treat a medical condition
- Proper for the symptoms, diagnosis, or treatment of the medical condition
- Performed in the proper setting or manner required for the medical condition, and
- Within the standards of generally accepted health care practice.

The term "medically necessary" does not include expenses for:

- A service or supply which is provided as a convenience, even if ordered by a physician
- Repeated tests which are not needed, even if ordered by a physician

- Charges that are more than the plan's UCR charge in the locale where the expenses are incurred.

Member: A member of the United Food and Commercial Workers Union Local #1496 or an individual participating in the plan under a special agreement with the Board of Trustees.

Nonoccupational illness: An illness that does not arise out of or in the course of work for pay or profit, and does not in any way result from such an illness. However, if proof is furnished that the individual is covered under a Worker's Compensation or similar law, but is not covered for a particular illness under such law, that illness will be considered nonoccupational and may be covered under the plan, regardless of cause.

Nonoccupational injury: An accidental bodily injury that does not arise out of or in the course of work for pay or profit, and does not in any way result from such an injury.

Occupational therapist: A person licensed as an occupational therapist in the state where services are performed and who is practicing within the scope of that license. If there is no licensing requirement in the state where services are performed, the person must be certified by the American Occupational Therapy Association.

Outpatient surgery center: A facility that meets professionally recognized standards and is certified by either Medicare or a national affiliation as an outpatient surgical facility. It is not the office or clinic of one or more physicians.

Physical therapist: A person licensed as a physical therapist in the state where services are performed and who is practicing within the scope of that license. If there is no licensing requirement in the state where services are performed, the person must be certified as a registered physical therapist by the American Physical Therapy Association. The services of a physical therapy assistant are also covered if practicing within the scope of their license in the state where the services are performed.

Physician: A legally licensed Medical Doctor (MD) or Doctor of Osteopathy (DO).

For purposes of this plan, the term "physician" may also include the following practitioners of the healing arts who practice within the scope of their license in the state where services are performed and provide services covered under the plan:

- physician's assistant (PA),
- dentist (DDS),
- podiatrist (DPM),
- naturopathic doctor (ND),
- doctor of optometry (OD),
- psychologist (Ph.D. or Psy D.),
- optometrist,
- denturist,
- chiropractor,
- nurse midwife,
- licensed clinical social worker (LCSW),
- licensed professional counselor (LPC),
- registered nurse (RN),
- registered nurse practitioner (ARNP),
- licensed practical nurse (LPN) or
- licensed marriage and family therapist (LMFT).

Physician does not include a massage therapist. Before you receive treatment from any practitioner other than an MD or DO, check with the Administration Office to find out if the expenses will be recognized as covered expenses.

Plan: The Alaska United Food and Commercial Workers Health and Welfare Plan.

Plan Administrator: The Board of Trustees of the Alaska United Food and Commercial Workers Health and Welfare Trust.

PPO contracted rate: The discounted fee negotiated by the Preferred Provider Organization (PPO) with the PPO provider.

Preferred Provider or PPO Provider: A health care provider in the Aetna Choice® POS II (Open Access) Network that has agreed to provide services and supplies at a discounted rate.

Prescription: A written order for a legend drug or medicine issued individually to an eligible person by a legally qualified physician to a pharmacist who is licensed in the jurisdiction where he or she conducts business. Legend drugs are drugs that require a prescription to be dispensed.

QMCSO or Qualified medical child support order: A court or administrative order that determines a child's right to receive benefits that a member is eligible for under the plan and that the Administration Office has reviewed and found to be qualified under ERISA and any other applicable law. A complete description of the procedures governing qualified medical child support orders may be obtained at no charge from the Administration Office.

Room and board charges: An institution's charges for room and board and 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.

Semiprivate room rate: The daily room and board charges an institution applies to the greatest number of beds in its semiprivate rooms containing two or more beds. If the institution has no semiprivate rooms, the semiprivate rate will be the daily rate most commonly charged for semiprivate 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.)

Skilled care facility: An institution which satisfies all of the following:

- It is regularly engaged in providing skilled nursing care for sick or injured persons under 24-hour-a-day supervision by a physician or 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 per day, a graduate registered nurse, licensed vocational nurse, or licensed practical nurse, and has a graduate registered nurse on duty at least eight 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 a similar institution

Speech therapist: A person licensed as a speech therapist in the state where services are performed and who is practicing within the scope of that license. If there is no licensing requirement in the state where services are performed, the person must be certified as a registered speech therapist by the American Speech and Hearing Association.

