ALASKA UNITED FOOD AND COMMERCIAL WORKERS HEALTH AND WELFARE TRUST

Active Employees

Summary Plan Description and Plan Document

January 1, 2024

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 January 1, 2024.

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

Also, do not forget to notify the Trust Office whenever your address (or the address of a dependent child or spouse) changes.

If you have any questions about your eligibility or benefits, please call the Trust Office at 833-942-2315.

Sincerely,

Board of Trustees

Employer Trustees
Brent Bohn
Scott Powers

Union Trustees
Dan Clay
Frank Mutchie
Silvana Tirban

Notice Informing Individuals About Non-Discrimination 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.

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 the Trust Office at Zenith American Solutions, Inc., 12205 S.W. Tualatin Road, Suite 200, Tualatin, OR 97062., Phone 833-942-2315, Fax 503-575-9265.

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 1-833-942-2315.

Spanish – ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-833-942-2315.

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 1-833-942-2315.

Russian – ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-833-942-2315.

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: 1-833-942-2315.

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 1-833-942-2315.

Laotian –
. ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, , ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-833-942-2315.

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。1-833-942-2315. 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 1-833-942-2315.

Vietnamese - CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-833-942-2315.

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

Thai - เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-833-942-2315.

German - ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-833-942-2315.

Polish - UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-833-942-2315.

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WEBSITE

The Alaska United Food and Commercial Workers Trust (the "Trust") has established a website to provide you with immediate access to your plan information. The site is located at https://edge.zenith-american.com and 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
- 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.

If you have any questions about the contents of the website or access to information, please contact the Trust Office at 1-833-942-2315.

SUMMARY OF BENEFITS FOR EMPLOYEES

The following chart summarizes what the Plan will reimburse Employees and their Eligible Dependents 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 sa 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 Maximums	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 or a combination of PPO and non-PPO Providers • Annual Out-of-Pocket Maximum maintained separately for PPO and non-PPO Providers
Prescription Drug Benefits	Provided through Avia Partners. See pages 56-63 for details
Dental Benefits	$1,500 annual benefit. See pages 64-69
Vision Benefits	Provided through Vision Service Plan. See pages 70-73 for details.
Life Insurance	• Employee – $5,000 • Spouse – $1,000 • Children – $100 to $1,000 (see pages 82-84)

Accidental Death & Dismemberment Insurance	Employee – $5,000 principal sum (see page 85-86)

Benefits for Non-Medicare retirees are summarized on pages beginning at page 87of this Booklet.

This plan is maintained for employees whose employers contribute to the 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 (3) 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. Your coverage is 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 Trust Office or your local union office. In completing these, you should list your eligible dependents (see

page 12) 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 for the second month following the month you had at least 90 reportable hours 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	0
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	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 terminate employment mid-September, coverage would terminate September 30.

Month	AUG	SEPT	OCT	NOV
Hrs. Worked	120	90		
Eligible	Yes	Yes	No	No

Reinstating Eligibility

If you lose eligibility for any reason, and the work at least 90 hours in a calendar month within the next 12 months, you will again become eligible for coverage, starting on the first day of the second month following the month you again work 90 hours.

Month	AUG	SEPT	OCT	NOV	DEC
Hrs. Worked	90	50	90	90	
Eligible	Yes	Yes	Yes	No	Yes

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 as described on page 5.

Associate Agreements

The Board of Trustees may authorize an employer's non-bargaining unit employees to participate in the Trust pursuant to an Associate Agreement. An employer must have bargaining unit employees participating in the Trust to have an Associate Agreement which extends insurance coverage to designated non-bargaining unit employees and owners of the employer. The participation of non-bargaining unit employees, the contribution rates for such coverage and the terms and conditions of such agreements shall be at the sole discretion of the Trustees.

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 and the required contribution was paid.

You and your enrolled dependents' eligibility for benefits is as follows:

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

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

***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 spousal coverage until the 25th month when weekly employee payroll deductions for spousal coverage begin. Contact the Trust Office for information on this option and the monthly self-pay contribution required by you.

Additionally, if your Spouse is eligible for benefits through his or her employment and does not take it, they will not be eligible for coverage through the Trust.

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. The current contribution amount for covering children or families is available from the Trust Office. Any employee contribution required for coverage will be automatically collected through payroll deduction. 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 Trust Office. No claims will be processed unless an enrollment form is on file at the Trust Office. Enrollment forms can be obtained on the Trust's website as well as from the Trust Office or your local union office.

If you wish to cover your children you must indicate who you wish to cover on your enrollment form and provide required documentation such as birth certificates or adoption decrees. When you become eligible for spousal coverage, you must complete and return an authorization form to the Trust Office within 60 days of the date you first become eligible for such 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 or if a change in family status occurs and you provide timely notice. For dependents to be eligible, an enrollment form must be on file listing all eligible dependents you wish to cover. Supporting documentation such as marriage or birth certificates is also 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.

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 Trust Office within 30 days of the change.

This change will be effective the date of the status change if timely notice is provided. 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 or adoption of a child, you must provide a copy of the birth or adoption 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 30 days of the change in family status, you will not have another opportunity to elect coverage until the next open enrollment, or if another special enrollment event occurs.

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 unless a change in family status occurs.

- Add or remove eligible dependents from your medical, dental and vision coverage.

Any changes made during the annual open enrollment will be effective on January 1 of the following year. Changes are made by submitting a completed enrollment form to the Trust Office by the required date and provide any supporting documentation (like a marriage certificate or a birth certificate).

You are required to submit an enrollment form each year. Failure to complete and return this form to the Trust 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.

Please Note: The requirement to submit an open enrollment form has been waived for the 2024 calendar year only. Enrollment forms will only be required if an employee wishes to add or drop coverage or change what family members are covered.

Special Enrollment

If you declined enrollment for yourself or your covered dependents (including your Spouse) because of other health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or the employer stops contributing towards your or your dependent's other coverage). You must request enrollment within 30 days after you or your dependents' other coverage ends.

You may also be able to enroll yourself or your covered dependents if you or your dependents lose health coverage under Medicaid or your state's Children's Health Insurance Program (CHIP) or become eligible for state premium assistance for purchasing coverage under a group health plan, provided that you request enrollment within 60 days after that coverage ends.

In addition, if you have a new dependent because of marriage, birth, adoption or placement of adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption. To request special enrollment or obtain more information, contact the Trust Administrative Office.

