Alaska United Food and Commercial Workers Trust Funds

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Administered by
Welfare & Pension Administration Service, Inc.

December 21, 2012

To: All Active Eligible Plan Participants
Alaska United Food and Commercial Workers Health and Welfare Trust

Re: Employee Contribution, Enrollment and Benefit Changes

Important Information – *Please be sure that you and your family read this notice carefully and keep it with your benefit booklet or important insurance papers for future reference.*

Effective January 1, 2013, certain eligibility and benefit provisions have been changed. As a result, the Trust's health plan is no longer considered "grandfathered" under the Patient Protection and Affordable Care Act (informally known as "health care reform"). The Plan is being amended to reflect the eligibility and benefit changes as well as changes that are required as a result of losing grandfather status under PPACA. The Plan changes are summarized below. This notice should be considered an insert to your January 2010 Summary Plan Description and Plan Document.

Your Monthly Contribution – Effective With Hours Worked February 1, 2013 and After

- In addition to the negotiated employer contribution, an employee contribution is required to cover yourself, your child(ren), and/or your spouse/family. The rates below go into effect in February 2013. The contribution for coverage will automatically be made by payroll deduction each pay period. The weekly rates are as follows:

Type of Coverage	Employee Contribution
Employee Only	$10 per week
Employee + Child(ren)	$25 per week
Employee + Spouse and/or Family	$30 per week

IMPORTANT NOTE: If you wish to continue your current "Type of Coverage" based on the Open Enrollment conducted over the past month, it is not necessary for you to complete a new Enrollment Form.

If you wish to change your "Type of Coverage" and either *enroll yourself, your children, and/or your spouse/family and you have not already done so, or wish to terminate coverage for yourself or your other eligible dependents,* you must complete and return a new Enrollment Form to the Administration office by January 18, 2013. Any change you make now will be effective April 1, 2013; the type of coverage you have in place now will stay in place until the end of March 2013. You may contact the Administration Office at (800) 478-8329 for an Enrollment form, or use the online form located at:

https://www.wpas-inc.com/documents/F45-02-Form-Enrollment-2011.pdf

Eligibility

- *Coverage* (pages 11-13) – The months of eligibility required for your dependents to qualify for coverage have changed for certain benefits. Beginning with January 2013 eligibility, Enrolled Dependents of eligible Employees will qualify for Medical and Prescription Drug coverage on the Employee's 13th month of coverage (formerly on the 25th month) and both Employees and Enrolled Dependents will qualify for Dental coverage on the 25th month of coverage (formerly on the 49th month).

  Coverage for all dependent children, who satisfy the requirements as defined by the Plan, is now extended to age 26, regardless of other available coverage. This Plan will be secondary to a plan that covers a dependent as an active employee.

Medical Benefits

- *Emergency Room Services* (pages 22-23) – The Plan covers certain emergency services provided in hospital emergency rooms when you are suffering from an emergency medical condition. 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 Usual, Customary and Reasonable allowance.

- *Percentage Payable* (page 22) – For services incurred on and after March 1, 2013, the plan will continue to pay 80% for most covered medical expenses, and 70% for hospital services at a non-PPO hospital in the Anchorage area. The plan will increase that percentage to 100% for the remainder of the calendar year after:

  You (each covered individual) have incurred $20,000 of covered expenses,
  or your eligible Family has incurred $40,000 of covered expenses.

- *Annual Maximum Benefit* (page 26) – Effective January 1, 2013, the Plan's annual maximum benefit will increase to $2,000,000. The annual limit shall apply to the greater of $2,000,000 in claims for all medical benefits or $2,000,000 in claims for Essential Medical Benefits incurred from January 1, 2013 through December 31, 2013.

- *Preventive Care Services* (page 32) – The Plan will pay 100% of the costs incurred for certain preventive services when those services are provided by a network preferred provider. Services performed at a non-PPO provider are subject to deductible and coinsurance. This means that these services will not be subject to any deductible, and you will not have to pay any cost sharing (in other words, you will not have to pay coinsurance for these services). The preventive services to which this new rule applies are those that are recommended under the Affordable Care Act. The required services include services that are highly recommended by the U.S. Preventive Services Task Force (for example, screening mammography every 1-2 years for women age 40 and older and colorectal cancer screening at specified intervals for adults age 50 to 75). In addition, certain pediatric preventive services, for example, well baby and well child visits at specified intervals, will be covered. You will also have coverage for immunizations for infants, children, adolescents, and adults as recommended by the federal Centers for Disease Control and Prevention.

A complete list can be reviewed at www.uspreventiveservicestaskforce.org.

The Preventive Care Benefit also includes a limited number of over-the-counter pharmaceuticals, paid at 100% when prescribed by your physician and purchased through the Plan's pharmacy network. Please check with the Trust Office or Avia (the Pharmacy Benefit Manager) for limitations that may apply:

- aspirin (325 mg and 81 mg) for cardiovascular disease for men and women
- folic acid (0.4 mg and 0.8 mg) supplements for women
- smoking cessation products are covered at 100% when prescribed by a physician and purchased through the Plan's pharmacy network

- *Preferred Provider Organization* (page 23) – Beginning January 1, 2013, the Mat-Su Regional Medical Center has been added as a Preferred Provider facility.

- *Claim Appeals* (pages 78-83) – The following is a summary of changes to the Appeal Procedures which are effective for appeals reviewed on or after January 1, 2013.

  For the most part, the standard procedures for appealing the denial of a claim will remain the same. Specifically, claimants may appeal any adverse decision by the Trust including the denial of a claim, the receipt of less than full benefits, or the rescission of coverage to the Trust's Board of Trustees. Appeals must be submitted within 180 days of the denial or adverse decision. A properly submitted appeal will be presented to the Board of Trustees within the timeframe set forth in the Plan Booklet. A claimant may present witnesses and additional documentation in support of the appeal. A claimant may also request a copy of any documents considered, relied upon or generated in the processing the appeal.

  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 weekly disability, 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.
  PO 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.

If you have any questions concerning this notice or enrollment, please contact the Administration office at (800) 478-8329.

Sincerely,

Board of Trustees
Alaska United Food and Commercial Workers Health and Welfare Trust

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Receipt of this notice does not constitute a determination of benefits or your eligibility. If you wish to verify benefits or eligibility, or if you have any questions regarding medical benefit changes, please contact the Administration Office at (800) 478-8329.