Trust: The Alaska United Food and Commercial Workers Health and Welfare Trust.

Usual, customary and reasonable (UCR) charge: The usual, customary and reasonable charge for a service or supply is the lesser of:

- The usual fee which the provider of the service most frequently charges to the majority of his or her patients for a similar service or medical procedure
- The fee which falls within the customary range of fees charged in a locality by most providers of similar training and experience to perform a similar service or medical procedure
- The fee resulting from unusual circumstances or medical complications requiring additional time, skill, and experience in connection with a particular service or medical procedure

There will be differences in physician charges because of factors such as geographical location, skill of the provider of service, and complexity of the service performed. The Trust shall make the final determination as to whether or not a fee is "usual, customary and reasonable."

Vision benefit or vision plan: The vision expense coverage provided under the plan.

HOW TO FILE A CLAIM

To receive prompt payment of claims, you should follow the procedures outlined in this section as closely as possible. *All claims must be submitted within one year following the date expenses were incurred. No claim submitted after this deadline will be considered for payment.*

Unless you have assigned benefits to your doctor, dentist, hospital, or other provider, the check for your medical, prescription drug, dental, or vision claim will be sent to you. For a life or accidental death and dismemberment claim, the check will be forwarded to you, your estate, or your designated beneficiary, as applicable.

Note, according to Alaska law: "A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law." (Alaska Insurance Code Section 21.36.380.) False claims on a Trust are also a violation of federal law (18 U.S.C. 664).

Medical and Dental Benefits

- Obtain a claim form from the Trust's website (www.akufcwtrust.com), your local union office or the Administration Office
- Complete and sign your portion of the claim form
- Have your physician or dentist complete and sign his or her portion
- Enclose an itemized bill describing all services and treatments received
- Mail the completed claim to:

  Alaska UFCW
  Health and Welfare Trust
  P.O. Box 34945
  Seattle WA 98124-1945

Prescription Drug Benefits

If you use a custom network pharmacy in Alaska or an Avia Partners pharmacy outside Alaska (except Kmart, Wal-Mart, or Walgreens), you won't need to file a claim.

When you use a noncustom network pharmacy in Alaska, (except Kmart, Wal-Mart, or Walgreens), or a non-Avia Partners pharmacy anywhere (except Kmart, Wal-Mart, or Walgreens), you'll need to pay the full cost and then file a claim for reimbursement with Avia Partners. Claim forms are available on the Trust's website (www.akufcwtrust.com), from Avia Partners and the Administration Office. Be sure you sign and complete the form and attach your pharmacy receipt. Mail to:

Avia Partners, Inc.
250 E Parkcenter Blvd
Boise, ID 83706

The plan will not reimburse you for the cost of a prescription filled at Kmart, Wal-Mart or Walgreens, regardless of whether the prescription was filled in or out of the State of Alaska.

Vision Benefits

If you use a VSP network doctor, you won't need to file a claim.

When you use a non-VSP provider, you'll need to pay the full cost and then file a claim for reimbursement with VSP. A claim form can be obtained from the Trust's website (www.akufcwtrust.com), your local union office or the Administration Office. Attach your itemized receipt and send to:

VSP
PO Box 385018
Birmingham, AL 35238-5018

You may also have your non-VSP provider, if they are willing, submit a HCFA claim form to VSP, and VSP will pay the provider directly.

Life and Accidental Death and Dismemberment Insurance

- Obtain a claim form from the Administration Office
- Complete and sign your portion of the claim form
- In the case of death, enclose a copy of the death certificate
- In the case of dismemberment, have your physician complete the physician portion of the claim form
- Return the completed claim to the Administration Office

IF YOUR CLAIM IS DENIED

The Board of Trustees has established procedures for review and appeal of denied claims.

Processing of Claims

Post-Service Medical, Dental, Vision, and Prescription Drug Claims

A post-service claim is a claim for medical, dental, vision, or prescription drug benefits that does not require preauthorization to receive full benefits. A post-service claim will generally be processed within 30 days of receipt. This period may be extended for up to 15 days if the plan determines an extension is necessary due to matters beyond the control of the plan, and notifies you within the initial 30-day period of the circumstances requiring the extension of time and the date by which the plan expects to render a decision.