Dependent Eligibility

Eligible Dependents

Eligible dependents include your:

- Legal spouse as determined by applicable law. (There is no coverage for domestic partners)
- 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 Trust Office for determining if a medical child support order is qualified.

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 can start at the same time you become eligible. Coverage for your spouse can start 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. You must self-pay for spousal coverage directly to the Trust Office until your 25th month of eligibility when weekly employee payroll deductions can 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 24 months of eligibility.

To cover your dependents, you must submit an enrollment form naming your dependents within 60 days of their being eligible to enroll. You also must make any self-payment required for any dependent coverage you have chosen and provide any documentation required by the Trust.

Spouses acquired while your coverage is in effect, and after you have met the eligibility 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 are eligible as follows:

- for children you acquire through birth, adoption, or placement for adoption coverage starts on the date they are born or placed for adoption or born, provided they are enrolled within 60 days and the required contributions for dependent coverage is made.
- for 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 contribution for dependent children is made.

Example 1: When your coverage begins 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 Is Disabled

You may continue medical, prescription drug, dental, and vision benefits beyond age 25 if your enrolled child is disabled and otherwise eligible for coverage. Disabled means being incapable of self-sustaining employment because of a mental or physical condition present on the date the child would otherwise lose eligibility due to age. To continue coverage for a disabled child, you must provide satisfactory proof of incapacity no later than 31 days after when they would lose eligibility because of age. Contact the Trust 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 Trust 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. When you request to enroll a spouse, you will be required to submit proof that your spouse is not eligible for other benefits coverage through their employer. This documentation may also be requested as part of each annual enrollment.

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. See page 74 for details.

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 any required self-payment for coverage is made.
- The last day of the month that your employment terminates, unless any required self-payment is made.
- The last day of the month in which your employer ceases contributing to the plan.
- The last day of the month preceding the month for which any required self-payment is not made on a timely basis.
- 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 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 12).

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 if your disability causes your hours to fall below 90 in a month.

With a waiver, you and any eligible dependents, who were enrolled in the plan immediately preceding when you became disabled, are eligible for benefits without having to contribute for the cost of coverage. Only those benefits that you were eligible immediately preceding when you become disabled will be continued.

To apply for a disability waiver contact the Trust Office within 60 days of when you would otherwise lose coverage. A physician's certification of your disability is required. In addition, you must be under the ongoing care of a physician while receiving a waiver.

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 eligibility based on employer paid contributions.

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

You may be eligible to continue medical/prescription drug only or medical/prescription drug-dental-vision coverage after it would otherwise terminate through 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 timely notify the Trust 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 they lose coverage due to a reduction in your hours worked or termination of your employment.

Your spouse and/or dependent child may also independently 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.

To elect additional COBRA benefit following a second qualifying event, the Dependent must provide notice to the Trust Office within 60 days of the second qualifying event.

It is your responsibility, as the employee or family member, to inform the Trust 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 Trust Office timely notice of the qualifying event.

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

When the Trust Office receives information from you, another family member or your employer concerning a qualifying event, the Trust 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 Trust 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 elect continuation coverage it must be continuous from the date that your coverage through the Trust would have otherwise ended.

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

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

You are required to pay the cost of continuation coverage. The initial payment must be made within 45 days of your COBRA election. Subsequent COBRA payments are due by the first of the month for which coverage is sought. Failure to pay by the end of the month for which coverage is sought will cause your coverage to end as it normally would under the terms of the plan. Payment may be made by check or money order payable to:

Alaska United Food and Commercial Workers
Health and Welfare Trust
c/o Zenith American Solutions
12205 S.W. Tualatin Road, Suite 200
Tualatin, OR 97062

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

Continuation coverage will terminate on the last day of the month in which any of the following occur before the end of the 18-month, 29-month, or 36-month continuation coverage period:

- Your last employer no longer participates in the Trust unless that Employer or its successor no longer offers a health plan for any classification of its employees which previously participated in the Trust.
- 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.
- The Plan terminates.

Contact the Trust 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. If you elect COBRA coverage, however, and drop it before the end of the maximum COBRA continuation period it can affect your ability to enroll in a Marketplace plan outside the open enrollment period. 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)

Coverage can also be continued for otherwise eligible Employees who do not have sufficient hours because of being on a leave under the Family Medical Leave Act of 1993 (FMLA). Coverage is conditioned upon the Employer being eligible from FMLA leave under applicable law and the Employer paying the required contributions. An Employee on FMLA leave because of his or her own service, health condition may be eligible for coverage under the Trust's Disability Waiver of Premium provision.

Leave for Military Service/Uniformed Services Employment and Reemployment Rights Act (USERRA)

The following information applies to reservists, members of the National Guard and Participants who enlist in the uniformed services of the United States.

An active employee who enters military service shall be provided continuation and reinstatement rights in accordance with the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA).

If a Participant has lost coverage because he or she, or the Employee through which he or she has eligibility, has entered military service and is covered by a federal law referred to as USERRA, the Participant may self-pay for Trust coverage for up to 60 months. The terms under which such contribution coverage will be administered are otherwise the same as for the COBRA continuation coverage outlined above.

However, unlike COBRA Continuation Coverage, if the employee does not elect USERRA for the dependents, those dependents cannot elect USERRA separately. Additionally, the employee (and any eligible dependents covered under the Plan on the day the leave started) may also be eligible to elect COBRA temporary continuation coverage. Note that USERRA is an alternative to COBRA therefore either COBRA or USERRA continuation coverage can be elected, and that coverage will run simultaneously, not consecutively. Contact the Trust Office to obtain a copy of the COBRA or USERRA election forms. Completed USERRA election forms must be submitted to the Plan in the same timeframes as is permitted under COBRA. Note that USERRA is an alternative to COBRA therefore either COBRA or USERRA continuation coverage can be elected (both cannot be elected by the same person).

If an Employee who lost coverage because he left for military duty returns to work with an Employer within the time period provided for under applicable law, he or she will have coverage immediately from the date he or she returns to work.

Duty to Notify the Trust Fund Office

It is important that you advise the Trust Office in writing that hours will not be reported for you because you have been called up for active military service or you have enlisted in the uniformed services. This will protect your status in the Plan after you are discharged.

Additional Information

More information about the rights under ERISA (including COBRA) and other laws affecting group health plans can be obtained by contacting the U.S. Department of Labor's Employee Benefits Security Trust or visiting its website at www.dol.gov/ebsa.

To help ensure the Participant receives necessary notices, the Participant should notify the Trust Office if the Participant's address changes and should keep a copy of any written notices sent to the Trust.