If an extension is necessary due to your failure to submit the information necessary to process the claim, the notification of the extension will describe the necessary information needed. You will be provided at least 45 days from receipt of the notification to submit the additional information. The plan's maximum period for making a determination will exclude the time from the date on which the notification of the extension is sent to you until the date on which you respond to the request for additional information.

The plan does require preauthorization for a non-emergency hospital admission. However, there is no penalty for failure to do so, and therefore all medical, dental, vision, and prescription drug claims are handled as post-service claims, and not pre-service or urgent care claims. In order to minimize the potential cost of these services, you are requested to submit a pre-authorization for these services.

Life Insurance/Accidental Death and Dismemberment

A claim for life insurance or accidental death and dismemberment benefits will generally be processed within 90 days after receipt. This period may be extended by up to 90 days, if special

circumstances require an extension. If the plan needs additional information from you to make its decision, you will be notified as to what information must be submitted.

Notice of Denial

If a claim is denied, the written notice of denial will give:

- Specific reasons for denial
- A reference to pertinent plan provisions
- A description of any additional information necessary to perfect the claim and an explanation of why such material or information is needed
- If an internal rule, guideline, protocol, or other similar criterion was relied upon, either a copy of the rule, guideline, protocol or criterion, or a statement that it is available without charge
- If the denial is based on medical necessity or experimental treatment or a similar exclusion or limitation, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to the claimant's medical circumstances, or a statement that such an explanation will be provided free of charge upon request
- An explanation of the Board of Trustees' Procedures for Hearings, including a statement of your right to bring a civil action under ERISA

Board of Trustees' Procedure for Hearings

Right to Hearing

Any employee or beneficiary who applies for benefits and is ruled ineligible, or who is adversely affected by any action of the Trustees, shall have the right to request an appeal before the Board of Trustees (the Board). The appellant can request a hearing. All requests for hearing must be in writing. In the case of a denied benefit claim, the request must be received in writing at the Administration Office no later than one hundred and eighty (180) days after the employee or beneficiary receives written notice of the denial. Where Trust policy provides an employee or beneficiary with a right to an appeal prior

to a proposed cancellation or adjustment of benefits, the request must be received at the Administration Office no later than one hundred and eighty (180) days after the employee or beneficiary receives notice of the proposed cancellation or adjustment. The time limits may be waived by the Board for good cause shown. Appeals without a request for a hearing will be conducted on the existing record.

All hearings will be heard either by the Board at the quarterly meeting, or by a duly authorized committee of the Board appointed by the Chair. The Chair of the Board (or in his/her absence, one of the other Trustees appointed by the Chair) shall chair the hearing. If a committee is appointed by the Chair, at least one (1) shall be from Labor and one (1) shall be from Management.

Scheduling of Appeal

The Trustees will review a properly filed appeal. The decision on review will ordinarily be made no later than 60 days after the request for review is received. However, if special circumstances exist then the Trustees may extend the time for issuance of a decision for an additional 60 days. In such cases the plan will notify the participant of the extension, the circumstances, and the new expected date by which a decision may be expected. Also, the parties may mutually agree to any extension of time.

In cases where the review by the Board of Trustees cannot be reasonably completed in the above time frames, the chair and secretary of the Trust, shall serve as a special subcommittee of the Board for the purpose of reviewing and deciding appeals. Also, the Board may, at its discretion, delegate authority to a standing or temporary subcommittee to review and act on appeals.

The Hearing Procedure

If an applicant fails to attend a scheduled hearing after notice, the Board may render its decision at the time of the scheduled hearing, based solely on the contents of the administrative file and any other evidence previously submitted. Failure to attend may be excused and a hearing rescheduled by the Board for circumstances beyond the control of the applicant. “Circumstances” shall include such items as inclement weather and transportation delays. An applicant may be

represented at the hearing by counsel or by a representative of his/her choosing at the applicant's cost. The Board may be represented by its counsel.

Not later than seven (7) days before the hearing; (a) the administrator for the Board shall provide the applicant, or his/her counsel or other representative, with a duplicate copy of all the materials in the administrative file which are relevant to the matter under review; and (b) the applicant, or his/her counsel or other representative, shall furnish to counsel for the Board a summary of the additional or supplementary evidence he/she intends to offer at the hearing, including the names of any witnesses. Likewise, counsel for the Board shall furnish to the applicant or his/her counsel or other representative a summary of the additional or supplementary evidence he/she intends to offer at the hearing, including the names of any witnesses.

Persons having a direct interest in the matter under review are entitled to attend the hearing. The Board may, in its discretion, require the exclusion of any witness or witnesses during the testimony of other witnesses. Also, the Board may, in its discretion, determine the propriety of the attendance of any other persons.

The applicant must introduce sufficient credible evidence on appeal to establish entitlement to the relief from the decision or other action from which the appeal is taken. The applicant will have the burden of proving his/her right to relief from the decision or action appealed, by a preponderance of evidence. The Trustees will review all comments, documents, records, and other information submitted by the applicant related to the claim, regardless of whether such information was submitted or considered in the initial benefit determination. The Trustees will not defer to the initial adverse benefit determination.

When deciding an appeal of a claim that is based in whole or in part on a medical judgment, the Trustees will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. Any medical or vocational expert whose advice was obtained on behalf of the plan in connection with the adverse benefit determination will be identified to the claimant. Any health care professional engaged for the purpose of a consultation on a claim will not be an individual

who was consulted in connection with the initial adverse benefit determination that is the subject of the appeal, nor the subordinate of any such individual.

Decision After Appeal Hearing

The Trustees will issue a written decision on review of a claim as soon as possible, but not later than 5 days following the conclusion of the Board, or authorized committee meeting. Where necessary, the Trustees may issue a more detailed explanation of the reasons for an adverse decision within 30 days of the conclusion of the Board, or authorized committee meeting. In the case of an adverse benefit determination, the written denial will indicate:

- The specific reasons for the adverse benefit determination and a specific reference to pertinent plan provisions on which the denial is based
- A statement that the applicant is entitled to receive, upon request and free of charge, reasonable access to, and copies of all documents, records, and other information relevant to the claimant's claim for benefits
- A statement of the applicant's right to bring a civil action under ERISA
- If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion, or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the determination and that a copy of the same will be provided free of charge to the applicant upon request.

External Review

If a claimant remains dissatisfied after the Board of Trustees issues its decision on appeal, he or she may request an external review with an Independent Review Organization or bring a civil action under ERISA § 502(a). If the claimant requests an external review, such request is subject to the following:

- The plan's claim appeal process must be exhausted before external or judicial review can be sought.

- External reviews are only available for appeals involving medical judgment or the retroactive rescission of coverage. There is no external review for accidental death and dismemberment or life insurance benefits.
- A claimant has four months from the date of the final adverse benefit determination to file a request for external review. Failure to request an external review within the four-month period will end the claimant's ability to seek external review.
- Requests for external review should be sent to the Trust Administration Office at the following address:

  Attention Appeals
  WPAS, Inc.
  P.O. Box 34203
  Seattle, WA 98124-1203

Preliminary Review of External Review Request

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

Expedited External Review

A claimant may request an expedited external review if the claimant received:

- An adverse denial of benefits which involves a medical condition for which the timeframe for completing an expedited appeal to the Board of Trustees would seriously jeopardize the claimant's life or health or the claimant's ability to regain maximum function and the

claimant filed a request for an expedited appeal to the Board of Trustees; or

- An adverse decision on appeal to the Trustees which involves a medical condition for which the timeframe for completion of a standard external review would seriously jeopardize the claimant's life or health or the claimant's ability to regain maximum function, or the decision concerns an admission, availability of care, continued stay, or health care item or service for which the claimant received emergency services, but has not been discharged from a facility.

Review by Independent Review Organization

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

If a claim satisfies the requirements for an expedited external review, the Independent Review Organization will provide a response to the claimant within 72 hours after it has received the request to review, provided that written confirmation may be provided within 48 hours after the date the response is provided.

Judicial Review of Appeal

If a claimant remains dissatisfied after the issuance of the Trustees' decision on appeal, or issuance of the Independent Review Organization's decision, the claimant may bring a civil action under ERISA § 502(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.

Review of Trustees' Determination

An applicant must exhaust the Trustees' Procedures for Hearings prior to filing a civil action. If the applicant is dissatisfied with the written decision, he/she may seek review in accordance with the provision of the Employee Retirement Income Security Act of 1974, as amended 29 USC 100 *et seq*.

Before requesting a hearing as set forth above, it is suggested that you contact the Administration Office. They may be able to help resolve any question or problem and thereby save you considerable time.

DISCLOSURE INFORMATION

Name of Plan

The name of the plan is the Alaska United Food and Commercial Workers Health and Welfare Trust.