Retiree Eligibility

To establish initial eligibility for retiree benefits on or after February 1, 2018, an Employee must meet the following requirements:

- You are age 57 or older or have 25 years of Credited Service in the Alaska UFCW Pension Trust as of April 1, 2018.
- You have had contributions made toward retiree coverage for at least 60 of the 80 months immediately preceding your retirement;
- You have been eligible for active employee coverage for at least 60 of the 80 months immediately preceding your retirement;
- You have active employee coverage the month immediately preceding your retirement date;
- You are receiving an early, normal, or late retirement benefit from the Alaska United Food and Commercial Workers Pension Trust;
- You have accrued at least 15 years of Credited Service in the Alaska UFCW Pension Plan;

- You have been a bargaining unit member covered by a Collective Bargaining Agreement providing for contractually required member contributions to the Retirement Medical Program and have made these hourly contributions for at least 10,400 hours within the 10 years immediately preceding eligibility for retiree health coverage; and
- To be eligible for retiree coverage, you must apply for retiree coverage to the Trust Office within 30 days of your retirement date.

Once eligibility for retiree coverage is established, it will continue until any of the following events occur:

- The last day of the month that your last employer stops contributing to the plan.
- The date the self-pay option for retiree coverage expires.
- The last day of the month for which any required self-pay contributions for retiree coverage have been made.
- The date the plan is terminated.
- For a dependent under the Retiree Plan, the last day of the month in which he or she ceases to meet the definition of eligible dependent. This includes loss of dependent status as a result of a divorce or otherwise no longer meeting the definition of an eligible Dependent.
- A dependent may continue to participate in the Retiree Plan after the Retiree dies if they continue to make the required self-pay contributions in a timely manner.

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. Medical and prescription drug benefits are available for Employees and Children with the Employee's first month of coverage. Spouses are eligible after 24 months of coverage or after the Employee has worked 1,200 hours if the Employee applies timely and pays the full cost of the spousal coverage until the 25th month.

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 (3) 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.

Preventive care benefits under the Affordable Care Act are not subject to the deductible if they are received from a PPO Provider.

Services provided at Coalition Health Centers (see page 52) are covered in full subject to a $20 copayment per person per visit and are not subject to the deductible.

Coinsurance Payable

After you satisfy your annual deductible, benefits for most Covered Medical Expenses are paid as follows:

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

These percentages apply to the PPO contracted rate for services received from PPO Providers and the Usual, Customary, and reasonable amounts for services rendered from Non-PPO Providers. Some services, like preventive care, skilled nursing facility, home health care, pre-admission testing done on an outpatient basis, home health care, and skilled care facility, are paid at 100% of the applicable PPO or Non-PPO rate.

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.
- Usual and Reasonable Charges for outpatient dialysis treatment shall be determined pursuant to the provisions of the Plan's Dialysis Program. See pages 39- 42.

Separate provisions apply to Outpatient Dialysis Treatment. See pages 39-42 for details.

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 for PPO

Providers or the UCR amount for Non-PPO Providers 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 the Non-PPO Provider 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)

The Trust uses Aetna to provide a PPO network. The Trust pays a greater percentage of Covered Medical Expenses when a PPO Provider is used and there is a lower out-of-pocket maximum when a PPO Provider is used. Please note that 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.

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.** Plan benefits and your share of Covered Medical Expenses (typically 20%) are based on the discounted fee charged by your provider. You never have to worry about paying amounts over the contracted amount, because the provider limits its charges to you based on the contracted amount. The PPO Provider bills the Trust directly, so you do not have to fill out a claim form. In addition, when 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 Medical Expenses is higher. The amount paid is based on the Usual, Customary and Reasonable ("UCR") amount determined by the Plan or its claim administrative agent. In addition, you may need to pay for services at the time you receive them from non-PPO Providers and file a claim for reimbursement. Also, you may be required to pay for expenses in excess of the UCR amount determined by the Plan.

- **Services that Require Use of PPO Providers.** Certain procedures require that a PPO Provider or a Transcarent Surgery Care Provider (see page 31) must be used. As of the date of this Booklet, this requirement is limited to non-emergency orthopedic services in defined situations. If the PPO Provider or Transcarent Surgery Care Provider is not used no benefits are payable.

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 PPO 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 services(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 services are not medically necessary and are not approved, no benefits will be paid. If the service is medically necessary, benefits will be paid according to the Plan terms.

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
- Orthognathic 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 https://edge.zenith-american.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

A complete list of these services requiring pre-certification can be found on the Trust's website at https://edge.zenith-american.com. A PPO Provider should be aware of what services must be pre-certified.

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 on a hospital inpatient basis, the plan will pay 100% of the PPO contracted rate or the UCR amount for Non-PPO Provider rather than the Plan's usual 80% or 60%. Of course, in a situation where inpatient care is medially 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. If the scheduled surgery is cancelled for any reason, the Plan's regular co-insurance requirements will apply.*

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 the 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, you should request a corrected bill and contact the Trust 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 Trust Office. For example, if you find a $1,000 overcharge that the Trust 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 pages 34 (Home Healthcare) and 45 (Skilled Care Facility) for further details), and the Covered Medical Expenses section starting on page 32 for details).

Transcarent Surgery Care Medical Surgery Benefit

The Trust has contracted with Transcarent Surgery Care (formerly 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. You may contact the Trust Office to access Transcarent Surgery Care.

Upon acceptance of your case, the following enhanced plan provisions will apply when you utilize Transcarent Surgery Care 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 Transcarent Surgery Care 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 Transcarent Surgery Care 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 Transcarent Surgery Care at 855-423-1294 and identify yourself as an Alaska UFCW Health and Welfare Trust participant or email them at surgerycare@transcarent.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 Trust Office. You must receive this authorization from Aetna before receiving the services. 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:

ABA Therapy is covered when medical necessity is established. Subject to pre-certification requirements. See page 27.

Ambulance or Air Transport 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.

Bariatric Surgery is covered when medical necessity is established, subject to pre-certification. See page 27.

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% of the contracted rate for PPO Providers or the UCR amount for Non-PPO Providers.

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 Trust 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 Trust 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 92. 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 unless the services are subject to the No Surprises Act.

Gender Identity related services and treatment are covered when medical necessity established. These services must be pre-certified. See page 27.

Home health care up to 100 visits per calendar year is payable at 100%. Home health care is only covered when used in 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 Trust 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 Trust 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 26 for details). You must obtain hospital pre-certification by Aetna (see page 29).

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, your spouse or dependent children, including pregnancy, childbirth, miscarriage or abortion.

Maternity services are covered on the same basis as any other condition. 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 Dialysis Treatment. The Board of Trustees of the Alaska United Food and Commercial Workers Health and Welfare Trust (the "Plan") have adopted the Dialysis Program described below for outpatient dialysis treatment services. The Dialysis Program shall be the exclusive means for determining the amount of Plan benefits to be provided to Plan members and for managing cases and claims involving dialysis services and supplies, regardless of the condition causing the need for dialysis.

Summary of Benefits		
	PPO Provider	**Non-PPO Provider**
Dialysis Treatment – Outpatient	150% of the Usual and Reasonable Charge after all applicable deductibles and coinsurance. **NOTE: Outpatient Dialysis Treatment claims are subject to specific conditions which do not apply to other types of claims. Participants should enroll in Medicare Part B when eligible to avoid balance billing.**	

The components of the Dialysis Program are as follows:

(1) Application. The Dialysis Program shall apply to all claims filed by, or on behalf of, plan members for reimbursement of products and services provided for purposes of outpatient dialysis, regardless of the condition causing the need for dialysis ("dialysis-related claims"). The Dialysis Program applies to all dialysis-related claims received by the plan on or after **August 1, 2021**, regardless of when the expenses related to such claim were incurred or when the initial claim for such products or services was received by the plan with respect to the plan member.

(2) Mandated Cost Review. All dialysis-related claims will be subject to cost review by the plan to determine whether the charges

indicate the effects of market concentration or discrimination in charges. In making this determination the plan shall consider factors including:

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

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

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

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

(b) Where the provider is or has been a participating provider under a Preferred Provider Organization (PPO) available to the

plan's members, upon the plan's determination that payment limitations should be implemented, the rate payable to such provider shall be subject to the limitations of this Section.

(c) Maximum Benefit. The maximum plan benefit payable to dialysis-related claims subject to the payment limitation shall e the Usual and Reasonable Charge for covered services and/or supplies after deduction of all amounts payable by coinsurance or Deductibles.

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

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

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

(4) Provider Agreements. Where appropriate, and a willing appropriate provider acceptable to the plan member is available, the

plan may enter into an agreement establishing the rates payable for outpatient dialysis goods and/or services with the provider, provided that such agreement must identify this Section of the plan and clearly state that such agreement is intended to supersede this Section.

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

(6) Providers Accepting Plan Payments. To the full extent allowable under applicable law, a provider that accepts the payment from the plan will be deemed to consent and agree that (i) such payment shall be for the full amount due for the provision of services and supplies to a plan member and (ii) it shall not "balance bill" a plan member for any amount billed but not paid by the plan.

The Preferred Providers provision of the Plan do not apply to outpatient dialysis services.

Medical coverage benefits of this Plan may not be assigned, transferred or in any way made over to another party by a participant. Nothing contained in the written description of medical coverage shall be construed to make the Plan liable to any third-party to whom a participant may be liable for medical care, treatment, or services.

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. Teladoc visits which meet Plan medical necessity requirements are treated the same as other Physician services.

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 the UCR amount for Non-PPO Provider, 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 were 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 29.)

Preventive care services as mandated by the Affordable Care Act will be covered at 100% of the contracted rate, with no coinsurance or deductible if a PPO Provider is used. Preventive care services performed by a non-PPO Provider are covered, but subject to the plan's deductible and coinsurance. What preventive services are covered at 100% are updated annually. They include the following:

- 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 vaccine 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 Trust (HRSA).

- Preventive care services and screenings for women recommended by the Health Resources and Services Trust (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 Trust 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: As with any inpatient treatment, 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 Trust 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 skilled care facility charges:

- 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 subject to the same precertification requirements (see page 29) and is payable the same as any other covered condition.

Note: As with any inpatient treatment, 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 Transcarent Surgery Care (see page 31).

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 Transcarent Surgery Care surgery benefit, which includes a waiver of your deductible and any coinsurance, is available for certain surgeries. Please see page 31 for further details.

Telehealth services received from a Physician are covered on the same basis as in-office visits when Plan requirements, such as medical necessity, are met. The Trust also covers services received through Aetna's Teladoc program. See page 54 for details.

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.

Vaccines that are considered preventive care that are received from in-network medical Providers and pharmacies are covered at 100%.

Vaccines from out-of-network medical providers and pharmacies are not covered.

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:

- Any services which are not medically necessary (see page 96 for definition.)
- Procedures, services, drugs, and other supplies that are determined to be experimental or investigational (see page 92 for definition.)
- Dental x-rays (unless necessitated by an injury)
- Services rendered and supplies acquired when you or a dependent 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. Plan provisions dealing with the advancement of benefits when there is a potential third-party claim is discussed on page 79
- Expenses incurred due to Injuries or Illness caused by the act or omission of another person if the costs associated with the Illness or Injury are recoverable from a third party or other source. The Plan provisions dealing with Third-Party Reimbursement Requirements and the advancement of benefits are set forth on page 79
- 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 97), 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 or any ACA-mandated preventive benefit for obesity)
- Services, procedures, and supplies (including drugs) rendered for cosmetic or reconstructive purposes, including complications resulting from such services, procedures and supplies, unless the initial service or procedure was Medically Necessary to correct a functional disorder or as the result of an Accidental Injury or is subject to the breast reconstruction benefit described on page 37
- 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, ABA Therapy or other treatment which meets the Plan's medical necessity requirements
- 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 (these services may be covered under the Vision benefit)
- Eyeglasses or contact lenses (these services may be covered under the Vision benefit), or hearing aids
- 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 service in the armed forces, 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

- 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
- 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
- Charges for missed appointments
- 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 Transcarent Surgery Care
- Charges for claims that are not submitted timely
- Charges for services not permitted by the Provider's network agreement or applicable payment policies
- Charges for services or supplies which are not provided or billed in accordance with the Generally Accepted Professional and/or Medical Practice Standards

Appeals for Medical Claims

The procedures for filing an appeal of a denied claim are on page 110.

COALITION HEALTH CENTERS

As an alternative to using your regular provider, the Coalition Health Centers in Anchorage and Fairbanks are also available to plan participants.

Charges for services provided at the Coalition Health Centers 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 Centers are 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.

The Coalition Health Centers have a $75 fee for missed appointments. Any charge for a missed appointment will not be covered by the Trust and will not apply to your deductible or annual out-of-pocket maximum.