Plan for Exclusive Benefit of Eligible Employees and Dependents

The plan has been established and is maintained by the Board of Trustees of the Alaska United Food and Commercial Workers Health and Welfare Trust for the exclusive purposes of providing benefits to eligible employees and their eligible dependents and of defraying reasonable expenses of administering the plan. Participants and beneficiaries may obtain information on whether a particular employer or member organization is a plan sponsor – and if it is, receive its address – by writing to the Administration Office. Participants and beneficiaries may also obtain a complete list of the employers and member organizations sponsoring the plan by writing to the Administration Office. The Trustees may impose a reasonable charge to cover the cost of furnishing this information. Participants and beneficiaries may wish to inquire as to the amount of the charges before requesting copies. These lists are also available for examination between 8:30 a.m. and 4:30 p.m. Monday through Friday at the Administration Office, or at local union offices upon 10 days advance written notice.

Employer Identification Number and Plan Number

The employer identification number assigned by the Internal Revenue Service to the plan is 92-6003453.

The plan number assigned by the plan sponsor is 501.

Type of Welfare Plan

The plan is a welfare plan that provides medical, prescription drug, dental, vision, life, and accidental death and dismemberment benefits.

Plan Administrator

The plan is administered by the Board of Trustees with the assistance of Welfare & Pension Administration Service, Inc., a contract administration organization. The Plan Administrator has all powers necessary to carry out its duties, including the authority, in its sole discretion, to interpret plan provisions, including eligibility to participate and the facts and circumstances of claims for benefits. Benefits under this plan will be paid only if the Plan Administrator or its delegate decides in its discretion that the applicant is entitled to them. The duties and authority of the Board of Trustees are detailed in the Amended Agreement and Declaration of Trust of Alaska United Food and Commercial Workers Health and Welfare Trust, which is incorporated here by reference. For more information or a copy of the Trust document, contact the Administration Office.

Administration of Plan

If you have questions about plan participation, eligibility for benefits, the nature or amount of plan benefits, or any matter of Trust or plan administration, contact the Administration Office:

Alaska United Food and Commercial Workers
Health and Welfare Trust
c/o Welfare & Pension Administration Service, Inc.

Mailing Address
P.O. Box 34203
Seattle, WA 98124-1203

Physical Address
7525 SE 24th Street, Suite 200
Mercer Island, WA 98040

You may also call the Administration Office at:

(800) 478-8329
(206) 441-7574

The only party authorized by the Board of Trustees to answer questions concerning the trust fund and plan is the Administration Office. No participating employer, employer association, or labor organization, or its employees, nor any individual Trustee has the authority to answer your questions.

Agent for Service of Legal Process

Service of legal process may be made upon the Administration Office. Service of process may also be made upon any member of the Board of Trustees at the following addresses:

Employer Trustees	**Union Trustees**
Robert McLauchlin Safeway, Inc. 1121 124th Ave NE Bellevue, WA 98005-2101	Gaither "Buster" Martin UFCW Union Local 1496 Suite 200 501 W Northern Lights Blvd Anchorage, AK 99503-2577
Frank W. Jorgensen Safeway, Inc. 1121 124th Ave NE Bellevue, WA 98005-2101	Walter E. Stuart WPAS 7525 SE 24th Street, Suite 200 Mercer Island, WA 98040
H.L. "Buzz" Ravenscraft WPAS 7525 SE 24th Street, Suite 200 Mercer Island, WA 98040	Silvana Tirban UFCW Union Local 1496 Suite 201 2120 S. Cushman St. Fairbanks, AK 99701-6629

Collective Bargaining Agreements

The plan is maintained under more than 10 separate collective bargaining agreements. Eligible employees, dependents, and beneficiaries may obtain a copy of these agreements by writing to the Administration Office. The Trustees may impose a reasonable charge to cover the cost of furnishing these agreements. You may wish to inquire as to the amount of the charges before requesting copies. These agreements are also available for examination between 8:30 a.m. and 4:30 p.m. Monday through Friday at the Administration Office.

Plan Contributions and Medium for Providing Benefits

This plan is funded by employee and employer contributions, in the amounts specified in collective bargaining between participating employers and labor organizations. Self-payments by you are also permitted as outlined on page 19. Employer and employee contributions are received and held in trust by the Board of Trustees pending the payment of claims, insurance premiums, and administrative expenses. Medical, prescription drug, and dental benefits are paid directly from Trust assets. Prescription drug benefits are administered by Avia Partners, Inc., 250 E. Parkcenter Blvd., Boise, ID 83706. Vision benefits are administered by VSP, 3333 Quality Drive, Rancho Cordova CA 95670. Medical plan stop loss insurance is underwritten by The Union Labor Life Insurance Company, 8403 Colesville Road, Silver Spring, MD 20910. Life and accidental death and dismemberment insurance is underwritten by United of Omaha Life Insurance Company under policy no. GLUG-5D27.