Health Center Locations

The Coalition Health Center in Anchorage is located at 701 East Tudor Road. They can be reached by phone at 907-264-1370.

The Coalition Health Center in Fairbanks is located in the Ridgeview Business Park, 570 Riverstone Way, Unit 3. They can be reached by phone at 907-450-3300.

Both centers can also be reached online at https://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.

TELADOC SERVICES

The Trust provides telephone or video access to a doctor through Aetna's Teladoc program. Teladoc provides 24/7 access to a board certified, licensed family practice doctor or pediatrician via phone or video without leaving your home. Teladoc is not a substitute for a primary care doctor, but can be used to diagnose and treat acute, non-emergent medical issues that may arise such as:

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

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

Visits with Teladoc will be **covered in full** by the Trust with no copay or coinsurance charge to eligible participants and dependents.

You do not need to wait until your Teladoc Welcome Letter arrives to set up an account with Teladoc and begin using their services. To set up an account, please call 855-835-2362 or visit their website at https://www.teladoc.com/Aetna/.

Step by Step instructions for registering on the website:

- From the "Get started" page, enter your first and last name exactly as it appears on your Aetna ID card, date of birth, and zip code then click "Submit"
- Your member account information will automatically populate the application based on Plan eligibility previously provided to Aetna

- Complete the remaining fields, and click "Complete Registration' to create your Teladoc member account
- Once your account has been successfully created, to add a dependent, first click 'Visit Homepage'
- From the Homepage, select 'My Family' in the top menu
- Then select 'My Dependents' from the drop-down menu
- Select 'Add New Dependent' on the right-hand side of the screen
- Enter your dependent's first and last name, Aetna member ID (same as member's Aetna ID), and date of birth
- The system will verify your dependent's eligibility
- Complete the form fields, click 'Add New Dependent,' and repeat this process to add your other dependents. (Note: any dependent age of 18 or over will need to set up their own Teladoc account and create a unique username and password.)

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 Trust Office.

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 will not have to fill out a claim form. To locate a network pharmacy, go to www.aviapartners.com.
- **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 which are excluded), 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 which are

excluded), 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 will not 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 which are excluded), 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** • **If a generic alternative exists**	 $15 or 20% of the retail price (up to $75 maximum per prescription) $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
Specialty	Greater of $15 copay or 20% coinsurance up to a $75 maximum

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 www.aviapartners.com.

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** • **If a generic alternative exists**	 $30 or 20% of the retail price (up to $150 maximum per prescription) $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
Specialty Drugs	$30 copay or 20% coinsurance up to $150 maximum

You may fill mail order prescriptions through the Carrs/Safeway store at 2920 Seward Highway, Anchorage, Alaska 99503. You can also call the pharmacy at 907-339-0660. Please note that Schedule II prescriptions cannot be filled by mail order and that mail order is not available outside 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. As of January 1, 2023, the prescription drug annual out-of-pocket maximum is:

	Out-of-Pocket Maximum
Person	$4,600 per calendar year
Family	$9,200 per calendar year

This annual out-of-pocket is separate from your annual out-of-pocket maximum for Covered Medical services. See page 25 for details.

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 (Though these may be covered under the medical portion of the Plan)
- DESI drugs, which are drugs the U.S. Food & Drug Trust 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 or potentially recoverable from a third-party or other source. These may be available subject to the Plan's third-party reimbursement provisions. See page 79 for details.

Appeals for Prescription Drug Claims

The procedures for appealing a denial of a prescription drug claim are set forth at page 110.

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The plan is designed to reimburse you for covered expenses for dentally necessary dental treatment after you satisfy the annual deductible. Employees are eligible for dental benefits after 24 months of eligibility. Dependents whom the Employee elects to enroll are eligible at the same time as the Employee or when acquired or enrolled, if later.

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 in a year, 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 as described on page 66.

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 for services that are dentally necessary.

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 Trust Office. The Trust 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)

Type A expenses are covered at 80% of the UCR charge up to the annual maximum and are not subject to the Dental Plan's deductible.

- 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)

Type B expenses are paid at 80% of the UCR up to the annual maximum.

- 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)

Type C expenses are paid at 50% of the UCR up to the annual maximum.

- 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:

- Services required because of an 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.

Appeals for Dental Claims

The procedures for appealing a denied dental claim are set forth at page 110.

Vision benefits are administered by Vision Service Plan (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. Employees are eligible for vision benefits after 24 months of eligibility. Dependents whom the Employee elects to enroll are eligible at the same time as the Employee or when enrolled or acquired if later.

Copay

There is a $25 copay required for an exam and a $35 copay required for 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 Trust 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 (61 mm 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

Appeals for Vision Claims

The procedures for appealing a denied vision claim are set forth at page 110.

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 Trust 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, or dental, 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 Trust 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 will be reduced by benefits payable under the primary plan. When a covered dependent has other primary insurance and this Plan is a secondary payer, this Plan will pay an amount that when added to the Primary plan's payment does not exceed 100% of covered medical expenses. Prior to this change, when this Plan was the secondary payer, this Plan would calculate what it would have paid if primary and subtract the primary plan's payment to determine this Plan's payment. For example, if this Plan would have paid 80%, and the primary plan paid 80%, no additional payment would have been made by this Plan.

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, 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

In certain situations, this Plan is primary to Medicare. This means that when the Participant is enrolled in Medicare and this Plan at the same time, this Plan pays benefits for Covered Expenses first and Medicare pays second. Those situations are:

- When the Employee or spouse is age 65 or over and by law Medicare is secondary to the employer group health plan;
- When the Participant incurs Covered Expenses for a kidney transplant or kidney dialysis and when by law Medicare is secondary to the employer group health plan; and
- When the Participant is entitled to benefits under Section 226(b) of the Social Security Act (Medicare disability) and by law Medicare is secondary to the Participant's employer group health plan.

In all other instances, the Plan will not pay benefits toward any part of a Covered Expense to the extent the Covered Expense is actually paid or would have been paid under Medicare Part A or B had the Participant properly applied for and maintained Medicare coverage.

Accordingly, it is important that Participants eligible for Medicare in Parts A and B evaluate whether Medicare Parts A and B should be chosen.