Circumstances Which May Result in Ineligibility or Denial of Benefits

The circumstances which may result in disqualification, ineligibility, denial, or loss of benefits appear throughout this booklet.

Amendment or Termination

This plan is intended to be permanent. However, to the extent permitted by the applicable collective bargaining agreements and federal and state law and with respect to benefits for active and retired members and their dependents, the Board of Trustees has the authority to amend, alter, or change the schedule of benefits or terminate the plan at any time. Any amendment or termination shall be by a vote of the Trustees according to the terms of the Amended Agreement and Declaration of Trust of Alaska United Food and Commercial Workers Health and Welfare Trust. Any amendment or termination shall be made in writing and shall not adversely affect the payment of claims which were incurred before adoption of the amendment or termination. The plan will also terminate upon expiration of all

collective bargaining agreements and special agreements requiring the payment of contributions to the plan. In the event of plan termination, any and all monies and assets remaining in the plan after payment of expenses shall be used to continue the benefits provided by the then existing benefit plans, until these monies and assets have been exhausted.

Right of Recovery

If an individual receives a benefit payment under the plan which exceeds the benefit payment which should have been made, the Trustees shall have the right to recover the excess amount from any person with respect to whom these payments were made, any insurance company, and any other organization. Alternatively, the Trustees may direct the Administration Office to deduct the overpayment from any subsequent benefits payable to, or for, the individual.

Plan Fiscal Year

January 1 – December 31

Statement of ERISA Rights

As a participant in the Alaska United Food and Commercial Workers Health and Welfare Trust, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA), as amended. ERISA provides that all plan participants shall be entitled to:

Receive Information About Your Plan and Benefits

Examine, without charge, at the plan administrator's office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain, upon written request to the plan administrator, copies of all 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 an updated summary plan description. The administrator may make a reasonable charge for the copies.

Receive a summary of the plan's annual financial report. The plan administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

Continue health care coverage for yourself, spouse, or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the plan on the rules governing your COBRA continuation coverage rights.

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 benefit plan. The people who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to $147 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 eligibility or 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 domestic relations order or 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 N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration at (866) 444-3272 or by visiting http://askebsa.dol.gov.

Assignment

Benefits of an individual eligible under this plan may not be assigned without consent of the Board of Trustees.

Applicable Law

This plan and all rights under it shall be governed and construed in accordance with applicable federal law and, to the extent not preempted by federal law, with the laws of the State of Alaska. Venue shall lie in Alaska for any dispute arising under this plan. Any plan

provision which on its effective date conflicts with the statutes of the jurisdiction of Alaska, is hereby amended to conform to the minimum requirements of those statutes.

Severability

If a court of competent jurisdiction holds any provision of this plan invalid or unenforceable, the plan shall be construed or enforced as if such provision had not been included in it, and the remaining provisions of the plan shall continue to be fully effective.

Number and Pronouns

Whenever any words are used herein in the singular form, they shall be construed as though they were used in the plural form, in all cases where they would so apply. Also, although the terms “you” and “your” are used throughout in the singular, they shall refer to each and every employee or eligible employee, individually or collectively, as appropriate in the context.

Effective Date

The effective date of this plan restatement is June 1, 2017.

These Benefits Are Not Guaranteed

Benefits in a health and welfare plan are not vested. The Board of Trustees has the authority to amend, terminate, or change benefits paid under this plan at any time. *No benefit in this plan is guaranteed.*

NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Protected Health Information (PHI) is information, including demographic information, that may identify you and that relates to health care services provided to you, the payment of health care services provided to you, or your physical or mental health or condition, in the past, present or future. This Notice of Privacy Practices describes how we may use and disclose your PHI. It also describes your rights to access and control your PHI.

As a group health plan we are required by Federal law to maintain the privacy of PHI and to provide you with this notice of our legal duties and privacy practices.

Changes to the Terms of This Notice

We are required to abide by the terms of this Notice of Privacy Practices, but reserve the right to change the Notice at any time. Any change in the terms of this Notice will be effective for all PHI that we are maintaining at that time. If a change is made to this Notice, a copy of the revised Notice will be provided to all individuals covered under the Plan at that time.

Permitted Uses and Disclosures

Treatment, Payment and Health Care Operations

- Treatment. Treatment refers to the provision and coordination of health care by a doctor, hospital or other health care provider. As a group health plan we do not provide treatment.
- Payment. Payment refers to the activities of a group health plan in collecting premiums and paying claims under the Plan for health care services you receive. Examples of uses and disclosures under this section include the sending of PHI to an external medical review company to determine the medical necessity or experimental status of a treatment; sharing PHI with other insurers to determine the coordination of benefits or settle subrogation claims; providing

PHI for pre-certification or case management services; providing PHI in the billing, collection and payment of premiums and fees to Plan vendors such as PPO or Prescription Drug Card Companies and reinsurance carriers; and sending PHI to a reinsurance carrier to obtain reimbursement of claims paid under the Plan.

- Health Care Operations. Health Care Operations refers to the basic business functions necessary to operate a group health plan. Examples of uses and disclosures under this section include conducting quality assessment studies to evaluate the Plan's performance or the performance of a particular network or vendor; the use of PHI in determining the cost impact of benefit design changes; the disclosure of PHI to underwriters for the purpose of calculating premium rates and providing reinsurance quotes to the Plan; the disclosure of PHI to stop-loss or reinsurance carriers to obtain claim reimbursements to the Plan; disclosure of PHI to Plan consultants who provide legal, actuarial and auditing services to the Plan; and use of PHI in general data analysis used in the long term management and planning for the Plan and company.

Other Uses and Disclosures Allowed Without Authorization

Federal law also allows a group health plan to use and disclose PHI, without your consent or authorization in the following ways:

- To you, as the covered individual.
- To a personal representative designated by you to receive PHI or a personal representative designated by law such as the parent or legal guardian of a child, or the surviving family members or representative of the estate of a deceased individual.
- To the Secretary of Health and Human Services (HHS) or any employee of HHS as part of an investigation to determine our compliance with the HIPAA Privacy Rules.
- To a Business Associate as part of a contracted agreement to perform services for the group health plan.
- To a health oversight agency, such as the Department of Labor (DOL), the Internal Revenue Service (IRS) and the Insurance Commissioner's Office, to respond to inquiries or investigations of the Plan, requests to audit the Plan, or to obtain necessary licenses.

- In response to a court order, subpoena, discovery request or other lawful judicial or administrative proceeding.
- As required for law enforcement purposes. For example to notify authorities of a criminal act.
- As required to comply with Workers' Compensation or other similar programs established by law.
- To Plan Trustees, as necessary to carry out administrative functions of the Plan such as evaluating renewal quotes for reinsurance of the Plan, funding check registers, reviewing claim appeals, approving subrogation settlements and evaluating the performance of the Plan.
- In providing you with information about treatment alternatives and health services that may be of interest to you as a result of a specific condition that the Plan is case managing.

The examples of permitted uses and disclosures listed above are not provided as an all-inclusive list of the ways in which PHI may be used. They are provided to describe in general the types of uses and disclosures that may be made.

Other Uses and Disclosures

Other uses and disclosures of your PHI will only be made upon receiving your WRITTEN AUTHORIZATION. You may revoke an authorization at any time by providing written notice to us that you wish to revoke an authorization. We will honor a request to revoke as of the day it is received and to the extent that we have not already used or disclosed your PHI in good faith with the authorization.

Your Rights in Relation to Protected Health Information

Right to Request Restrictions on Uses and Disclosures

You have the right to request that the Plan limit its uses and disclosures of PHI in relation to treatment, payment and health care operations or not use or disclose your PHI for these reasons at all.

You also have the right to request the Plan restrict the use or disclosure of your PHI to family members or personal representatives. Any such request must be made in writing to the Privacy Contact listed in this Notice and must state the specific restrictions requested and to whom that restriction would apply.

The Plan is not required to agree to a restriction that you request. However, if it does agree to the requested restriction, it may not violate that restriction except as necessary to allow the provision of emergency medical care to you.

Right to Receive Confidential Communications

You have the right to request that communications involving PHI be provided to you at an alternative location or by an alternative means of communication. The Plan is required to accommodate any reasonable request if the normal method of disclosure would endanger you and that danger is stated in your request. Any such request must be made in writing to the Privacy Contact listed in this Notice.