Importance of Enrollment in Medicare Part B: **Medicare Part A (Hospital Charges) is generally automatic on the attainment of age 65 while Medicare Part B (Physicians Charges) requires enrollment and monthly premium payments.** If Medicare Part B coverage is maintained, it may cover certain expenses not paid by the Plan. If you subsequently enroll in the Trust's Retiree Plan or continue your coverage through COBRA after you are Medicare-

eligible, Medicare can be primary instead of your Trust coverage. If Medicare is primary, the Trust will provide as if Medicare Parts A and B are in place even if the individual has failed to obtain these coverages. If you are Medicare eligible and participating in an active plan, you should contact Medicare to determine the rules that will apply when your active coverage ends.

Third-Party Reimbursement Requirements

The Plan excludes medical prescription drug for any illness or injury if the costs associated with the illness or injury may be recoverable from a third party, through a workers' compensation system or from any other source.

If a Participant has a potential right of recovery for Illnesses or Injuries for which a third party may have legal responsibility, the Plan may advance benefits pending the resolution of the claim upon the following conditions:

- By accepting or claiming benefits, the Participant agrees that the Plan is entitled to reimbursement of the full amount of benefits that the Plan has paid out of any settlement or recovery from any source including any judgment, settlement, disputed claim settlement, uninsured motorist payment or other recovery related to the illness or injury for which the Plan has provided benefits.
- This right applies without regard to the characterization of the recovery by the affected Participant and/or any third party or the recovery source.
- The Plan does not recognize any make whole doctrine or otherwise limit its right to reimbursement based on the amount of the Participant's recovery. The Plan's right to reimbursement, however, will not exceed the amount of recovery.
- The Plan can require a Participant and the Participant's legal representative to sign and deliver all legal papers and take any other actions necessary to secure the rights of the Plan (including an assignment of rights to pursue the Participant's claim if the Participant fails to pursue his or her claim). If the Plan asks a Participant or the Participant's legal representative to sign an Agreement to Reimburse the Plan from the proceeds of any recovery, this must be done before the Plan will advance any benefits.
- The affected Participant agrees that he or she will do nothing to prejudice the Plan's reimbursement rights and

will cooperate fully with the Plan, including signing any necessary documents and providing prompt notice of any settlement.

- The Participant acknowledges that the Plan is authorized to recover directly any benefits paid from any party liable to the Participant upon mailing of written notice to the potential payer and affected Participant or his or her representative.
- The maximum amount which will be advanced under an agreement to reimburse is $10,000 for medical benefits. The maximum will be waived and removed upon confirmation that all necessary documentation and information has been provided to the Plan and the Plan is fully assured that the Participant and the Participant's legal representative have complied and in the future will comply with the Plan's reimbursement provisions and the Agreement to Reimburse.
- When any recovery is obtained from a third party or insurance company whether by direct payment or settlement (including a disputed claims settlement) or award, judgment or in any other way, an amount sufficient to satisfy the Plan's reimbursement amount will be paid into a trust account and held there until the Plan's claim is resolved. The individual or entity that will hold the funds in trust is to be identified. The obligation to place the reimbursement amount in trust is independent of the obligation to reimburse the Plan and may be independently enforced. If the funds necessary to satisfy the Plan's reimbursement amount are not placed in trust, the injured person will be personally liable for any loss the Plan suffers as a result.

  If there are multiple parties or recoveries, the amount necessary to satisfy the reimbursement amount will be paid from each successive recovery until there is a sufficient amount in the trust to satisfy the Plan's claim at the time of settlement.

The Plan will be automatically paid from the amount held in trust without regard to whether the injured person is made whole except the following reductions will be made if the injured person complies with the terms of the Plan and the Agreement to Reimburse: (a) the Plan will deduct a proportionate share of the injured person's attorney's fees and costs from the reimbursement amount; and (b) if application of the general rule results in the Plan receiving a greater reimbursement than the injured person, the Plan will reduce its claim so that it does not exceed 50% of the amount payable to or on behalf of the injured party.

- Venue for any enforcement action will be in the county and state the Plan is administered. The Plan may bring an action in an appropriate court to enforce the Agreement to Reimburse, enforce the requirement that funds be placed in trust or to seek other appropriate relief. The Plan may also in its discretion offset future benefits pursuant to the Plan's Repayment of Improperly Paid Benefits provision to recover advanced benefits.
- The Plan may cease advancing benefits if there is a reasonable basis to determine the Plan provisions or any Agreement to Reimburse in any particular case is not enforceable, there is a reasonable basis for believing that the parties to the Agreement to Reimburse will not honor the terms of the Plan or the Board of Trustees modifies the Plan provisions related to the advancement of benefits.

Agreements to Reimburse forms and additional information are available from the Trust Office at the numbers listed at the front of the Booklet.

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. Employees are eligible for life and AD&D benefits after 48 months of eligibility. Dependents are eligible for life insurance benefits at the same time as the Employee or when enrolled, if later.

Life insurance is provided by the plan through an insurance contract with United of Omaha. An insurance certificate is available; contact the Trust 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 Trust Office. Forms are available on the Trust's website (https://edge.zenith-american.com), from the Trust 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 dependent who is eligible under the Trust 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 aged 26 or over. Children covered after age 25 because they are incapable of self-support are not eligible for life insurance.

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 Trust Office for an application for conversion.

ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE

This benefit is payable to eligible Employees 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 Trust 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)

The Trust provides different benefits for Medicare and Non-Medicare retirees.

The Trustees have the full discretion to make changes to the Retiree Plan, including but not limited to, the right to change the eligibility rules, reduce or eliminate benefits, increase the amount of self-payment required to participate or eliminate the Retiree Plan in total. The benefits of this Retiree Plan are provided to eligible Retirees and eligible Dependents on a month-to-month basis to the extent that contributions from participating employers and Retiree self-payments are sufficient to pay for the Retiree Plan. There is no advance funding or reserve program. Retiree Plan benefits are not vested.

Medicare Retirees

Medicare retirees receive a subsidy towards the cost of the Medicare Plan from a Medicare Retiree HRA maintained by the Trust. Annually, a dollar amount is placed in the Medicare Retiree HRA which the eligible Medicare Retiree and spouse can use to pay towards the cost of a Medicare supplement choice by the Retiree. The Trust has engaged Via Benefits to help Medicare Retirees in choosing a Medicare Supplement Plan. The Medicare HRA Program is described in a separate booklet available from the Trust Office.

Non-Medicare Retirees

Non-Medicare Retirees and Dependents receive benefits through the same medical, prescription, dental and vision programs as the Active employees. The principal difference is the deductible under the medical plan and the prescription drug copayments under the prescription drug plan.

Medical Benefit for Retirees

The annual deductible for Non-Medicare retirees and spouses is $500 per individual and $1,000 per family. Otherwise the medical benefits are the same as for active employees.

Prescription Drug Benefit for Retirees

The prescription Drug Benefit is structured the same as for the Active Employees. Benefits are provided through Avia Partners. Avia maintains a coalition retail network in Alaska that will submit claims directly for your. There are Avia pharmacies that are outside the custom network in and outside of Alaska where you will be required to pay for 12 prescriptions up front and submit the bill for reimbursement. Finally, there are excluded pharmacies (K-Mart, Walmart, and Walgreens). The Trust will not cover prescriptions from these pharmacies.

If you have questions about locating a custom pharmacy network or Avia Partners pharmacy, contact Avia Partners at 800-273-9166 or online at www.aviapartners.com.

If You Use a…	You Pay the Greater of…
Preferred Generic Drug	$10 or 10% of the retail price (up to $30 maximum per prescription)
Preferred Brand Name Drug • **If no generic alternative exists** • **If a generic alternative exists**	 $20 or 20% of the retail price (up to $75 maximum per prescription) $25 or 30% of the retail price
Non-Preferred Generic or Brand Name Drug	Greater of $40 copay or 35% coinsurance
Specialty	Greater of $20 copay or 20% coinsurance up to a $75 maximum

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 $30 maximum per prescription)
Preferred Brand Name Drug • **If no generic alternative exists** • **If a generic alternative exists**	 $30 or 20% of the retail price (up to $150 maximum per prescription) $50 or 30% of the retail price
Non-Preferred Brand Name Drug	The greater of $50 copay or 30%
Specialty	$50 copay or 20% coinsurance up to a $150 maximum

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. As of January 1, 2023, the prescription drug annual out-of-pocket maximum is $4,600 per individual and $9,200 per family.

Dental and Vision for Retirees

Non-Medicare Retirees and spouses receive the same dental and vision benefits as Active Employees.

Life and Accidental Death and Dismemberment Coverage for Retirees

Non-Medicare and Medicare retirees do not receive life or accidental death or dismemberment coverage.

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

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 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 Trust and approval for marketing has not been given for regular nonexperimental or non-investigational 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 non-investigational therapy; and
- There is no therapy that is clearly superior to the trial treatment.

The Trust Office will investigate each claim for benefits which might include Experimental or Investigational treatment. The Trust Office will consult with medical professionals to determine whether the treatment is excluded as Experimental or Investigational. The Trust 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 Trust 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 Trust 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 written 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 Trust 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 Trust 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 Trust 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.

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.

Medical and Dental Benefits

Obtain a claim form from the Trust's website (https://edge.zenith-american.com), your local union office, or the Trust 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
  c/o Zenith American Solutions
  12205 S.W. Tualatin Road, Suite 200
  Tualatin, OR 97062

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 will not need to file a claim.

When you use a non-custom network pharmacy in Alaska, (except Kmart, Wal-Mart, or Walgreens), or a non-Avia Partners pharmacy

anywhere (except Kmart, Wal-Mart, or Walgreens), you will 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 https://edge.zenith-american.com), from Avia Partners, or the Trust 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 will not need to file a claim.

When you use a non-VSP provider, you will 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 https://edge.zenith-american.com, your local union office, or the Trust 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 Trust 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 Trust Office

Statement of Purpose

The Benefit and Claim Appeal Procedures summarize the requirements for filing a claim for benefits with the Plan, the time frames for making an initial determination on properly submitted claims, the contents of a denial of benefits, the procedures for filing an appeal, the Plan's appeal procedures, and the claimant's rights if an appeal is denied. These Procedures are intended to help ensure the consistent processing of claims and claim appeals. The Board of Trustees will interpret and administer these Procedures in accordance with the requirements of applicable law.

Filing a Claim

General Requirements

To constitute a claim, the claimant must comply with the procedures set forth.

To be considered a claim, the claimant must request that the Plan provide benefits for a specific service or supply or take a specific action. If the adverse action which is the subject of the appeal does not involve the denial of a specific claim, the individual may move directly to file an appeal concerning the adverse action. Claims must be submitted within one year of the date expenses for the services or supplies for which benefits are sought were first incurred. If the Participant is appealing an adverse action not involving a claim, the appeal must be filed within 180 days of the adverse action.

Subject to the special provisions dealing with urgent claims, claims must be submitted in writing by a claimant to the proper address and indicate that it is an appeal.

The Plan may require additional information to process any claims or to meet Plan requirements. This may include inquiries related to eligibility, the nature of services or supplies provided, Coordination of Benefits, other insurance, Third-Party Reimbursement

Requirements, or other Plan provisions. Failure to provide this required information may result in the denial of a claimant's claim for benefits.

Requirements for Specific Claims

The following requirements exist for filing specific types of claims:

(1) Self-Funded Medical Plans: The claim filing requirements for the Trust's self-funded medical plans are as follows:

In most situations, providers will submit bills to Aetna. If the provider does not bill directly, claimants should request an itemized statement of the services and charges including a diagnosis. The claimant should copy the identification number from the Plan identification card and submit it to:

Zenith American Solutions, Inc.
12205 S.W. Tualatin Road, Suite 200
Tualatin, OR 97062
Phone: 833-942-2315

(2) Prescription Drug Claims: No claim form is normally required if a Participating Pharm is used. If a situation exists when a claim needs to be submitted, such as you use a non-Avia Partner pharmacy, send the required claim forms to:

Avia Partners, Inc.
250 E Parkcenter Blvd
Boise, ID 83706
Phone: 800-273-9166

(3) Dental Claims: Claims for dental services should be filed with:

Zenith American Solutions, Inc.
12205 S.W. Tualatin Road, Suite 200
Tualatin, OR 97062
Phone: 833-942-2315

(4) Vision Claims: If you use a Vision Service Plan provider, it should not be necessary to file a claim. If you use a non-VSP Provider, submit your claims to:

Vision Service Plan
P.O. Box 997105
Sacramento, CA 95899-7193

(5) Life Insurance Benefits: The procedures for filing a claim begin on page 103 of this Booklet and appeal procedures are listed on page 110.

(6) Eligibility and Other Matters: Claims involving eligibility, self-payments or any other Trust action that the individual asserts have adversely impacted him or her should be submitted in writing to the Trust Office and identify the action the individual is appealing. The Trust Office's address is:

Zenith American Solutions, Inc.
12205 S.W. Tualatin Road, Suite 200
Tualatin, OR 97062
Phone: 833-942-2315

Procedures for Processing Claims

Claims for self-funded benefits (medical and time loss benefits) which are properly filed will be processed in accordance with the guidelines set forth below.