Right to Access to Your Protected Health Information

You have the right to inspect and copy your PHI that is contained in a designated record set for as long as the Plan maintains the PHI. A designated record set contains claim information, premium and billing records and any other records the Plan has created in making claim and coverage decisions relating to you. Federal law does prohibit you from having access to the following records: psychotherapy notes; information compiled in reasonable anticipation of, or for use in a civil, criminal or administrative action or proceeding; and PHI that is subject to a law that prohibits access to that information. If your request for access is denied, you may have a right to have that decision reviewed. Requests for access to your PHI should be directed to the Privacy Contact listed in this Notice.

Right to Amend Protected Health Information

You have the right to request that PHI in a designated record set be amended for as long as the Plan maintains the PHI. The Plan may deny your request for amendment if it determines that the PHI was not created by the Plan, is not part of designated record set, is not information that is available for inspection, or that the PHI is accurate and complete. If your request for amendment is declined, you have the right to have a statement of disagreement included with the PHI and the Plan has a right to include a rebuttal to your statement, a copy of which will be provided to you. Requests for amendment of your PHI should be directed to the Privacy Contact listed in this Notice.

Right to Receive an Accounting of Disclosures

You have the right to receive an accounting of all disclosures of your PHI that the Plan has made, if any, for reasons other than disclosures for treatment, payment and health care operations, as described above, and disclosures made to you or your personal representatives. Your right to an accounting of disclosures applies only to PHI created by the Plan after April 14, 2003 and cannot exceed a period of six years prior to the date of your request. Requests for an accounting of disclosures of your PHI should be directed to the Privacy Contact person listed below in this Notice.

Right to Receive a Paper Copy of this Notice

You have the right to receive a paper copy of this Notice upon request. This right applies even if you have previously agreed to accept this Notice electronically. Requests for a paper copy of this Notice should be directed to the Privacy Contact listed in this Notice. You will also be able to obtain a copy of the current version of the Trust's Notice at its website, www.akufcwtrust.com.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions. In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in payment for your care
- Share information in a disaster relief situation

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we *never* share your information unless you give us written permission:

- Marketing purposes
- Sale of your information

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see:

www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html

Complaints

If you believe your privacy rights have been violated, you may file a complaint with the Plan or the Secretary of the Department of Health and Human Services.

To file a complaint with the Plan, please contact:

Privacy Official
Claims Manager
c/o Welfare & Pension Administration Service, Inc.
P.O. Box 34203
Seattle, WA 98124-1203
Phone No.: (800) 478-8329
Fax No.: (206) 441-9110

COMPLAINTS MUST BE FILED IN WRITING.
You can also file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling (877) 696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.

YOU WILL NOT BE PENALIZED FOR FILING A COMPLAINT AND THE PLAN WILL NOT RETALIATE AGAINST YOU FOR FILING A COMPLAINT.

Privacy Contact

Should you have a question about a specific right you have or should you have a question about filing a complaint, you may contact:

Privacy Contact Person
Assistant Claims Manager
c/o Welfare & Pension Administration Service, Inc.
P.O. Box 34203
Seattle, WA 98124-1203
Phone No.: (800) 478-8329
Fax No.: (206) 441-9110

ADOPTION OF PLAN

IT IS AGREED by the Trustees that the provisions contained in this plan document are acceptable and will be the basis for the administration of the Alaska United Food and Commercial Workers Health and Welfare Trust.

United Food and Commercial Workers
Local Union #1496

501 W. Northern Lights Blvd.
Suite 200
Anchorage, AK 99503-2577
(907) 258-1496
(800) 478-1496

2120 S. Cushman St.
Suite 201
Fairbanks, AK 99701
(907) 452-7882
(907) 456-6571

Administration and Claims Payment Provided By

Welfare & Pension Administration Service, Inc.

Administration Mailing Address
P.O. Box 34203
Seattle, WA 98124-1203

Claims Submission Address
P.O. Box 34945
Seattle, WA 98124-1945

Physical Address
7525 SE 24th Street, Suite 200
Mercer Island, WA 98040
(800) 478-8329
(206) 441-7574

Member Services (Eligibility) Provided By

Labor Trust Services, Inc.

Mailing Address
P.O. Box 93870
Anchorage, AK 99509-3870

Physical Address
375 W. 36th Avenue, Suite 200
Anchorage AK 99503-5814
(907) 561-5119
(800) 478-8329

Trust Website

www.akufcwtrust.com