Post-Service Health, Prescription Drug, and Dental Claims

Any properly filed claim for medical, prescription drug, or dental benefits that does not involve urgent care or a pre-service claim will be processed as a post-service health claim.

If additional information is needed, the claimant will be notified and given 45 days to provide the additional required information. The

time period for making a benefit determination will be tolled from the date the request for additional information is sent until the earlier of the date the requested information is received or 45 days have passed.

A claim will be processed within 30 days of receipt. This may be extended by an additional 15 days if a notice is provided within the initial 30-day period.

Pre-Service Health Claims

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

Currently, these are inpatient or residential admissions to Hospitals, Skilled Nursing Facilities, and chemical dependency and mental health treatment centers.

Claimants will be notified within five days if additional information is required to complete a pre-service claim or to allow processing. Claimants will be provided 45 days to submit any additional information.

The time period for making a determination will be tolled from the date the information is requested until the earlier of the date information is received or 45 days have passed.

A decision on a pre-service claim will be made within 15 days. If additional time is necessary, the Claims Administrative Office may extend this 15-day period by an additional 15 days by providing notice to the claimant prior to the expiration of the initial 15-day period.

If services which require preauthorization have been provided and the issue is what payment, if any, will be made, the Plan will process the claim as a post-service health claim.

Urgent Care Health Claims

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

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

The Claims Administrative Office will develop procedures for identifying urgent care claims which may include seeking additional information from the claimant or his or her providers about why the treatment involves urgent care. Decisions on urgent care claims will normally be made within 72 hours of receipt of the claim or earlier if required by law.

If services which constitute urgent care have been provided and the issue is what payment, if any, will be made, the Plan will process the claim as a post-service claim.

Notice of Administrative Denial

After a claim is denied, the following information will be available:

(1) The reason for the denial.

(2) A reference to the Plan provision relied on.

(3) A description of any additional material needed to perfect the claim.

(4) An indication if any internal guidelines or protocols have been relied on in denying the claim and statement that any such internal guidelines are available on request.

(5) If a denial is based on Medical Necessity, the service or supply being Experimental or Investigational in nature or

an equivalent exclusion, a statement that an explanation of the medical judgment will be provided upon request.

(6) An explanation of the Plan's appeal procedures.

A notice of denial will be mailed to the Participant at his or her last known address.

Appeal of Benefit Denial

Claimants under the Trust's self-funded plan will have 180 days from the date of denial to appeal an adverse benefit determination. An appeal will be submitted by the claimant or an authorized representative in writing. It will be submitted to the Trust Administrative Office. An appeal will identify the benefit determination involved, set forth the reasons for the appeal and provide any information the claimant believes is pertinent.

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

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

Procedure on Appeal

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). 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 Trust Office no later than one hundred and eighty (180) days after the employee or beneficiary receives written notice of the denial. Failure to appeal in this time will result in a permanent

denial of your claim that is not subject to review. 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 Trust 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. If a committee is appointed by the Trust Officers, 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. Except for urgent care claims, an appeal will be heard by the Trustees at the next regularly scheduled meeting. If an appeal is received less than 30 days before the next meeting, the appeal may be postponed to the second Board meeting following receipt of the appeal.

In cases where the review by the Board of Trustees cannot be reasonably completed in the above time frames, the Trust Officers 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.

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 medical, dental or vision benefits denied for other reasons, or 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 Office at the following address:

  Attention Appeals
  Zenith American Solutions, Inc.
  12205 S.W. Tualatin Road, Suite 200
  Tualatin, OR 97062

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 time frame 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

A Claimant must exhaust the Trust's claims appeal procedure prior to pursuing any legal action. 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 the adverse decision, the issuance of the Trustees' decision on an appeal or the decision of an Independent Review Organization. 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.

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 Trust Office. Participants and beneficiaries may also obtain a complete list of the employers and member organizations sponsoring the plan by writing to the Trust 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 Trust 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 Zenith American Solutions, 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 Trust 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 Trust Office:

Alaska United Food and Commercial Workers
Health and Welfare Trust
c/o Zenith American Solutions

Mailing Address
12205 S.W. Tualatin Road, Suite 200
Tualatin, OR 97062

Physical Address
12205 S.W. Tualatin Road, Suite 200
Tualatin, OR 97062

You may also call the Trust Office at:

833-942-2315

The only party authorized by the Board of Trustees to answer questions concerning the trust fund and plan is the Trust 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 Trust Office. Service of process may also be made upon any member of the Board of Trustees at the following addresses:

Employer Trustees

Brent Bohn
Safeway/Albertson
1421 S. Manhattan Ave.
Fullerton, CA 92831

Scott Powers
Allied Employers
811 Kirkland Ave., Suite 100
Kirkland, WA 98033

Union Trustees

Dan Clay
UFCW 555
7095 S.W. Sandburg Road
Tigard, OR 97223

Frank Mutchie
UFCW Local 1496
501 W Northern Lights Blvd.
Suite 200
Anchorage, AK 99503-2577

Silvana Tirban
UFCW Union Local 1496
Suite 201
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 Trust 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 Trust 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 pages 12 and 16-19. 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, dental, and vision 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 Trust 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 the following:

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 the county and state where the Plan is administered for any dispute arising under this plan.

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 January 1, 2024.

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, which 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:

https://edge.zenith-american.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
Pati-Piro-Bosley
c/o Zenith American Solutions
12205 S.W. Tualatin Road, Suite 200
Tualatin, OR 97062

Phone No.: 1-833-942-2315
Fax No.: 1-503-575-9265

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

or calling
877-696-6775

or by 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
Pati Piro-Bosley
c/o Zenith American Solutions
12205 S.W. Tualatin Road, Suite 200
Tualatin, OR 97062

Phone No.: 1-833-942-2315
Fax No.: 1-503-575-9265

CONTACT INFORMATION

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

Trust and Medical Claims Payment Provided By:
Zenith American Solutions

Trust Office Mailing Address
Zenith American Solutions
12205 S.W. Tualatin Road, Suite 200
Tualatin, OR 97062

Claims Submission Address
12205 S.W. Tualatin Road, Suite 200
Tualatin, OR 97062
Physical Address
12205 S.W. Tualatin Road, Suite 200
Tualatin, OR 97062

or call
1-833-942-2315

Trust Website
https://edge.zenith-american.com